OREGON BULLETIN

Supplements the 2006 *Oregon Administrative Rules Compilation*

Volume 45, No. 7
July 1, 2006

For May 16, 2006–June 15, 2006

Published by
BILL BRADBURY
Secretary of State
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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, Opinions of the Attorney General, and orders issued by the Director of the Dpartment of Revenue.

Background on Oregon Administrative Rules

ORS 183.310(9) defines "rule" as "any agency directive, standard, regulation or statement of general applicability that implements, interprets or prescribes law or policy, or describes the procedure or practice requirements of any agency." Agencies may adopt, amend, repeal or renumber rules, permanently or temporarily (up to 180 days), using the procedures outlined in the *Oregon Attorney General's Administrative Law Manual*. The Administrative Rules Unit, 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 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" 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 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

2005–2006 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 97301. To expedite the rulemaking process agencies are encouraged file a Notice of Proposed Rulemaking Hearing specifying hearing date, time and location, and submit their filings early in the submission period to meet the following publication deadlines.

Submission Deadline	Publishing Date
December 15, 2005	January 1, 2006
January 13, 2006	February 1, 2006
February 15, 2006	March 1, 2006
March 15, 2006	April 1, 2006
April 14, 2006	May 1, 2006
May 15, 2006	June 1, 2006
June 15, 2006	July 1, 2006
July 14, 2006	August 1, 2006
August 15, 2006	September 1, 2006
September 15, 2006	October 1, 2006
October 13, 2006	November 1, 2006
November 15, 2006	December 1, 2006

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 97301, 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, 97301; (503) 373-0701. The Archives Division charges for such copies.

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EXECUTIVE ORDER NO. 06 - 08

AUTHORIZATION FOR ACCESS 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 access for additional state and local agencies for various purposes.

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 Housing Authority of Douglas County with access to the Oregon State Police criminal offender information system for purposes consistent with Public Law 104-120, including screening public housing applicants and enforcing leases.

2. Pursuant to ORS 181.010(6) and OAR 257-010-0025(1)(b), I hereby authorize the Oregon State Police to provide the Department of Consumer & Business Services with access to the Oregon State Police criminal offender information system solely for the purpose of conducting background investigations on prospective employees or service providers for positions involved with cash receipting and depositing, payroll preparation functions, mail services, access to personal information about employees or members of the public, or access to tax or financial information about individuals or business entities.

3. Executive Order No. 90-05 continues to govern the compilation, maintenance, and dissemination of criminal offender information as defined in ORS 181.010(3), and that Order governs the access to the Oregon State Police criminal offender information system authorized by this Order.

Done at Salem, Oregon, this 30th day of May, 2006.

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

ATTEST

/s/ Bill Bradbury
Bill Bradbury
SECRETARY OF STATE

EXECUTIVE ORDER NO. 06-09

STATE EMPLOYMENT OPPORTUNITIES FOR OCEAN FISHING INDUSTRY WORKERS

In April, 2006, I issued Executive Orders No. 06-06 and 06-07, declaring that a State of Emergency exists in Tillamook, Lincoln, Coos, Curry and Clatsop Counties and the coastal portions of Douglas and Lane Counties due to the virtual elimination of a viable commercial salmon fishing season and severe restrictions on the sport salmon fishing season along the Oregon coast south of Cape Falcon.

I directed all state agencies to work in a cooperative and coordinated manner in order to mitigate the impacts of this emergency, provide expedited service and resources to persons and businesses adversely affected by the emergency, and focus state efforts in a manner most likely to relieve the unemployment, human suffering, financial loss and other economic impacts of this emergency. Additionally, I encouraged all state agencies to think broadly and creatively about actions that agencies can take to address this emergency.

The Oregon Employment Department can assist in helping reduce the adverse financial effects of this current emergency by targeting available state job opportunities to displaced employees of the commercial and recreational fishing industries. State agencies can assist the Employment Department by identifying available jobs, locations, pay and the necessary skill sets for vacant positions. The State Department of Parks and Recreation and the Oregon Watershed Enhancement Board are examples of state agencies that are expected to engage in hiring that may provide opportunities to persons impacted by this emergency.

State agencies can also develop criteria and guidelines for determining applicant eligibility for available job openings consistent with collective bargaining agreements, statutes and administrative rules.

NOW THEREFORE, IT IS HEREBY ORDERED AND DIRECTED:

Consistent with the collective bargaining agreements, statutes and administrative rules, all state agencies shall seek to hire qualified individuals covered by Executive Orders 06-06 and 06-07 when filling vacancies or making temporary appointments, for one year from the date of this Executive Order.

Done at Salem, Oregon this 1st day of June, 2006.

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

ATTEST

/s/ Bill Bradbury
Bill Bradbury
SECRETARY OF STATE

A CHANCE TO COMMENT ON PROPOSED CONSENT JUDGMENT FOR A PROSPECTIVE PURCHASER AGREEMENT FOR PROPERTY LOCATED AT 2644 AND 2740 SE POWELL BLVD., 3601 SE 27TH AVE., AND 3605 SE 28TH AVE., PORTLAND, OREGON

COMMENTS DUE: July 31, 2006
PROJECT LOCATION: 2644 and 2740 SE Powell Boulevard., 3601 SE 27th Avenue, and 3605 SE 28th Avenue, Portland, Oregon (the Property).
PROPOSAL: The Department of Environmental Quality (DEQ) is proposing to enter into a Consent Judgment for a Prospective Purchaser Agreement (PPA) with Catholic Charities of Oregon for the Property.
HIGHLIGHTS: The Property is currently owned by St. Vincent DePaul. Investigations conducted by the City of Portland Brownfields Program and the purchaser revealed that historic fill materials at the Property contain various metals and that methane is being released at areas of the site. Purchaser intend to redevelop the Property for affordable housing

The Consent Judgment will require Purchasers to implement a Construction Management Plan and, if necessary, abide by the requirements of an Easement and Equitable Servitude in favor of the DEQ and to observe the requirements of a Cap Management, Inspection and Maintenance Plan and a Soil Management Plan.

DEQ's Prospective Purchaser Program was created in 1995 through amendments to the state's Environmental Cleanup Law. The Prospective Purchaser Agreement is a tool that facilitates the cleanup of contaminated property and encourages property transactions that would otherwise not likely occur because of the liabilities associated with purchasing a property with existing contamination. DEQ has approved 82 Prospective Purchaser Agreements throughout the State since the program began.

The proposed Consent Judgment will provide Purchaser, as the new owner, with a release from liability for claims by the State of Oregon under ORS 465.255 relating to historical releases of hazardous substances at or from the site. The proposed Consent Judgment will also provide Purchaser with protection from potential contribution actions by third parties relating to the releases at or from the Property. DEQ retains all existing rights it may have as to all other parties potentially liable for the releases.
HOW TO COMMENT: Written comments concerning the proposed Consent Judgment should be sent to Charlie Landman at DEQ Headquarters, 811 SW 6th Avenue, Portland, Oregon 97204. Comments must be received by DEQ by 5:00 pm July 31, 2006. Questions may be directed to Mr. Landman at that address or by calling (503) 229-6461. The proposed Consent Judgment and DEQ file on the Property may be reviewed at DEQ's Northwest Region office in Portland by contacting Bob Williams at (503) 229-6802.

Upon written request by ten or more persons, or by a group having ten or more members, a public meeting will be held to receive verbal comments on the proposed Consent Judgment.
THE NEXT STEP: DEQ will consider all public comments. A final decision concerning the proposed Consent Judgment will be made after consideration of public comments.

A CHANCE TO COMMENT ON PROPOSED CONSENT JUDGMENT FOR A PROSPECTIVE PURCHASER AGREEMENT AT THE FORMER PREMIER EDIBLE OILS FACILITY IN PORTLAND, OREGON

COMMENTS DUE: July 31, 2006
PROJECT LOCATION: 10400 North Burgard Way, Portland, Oregon.
PROPOSAL: The Department of Environmental Quality (DEQ) is proposing to enter into a Consent Judgment for a Prospective Purchaser Agreement (PPA) with International Bio Fuels Corp. (IBC) for the property located at 10400 North Burgard Way, Portland, Oregon (Former Premier Edible Oils Property or Property).
HIGHLIGHTS: According to information provided to DEQ, Schnitzer Investment Corporation (SIC) has owned the Property since 1972. During World War II the Property was used primarily to store materials in logistical support for the Liberty ship building efforts by the Oregon Shipyards. The Property was generally vacant from 1945 through 1972. From approximately 1973 through the late 1990s the Property was primarily used to process crude grade vegetable oil into food grade vegetable oils. Historic operations at or adjacent to the Property have resulted in the release of hazardous substances, including petroleum products, to the environment. .

The current owner (SIC) is working with DEQ to investigate and ascertain the extent of the residual contamination at the Property. The Consent Judgment will allow IBC to develop the Property for the processing and storage of biofuels to meet the growing demand for clean, alternative energy in Oregon and the region.

DEQ's Prospective Purchaser Program was created in 1995 through amendments to the state's Environmental Cleanup Law. The Prospective Purchaser Agreement is a tool that facilitates the cleanup of contaminated property and encourages property transactions that would otherwise not likely occur because of the liabilities associated with purchasing a property with existing contamination. DEQ has approved 82 Prospective Purchaser Agreements throughout the State since the program began.

The proposed Consent Judgment will provide IBC as the new owner with a release from liability for claims by the State of Oregon under ORS 465.255 relating to historical releases of hazardous substances at or from the Property. The proposed Consent Judgment will also provide IBC with protection from potential contribution actions by third parties relating to the releases at or from the Property. DEQ retains all existing rights it may have as to all other parties potentially liable for the releases.
HOW TO COMMENT: Written comments concerning the proposed Consent Judgment should be sent to Charlie Landman at DEQ Headquarters, 811 SW 6th Avenue, Portland, Oregon 97204. Comments must be received by DEQ by 5:00 pm July 31, 2006. Questions may be directed to Mr. Landman at that address or by calling (503) 229-6461. The proposed Consent Judgment and DEQ file on the Property may be reviewed at DEQ's Northwest Region office in Portland by contacting Mike Romero at (503) 229-5563.

Upon written request by ten or more persons, or by a group having ten or more members, a public meeting will be held to receive verbal comments on the proposed Consent Judgment.
THE NEXT STEP: DEQ will consider all public comments. A final decision concerning the proposed Consent Judgment will be made after consideration of public comments.

DEQ SEEKING PUBLIC COMMENT ON PROPOSED STATE CONSENT JUDGMENT REGARDING PORTLAND HARBOR SUPERFUND SITE

Notice issued: July 1, 2006
Written comments due: August 1, 2006, 5:00 p.m.
Verbal comments at public information meeting: Tuesday, July 18, 2006; 6:00 p.m.
Public meeting location: City of Portland Bureau of Environmental Services Water Pollution Control Lab, Smith Room, 6543 N. Burlington Ave., Portland, OR 97203
Where can I review the document? The proposed state consent judgment regarding the Portland Harbor Superfund Site is available on DEQ's web site at http://www.deq. state.or.us/nwr/Portland Harbor/ph.htm; scroll down to "Recent Announcements." You may also review the document at DEQ's Northwest Region Office, located at 2020 SW 4th Ave., fourth floor, Portland, Oregon.

Where can I send comments and get more information? Comments may be submitted to Jim Anderson, Portland Harbor Project Manager, at anderson.jim@deq.state.or.us or at DEQ, 2020 SW 4th Ave., Suite 400, Portland, OR 97201. For more information, please contact Jim Anderson at 503-229-6825, or Mikell O'Mealy, Portland Harbor Project Outreach Coordinator, at omealy.mikell@deq.state.or.us or 503-229-6590.

Where is the site located? The Portland Harbor Superfund site is federally listed as being located on the lower Willamette River in Portland between River Miles 3.5 and 9.2, while studies are currently being conducted between River Miles 2 and 11. The final boundaries of the site will be established by the U.S. Environmental Protection Agency ("EPA") when it selects a final cleanup remedy for the site.

What will happen at the public information meeting? DEQ will provide information, answer questions, and receive comments about the proposed consent judgment.

Background: Investigations of sediments and water quality in the lower Willamette River within the Portland Harbor area have revealed a broad range of hazardous substance contamination. In response to this contamination, DEQ undertook a number of measures for the protection of public health and the environment, including but not limited to site discovery and assessment to locate sources of the contamination, development of a Portland Harbor Sediment Management Plan and Sediment Investigation Work Plan to guide investigation of sediment contamination, consultation and negotiation with potentially responsible parties ("PRPs") regarding the design and implementation of the plans, coordination with federal agencies and tribes having interests in the Willamette River, and the entry of cooperative agreements and public outreach necessary to these efforts. DEQ undertook these measures pursuant to its authorities under the state environmental cleanup law, ORS 465.200 et seq.

On December 1, 2000, EPA placed the Portland Harbor area on the National Priority List pursuant to the federal Superfund law. DEQ and EPA have agreed to share responsibility for investigation and cleanup of the Portland Harbor Superfund Site. DEQ is responsible for overseeing the investigation and control of upland contaminant sources to the harbor. EPA is responsible for overseeing the investigation and cleanup of in-water contamination. Each agency also acts as a support agency to the other agency's efforts. EPA is currently administering the performance of an in-water remedial investigation and feasibility study ("RI/FS"), under an Administrative Order on Consent issued by EPA on September 28, 2001. Ten PRPs are signatories to the consent order with EPA. Those consent order parties, along with four other PRPs, have formed what is called the Lower Willamette Group ("LWG") for the purpose of jointly performing or financing the in-water RI/FS. EPA has requested that other PRPs become cooperating parties by signing the consent order, and is encouraging the PRPs to participate in the LWG. The LWG has requested that DEQ provide a similar opportunity to LWG members and other PRPs to enter a state settlement recognizing the in-water RI/FS work performed under the EPA consent order. DEQ is proposing to enter such a settlement.

What is proposed? The settlement proposed by DEQ is in the form of a consent judgment that would be entered in state circuit court pursuant to ORS 465.325. The consent judgment would require PRPs to pay an amount in satisfaction of outstanding DEQ remedial action costs, reimburse DEQ's support agency costs under the RI/FS consent order administered by EPA, and perform or help finance the in-water RI/FS under the EPA consent order. In return, DEQ would provide a covenant-not-to-sue, right of contribution, and contribution protection regarding the same matters. The covenant-not-to-sue would apply to claims under state laws found at ORS Chapters 465, 466, and 468B, and under the federal Superfund law.

The consent judgment would not apply to the following: ongoing environmental investigations and source control work at specific upland facilities pursuant to DEQ agreement and orders; EPA's selection and implementation of a final cleanup remedy for the in-water contamination; other possible PRP liabilities at Portland Harbor such as natural resource damages.

DEQ proposes to enter this consent judgment with the following parties: Arkema Inc.; Bayer CropScience, Inc.; BNSF Railway Company; Chevron U.S.A. Inc., a Pennsylvania corporation; City of Portland; ConocoPhillips Company; Gunderson LLC; Kinder Morgan; NW Natural; Oregon Steel Mills, Inc.; Port of Portland; Siltronic Corporation; Time Oil Co.; and Union Pacific Railroad Company.

What happens next? DEQ will review and consider all comments received during the comment period. If DEQ then determines to enter the consent judgment, the settlement will be executed by the parties and filed with the Multnomah County Circuit Court. The court must approve the consent judgment for it to take effect.

What are DEQ's responsibilities? DEQ is the state regulatory agency responsible for protecting and enhancing Oregon's water and air quality, for cleaning up hazardous substances contamination in the environment, and for managing the proper disposal of hazardous and solid wastes.

Accessibility Information: If you need special physical, language or other accommodations to review the proposed Consent Judgment, provide comments or attend the public information meeting, please contact Mikell O'Mealy at 503-229-6590 or omealy.mikell@deq.state.or.us.

PUBLIC COMMENT PERIOD
NOTICE OF REMEDIAL ACTION
FORMER GLENBROOK NICKEL FACILITY,
63776 MULLEN STREET, COOS BAY, OREGON

COMMENTS DUE: July 31, 2006

PROJECT LOCATION: Former Glenbrook Nickel Facility, 63776 Mullen Street, Coos Bay Oregon

PROPOSAL: As required by ORS 465.320, the Department of Environmental Quality (DEQ) invites public comment on the proposed cleanup approach for contaminated soils at the former Glenbrook Nickel facility in Coos Bay, Oregon. The proposed final approach includes covering the soils in the former ore stockpile areas and institutional controls to maintain the cap.

HIGHLIGHTS: Glenbrook Nickel Company, an affiliate of Teck Cominco American Incorporated, used the site for off-loading, storage, and distribution of nickel ore. The ore was dried, crushed, and shipped from the site to the Glenbrook's Nickel smelting facility in Riddle, Oregon. Tests were performed on surface material across the previous ore yard. Concentrations of nickel in the surface soil were found to be acceptable for human health but elevated for ecological receptors, particularly birds.

DEQ proposes the following measures to address remaining nickel contamination at the site:

- Covering the former ore stockpile areas with 6-inches of soil, gravel, or sand. The full extent of the cover will be approximately 610,000 sq ft across the northern portion of the site. This cover will prevent ecological receptors from exposure to the soils containing high levels of nickel.
- Placing an institutional control measure, known as an Easement and Equitable Servitude, on the property deed notifying future property owners/operators of the presence of the cover and associated protocols for proper handling and disposal should the cover material be excavated for any reason.
- Periodic inspections of the cover to ensure that it is properly maintained.

HOW TO COMMENT: Written comments on the proposed remedial 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 July 31, 2006. Questions may be directed to Angie Obery by calling her at 1800-844-8467 x7464.

A public meeting to answer questions and receive verbal comments on the proposed remedial 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.

PROPOSED REMEDIAL ACTION
PRINEVILLE BP QUICK STOP (FORMER)
PRINEVILLE, OREGON

COMMENTS DUE: August 2, 2006

PROJECT LOCATION: 205 W. Third St., Prineville, Crook County, Oregon

PROPOSAL: The Department of Environmental Quality is proposing a remedial action for the former Prineville BP Quick Stop. This action would involve a deed restriction or a city ordinance prohibiting residential development and use of shallow groundwater for drinking. Once these measures are implemented, the Department would issue a No Further Action determination, contingent on compliance with these restrictions. Public notification is required by ORS 465.320.

HIGHLIGHTS: The former Prineville BP Quick Stop site occupies about 0.2 acres on the northwest corner of West Third and Beaver Streets in downtown Prineville. Since at least 1997, this was one of two primary sites from which gasoline was leaking from underground tanks and causing gasoline vapors to enter nearby shop buildings. The other site is the former Prineville Texaco station, where the new City Hall now stands.

The gasoline tanks were removed from the site in December 1997. Modifications were made to the nearby affected buildings in 1998 and 1999 to reduce the amount of subsurface vapors that could enter through the floor and walls. The affected buildings were on the northeast corner of the intersection of Third and Claypool Streets. A soil vapor extraction system was installed around these buildings in December 1998, to remove the gasoline contamination before it could enter these buildings. This system was operated until 2002.

In 1999, about 400 cubic yards of petroleum-contaminated soil was removed from the BP Quick Stop property and treated offsite. A soil vapor extraction system and an air sparge system were installed on the property at that time and operated until 2002. Extensive soil, groundwater, and air sampling was conducted between 1997 and 2006. Contaminant levels have been reduced to safe levels.

This conclusion is based on the assumptions that shallow groundwater will not be used for drinking, and the site will not be used for residential development. To ensure that these assumptions remain valid, DEQ will require either a deed restriction or city ordinance prohibiting these land and water uses. Once the deed restriction or ordinance is in place, DEQ intends to issue a No Further Action determination, contingent upon compliance with these restrictions.

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, August 2, 2006.

THE NEXT STEP: DEQ will consider all comments received. A final decision concerning the proposed remedial action and conditional No Further Action determination will be made after consideration of public comments.

PROPOSED REMEDIAL ACTION AT
THE FORMER BATTIN POWER SERVICE SITE

COMMENTS DUE: July 30, 2006

PROJECT LOCATION: 8320 SE Otty Road, Portland, Oregon

PROPOSAL: As required by ORS 465.320, the Department of Environmental Quality (DEQ) invites public comment on remedial action proposed for the Former Battin Power Service (Battin) site located in Portland, Oregon. A no further action determination was issued for soil in 1999. A remedy consisting of natural attenuation monitoring and restrictions on groundwater use are proposed to address groundwater contamination, with contingency measures for additional site treatment by enhanced bioremediation if off-site contaminant concentrations exceed screening criteria.

HIGHLIGHTS: The 2.91-acre site is located in an area of mixed residential and commercial development in southwest Portland. Prior to the 1950s the site was used only for agriculture. In the 1950s through early 1990s the site was used for a variety of commercial activities including metal scrap collection, logging truck storage and repair, and the repair and sale of power generation equipment. Electrical transformers were accepted at the site starting in the mid 1970s; transformer cores were sold to scrap dealers and transformer oil was used in trucks and other equipment. A number of commercial lessees also operated at the site. The site was cleared in 1995 for development of a Home Depot store off-site to the immediate east, with the Battin site consisting of asphalt-paved parking for the store. The Home Depot store was replaced by a Wal-Mart in 2004; the site remains asphalt-covered and used for parking. Activity at the site in the 1950s through the early 1990s resulted in the release of petroleum hydrocarbons, solvents, and polychlorinated biphenyls (PCBs) in soil. Solvents and minor petroleum hydrocarbons have also bee detected in groundwater. Soil investigation and cleanup was performed in the mid-1990s prior to redevelopment, and results in DEQ issuance of a no further action determination for soil in 1999. Groundwater investigation continued through 2005; solvents have been detected in shallow groundwater in the southern portion of the site, and extending off-site to the south-southwest. The groundwater plume is expected to be stable, with contaminant concentrations within the plume decreasing over time. No impacts have been observed in the only groundwater well identified within the site vicinity. A natural attenuation remedy consisting of groundwater monitoring and implementation of contingency measures (on-site treatment using enhanced bioremediation) is proposed for the site. The remedy is considered to be protective of human and ecological health.

HOW TO COMMENT: To review project records, contact Dawn Weinberger at (503) 229-5425. The DEQ project manager is Dan Hafley (503-229-5417). Written comments should be sent to the project manager at the Department of Environmental Quality, Northwest Region, 2020 SW 4th Avenue, Suite 400, Portland, OR 97201 by July 30, 2006. A public meeting will be held to receive verbal comments if requested by 10 or more people, or by a group with a membership of 10 or more.

THE NEXT STEP: DEQ will consider all comments received and make a final decision after consideration of these comments.

PROPOSED NO FURTHER ACTION DETERMINATION
BOWERS EXCAVATING SITE
KLAMATH FALLS, OREGON

COMMENTS DUE: August 3, 2006

PROJECT LOCATION: 3427 Washburn Way, Klamath Falls, Klamath County, Oregon

PROPOSAL: The Department of Environmental Quality is proposing to issue a No Further Action determination following investigation and cleanup of petroleum-contaminated soil at the former Bowers Excavating site. Public notification is required by ORS 465.320.

HIGHLIGHTS: Bowers Excavating operated an excavating and fencing company on the property from the early 1970s until the late 1990s. South Valley Bank & Trust received the property through

foreclosure in 2000, and sold it to the current owner, Campus Investments, in 2001. The primary source of contamination on the property was from accidental discharge of several hundred gallons of heating oil from equipment associated with a heating oil tank in the northwest corner of the property. DEQ first became aware of contamination at the site in fall 1998, when petroleum was discovered during site grading on the property immediately to the north.

Environmental investigations conducted between 2000 and 2006 indicated there were four contamination areas within the 3-acre property. About 15 tons of petroleum-contaminated soil was disposed of at the Klamath County Landfill. Contaminated soil from the heating oil releases was excavated in three phases in 2002 and 2003. In total, about 300 cubic yards of soil were removed from an excavation 40 feet long, 30 feet wide and 8 feet deep.

This soil was treated on site in five lined cells. Nutrients were applied in November 2001, June 2002 and May 2005 to stimulate biological activity. The material was a common lawn fertilizer consisting mainly of nitrogen, potassium and phosphorous. The material was tilled into the contaminated soil with a tractor-mounted tiller. Soil in the treatment cells was tested five times between September 2002 and February 2006.

The property and surrounding area are currently used for industrial and commercial purposes. The area is also supplied by city water, so it is unlikely that shallow groundwater beneath the site will be used for drinking. These land and water uses are likely not to change in the foreseeable future. Based on site sample results, DEQ has determined that residual contaminant levels do not exceed acceptable risk levels. We therefore propose 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, August 2, 2006.

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.

NO FURTHER ACTION REQUIRED AT FORMER HEWLETT-PACKARD PROPERTY IN MCMINNVILLE, OREGON

PROJECT LOCATION: Former Hewlett-Packard Company Site, currently part of Linfield College, 1700 South Baker Street, McMinnville, Oregon, Lots 100 and 7000

BACKGROUND: The Department of Environmental Quality (DEQ) has determined that no further action is required at the Former Hewlett-Packard Company site, currently part of Linfield College, in McMinnville, Oregon.

In 1997, the Hewlett-Packard Company conducted several environmental assessments at their former property located at 1700 South Baker Street in McMinnville, Oregon. Based on preliminary assessments, the focus of investigation for the Voluntary Cleanup Program site was narrowed down to an area in the vicinity of Building 1 and the Support building.

In 1998, ground water monitoring wells were installed between Building 1 and the Support building. The volatile organic levels seen in earlier temporary well point samples were greatly reduced in the monitoring wells. In 2001, a beneficial use survey was conducted to determine the use of the ground water in the site vicinity. The beneficial use survey concluded that the shallow aquifer is not used for drinking water.

The site was screened for human health risk from exposure to volatile organic-contaminated soil and ground water. Under current and reasonably likely future land and water uses at the site, DEQ has concluded that there are no significant human health risks associated with the volatile organic-contaminated soil and ground water at the Site. Therefore, DEQ has determined that no further investigation or remediation is needed for environmental impacts from the Former Hewlett-Packard Company Site in McMinnville.

A file containing detailed information for the site is available for review in DEQ's Eugene office located at 1102 Lincoln St., Suite 210, Eugene, Oregon 97401. Questions concerning this site should be directed to Mindi English at DEQ's Eugene office or by calling her at 541-686-7763 or toll-free in Oregon at 1-800-844-8467, extension 7763.

DEQ DETERMINES NO FURTHER ACTION REQUIRED FORMER ROSEBURG FOREST PRODUCTS GREEN MILL SITE, GREEN, OREGON

PROJECT LOCATION: Former Roseburg Forest Products Green Mill Site, 3442 Carnes Road, Roseburg

HIGHLIGHTS: The Department of Environmental Quality (DEQ) has determined that no further action is required at the Former Roseburg Forest Products Green Mill site in Green, Oregon.

This site is a former softwood plywood mill. During July 2005, approximately 111 tons of petroleum impacted soil was removed and disposed of offsite. During the site investigation, arsenic was detected above industrial standards near the former equipment pits. Additional sampling was conducted, and none of the samples were significantly above Oregon's background levels. There is no unacceptable human health residual risk for this site, as petroleum contaminated soils have been removed and disposed of and arsenic soil levels are near acceptable background levels for Oregon. Remaining concentrations of total petroleum hydrocarbon (TPH) - diesel and TPH-oil in soil are below residential risk- based concentrations for ingestion, dermal contact, and inhalation human exposure.

A file containing detailed information for the site is available for review in DEQ's Eugene office located at 1102 Lincoln St., Suite 210, Eugene, Oregon 97401. Questions concerning this site should be directed to Mindi English at DEQ's Eugene office or by calling her at 541-686-7763 or toll-free in Oregon at 1-800-844-8467, extension 7763.

DEQ NOTICE OF AGREEMENT

The Oregon Department of Environmental Quality (DEQ) has entered into a Prospective Purchaser Agreement (PPA) with Lake County for 0.72 acres (Parcel II) located at 87038 Christmas Valley Highway in Christmas Valley, Oregon.

Under the PPA, Lake County will include cleanup of contamination at this property into remedial actions being performed as part of the Christmas Valley Airport Enhancement brownfield cleanup project. In exchange for conducting these remedial measures, DEQ has agreed to limit the liability of Lake County under state law for the existing contamination.

DEQ's Prospective Purchaser Program was created in 1995 through amendments to the state's Environmental Cleanup Law. The Prospective Purchaser Agreement is a tool which facilitates the cleanup of contaminated property and encourages property transactions which would otherwise not likely occur because of the liabilities associated with existing contamination. DEQ has approved over 70 Prospective Purchaser Agreements throughout the State since the program began.

For additional information on DEQ's Prospective Purchaser Program, contact Charlie Landman, Oregon DEQ, at (503) 229-6461.

DEQ NOTICE OF AGREEMENT

The Oregon Department of Environmental Quality (DEQ) has entered into a Prospective Purchaser Agreement (PPA) with SSSS Mountain Properties for 3.75 acres located in the southwest corner of Ferndale Road and Highway 11 in Milton-Freewater, Oregon.

Under the PPA, SSSS Mountain Properties will install and monitor three groundwater monitoring wells to fully delineate groundwater contamination documented on- and off-site. In exchange for conducting these remedial measures, DEQ has agreed to limit the liability of SSSS Mountain Properties under state law for the existing contamination.

DEQ's Prospective Purchaser Program was created in 1995 through amendments to the state's Environmental Cleanup Law. The Prospective Purchaser Agreement is a tool which facilitates the cleanup of contaminated property and encourages property transactions which would otherwise not likely occur because of the liabilities associated with existing contamination. DEQ has approved over 70 Prospective Purchaser Agreements throughout the state since the program began.

For additional information on DEQ's Prospective Purchaser Program, contact Charlie Landman, Oregon DEQ, at (503) 229-6461.

INVITATION FOR PUBLIC COMMENT PROPOSED MODIFICATION TO THE GREEN PERMIT ISSUED TO ON SEMICONDUCTOR (FORMERLY LSI LOGIC)

Comments Due Date: 5:00 pm, July 30, 2006

Where Can I Get More Information and Send Comments? DEQ accepts comments by mail, fax and e-mail.

Name: David Kunz, ON Semiconductor Green Permit Team Leader

Phone: 503-229-5336 or toll free in Oregon (800) 452-4011

Mailing Address: DEQ Northwest Region Office, 2020 SW 4th Avenue, Suite 400, Portland, OR 97201-4987

Fax: 503-229-6945

E-mail: Kunz.David@deq.state.or.us (Email comments will be acknowledged immediately. If there is a delay between servers, e-mails may not be received before the deadline.)

Who is the Applicant? ON Semiconductor, formerly known as LSI Logic Corp.

Where is the Facility Located? 23400 NE Glisan Street, Gresham, Multnomah County, OR 97030- 8411

What does ON Semiconductor Do? ON Semiconductor's Gresham facility manufactures a broad line of integrated circuits.

What is Proposed? The Green Permit Program was created by the 1997 Oregon Legislature as a voluntary program to encourage regulated facilities to achieve environmental results that are significantly better than otherwise required by law. The DEQ developed the rules and procedures with the assistance of an advisory committee comprised of regulated businesses, environmental organizations, and public citizens. The rules were adopted by the Environmental Quality Commission at their August 13, 1999 meeting.

ON Semiconductor has applied for minor modifications to the Green Environmental Management System (GEMS) Permit - Tier II Achiever Level. DEQ has verified that On Semiconductor has met the program criteria.

What are the Special Conditions of this Permit? The permittee must: maintain and implement a robust environmental management system that is ISO 14001-registered or meets the intent of the ISO standards. In addition, the permittee must meet ongoing requirements to evaluate environmental impacts, set goals that will achieve superior environmental performance, establish performance measures, demonstrate continual environmental performance improvements, and implement an effective stakeholder involvement plan. The permittee must submit a GEMS update report annually that addresses those requirements.

DEQ may provide specific incentives to the permittee, subject to conditions documented in the permit and permit review report.

What are the Incentives Granted in this Permit? These incentives include:

- DEQ Single Point of Contact,
- technical assistance,
- compliance inspection considerations,
- maximum review time for permit applications and modifications,
- permit flexibility for process changes and construction,
- extended air permit duration
- hazardous waste accumulation options
- consolidated reporting,
- tailored enforcement response, and
- public recognition.

Specific information about these incentives can be found in the draft permit.

The proposed Green Permit does not waive, limit or reduce the permittee's obligations under any applicable local, state, or federal requirements, except as specified in the Green Permit. Where conditions of the proposed Green Permit replace provisions of the permittee's existing permits, the conditions become part of those permits until the Green Permit expires or is terminated.

Who is Affected? Property owners and residents in the vicinity of the facility.

Compliance History: DEQ has determined that ON Semiconductor complies with regulatory requirements and that its compliance history is consistent with GEMS Achiever Permit requirements for a positive environmental record.

Other Permits Required: The permittee currently has four permits or registrations related to federal, state and/or local environmental regulatory programs:

- Large Quantity Hazardous Waste Generator registration (ORQ000004382)
- Standard Air Contaminant Discharge Permit (26-0027)
- Stormwater No Exposure Certificate
- City of Gresham Industrial Wastewater Discharge (Number 332).

ON Semiconductor currently complies with requirements under Oregon's Employee Commute Options program.

How Can I Review Documents? You can review the permit application at the DEQ Northwest Region Office, 2020 SW 4th Avenue, Suite 400, Portland, OR 97201-4987. For an appointment, call (503) 229-5263. That document is also available on the DEQ web site at: www.deq.state.or.us/programs/greenpermits

Why is this Notice Being Sent? This notice is the final public notice provided for under the Green Permits program rules and is being sent to persons who have requested information about proposed DEQ permits in the county in which the facility is located and those individuals who asked to be notified during the initial public notice period. The purpose of the notice is to inform the public that a Green Permit has been drafted for ON Semiconductor, and DEQ is requesting that the public provide comments at this time.

What Happens Next? DEQ will review and consider all comments received during the comment period. Following this review, DEQ may issue the permit as proposed, modify the Green Permit, or deny the Green Permit.

Accessibility Information: DEQ is committed to accommodating people with disabilities at our hearings. Please notify DEQ of any special physical or language accommodations or if you need information in large print, Braille or another format. To make these arrangements, contact DEQ Public Affairs toll free in Oregon at (800) 452-4011.

People with hearing impairments may call DEQ's TTY number, (local office TTY).

NOTICES OF PROPOSED RULEMAKING

Correction

The following Rulemaking Hearing Notice was published in the June 1, 2006 *Oregon Bulletin* (print version) with incorrect Hearing and Last Date for Comment dates. The correct version is printed here.

Rule Caption: Reflecting visual services changes in the Oregon Health Plan Plus benefit package.

Date:	**Time:**	**Location:**
7-21-06	10:30 a.m.–12 p.m.	DHS Bldg. Rm. 137C Salem, OR

Hearing Officer: Darlene Nelson
Stat. Auth.: ORS 409.010, 409.110 & 409.050
Stats. Implemented: ORS 414.065
Proposed Amendments: 410-130-0240
Last Date for Comment: 7-21-06, 5 p.m.
Summary: The Medical-Surgical Services program rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP will amend 410-130-0240 to reference the Visual Services program administrative rules related to coverage and limitations on eye exams and eyewear.

These revisions are contingent upon Centers for Medicare and Medicaid services (CMS) approval. While OMAP expects these revisions to be effective on August 1, 2006, the effective date for implementation is not confirmed as it is based upon receipt of CMS approval. Following CMS approval, OMAP will implement the rule revisions and file the rules permanently. On or before the effective date, the permanent rule revisions will be available on OMAP's website at: http://www.dhs.state.or.us/policy/healthplan/guides/main.html
Rules Coordinator: Darlene Nelson
Address: Department of Human Services, Departmental Administration and Medical Assistance Programs, 500 Summer St. NE, E-35, Salem, OR 97301
Telephone: (503) 945-6927

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Notices of Proposed Rulemaking and Proposed Rulemaking Hearings

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

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

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

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

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

Board of Chiropractic Examiners
Chapter 811

Rule Caption: Implements national criminal background checks & fee.

Date:	**Time:**	**Location:**
7-20-06	10 a.m.	Phoenix Inn Suites 300 NW Franklin Ave. Bend, OR

Hearing Officer: Dave McTeague, Exec. Director
Stat. Auth.: ORS 684, 684.100, 183, (HB 2157), OL 2005 Ch. 730
Stats. Implemented: ORS 684.100, 183, (HB 2157), OL 2005 Ch. 730
Proposed Adoptions: 811-010-0084
Proposed Amendments: 811-010-0084(T)
Last Date for Comment: 7-20-06
Summary: OAR 811-010-0084 Fitness Determinations for Licensure. State and Nationwide Criminal Background checks. This is a proposed new rule that implements the HB 2157 requirements for state and national criminal background checks for all Doctor of Chiropractic applicants.
Rules Coordinator: Dave McTeague
Address: Board of Chiropractic Examiners, 3218 Pringle Rd. SE - Suite 150, Salem, OR 97302-6311
Telephone: (503) 378-5816

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Board of Examiners of Nursing Home Administrators
Chapter 853

Rule Caption: Update Relicensing Fee and Remove Written Exam and Interview Requirement for Certain Lapsed Licenses.
Stat. Auth.: ORS 678.820
Stats. Implemented: ORS 678.730 & 678.760
Proposed Amendments: 853-010-0055
Last Date for Comment: 8-18-06
Summary: The proposed amendment updates the relicensing fee amount and removes the personal interview and written examination requirements for licenses lapsed longer than one but less than five years. The revisions were previously approved by the Board in 2001 and filed incorrectly with the Secretary of State's office.
Rules Coordinator: Janet Bartel
Address: Board of Examiners of Nursing Home Administrators, 800 NE Oregon - Suite 407, Portland, OR 97232
Telephone: (971) 673-0196

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Board of Geologist Examiners
Chapter 809

Rule Caption: Definitions: wordsmithing numerous definitions and revising misconduct.
Stat. Auth.: ORS 183, 192 & 672
Stats. Implemented: ORS 183.341, 183.355, 183, 192 & 672
Proposed Amendments: 809-003-0000
Last Date for Comment: 7-31-06, 5 p.m.
Summary: None of the revisions to definitions are substantive. The Board refers to those individuals registered to practice geology as "registrants", not licensees, so numerous changes are made to input the word "registrant". ASBOG is the national body charged with developing the national examination. The acronym is ASBOG and a revision is made to the definition of this acronym. Word usage is revised from "mitigatory" to "mitigation". Much of the definition of misconduct is being removed, but no new language is being added. The word tsunami is being included in the definition of "threat to the public health, safety, etc."
Rules Coordinator: Susanna R. Knight
Address: 1193 Royvonne Avenue SE #24, Salem, Oregon 97302
Telephone: (503) 566-2837

Board of Optometry
Chapter 852

Rule Caption: Amend Rules regarding CPR requirements for Nontopical Pharmaceutical Agent Certification.
Stat. Auth.: ORS 683 & 182
Stats. Implemented: ORS 683.270 & 182.466
Proposed Amendments: 852-080-0040
Last Date for Comment: 7-31-06
Summary: 852-080-0040 - Remove reference to American Heart Association in requirements for renewal of CPR certification.
Rules Coordinator: David W. Plunkett
Address: Board of Optometry, P.O. Box 13967, Salem, OR 97309-1967
Telephone: (503) 399-0602, ext. 23

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Board of Parole and Post-Prison Supervision
Chapter 255

Rule Caption: Amendment of Rules Regarding Procedure for Designation of Predatory Sex Offenders.
Stat. Auth.: ORS 144.050, 144.140, 181.585 & 181.586
Other Auth.: V.L.Y. v. Board of Parole and Post-Prison Supervision, 338 Or 44 (2005)
Stats. Implemented:
Proposed Amendments: 255-060-0011
Last Date for Comment: 8-21-06
Summary: (Exhibit Q-III) The amendment of this rule is necessary in order to be consistent with the Oregon Supreme Court ruling in V.L.Y. v. Board of Parole and Post-Prison Supervision, 338 Or 44 (2005).
Rules Coordinator: Michael R. Washington
Address: Board of Parole & Post-Prison Supervision, 2575 Center St. NE - Suite 100, Salem, OR 97301
Telephone: (503) 945-9009

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Bureau of Labor and Industries
Chapter 839

Rule Caption: Clarifying eligibility of re-employed uniformed service personnel for leave under Oregon Family Leave Act.
Stat. Auth.: ORS 659A.805
Other Auth.: Uniformed Services Employment and Reemployment Rights Act of 1993 (USERRA), 38 U.S.C. 4301-4333, U.S. Dept. of Labor regulations at 20 CFR 1002.210
Stats. Implemented: ORS 659A.150 – 659A.186 (OR Family Leave Act)
Proposed Amendments: 839-009-0210
Last Date for Comment: 7-21-06
Summary: This proposed rule would amend the Oregon Administrative Rules regarding the Oregon Family Leave Act, ORS 659A.150 – ORS 659A.186 (OFLA) to reflect the rights of re-employed members of the uniformed services under the federal Uniformed Services Employment and Reemployment Rights Act of 1993 (USERRA). The United States Department of Labor (USDOL), which enforces both USERRA and the federal Family Medical Leave Act, 29 U.S.C. 2601-2654 (FMLA) interprets USERRA to apply to eligibility for FMLA. USERRA regulation 20 C.F.R. 1002.210 states in part: "The employee is entitled to the seniority and seniority-based rights and benefits that he or she had on the date the uniformed service began, plus any seniority and seniority-based rights and benefits that the employee would have attained if he or she had remained continuously employed...In the event that a service member is denied FMLA leave for failing to satisfy the FMLA's hours of work requirement due to absence from employment necessitated by uniformed service, the service member may have a cause of action under USERRA but not under the FMLA." The proposed amendment to OAR 839-009-0210 would add similar language to reflect the application of USERRA to eligibility for leave under OFLA.
Rules Coordinator: Marcia Ohlemiller
Address: Bureau of Labor and Industries, 800 NE Oregon St., Ste. 1045, Portland, OR 97232
Telephone: (971) 673-0784

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Department of Administrative Services,
Human Resource Services Division
Chapter 105

Rule Caption: Updated to reflect new statutory language exempting pubilc safety officers' personal information from public disclosure.
Stat. Auth.: ORS 184.340 & 240.145(3)
Stats. Implemented: ORS 192.501 & 192.502
Proposed Amendments: 105-010-0011
Last Date for Comment: 7-21-06, 5 p.m.
Summary: Added language from HB 2724 of the 2005 legislative sessions to exempt a public safety officer's home address, home telephone number and electronic mail address from public disclosure when requested by the public safety officer.

Other minor administrative changes with no substantive change or significant impact to rule: Add clarifying language to rule text to reflect actual statutory language.
Rules Coordinator: Kristin Keith
Address: Department of Administrative Services, Human Resource Services Division, 155 Cottage St. NE U90, Salem, OR 97301
Telephone: (503) 378-2349, ext. 325

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

Rule Caption: Training program for journeyman and apprentice plumbers who test backflow prevention devices.

Date:	Time:	Location:
7-18-06	9:30 a.m.	1535 Edgewater St. NW Salem, OR

Hearing Officer: Casey Hoyer
Stat. Auth.: ORS 455.110
Stats. Implemented: ORS 455.110
Proposed Adoptions: 918-030-0140
Last Date for Comment: 7-21-06, 5 p.m.
Summary: This rule establishes a training program for Oregon journeyman plumbers or apprentice plumbers, who test backflow prevention device assemblies.
Rules Coordinator: Dodie Wagner
Address: Department of Consumer and Business Services, Building Codes Division, PO Box 14470, Salem, OR 97310
Telephone: (503) 373-7438

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Rule Caption: Allows Class 5 Pressure Piping Mechanic applicants to use brazing experience toward certification.

Date:	Time:	Location:
7-18-06	10 a.m.	1535 Edgewater St. NW Salem, OR

Hearing Officer: Casey Hoyer
Stat. Auth.: ORS 480.520, 480.545 & 480.630
Stats. Implemented: ORS 480.630
Proposed Amendments: 918-225-0691
Last Date for Comment: 7-21-06, 5 p.m.
Summary: This rule corrects an error in the rule for the Class 5 Pressure Piping Mechanic License requirements. Reinserts brazing experience toward the required 2,000 hours of verifiable experience needed to qualify.
Rules Coordinator: Dodie Wagner
Address: Department of Consumer and Business Services, Building Codes Division, PO Box 14470, Salem, OR 97310
Telephone: (503) 373-7438

Department of Consumer and Business Services, Insurance Division
Chapter 836

Rule Caption: Relating to Notice Required to be Posted by Auto Rental Agencies Offering Collision Damage Waivers.
Stat. Auth.: ORS 705.135
Stats. Implemented: ORS 646.859
Proposed Ren. & Amends: 440-010-0001 to 836-200-0100
Last Date for Comment: 8-8-06
Summary: This rulemaking proposes to move a rule that is currently located in OAR chapter 440, the rules governing DCBS generally, to OAR chapter 836, the rules governing the Insurance Division, and to update the statutory citation. The rule implements ORS 646.859, which requires every auto rental company that offers collision damage waivers to post a sign, approved by the Department of Consumer and Business Services, relating to the topic.
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, Oregon Occupational Safety and Health Division
Chapter 437

Rule Caption: Propose to adopt changes throughout Divsion 1, General Administrative Rules.

Date:	**Time:**	**Location:**
8-1-06	9:30 a.m.	Dept. of Fish & Wildlife Bldg. 3406 Cherry Ave. NE Commission Rm. - 1st Flr. Salem, OR 97303

Hearing Officer: Sue Joye
Stat. Auth.: ORS 654.025(2) & 656.726(4)
Stats. Implemented: ORS 654.001 - 654.295
Proposed Amendments: 437-001-0002, 437-001-0015, 437-001-0057, 437-001-0270, 437-001-0700, 437-001-0765
Last Date for Comment: 8-8-06
Summary: 437-001-0002 Add language from HB 2204 to include e-mail notification.

437-001-0015 Adding a North American Industry Classification System (NAICS) Definition.

437-001-0057(11) Scheduling inspections. HB 2093 changes the criteria used by OR-OSHA to identify employers who receive notification of increased likelihood of receiving a workplace inspection.

437-001-0270 Discretion If there is No Timely Appeal. Delete the first paragraph.

437-001-0700 Recordkeeping and Reporting. (6) Work Related. Adding new paragraph (a) on when an employee leaves the company with a work related injury. (11) Occupational Hearing Loss Recoding Criteria. Adding Definitions for ease of reader for STS and audiometric zero. (17) Annual Summary. Changing the title to “Annual Summary and Posting Requirements.” (18) Paperwork Retention and Updating. Removing paragraph (b) on the retention of OSHA 200 log and old 801 forms. (21) Reporting Fatalities and Hospitalizations to Oregon OSHA. Adding clarifying language, additional reporting of motor vehicle accidents and adding a definition for ease of reader.

437-001-0765(2)(b) Change the paragraph from Loss Workday Case Incidence Rate (LWCIR) to Days Away, Restricted, or Transferred (DART).

Please visit our web site www.orosha.org Click “Rules & Laws” in the left vertical column and view our proposed, adopted, and final rules.
Rules Coordinator: Sue C. Joye
Address: Department of Consumer and Business Services, Oregon Occupational Safety and Health Division, 350 Winter St. NE , Salem, OR 97301-3882
Telephone: (503) 947-7449

Rule Caption: Propose to adopt Federal OSHA’S standard on Hexavalent Chromium in General Industry, Construction, and Maritme.

Date:	**Time:**	**Location:**
8-1-06	9:30 a.m.	Dept. of Fish & Wildlife Bldg. 3406 Cherry Ave. NE Commission Rm. - 1st Flr. Salem, OR 97303

Hearing Officer: Sue Joye
Stat. Auth.: ORS 654.025(2) & 656.726(4)
Stats. Implemented: ORS 654.001 - 654.295
Proposed Amendments: 437-002-0360, 437-002-0382, 437-003-0001, 437-003-1000, 437-004-9000, 437-005-0001, 437-005-0002, 437-005-0003
Last Date for Comment: 8-8-06
Summary: This rule adds new requirements for exposures to hexavalent chromium, including a lower airborne permissible exposure limit, and action level, airborne exposure assessments, regulated areas and washing facilities, medical surveillance, and training.

These changes are required to keep OR-OSHA standards as effective as Federal OSHA.

Please visit our web site www.orosha.org Click “Rules & Laws” in the left vertical column and view our proposed, adopted, and final rules.
Rules Coordinator: Sue C. Joye
Address: Department of Consumer and Business Services, Oregon Occupational Safety and Health Division, 350 Winter St. NE , Salem, OR 97301-3882
Telephone: (503) 947-7449

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Department of Energy
Chapter 330

Rule Caption: Business Energy Tax Credit program changes that primarily impact transportation projects.

Date:	**Time:**	**Location:**
7-25-06	1 p.m.	Jackson County Ctrl. Library 205 S. Central Medford, OR
8-2-06	10 a.m.	One World Trade Ctr. 121 SW Salmon, Suite 205 Portland, OR
8-9-06	1 p.m.	Central Oregon Environmental Ctr. 16 NW Kansas Bend, OR
8-16-06	10 a.m.	Oregon Dept. of Energy 625 Marion St. NE Salem, OR
9-6-06	10 a.m.	Oregon Dept. of Energy 625 Marion St. NE Salem, OR

Hearing Officer: Suzanne C. Dillard
Stat. Auth.: ORS 496.185, 315.354 & 315.356
Stats. Implemented: ORS 496.185, 315.354 & 315.356
Proposed Amendments: 330-090-0105 – 330-090-0150
Last Date for Comment: 9-12-06
Summary: This rulemaking will address changes to the Business Energy Tax Credit program in the following areas:

Documentation for Business Energy Tax Credit: Review documentation requirements for applying for Business Energy Tax Credit final certificate.

All Types of Transportation, except Research Development and Demonstration: Adopt a model to evaluate project cost effectiveness by establishing the cost per Vehicle Mile Reduced to calculate the maximum eligible cost of each project.

Bicycle: Establish a maximum eligible cost for a commuting bicycle.

Commuter Pool Vehicles: Increase the ridership requirement commuter pool vehicle purchase projects from two to three.

New Types of Transportation projects: Establish definitions and criteria for the following new types of transportation projects to be eligible for the Business Energy Tax Credit: individualized travel behavior change program, ridershare, ride-match program, carpool and vanpool.

Housekeeping: Housekeeping changes will be considered including re-formatting 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) 378-4040

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Department of Fish and Wildlife
Chapter 635

Rule Caption: Review eligibility requirements for commercial sardine limited entry permits and adjust if deemed necessary.

Date:	**Time:**	**Location:**
8-4-06	8 a.m.	3406 Cherry Ave. NE Salem, OR

Hearing Officer: ODFW Commission
Stat. Auth.: ORS 496.146, 506.036, 506.109 & 506.119
Stats. Implemented: ORS 506.129
Proposed Adoptions: Rules in 635-006
Proposed Amendments: Rules in 635-006
Proposed Repeals: Rules in 635-006
Last Date for Comment: 8-4-06
Summary: Review eligibility requirements for commercial sardine limited entry permits and adjust if deemed necessary. Housekeeping and technical correction to the regulations may occur to ensure rule consistency.
Rules Coordinator: Casaria Tuttle
Address: Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
Telephone: (503) 947-6033

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Rule Caption: Amends bay clam limited entry permits rule to allow unrestricted transfers twice per year.

Date:	**Time:**	**Location:**
8-4-06	8 a.m.	3406 Cherry Ave. NE Salem, OR

Hearing Officer: ODFW Commission
Stat. Auth.: ORS 506.036, 506.109 & 506.119
Stats. Implemented: ORS 506.129
Proposed Adoptions: Rules in 635-006
Proposed Amendments: Rules in 635-006
Proposed Repeals: Rules in 635-006
Last Date for Comment: 8-4-06
Summary: Amends rules for limited entry permits for bay clams to allow unrestricted transfers up to two times per year. Housekeeping and technical correction to the regulations may occur to ensure rule consistency.
Rules Coordinator: Casaria Tuttle
Address: Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
Telephone: (503) 947-6033

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Rule Caption: Rules related to 2007 Oregon Sport Fishing Regulations.

Date:	**Time:**	**Location:**
8-4-06	8 a.m.	3406 Cherry Ave. NE Salem, OR

Hearing Officer: ODFW Commission
Stat. Auth.: ORS 496.138, 496.146, 497.121 & 506.119
Stats. Implemented: ORS 496.004, 496.009, 496.162 & 506.129
Proposed Adoptions: Rules in 635-011, 013, 014, 016, 017, 018, 019, 021, 023 & 039
Proposed Amendments: Rules in 635-011, 013, 014, 016, 017, 018, 019, 021, 023 & 039
Proposed Repeals: Rules in 635-011, 013, 014, 016, 017, 018, 019, 021, 023 & 039
Last Date for Comment: 8-4-06
Summary: Amend rules to adopt sport fishing regulations for finfish, shellfish, and marine invertebrates for 2007. Housekeeping and technical corrections to the regulations may occur to ensure rule consistency.
Rules Coordinator: Casaria Tuttle
Address: Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
Telephone: (503) 947-6033

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Rule Caption: Amend rules regarding the harvest of game birds season dates, open areas, and bag limits.

Date:	**Time:**	**Location:**
8-4-06	8 a.m.	3406 Cherry Ave. NE Salem, OR 97303

Hearing Officer: Fish & Wildlife Commission
Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.232 & 497.112
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.232 & 497.112
Proposed Amendments: Rules in 635-043 & 050
Last Date for Comment: 8-4-06
Summary: Amend rules regarding the harvest of game birds including 2006-2007 season dates, open areas, and bag limits.
Rules Coordinator: Casaria Tuttle
Address: Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
Telephone: (503) 947-6035

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Department of Human Services,
Child Welfare Programs
Chapter 413

Rule Caption: Changing OARs affecting Child Welfare programs.

Date:	**Time:**	**Location:**
7-25-06	9:30 a.m.	Rm. 255 500 Summer St. NE Salem, OR

Hearing Officer: Annette Tesch
Stat. Auth.: ORS 418.005 & 418.640
Stats. Implemented: ORS 418.005 & 418.635
Proposed Amendments: 413-200-0210, 413-200-0220
Proposed Repeals: 413-200-0210(T), 413-200-0220(T)
Last Date for Comment: 7-25-06
Summary: OAR 413-200-0210 and 413-200-0220 about Family Group Home Standards are being amended to incorporate language that is currently part of DHS Child Welfare Policy I-E.4.2.1, “Family Foster Group Homes” which will be deleted. OAR 413-200-0210 is being amended to update its terminology and to indicate the importance of safety concerns as a purpose for the rule. OAR 413-200-0220 is being amended to define its terms and to state a complete list of requirements for family group home providers, including cross-references to other rules and policies.
Rules Coordinator: Annette Tesch
Address: Department of Human Services, Child Welfare Programs, 550 Summer St. NE, E-48, Salem, OR 97301
Telephone: (503) 945-6067

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Rule Caption: Changing OARs affecting Child Welfare programs.

Date:	**Time:**	**Location:**
7-25-06	9 a.m.	Rm. 255 500 Summer St. NE Salem, OR

Hearing Officer: Annette Tesch

Stat. Auth.: ORS 418.640
Other Auth.: Adoption & Safe Families Act of 1997 (ASFA), Pub. L. 105-89; Title IV-E of the Social Security Act, 42 U.S.C. 670 et seq
Stats. Implemented: ORS 418.005 - 418.640
Proposed Amendments: 413-200-0307
Last Date for Comment: 7-25-06, 5 p.m.
Summary: OAR 413-200-0307, which is part of DHS Child Welfare Policy II-B.1, "Safety Standards for Foster Care, Relative Care and Adoptive Families," is being amended to provide a more detailed description of the assessment process to become a certified family, including a specific requirement that a certifying worker obtain management approval prior to certifying a family if a member of the household has a founded or unable to determine child abuse disposition.

In addition, the above rule may also be changed to reflect new Department terminology and to correct formatting and punctuation.
Rules Coordinator: Annette Tesch
Address: Department of Human Services, Child Welfare Programs, 550 Summer St. NE, E-48, Salem, OR 97301
Telephone: (503) 945-6067

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Department of Human Services,
Vocational Rehabilitation Services
Chapter 582

Rule Caption: Adoption of a time standard for completion of the Individualized Plan of Employment.

Date:	Time:	Location:
7-17-06	10 a.m.–12 p.m.	Pendleton Convention Ctr. 1601 Westgate Pendleton, OR 97801
7-19-06	10 a.m.–12 p.m.	ODOT Annex 63085 Hwy 97 Bend, OR
7-21-06	10 a.m.–12 p.m.	Rm. 137B Dept. of Human Resources 500 Summer St. Salem, OR
7-25-06	10 a.m.–12 p.m.	Rogue Family Ctr. 3131 Ave. C White City, OR

Hearing Officer: Ron Barcikowski
Stat. Auth.: ORS 344.530
Other Auth.: 34 CFR 361.45(e)
Stats. Implemented: ORS 344.570
Proposed Amendments: 582-050-0000
Last Date for Comment: 7-31-06
Summary: Amending OAR 582-050-0000 to add a time standard of 180 days for the number of days between determination of eligibility and the signing of an Individual Plan of Employment by the client and vocational rehabilitation counselor. The amendment also lists the exceptions under which it can take longer than 180 days for the Individualized Plan of Employment to be signed.
Rules Coordinator: Ron Barcikowski
Address: Department of Human Services, Vocational Rehabilitation Services, 500 Summer St. NE, E-87, Salem, OR 97301
Telephone: (503) 945-6734

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

Rule Caption: Proof that an accident is not reportable and suspensions for uninsured accidents.
Stat. Auth.: ORS 184.616, 184.619, 802.010 & 809.417
Stats. Implemented: ORS 809.417 & 811.720
Proposed Amendments: 735-050-0010, 735-050-0070
Last Date for Comment: 7-21-06
Summary: OAR 735-050-0010 establishes what proof a party to an accident can provide to DMV to show that an accident is not reportable under ORS 811.720. The proposed amendments align the rule with changes to the accident reporting requirements passed by the 2003 Legislature. No longer are all persons involved in a reportable accident required to report. There are times when only the person whose vehicle sustained damage of a certain level is required to report. The proposed rule amendments outline the proof a party may provide to show the accident is not reportable.

OAR 735-050-0070 establishes when and how DMV will suspend the driving privileges of a person who is driving a vehicle that is uninsured at the time of an accident. DMV is proposing a couple of wording changes to clarify the rule, as the current wording is confusing as it uses DMV jargon rather than wording that the general public can easily understand.

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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Rule Caption: Acceptable Proofs of Age, Identity and Residence Address for Driver License, Driver Permit, ID Card.
Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.050, 807.150 & 807.400
Stats. Implemented: ORS 807.050, 807.062, 807.110, 807.150, 807.160, 807.220, 807.230, 807.280 & 807.400
Proposed Amendments: 735-062-0020, 735-062-0030
Last Date for Comment: 7-21-06
Summary: These rules outline acceptable proof of an applicant's identity, age and residence address when applying to DMV for an original, renewal or replacement driver permit, driver license or identification card. Because of the tremendous problem identity theft and use of fraudulently obtained documents present nationwide, and because a driver license or identification card are the primary forms of identification, these rules amendments are intended to provide DMV with the documentation necessary to verity the identity, age and residence address of a person issued a driver permit, driver license or identification card. DMV has amended these two rules several times in the last few years to insure that DMV requires documents that accurately verify a person's identity, age and residence address without limiting the list of acceptable documents so that is becomes impossible for some individuals to provide the verification necessary to obtain a driver license, permit or identification card. These proposed rule amendments clarify current document requirements to add documents that meet the DMV criteria for verifying age, identity and residence address.

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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Rule Caption: Requirements for Issuance and Retention of Hazardous Materials Endorsement.
Stat. Auth.: ORS 184.616, 184.619, 802.010 & 807.173
Other Auth.: 49 CFR Part 1572
Stats. Implemented: ORS 807.170, 807.173, 807.350, 809.310 & 49 USC sec. 5103a
Proposed Amendments: 735-062-0190
Last Date for Comment: 7-21-06
Summary: OAR 735-062-0190 establishes the requirements for issuance and retention of a hazardous materials endorsement. In accordance with federal law a person must complete and pass a security check at regular intervals to qualify for and retain an endorsement that allows the person to transport hazardous materials. DMV initially implemented this process through rule on January 31, 2005. Federal regulations require a security check every five years which

is inconsistent with Oregon's eight year licensing period. This requires an interim security check. For administrative purposes, DMV requires this interim check four years prior to expiration of the CDL. Under OAR 735-062-0190, this may result in cancellation of the CDL when the driver does not pass a TSA security check within this four year time period even though the driver has timely completed the submission requirements for the security check but there is a delay at TSA. DMV proposes to amend OAR 735-062-0190 to avoid cancellation of the CDL if within the required time period the driver submits proof of completion of the submission requirements, including the application, fingerprints, proof of citizenship/lawful immigration status and payment of fees. DMV also proposes to amend this rule to authorize issuance at no charge of a replacement CDL without a hazardous materials endorsement if the person fails to complete or does not pass a security check.

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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Rule Caption: Requires DMV to check NDR/PDPS and CDLIS when Reinstating Driving Privileges, Exceptions Listed.
Stat. Auth.: ORS 184.616, 184.619 & 802.010
Stats. Implemented: ORS 807.040, 807.060, 807.249, 809.380, 809.390 & 809.400
Proposed Adoptions: 735-070-0015
Last Date for Comment: 7-21-06
Summary: A 2004 commercial driver license (CDL) compliance review conducted by the Federal Motor Carrier Safety Administration (FMCSA) determined DMV's CDL program procedures were not in compliance with federal regulations requiring submission of an inquiry to the National Driver Register/Problem Driver Pointer System (NDR/PDPS) and the Commercial Driver License Information System (CDLIS) – before reinstating suspended driving privileges. The purpose of this inquiry is to determine if the driving privileges of the person requesting reinstatement in Oregon are suspended, revoked, canceled, or otherwise not valid in any other jurisdiction. The proposed rule requires that DMV check NDR/PDPS and CDLIS before reinstating suspended driving privileges, unless the person does not have Oregon driving privileges or has been issued driving privileges in another jurisdiction. The proposed rule also prohibits DMV from reinstating Oregon driving privileges until the persons driving privileges are reinstated in all jurisdictions, unless the only reinstatement requirement in the other jurisdiction is proof of financial responsibility. It also authorizes DMV to reinstate Class C driving privileges to a person whose commercial driving privileges are not valid in another jurisdiction if the person's Class C driving privileges are valid in all jurisdictions.

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 Transportation,
Motor Carrier Transportation Division
Chapter 740

Rule Caption: Remove civil monetary penalties for certain violations that are not supported by statute.
Stat. Auth.: ORS 825.245 & 825.950
Stats. Implemented: ORS 825.100, 825.245 & 825.950
Proposed Amendments: 740-300-0035
Last Date for Comment: 7-21-06
Summary: OAR 740-300-0035 provides civil monetary penalties of up to $500 per violation for certain violations. The statutory authority for the rule (ORS 825.950) authorizes the $500 penalty only for violations of statute. The rule, when adopted, inadvertently exceeded the statutory authority by applying the civil penalty to violations of rules and orders.

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, Motor Carrier Transportation Division, 1905 Lana Ave. NE, Salem, OR 97314
Telephone: (503) 945-5278

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Department of Transportation,
Rail Division
Chapter 741

Rule Caption: Inserts English Measurements for Clearance and Walkway Rules; Deletes "Locomotive" from Sanitation Facilities Rules.
Stat. Auth.: ORS 184.616, 184.619, 823.011, 824.050, 824.052, 824.056 & 824.068
Stats. Implemented: ORS 824.050, 824.052, 824.056 & 824.068
Proposed Amendments: OAR 741-300-0021, 741-300-0041, 741-305-0010, 741-305-0020, 741-310-0010 – 741-310-0050, 741-315-0010, 741-320-0010, 741-320-0020, 741-320-0050, 741-320-0060, 741-320-0080, 741-320-0090, 741-320-0100, 741-320-0110, 741-320-0120, 741-320-0130, 741-320-0150, 741-320-0160, 741-330-0010, 741-330-0020, 741-330-0030, 741-335-0010, 741-335-0020, 741-335-0040, 741-335-0050, 741-335-0070, 741-335-0080, 741-335-0090, 741-335-0110
Proposed Repeals: 741-335-0060
Last Date for Comment: 7-21-06
Summary: These rules establish standards for minimum clearances, walkways, signing and sanitation. The proposed amendments change measurements from metric to English (standard) and remove references to "locomotive" in sanitation rules where Oregon is preempted by Federal laws. Other proposed amendments add definitions and clarify 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, Rail Division, 1905 Lana Ave. NE, Salem, OR 97314
Telephone: (503) 945-5278

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Department of Veterans' Affairs
Chapter 274

Rule Caption: Personal Service Contract Amendments.
Stat. Auth.: ORS 279A, 291.021, 406.005, 406.0030 & 407.115
Stats. Implemented: ORS 406.005, 406.410, 407.115, 407.225, 407.377, 407.465 & 408.360
Proposed Amendments: 274-005-0060
Last Date for Comment: 7-21-06
Summary: Minor changes are needed for accuracy and do not alter the meaning of the Rule.

(1) With the implementation of ORS 406.005, "Director" is being amended to read "Department of Veterans' Affairs."

(2) The reference to OAR "125-020-0520 through 125-020-0540" is amended to correctly refer to the Department of Administrative Services administrative rule "125-246-0560."

Rules Coordinator: Herbert D. Riley
Address: Department of Veterans' Affairs, 700 Summer St. NE, Salem, OR 97301-1285
Telephone: (503) 373-2055

Rule Caption: Covered Care Program.
Stat. Auth.: ORS 406.050, 408.360, 408.365 & 408.368
Stats. Implemented: ORS 408.365 & 408.368
Proposed Adoptions: 274-040-0031, 274-040-0032, 274-040-0033
Proposed Amendments: 274-040-0030
Last Date for Comment: 7-21-06
Summary: The text of OAR 274-040-0030 is being reorganized for readability and clarity. As a result, several sections of OAR 274-040-0030 have been adopted into separate rules. These amended and adopted rules have also been given the subtitle name of "Covered Care Program."
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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Rule Caption: Readmission to the Oregon Veterans' Home.
Stat. Auth.: ORS 406.030, 406.050, 408.510, 408.520 & 408.530
Stats. Implemented: ORS 406.030, 406.040 & 406.050
Proposed Amendments: 274-040-0015
Last Date for Comment: 7-21-06
Summary: OAR 274-040-0015(4) is being amended to establish that former residents of the Home, who are eligible for readmission, have first priority for admission to the Home.
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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Employment Department
Chapter 471

Rule Caption: OAR 471-041-0045 Statement of Purpose.

Date:	Time:	Location:
7-20-06	2:15 p.m.	Employment Dept. Auditorium Salem, OR

Hearing Officer: Lynn Nelson
Stat. Auth.: ORS 183, 657.610 & 657.685
Stats. Implemented: ORS 657.685(6)
Proposed Amendments: 471-041-0045
Last Date for Comment: 7-20-06, 5 p.m.
Summary: In its present form, OAR 471-041-0045 states that EAB has the authority to adopt procedural rules under ORS 657.685(6), but it is actually the Employment Department that adopts the rules. EAB just proposes them. The amendment merely brings the rule into conformity with the statute.
Rules Coordinator: Lynn M. Nelson
Address: Employment Department, 875 Union St. NE, Salem, OR 97311
Telephone: (503) 947-1724

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Rule Caption: OAR 471-041-0060.

Date:	Time:	Location:
7-20-06	3:15 p.m.	Employment Dept. Auditorium 875 Union St. NE Salem, OR 97311

Hearing Officer: Lynn Nelson
Stat. Auth.: ORS 657.685
Stats. Implemented: ORS 657.685
Proposed Amendments: 471-041-0060
Last Date for Comment: 7-20-06, 5 p.m.
Summary: An application for review under the current rule must meet unnecessarily technical requirements. The amendments would relax the standard and allow applications that "express a present intent to appeal."
Rules Coordinator: Lynn M. Nelson
Address: Employment Department, 875 Union St. NE, Salem, OR 97311
Telephone: (503) 947-1724

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Landscape Contractors Board
Chapter 808

Rule Caption: New requirements in contracts, defines irrigation system, payroll requirements for individual contractors & updates.

Date:	Time:	Location:
7-21-06	11 a.m.	1130 Wallace Rd. Salem, Oregon

Hearing Officer: Martin Seibold
Stat. Auth.: ORS 670.310 & 671.670
Stats. Implemented: ORS 183, 671.520, 671.540, 671.560, 671.570, 671.625, 671.660, 671.690, 671.703 & 671.710
Proposed Amendments: 808-001-0005, 808-002-0020, 808-002-0328, 808-002-0480, 808-002-0500, 808-002-0680, 808-003-0018, 808-004-0120, 808-004-0240, 808-004-0250, 808-004-0340, 808-004-0450, 808-004-0520, 808-004-0540, 808-004-0550, 808-004-0600
Proposed Repeals: 808-003-0050
Last Date for Comment: 7-21-06, 12 pm
Summary: 808-001-0005 Adopts the Attorney General's Mode Rules of Procedure that became effective January 1, 2006.

808-002-0020 Requires a statement in all contracts about whether the work performed is or is not to be measured against the guidelines established by OLCA dated March 2004 and requires the bond amount to be stated in the contract. 808-002-0328 This rule currently states the individual landscape contractor is responsible for the landscaping work. The statutes state the landscaping business is responsible for the landscaping work. This amendment removes the incorrect language. 808-002-0480 Clarifies definition of Irrigation Systems to include: assemblies of valves, piping, sprinklers, nozzles, emitters, filters, or controllers and the positioning and piping of pumps that are installed for the purpose of watering lawns, trees, shrubs or nursery stock. Irrigation system do not include systems used to irrigate agricultural products including nursery stock grown for sale or for pasture used for the grazing or raising of animals unless done in conjunction with a landscape job. 808-002-0500 Adds statutory cites and clarifies definition of Landscaping Work to include planning and installing of fences, decks, arbors, patios, landscape edging, driveways, walkways and retaining walls when performed by a licensed landscaping business 808-002-0680 Add "case law that are not normally part of a landscaping claim" to the definition of Nature of Complexity so that those claims may be suspended and adjudicated in court.

808-003-0018 Requires the individual landscape contractor who is the phase basis for the landscaping business license to be on the payroll each hour or meet the salary test for salaried employees when the landscaping business is performing landscape work related to the landscape contractor's phase of license; the landscaping business must require the individual landscape contractor to directly supervise the non-licensed employees; moves requirement for the Verification form to this rule from 808-003-0050, which is being repealed; removes requirement to have verification of employment form notarized, changes name of form to "Verification" and only requires a copy of the licensed landscape contractor's most current pay stub if that individual is a paid employee. 808-003-0050 Is being repealed/moved to 808-003-0018.

808-004-0120 Adds limited partnership to the rule as a legal entity. 808-004-0240 Clarifies exhaustion of bond or security may be partial or full exhaustion. 808-004-0250 Adds arbitration award as appropriate and includes awards for interest expressly allowed as damages under a contract that is the basis of the claim. 808-004-0340 Removes requirement for claimant to give a brief statement of the nature of the claim and replaces it with an identification of the type of clam as already defined in OAR 808-002-0220 (negligent work, breach of contract, etc.). 808-004-0450 Adds requirement that the

individual landscape contractor whose phase of license is the basis for the landscaping business license must attend the on-site meeting for a claim. This is already a requirement as one of the supervisory duties, but this addition makes it clear when reading about the attendance of the on-site meeting. 808-004-0520 Adds that before suspending the processing of a claim because one or both of the parties filed a complaint in court and, if both parties to a claim are in agreement, the agency may hold an on-site meeting if the agency finds that it may help resolve the claim. 808-004-0540 Clarifies that the declaration of damages form submitted by the claimant is limited to the items listed in the statement of claim form. 808-004-0550 Adds arbitration award as appropriate and adopts the dismissal of a claim for failure to be licensed during all or part of the work period, lack of a direct contractual relationship or for work performed outside the state of Oregon. 808-004-0600 Clarifies that the notification to the surety company or deposit holder of claims ready for payment constitutes notice that payment is due and adds the language "irrevocable letter of credit" to comply with the statute.

Rules Coordinator: Kim Gladwill-Rowley
Address: 235 Union Street NE, Salem, OR 97301
Telephone: (503) 986-6570

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Oregon Health Licensing Agency
Chapter 331

Rule Caption: Establishing uniform consumer protection standards for the sale of hearing aids.

Date:	**Time:**	**Location:**
7-21-06	9 a.m.	700 Summer St. NE Rhoades Conf. Rm. Salem, OR

Hearing Officer: Bert Krages
Stat. Auth.: ORS 694.036, 694.042, 694.142, 694.155 & 694.170
Other Auth.: ORS 676.605, 676.607 & 676.615
Stats. Implemented: ORS 694.036, 694.042 & 694.142
Proposed Adoptions: 331-640-0055, 331-640-0060
Proposed Amendments: 331-640-0010, 331-640-0030, 331-640-0050
Last Date for Comment: 7-21-06
Summary: Consumers may purchase hearing aids from the following hearing health professionals, but only if they are licensed to do so by the Oregon Health Licensing Agency: hearing aid specialists, audiologists and physicians, such as otolayrngologists or ear, nose and throat (ENT) specialists. The term "licensee" used in the *Notice of Proposed Rulemaking Hearing and the Statement of Need and Fiscal Impact* refers to all three designations.

The common regulatory denominator is that all three must be licensed to sell hearing aids by OHLA, even though their individual hearing health practice is governed by different state regulatory agencies. *The key point for consumers: OHLA has statutory authority over the consumer's contractual rights when purchasing hearing aids*.

The Oregon Health Licensing Agency worked with licensees, small business owners, consumers, the Hearing Loss Association of American – Oregon chapter, and the Board of Speech Language Pathology and Audiology to strengthen and clarify consumer protection measures in the fitting and sale of hearing aids. OAR 331, Division 640 pertains to "Practice Standards". Amendments to this division and adoption of new rules were extensive in that licensees are required to adhere to uniform standards and to provide full disclosure of information to the consumer relating to the testing, fitting, purchase of a hearing aid, and rescission or cancellation of a sale.

Rules address the following issues, and are covered in more detail on the Statement of Need and Fiscal Impact: • Safety and Infection Control Requirements; • Statement to Prospective Purchaser — eliminating redundant statutory provisions, expanding consumer protection measures and requiring full disclosure to the consumer and acknowledgment by the consumer; • clarification of the 30-day rescission period for cancellation of a sale; • decreasing the amount of the total purchase price that may be retained by a licensee if the consumer cancels the sale; • written documentation to be provided to the consumer at the time of delivery of the hearing aids, • clarification of standards of conduct — recognizing and adopting a Code of Ethics; • identifying and requiring hearing tests to be performed during the initial hearing test or evaluation; • identifying and requiring specific verification tests to be completed within the 30-day rescission period and for a copy of the test results to be provided to the consumer; • requiring a post-delivery follow-up visit with the consumer during the 30-day rescission period; • recognition and adoption of uniform measurement standards (audiogram) for advising consumers on hearing loss; • recognition of an audiologist or physician's use of prevailing professional measurement standards in counseling consumers on the effect of hearing loss; • and adoption of client record requirements, including format and retention period.

Copies of the full text of permanent changes can be found on the Council's Web site at: http://oregon.gov/OHLA/HAS/HASlws_rules.shtml or by calling Samantha Patnode, Council Liaison at the Oregon Health Licensing Agency 503-378-8667, extension 4323.

Rules Coordinator: Patricia C. Allbritton
Address: Oregon Health Licensing Agency, 700 Summer St. NE, Ste. 320, Salem, OR 97302
Telephone: (503) 378-8667, ext. 4322

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Oregon Liquor Control Commission
Chapter 845

Rule Caption: Amend rule regulating restrictions on liquor licenses and service permits to clarify statutory authority.

Date:	**Time:**	**Location:**
8-9-06	10 a.m.–12 p.m.	9079 SE McLoughliln Blvd. Portland, OR 97222

Hearing Officer: Katie Hilton
Stat. Auth.: ORS 471, 471.030, 471.040 & 471.730(1) & (5)
Stats. Implemented: ORS 471.030, 471.040, 471.405(1) & 471.730(1) & (5)
Proposed Amendments: 845-005-0355
Last Date for Comment: 8-23-06
Summary: This rule regulates how and when the Commission places restrictions on liquor licenses and service permits. The rule allows the Commission to place restrictions when there is a basis to cancel, suspend or deny the license or service permit, when a restriction may prevent recurrence of problems, or when the Commission determines that a restriction is in the public interest or convenience. Proposed amendments will clarify that restriction violations will be enforced as Category I violations based on the Commission's general statutory authority.

Rules Coordinator: Katie Hilton
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222
Telephone: (503) 872-5004

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Rule Caption: Amend rule to allow mail-in rebate coupons for beer, wine and cider.

Date:	**Time:**	**Location:**
7-25-06	10 a.m.–12 p.m.	9079 SE McLoughlin Blvd. Portland, OR 97222

Hearing Officer: Katie Hilton
Stat. Auth.: ORS 471, 471.030 & 471.730(1) & (5)
Stats. Implemented: ORS 471.730(7)
Proposed Amendments: 845-007-0015
Last Date for Comment: 8-8-06
Summary: This rule describes the sorts of advertising the Commission permits for beer, wine and cider, and regulates the types of media (including coupons) through which alcohol may be advertised. The Commission has initiated rulemaking at the request of two petitioners to consider amending the rule to allow manufacturers of beer, wine and cider to offer mail-in, cents-off rebate coupons for beer,

wine and cider. These sorts of coupons are specifically prohibited by current rule language.
Rules Coordinator: Katie Hilton
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222
Telephone: (503) 872-5004

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Oregon Public Employees Retirement System
Chapter 459

Rule Caption: Amend Deferred Compensation Program rules and establish trading restrictions and loan program for participants.

Date:	**Time:**	**Location:**
7-25-06	2 p.m.	Boardroom PERS Headquarters 11410 SW 68th Parkway Tigard, OR

Hearing Officer: Daniel Rivas
Stat. Auth.: ORS 238A.450
Stats. Implemented: ORS 238A.160 & 238A.165
Proposed Adoptions: 459-050-0037, 459-050-0077
Proposed Amendments: 459-050-0025, 459-050-0070, 459-050-0150
Last Date for Comment: 9-22-06
Summary: 459-050-0025: Modifies procedures for distribution of meeting minutes (housekeeping). Clarifies procedures for filling vacancies on the Deferred Compensation Advisory Committee.

459-050-0037: Establishes restrictions on dollar amount and frequency of transfers of funds within OSGP investment options.

459-050-0070: Clarifies requirements for participation in the 3-Year Catch-Up Program. Allows participant to contribute total allowable amount in year of retirement under certain conditions.

459-050-0077: Establishes loan program for Deferred Compensation Program participants.

459-050-0150: Changes criteria for withdrawal eligibility. Participant is not eligible to apply for an “unforeseen emergency withdrawal” unless the participant has already utilized the loan provisions of the plan. Need for change is contingent upon adoption of 050-0077, establishing the loan program.

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

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Rule Caption: Repeal transitional rules.

Date:	**Time:**	**Location:**
7-25-06	2 p.m.	Boardroom PERS Headquarters 11410 SW 68th Parkway Tigard, OR

Hearing Officer: Daniel Rivas
Stat. Auth.: ORS 238.650 & 238A.450
Stats. Implemented: ORS 238 & 238A
Proposed Repeals: 459-070-0900
Last Date for Comment: 9-22-06
Summary: OAR 459-070-0900 was adopted to clarify and implement the provisions of House Bill 2020, adopted by the Oregon State Legislature in 2003. House Bill 2020 established OPSRP (chapter 238A), and because the transition from chapter 238 to OPSRP is complete, the transitional rules are no longer needed.

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

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Rule Caption: Clarify requirements for retirement as Police and Fire for members of the OPSRP Pension Program.

Date:	**Time:**	**Location:**
7-25-06	2 p.m.	Boardroom PERS Headquarters 11410 SW 68th Parkway Tigard, OR

Hearing Officer: Daniel Rivas
Stat. Auth.: ORS 238A.450
Stats. Implemented: ORS 238A.160 & 238A.165
Proposed Adoptions: 459-075-0200
Last Date for Comment: 9-22-06
Summary: Under the OPSRP Pension Program a Police and Fire (P & F) member is eligible for retirement if they are holding a position as a police officer or firefighter continuously for a period of five years “immediately before/preceding (both terms are used in different sections) the effective date of retirement.” The new rule is necessary to clarify the statutory standard for retirement eligibility of a P & F member.

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

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Rule Caption: Amend rule to more adequately reflect administration of benefits.

Date:	**Time:**	**Location:**
7-25-06	2 p.m.	Boardroom PERS Headquarters 11410 SW 68th Parkway Tigard, OR

Hearing Officer: Daniel Rivas
Stat. Auth.: ORS 238A.400 & 238A.450
Stats. Implemented: ORS 238A.400
Proposed Amendments: 459-080-0250
Last Date for Comment: 9-22-06
Summary: Proposes installment payments be adjusted monthly for intervening gains or losses while the account is in payout status. The rule is also being amended to reflect recent statutory changes.

Copies of the rules are available to any person upon request. The rules are also available at http://www.oregon.gov/PERS. Public comment may be mailed to the above address or sent via email to Daniel.Rivas@state.or.us
Rules Coordinator: Daniel Rivas
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

Rule Caption: Amendment removes language specifying monetary value of a credit when playing a video lottery game.

Date:	**Time:**	**Location:**
8-2-06	11–11:30 a.m.	Oregon Lottery 500 Airport Rd. SE Salem, OR

Hearing Officer: Larry Trott
Stat. Auth.: ORS 461
Other Auth.: OR Const., Article XV sec. 4(4)
Stats. Implemented: ORS 461.210
Proposed Amendments: 177-200-0010

Last Date for Comment: 8-2-06, 11:30 a.m.
Summary: The Oregon Lottery has initiated permanent rulemaking to amend this administrative rule to remove language specifying the monetary value of a credit when playing a video lottery game.
Rules Coordinator: Mark W. Hohlt
Address: Oregon State Lottery, 500 Airport Rd. SE, Salem, OR 97301
Telephone: (503) 540-1417

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Oregon State Treasury
Chapter 170

Rule Caption: Procedure for Submission, Review, and Approval of an Advance Refunding Plan.
Stat. Auth.: ORS 178.050
Stats. Implemented: ORS 288
Proposed Amendments: 170-062-0000
Last Date for Comment: 7-24-06
Summary: This Rule describes the procedures by which the State Treasurer approves refunding of outstanding obligations at least one year prior to their optional call date. There are three permissible purposes for this refunding: 1-a present value savings; 2-favorable reorganization of debt; and 3-fiscal distress. The amendment identifies the maturity requirements for an agreement for exchange of interest rates when used in an advance refunding plan. The maturity of the swap must be fixed to the length of the advance refunding bonds in order to correctly determine the amount of savings. Valid reasons for approval for a reorganization of debt are added, providing clarity of purpose and intent. Additionally, adoption of the rule amendment would no longer require that the financial advisor enter into a contract with the issuer which is non-contingent upon the sale of the advance refunding bonds. **This Rule was originally published in the May 2006 Oregon Bulletin. We are re-publishing in order to delete the requirement that the financial advisor certify the accuracy of the calculations submitted in the advance refunding plan.**
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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Rule Caption: Procedures for the Issuance of State of Oregon Industrial Development Revenue Bonds.
Stat. Auth.: ORS 178.050
Stats. Implemented: ORS 183 & 287
Proposed Amendments: 170-061-0100
Last Date for Comment: 7-24-06
Summary: This amendment clarifies and simplifies the procedures required for Oregon State Treasury approval for Industrial Development Revenue Bond (IDRB) issuance. Additionally, it changes requirements to qualify as bond counsel for an Oregon IDRB.
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 University System,
Portland State University
Chapter 577

Rule Caption: Corrects date and rule section references in part of Student Conduct Code.

Date:	Time:	Location:
7-19-06	3 p.m.	307 Cramer Hall (CH) Portland, OR

Hearing Officer: Michele Toppe
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Amendments: 577-031-0131
Last Date for Comment: 7-19-06, 5 p.m.
Summary: The proposed amendment would (1) correct a reference to the date upon which a prior amendment to the Student Conduct Code was adopted and (2) add a reference to one particular section of OAR 577-031-0140 to limit the retroactive applicability of prior rule changes.

Public comments should be submitted to Jeremy R. Dalton at the address above or by e-mail at jdalton@pdx.edu
Rules Coordinator: Jeremy R. Dalton
Address: Oregon University System, Portland State University, Portland State University, PO Box 751, Portland, OR 97207
Telephone: (503) 725-3701

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Rule Caption: Tri-annual updates and revisions to the Student Code of Conduct as proscribed by OAR 577-031-0148(2).

Date:	Time:	Location:
8-4-06	2 p.m.	Cramer Hall (CH 307) Portland, OR

Hearing Officer: Michele Toppe
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Amendments: 577-031-0125, 577-031-0130, 577-031-0131, 577-031-0132, 577-031-0133, 577-031-0135, 577-031-0136, 577-031-0137, 577-031-0140, 577-031-0141, 577-031-0142, 577-031-0143, 577-031-0145, 577-031-0146, 577-031-0147, 577-031-0148
Last Date for Comment: 8-11-06, 5 p.m.
Summary: The proposed amendment would provide various updates to the Student Code of Conduct deemed necessary by the appointed SCC Task Force as part of the Code revisions that occur every 3 years. The Student Code of Conduct outlines behavioral guidelines for Students and Student Groups that are consistent with the agencies policies designed to protect individual freedoms and fundamental rights.

Public comments should be submitted to Jeremy R. Dalton at the address above or by e-mail at jdalton@pdx.edu
Rules Coordinator: Jeremy Randall Dalton
Address: Oregon University System, Portland State University, Portland State University, PO Box 751, Portland, OR 97207
Telephone: (503) 725-3701

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Oregon University System,
Western Oregon University
Chapter 574

Rule Caption: Revisions to special course fees and general services fees and updates to access to student housing.
Stat. Auth.: ORS 351.070 & 351.072
Stats. Implemented: ORS 351.070 & 351.072
Proposed Amendments: 574-050-0005, 574-090-0010, 574-090-0020, 574-090-0030, 574-090-0040
Last Date for Comment: 7-24-06
Summary: Amendments will allow for increases, additions, and revisions of special course fees and general services fees and updates to access to student housing.
Rules Coordinator: Debra L. Charlton
Address: Oregon University System, Western Oregon University, 345 N Monmouth Ave., Monmouth, OR 97361
Telephone: (503) 838-8175

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Oregon Utility Notification Center
Chapter 952

Rule Caption: Updates and clarifies definitions and rules regarding utility locate requests and markings.

Date:	Time:	Location:
8-8-06	9:30 a.m.	Public Utility Commission Small Hearing Rm., 2nd Flr. 550 Capitol St. NE Salem, OR

Hearing Officer: Allan Arlow

Stat. Auth.: ORS 183 & 757, Sect. 105 & 8, Ch. 691 OL 1995
Stats. Implemented: ORS 757.542 & 757.552
Proposed Amendments: 952-001-0010, 952-001-0050, 952-001-0070
Last Date for Comment: 8-8-06, 5 p.m.
Summary: This rulemaking updates and clarifies the definitions used in the Utility Notification Center Administrative Rules. The amendments also clarify and update the rules regarding excavators giving notice of proposed work and the marking of underground facilities.
Rules Coordinator: Diane Davis
Address: Oregon Utility Notification Center, 550 Capitol St. NE, Suite 215, Salem, OR 97301-2551
Telephone: (503) 378-4372

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Public Utility Commission
Chapter 860

Rule Caption: Adopts and amends rules governing attachments to utility poles, conduits and facilities.

Date:	Time:	Location:
10-12-06	1:30 p.m.	Public Utility Commission Workshop with Commissioners Main Hearing Rm., 1st Flr. 550 Capitol St. NE Salem, OR
11-8-06	9 a.m.	Public Utility Commission Hearing Main Hearing Rm., 1st Flr. 550 Capitol St. NE Salem, OR

Hearing Officer: Christina Smith
Stat. Auth.: ORS 183, 756, 757 & 759
Other Auth.: Sec. 9 of Enacted HB 2271 (1999 OR Leg.)
Stats. Implemented: ORS 756.040, 757.035, 757.270 - 757.290, 759.045 & 759.650 - 759.675
Proposed Adoptions: 860-028-0050, 860-028-0060, 860-028-0070, 860-028-0080, 860-028-0100, 860-028-0115
Proposed Amendments: 860-028-0020, 860-028-0110, 860-028-0310
Last Date for Comment: 11-8-06, 5 p.m.
Summary: This rulemaking is the second phase of a two phase effort to establish more comprehensive safety and joint use rules that would apply to electric utilities, telecommunication utilities, telecommunications providers, cable television operators, and other entities that operate electric and communication lines. The purpose of this rulemaking is to ensure that Oregon's utility lines and facilities accommodate competitive changes and are constructed, operated and maintained in a safe and efficient manner.

This notice, for the second phase, will address new and amended attachment rules applicable to owners and occupants involved in the shared usage of utility poles, conduits and other facilities. This phase will address owner-occupant contracts (i.e., presumptively reasonable rates, terms, conditions), dispute resolution processes, attachment installation practices and other provisions.
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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Racing Commission
Chapter 462

Rule Caption: Provides rule for new type of wager.

Date:	Time:	Location:
7-20-06	10:30 a.m.	Rm. 140 800 NE Oregon St. Portland, OR

Hearing Officer: Jeff Gilmour, Chair
Stat. Auth.: ORS 462.270(3)
Stats. Implemented: ORS 462.270(3)
Proposed Adoptions: 462-200-0650
Last Date for Comment: 7-20-06
Summary: The Choose (n) is a form of pari-mutuel wagering in which each bettor attempts to select the winner of (n) races but chooses the races at his/her own discretion from a group of races established by the licensee instead of having the races designated for him/her by the licensee.
Rules Coordinator: Carol N. Morgan
Address: Oregon Racing Commission, 800 NE Oregon St., Suite 310, Portland, OR 97232
Telephone: (503) 673-0208

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Water Resources Department
Chapter 690

Rule Caption: Amends Mid Coast Basin Program Rules.

Date:	Time:	Location:
8-2-06	11 a.m.–1 p.m.	North Lincoln Co. Historical Museum 4907 SW Hwy 101 Lincoln City, OR

Hearing Officer: Jay Rasmussen
Stat. Auth.: ORS 536.025, 536.027 & 536.300
Stats. Implemented: ORS 536.310 & 537.356
Proposed Amendments: 690-518-0020
Last Date for Comment: 9-5-06, 5 p.m.
Summary: The Water Resources Department is proposing to amend rules related to the Mid-Coast Basin Program OAR Chapter 690, Division 518. On September 20, 2005, the Oregon Water Resources Department (OWRD) received a request by Lincoln City for three reservations of unappropriated water for multipurpose storage for future economic development on two waterways tributary to Devils Lake and a tributary of the Salmon River north of Lincoln City.

Reservation requests are processed as Basin Program amendments through the rulemaking process. Reservations of water for multipurpose storage for future economic development are allowed by ORS 537.356. Any local government, local watershed council, or state agency or any other individual cooperating jointly with a local government, local watershed council, or state agency may request the Water Resources Commission (Commission) to reserve unappropriated water for multipurpose storage for future economic development. If adopted, the priority date for a reservation is the date the Commission takes action to initiate the rulemaking process (ORS 537.356(3)). Reservations are reflected in OWRD's water availability model and future water right applications to appropriate reserved water may only request to use such water for multi-purpose storage for future economic development. ORS 537.356(1).

Approval of a reservation does not mean that any water right application will be approved or that a reservoir may be constructed. Rather, a reservation merely sets aside water for a certain use with a specific priority date. If a water user wishes to appropriate reserved water, they must submit a water right application to OWRD. OWRD would then review that water right application based on the applicable public interest review standards.

Lincoln City's reservation request included the following:

• A reservation of 374 acre-feet of unappropriated water in Rock Creek, tributary to Devil's Lake, for multipurpose storage for future economic development.

• A reservation of 1,350 acre-feet of unappropriated water from an unnamed stream (locally referred to as "Side Creek"), tributary to Devil's Lake, for multipurpose storage for future economic development for future application exclusively by the City of Lincoln City.

• A reservation of 1,250 acre-feet of unappropriated water from Treat River, tributary to Salmon River, for multipurpose storage for future economic development.

On May 5, 2006 the Commission approved initiation of rulemaking in response to Lincoln City's request. The Commission is likely to take action at its November 16 and 17, 2006 meeting. The Commission may choose to receive additional oral public comment

and written testimony on the proposed rules as part of an agenda item at any future Commission meeting. Written testimony presented to the Commission after the public comment period has closed will be limited to specific language suggestions related to changes made by the Department from the public hearing draft rules to the final proposed rules.

Rules Coordinator: Debbie Colbert

Address: Water Resources Department, 725 Summer St. NE, Suite A, Salem, OR 97301

Telephone: (503) 986-0878

Board of Architect Examiners
Chapter 806

Rule Caption: Recognized Jurisdictions.
Adm. Order No.: BAE 4-2006
Filed with Sec. of State: 6-7-2006
Certified to be Effective: 6-7-06
Notice Publication Date: 3-1-06
Rules Adopted: 806-010-0033
Subject: Multiple statutory references exist regarding jurisdictions recognized by the Oregon Board of Architect Examiners. This rule outlines the jurisdictions this Board has recognized by practice, but not before listed within the Oregon Administrative Rules.
Rules Coordinator: Carol Halford—(503) 763-0662

806-010-0033
Recognized Jurisdictions

(1) The Oregon Board of Architect Examiners recognizes the following jurisdictions:

(a) Each state of the United States;

(b) The District of Columbia;

(c) Guam;

(d) The Northern Mariana Islands

(e) Puerto Rico;

(f) The Virgin Islands; and

(g) Canada.

(2) The Oregon Board will consider applicants from other jurisdictions as being "foreign", and they must meet NCARB's evaluation standards before being considered for registration.

Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.010, 671.020, 671.041 & 671.065
Hist.: BAE 4-2006, f. & cert. ef. 6-7-06

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Board of Parole and Post-Prison Supervision
Chapter 255

Rule Caption: Amendment of Rules Regarding Procedures for Designation of Predatory Sex Offenders.
Adm. Order No.: PAR 5-2006
Filed with Sec. of State: 6-14-2006
Certified to be Effective: 6-14-06
Notice Publication Date: 5-1-06
Rules Amended: 255-060-0011
Subject: The amendment of this rules is necessary in order to be consistent with the Oregon Supreme Court ruling in V.L.Y. v. Board of Parole and Post-Prison Supervision, 338 Or 44 (2005).
Rules Coordinator: Michael R. Washington—(503) 945-8978

255-060-0011
Procedures for Predatory Sex Offender Designation

(1) For purposes of this rule, a predatory sex offender is defined as a person who exhibits characteristics showing a tendency to victimize or injure others and has been convicted of one or more of the following offenses: Rape in any degree, Sodomy in any degree, Unlawful Sexual Penetration in any degree or Sexual Abuse in any degree. In determining whether an inmate or offender is a predatory sex offender under this rule, the Board shall use the STATIC-99 (Exhibit Q-l) and definitions (Exhibit Q-ll), which have been approved by the Department of Corrections as required by ORS 181.585(2). The Board may also consider any other evidence that the inmate or the offender exhibits characteristics showing a tendency to victimize or injure others.

(2) Predatory sex offender designations made by the board for inmates or offenders released from a Department of Corrections institution before February 10, 2005, are not included in this rule. Those designations are governed by the rules in effect when the designation was made.

(3) Subject to the procedures set forth in this rule, the Board will make a finding that an inmate or offender is a candidate for predatory sex offender designation, if the inmate or offender scores six or more points on the STATIC-99.

(4) Subject to the procedures set forth below, inmates or offenders who score six or more points on the STATIC-99, and have been identified as a candidate for predatory designation, have the right to be advised of their score and submit written objections to the Board before the Board makes a predatory sex offender finding. The Notice of Rights and Written Objections form for this rule are Exhibits Q-lll and Q-IV of the Boardís rules.

(a) Written objections must be received by a Department of Correctionsí institution or release counselor, a supervising officer or the Board within three days of the date the offender or inmate signed the Notice of Rights (Exhibit Q-lll).

(b) The Board must receive and review the signed Notice of Rights (Exhibit Q-III) or written documentation that the inmate or offender refused to sign the Notice of Rights before an evidentiary hearing is conducted or waived to determine a predatory sex offender finding.

(c) The Board must consider any written objections to the score on the STATIC-99 timely submitted by the inmate or offender before an evidentiary hearing is conducted or waived to determine a predatory sex offender finding. The Board may find an inmate or offender is a candidate for predatory sex offender designation if there is evidence to support a score on the STATIC-99 of six or more points.

(d) Inmates or offenders may elect to waive their right to submit written objections. Any such waiver must be in writing. When an inmate or offender waives their right to submit written objections, the Board may find an inmate or offender is a candidate for predatory sex offender designation if the inmateís or offenderís score on the STATIC-99 is six or more points.

(5) A finding that an inmate or offender is a predatory sex offender may be made by one Board Member. The finding may only be made after the inmate or offender has participated in an evidentiary hearing or waived participation in such a hearing to determine whether the offender is exhibiting characteristics showing a tendency to victimize or injure others. A finding that an offender is a predatory sex offender will be contained in the inmateís or offenderís original order of supervision or an amended order of supervision.

(6) The sole purpose of the evidentiary hearing will be to determine whether the inmate or offender exhibits characteristics showing a tendency to victimize or injure others. The Board may receive a written report from a supervising officer or a release counselor of any Department of Corrections institution indicating that an inmate or offender who has been determined to be a candidate for designation as a predatory sex offender under paragraphs (3) and (4) exhibits characteristics showing a tendency to victimize or injure others.

(a) Upon receipt of a written report from a supervising officer or a release counselor, the Board will review it to determine whether it contains sufficient information to conduct an evidentiary hearing for purposes of determining whether the inmate or offender should be designated as a predatory sex offender. If the Board determines there is sufficient information in the report, it will forward the report to its Hearing Officer, who will schedule an evidentiary hearing.

(b) The Boardís Hearing Officer will provide the inmate or offender with a copy of the Notice of Rights (Exhibit Q-V) prior to the evidentiary hearing. Upon receipt of the Notice of Rights (Exhibit Q-V), the inmate or offender may proceed with the evidentiary hearing or waive their right to the hearing. At the evidentiary hearing, the Hearings Officer will consider the written report submitted by the supervising officer or release counselor and the results of the STATIC-99 risk assessment scale, and may accept additional evidence supporting the STATIC-99 score or otherwise indicating that the inmate or offender exhibits characteristics showing a tendency to victimize or injure others. The inmate or offender may present evidence rebutting claims made in the written report submitted by a supervising officer or release counselor, challenging the score on the STATIC-99, or rebutting other evidence that the inmate or offender exhibits characteristics showing a tendency to victimize or injure others. At the conclusion of the evidentiary hearing, the Hearing Officer will submit his report to the Board with a recommendation as to whether the inmate or offender exhibits characteristics showing a tendency to victimize or injure others.

(c) Upon receipt of the report and recommendation from the Boardís Hearing Officer, the Board will review the report and recommendation and determine whether the inmate or offender exhibits characteristics showing a tendency to victimize or injure others and is, therefore, a predatory sex offender.

(7) Pursuant to ORS 181.586, the community corrections agency supervising an inmate or offender found to be a predatory sex offender shall notify anyone whom the agency determines is appropriate that the person is a predatory sex offender. The agency shall make this determination as required by ORS 181.586.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 144.050, 144.140, 181.585 & 181.586
Stats. Implemented:
Hist.: PAR 4-2000, f. & cert. ef. 2-15-00; PAR 1-2002(Temp), f. & cert. ef. 1-15-02 thru 7-13-02; PAR 4-2002, f. & cert. ef. 3-12-02; PAR 5-2003, f. & cert. ef. 10-10-03; PAR 2-2004(Temp), f. & cert. ef. 1-41-04 thru 7-11-04; PAR 7-2004, f. & cert. ef. 6-14-04; PAR 1-2006(Temp), f. & cert. ef. 3-20-06 thru 9-15-06; PAR 5-2006, f. & cert. ef. 6-14-06

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Rule Caption: Amendment of Rules Regarding Procedure for Designation of Predatory Sex Offenders.

Adm. Order No.: PAR 6-2006(Temp)
Filed with Sec. of State: 6-14-2006
Certified to be Effective: 6-15-06 thru 12-11-06
Notice Publication Date:
Rules Amended: 255-060-0011
Subject: The amendment of this rules is necessary in order to be consistent with the Oregon Supreme Court ruling in V.L.Y. v. Board of Parole and Post-Prison Supervision, 338 Or 44 (2005).
Rules Coordinator: Michael R. Washington—(503) 945-9009

255-060-0011
Procedures for Predatory Sex Offender Designation

(1) For purposes of this rule, a predatory sex offender is defined as a person who exhibits characteristics showing a tendency to victimize or injure others and has been convicted of one or more of the following offenses: Rape in any degree, Sodomy in any degree, Unlawful Sexual Penetration in any degree or Sexual Abuse in any degree. In determining whether an inmate or offender is a predatory sex offender under this rule, the Board shall use the STATIC-99 (Exhibit Q-l) and definitions (Exhibit Q-ll), which have been approved by the Department of Corrections as required by ORS 181.585(2). The Board may also consider any other evidence that the inmate or the offender exhibits characteristics showing a tendency to victimize or injure others.

(2) Predatory sex offender designations made by the board for inmates or offenders released from a Department of Corrections institution before February 10, 2005, are not included in this rule. Those designations are governed by the rules in effect when the designation was made.

(3) Subject to the procedures set forth in this rule, the Board will make a finding that an inmate or offender is a candidate for predatory sex offender designation, if the inmate or offender scores six or more points on the STATIC-99.

(4) Subject to the procedures set forth below, inmates or offenders who score six or more points on the STATIC-99, and have been identified as a candidate for predatory designation, have the right to be advised of their score and submit written objections to the Board before the Board makes a predatory sex offender finding. The Notice of Rights and Written Objections form for this rule are Exhibits Q-lll and Q-IV of the Board's rules.

(a) Written objections must be received by a Department of Corrections' institution or release counselor, a supervising officer or the Board within three days of the date the offender or inmate signed the Notice of Rights (Exhibit Q-lll).

(b) The Board must receive and review the signed Notice of Rights (Exhibit Q-III) or written documentation that the inmate or offender refused to sign the Notice of Rights before an evidentiary hearing is conducted or waived to determine a predatory sex offender finding.

(c) The Board must consider any written objections to the score on the STATIC-99 timely submitted by the inmate or offender before an evidentiary hearing is conducted or waived to determine a predatory sex offender finding. The Board may find an inmate or offender is a candidate for predatory sex offender designation if there is evidence to support a score on the STATIC-99 of six or more points.

(d) Inmates or offenders may elect to waive their right to submit written objections. Any such waiver must be in writing. When an inmate or offender waives their right to submit written objections, the Board may find an inmate or offender is a candidate for predatory sex offender designation if the inmate's or offender's score on the STATIC-99 is six or more points.

(5) A finding that an inmate or offender is a predatory sex offender may be made by one Board Member. The finding may only be made after the inmate or offender has participated in an evidentiary hearing or waived participation in such a hearing to determine whether the offender is exhibiting characteristics showing a tendency to victimize or injure others. A finding that an offender is a predatory sex offender will be contained in the inmate's or offender's original order of supervision or an amended order of supervision.

(6) The sole purpose of the evidentiary hearing will be to determine whether the inmate or offender exhibits characteristics showing a tendency to victimize or injure others. The Board may receive a written report from a supervising officer or a release counselor of any Department of Corrections institution indicating that an inmate or offender who has been determined to be a candidate for designation as a predatory sex offender under paragraphs (3) and (4) exhibits characteristics showing a tendency to victimize or injure others.

(a) Upon receipt of a written report from a supervising officer or a release counselor, the Board will review it to determine whether it contains sufficient information to conduct an evidentiary hearing for purposes of determining whether the inmate or offender should be designated as a predatory sex offender. If the Board determines there is sufficient information in the report, it will forward the report to its Hearing Officer, who will schedule an evidentiary hearing.

(b) The Board's Hearing Officer will provide the inmate or offender with a copy of the Notice of Rights (Exhibit Q-V) prior to the evidentiary hearing. Upon receipt of the Notice of Rights (Exhibit Q-V), the inmate or offender may proceed with the evidentiary hearing or waive their right to the hearing. At the evidentiary hearing, the Hearings Officer will consider the written report submitted by the supervising officer or release counselor and the results of the STATIC-99 risk assessment scale, and may accept additional evidence supporting the STATIC-99 score or otherwise indicating that the inmate or offender exhibits characteristics showing a tendency to victimize or injure others. The inmate or offender may present evidence rebutting claims made in the written report submitted by a supervising officer or release counselor, challenging the score on the STATIC-99, or rebutting other evidence that the inmate or offender exhibits characteristics showing a tendency to victimize or injure others. At the conclusion of the evidentiary hearing, the Hearing Officer will submit his report to the Board with a recommendation as to whether the inmate or offender exhibits characteristics showing a tendency to victimize or injure others.

(c) Upon receipt of the report and recommendation from the Board's Hearing Officer, the Board will review the report and recommendation and determine whether the inmate or offender exhibits characteristics showing a tendency to victimize or injure others and is, therefore, a predatory sex offender.

(7) Pursuant to ORS 181.586, the community corrections agency supervising an inmate or offender found to be a predatory sex offender shall notify anyone whom the agency determines is appropriate that the person is a predatory sex offender. The agency shall make this determination as required by ORS 181.586.

[ED. NOTE: Exhibits referenced are available from the agency.]
Stat. Auth.: ORS 144.050, 144.140, 181.585 & 181.586
Stats. Implemented:
Hist.: PAR 4-2000, f. & cert. ef. 2-15-00; PAR 1-2002(Temp), f. & cert. ef. 1-15-02 thru 7-13-02; PAR 4-2002, f. & cert. ef. 3-12-02; PAR 5-2003, f. & cert. ef. 10-10-03; PAR 2-2004(Temp), f. & cert. ef. 1-41-04 thru 7-11-04; PAR 7-2004, f. & cert. ef. 6-14-04; PAR 1-2006(Temp), f. & cert. ef. 3-20-06 thru 9-15-06; PAR 5-2006, f. & cert. ef. 6-14-06; PAR 6-2006(Temp), f. 6-14-06 cert. ef. 6-15-06 thru 12-11-06

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Board of Pharmacy
Chapter 855

Rule Caption: Changes rules for Pharmacy Technicians, requires technicians to obtain certification by September 2008.
Adm. Order No.: BP 1-2006
Filed with Sec. of State: 6-9-2006
Certified to be Effective: 6-9-06
Notice Publication Date: 3-1-06
Rules Adopted: 855-025-0005, 855-025-0010, 855-025-0015, 855-025-0020, 855-025-0025, 855-025-0030, 855-025-0035, 855-025-0040, 855-025-0060
Rules Amended: 855-006-0005, 855-025-0001, 855-025-0050, 855-110-0005
Rules Repealed: 855-006-0010, 855-041-0200, 855-041-0203, 855-041-0205
Subject: These rules implement 2005 changes to the laws governing pharmacy technicians and adopt, repeal or amend rules related to virtually all aspects of licensing and employment of pharmacy technicians. The rules require a pharmacy technician to obtain certification by passing a national certification examination by a specified date, unless the pharmacy technician is under the age of 18. The rules set continuing education requirements for technicians; set licensure and renewal requirements for technicians; set recordkeeping responsibilities for technicians describe how technicians may be used within a pharmacy; establish confidentiality requirements; specify supervision responsibilities for pharmacists who supervise technicians; define "unprofessional conduct" of technicians; and explain how a technician's license may be reinstated after revocation, suspension or limitation.
Rules Coordinator: Karen Maclean—(971) 673-0005

855-006-0005
Definitions

As used in ORS Chapter 689 and OAR Chapter 855:

(1) "Certified Pharmacy Technician" means a person licensed by the State Board of Pharmacy who assists the pharmacist in the practice of

pharmacy pursuant to rules of the Board and has completed the specialized education program pursuant to OAR 855-025-0005. Persons used solely for clerical duties, such as record keeping, cashiering, bookkeeping and delivery of medications released by the pharmacist are not considered pharmacy technicians.

(2) "Collaborative Drug Therapy Management" means the participation by a pharmacist in the management of drug therapy pursuant to a written protocol that includes information specific to the dosage, frequency, duration and route of administration of the drug, authorized by a practitioner and initiated upon a prescription order for an individual patient and:

(a) Is agreed to by one pharmacist and one practitioner; or

(b) Is agreed to by one or more pharmacists at a single pharmacy registered by the board and one or more practitioners in a single organized medical group, such as a hospital medical staff, clinic or group practice, including but not limited to organized medical groups using a pharmacy and therapeutics committee.

(3) "Compounding" means the preparation, mixing, assembling, packaging, or labeling of a drug or device (i) as the result of a practitioner's prescription drug order or initiative based on the practitioner/patient/pharmacist relationship in the course of professional practice, or (ii) for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale or dispensing. Compounding also includes the preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns.

(4) "Confidential Information" means any patient information obtained by a pharmacist or pharmacy.

(5) The "Container" is the device that holds the drug and that is or may be in direct contact with the drug.

(6) "Dispensing" means the preparation and delivery of a prescription drug pursuant to a lawful order of a practitioner in a suitable container appropriately labeled for subsequent administration to or use by a patient or other individual entitled to receive the prescription drug.

(7) "Interpretation and evaluation of prescription orders" means the review of the order for therapeutic and legal correctness. Therapeutic review includes identification of the prescription drug ordered, its applicability and its relationship to the other known medications used by the patient and determination of whether or not the dose and time interval of administration are within accepted limits of safety. The legal review for correctness of the prescription order includes a determination that the order is valid and has not been altered, is not a forgery, is prescribed for a legitimate medical purpose, contains all information required by federal and state law, and is within the practitioner's scope of practice.

(8) "Labeling" means the process of preparing and affixing of a label to any drug container exclusive, however, of the labeling by a manufacturer, packer or distributor of a non-prescription drug or commercially packaged legend drug or device.

(9) "Monitoring of therapeutic response or adverse effect of drug therapy" means the follow up of the therapeutic or adverse effect of medication upon a patient, including direct consultation with the patient or his agent and review of patient records, as to result and side effect, and the analysis of possible interactions with other medications that may be in the medication regimen of the patient. This section shall not be construed to prohibit monitoring by practitioners or their agents.

(10) "Nationally Certified Exam" means an exam that is approved by the Board which demonstrates successful completion of a Specialized Education Program. The exam must be reliable, psychometrically sound, legally defensible and valid.

(11) "Non-legend drug" means a drug which does not require dispensing by prescription and which is not restricted to use by practitioners only.

(12) "Offering or performing of those acts, services, operations or transactions necessary in the conduct, operation, management and control of pharmacy" means, among other things:

(a) The creation and retention of accurate and complete patient records;

(b) Assuming authority and responsibility for product selection of drugs and devices;

(c) Developing and maintaining a safe practice setting for the pharmacist, for pharmacy staff and for the general public;

(d) Maintaining confidentiality of patient information.

(13) "Oral Counseling" means an oral communication process between a pharmacist and a patient or a patient's agent in which the pharmacist obtains information from the patient (or agent) and the patient's pharmacy records, assesses that information and provides the patient (or agent) with professional advice regarding the safe and effective use of the prescription drug for the purpose of assuring therapeutic appropriateness.

(14) Participation in Drug Selection and Drug Utilization Review:

(a) "Participation in drug selection" means the consultation with the practitioner in the selection of the best possible drug for a particular patient.

(b) "Drug utilization review" means evaluating a prescription drug order in light of the information currently provided to the pharmacist by the patient or the patient's agent and in light of the information contained in the patient's record for the purpose of promoting therapeutic appropriateness by identifying potential problems and consulting with the prescriber, when appropriate. Problems subject to identification during drug utilization review include, but are not limited to:

(A) Over-utilization or under-utilization;

(B) Therapeutic duplication;

(C) Drug-disease contraindications;

(D) Drug-drug interactions;

(E) Incorrect drug dosage;

(F) Incorrect duration of treatment;

(G) Drug-allergy interactions; and

(H) Clinical drug abuse or misuse.

(15) "Pharmaceutical Care" means the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life. These outcomes include:

(a) Cure of a disease;

(b) Elimination or reduction of a patient's symptomatology;

(c) Arrest or slowing of a disease process; or

(d) Prevention of a disease or symptomatology.

(16) "Pharmacy Technician" means a person licensed by the State Board of Pharmacy who assists the pharmacist in the practice of pharmacy pursuant to rules of the Board but has not completed the specialized education program pursuant to OAR 855-025-0005.

(17) "Prescription released by the pharmacist" means, a prescription which has been reviewed by the pharmacist that does not require further pharmacist intervention such as reconstitution or counseling.

(18) "Proper and safe storage of drugs and devices and maintenance of proper records therefore" means housing drugs and devices under conditions and circumstances that:

(a) Assure retention of their purity and potency;

(b) Avoid confusion due to similarity of appearance, packaging, labeling or for any other reason;

(c) Assure security and minimize the risk of their loss through accident or theft;

(d) Accurately account for and record their receipt, retention, dispensing, distribution or destruction;

(e) Protect the health, safety and welfare of the pharmacist, pharmacy staff and the general public from harmful exposure to hazardous substances.

(19) "Responsibility for advising, when necessary or when regulated, of therapeutic values, content, hazards and use of drugs and devices" means advice directly to the patient, either verbally or in writing as required by these rules or federal regulation, of the possible therapeutic response to the medication, the names of the chemicals in the medication, the possible side effects of major importance, and the methods of use or administration of a medication.

(20) "Specialized Education Program" means,

(a) A program providing education for persons desiring licensure as pharmacy technicians that is approved by the board and offered by an accredited college or university that grants a two-year degree upon successful completion of the program; or

(b) A structured program approved by the board and designed to educate pharmacy technicians in one or more specific issues of patient health and safety that is offered by:

(A) An organization recognized by the board as representing pharmacists or pharmacy technicians;

(B) An employer recognized by the board as representing pharmacists or pharmacy technicians; or

(C) A trade association recognized by the board as representing pharmacies.

(21) "Supervision by a pharmacist" means being stationed within the same work area as the pharmacy technician or certified pharmacy technician being supervised, coupled with the ability to control and be responsible for the pharmacy technician or certified pharmacy technician's action.

(22) "Therapeutic substitution" means the act of dispensing a drug product with a different chemical structure for the drug product prescribed under circumstances where the prescriber has not given clear and conscious direction for substitution of the particular drug for the one which may later be ordered.

(23) "Unprofessional conduct" means;

(a) Repeated or gross negligence in the practice of pharmacy; or

(b) Fraud or misrepresentation in dealings relating to pharmacy practice with:

(A) Customers, patients or the public;

(B) Practitioners authorized to prescribe drugs, medications or devices;

(C) Insurance companies;

(D) Wholesalers, manufactures or distributors of drugs, medications or devices;

(E) Health care facilities;

(F) Government agencies; or

(c) Illegal use of drugs, medications or devices without a practitioner's prescription, or otherwise contrary to federal or state law or regulation;

(d) Theft of drugs, medications or devices, or theft of any other property or services under circumstances which bear a demonstrable relationship to the practice of pharmacy;

(e) Dispensing a drug, medication or device where the pharmacist knows or should know due to the apparent circumstances that the purported prescription is bogus or that the prescription is issued for other than a legitimate medical purpose, including circumstances such as:

(A) Type of drug prescribed;

(B) Amount prescribed; or

(C) When prescribed out of context of dose.

(f) Any act or practice relating to the practice of pharmacy which is prohibited by state or federal law or regulation.

(g) The disclosure of confidential information in violation of Board rule.

(h) Engaging in collaborative drug therapy management in violation of ORS Chapter 689 and the rules of the Board.

(24) "Verification" means the confirmation by the pharmacist of the correctness, exactness, accuracy and completeness of the acts, tasks, or functions performed by a pharmacy technician and certified pharmacy technician.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.005(30)
Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; 1PB 3-1984, f. & ef. 4-16-84; PB 2-1988, f. & cert. ef. 5-3-88; PB 2-1989, f. & cert. ef. 1-30-89; PB 4-1992, f. & cert. ef. 8-25-92; PB 1-1994, f. & cert. ef. 2-2-94; BP 4-1998, f. & cert. ef. 8-14-98; BP 1-2006, f. & cert. ef. 6-9-06

855-025-0001
Transition from Registration of Technician to Licensure of Technician

(1) Effective June 28, 2005, pharmacy technicians ceased to be registered and became licensed. As part of licensure, pharmacy technicians are now subject to disciplinary action by the Board and subject to specialized education and training requirements established by the Board. This rule provides a framework for the transition from registration to licensure.

(2) The existing Board file containing information on each registered pharmacy technician or applicant for registration as a pharmacy technician remains in effect when the registration program transitions to a licensure program. Pharmacy technicians and applicants need not resubmit application material or other information to the Board because of the transition to licensure unless the Board specifically requests resubmission. Complaints, investigations, renewal information, criminal history information and registration history information remain in effect and carry over into the licensing history for each pharmacy technician or applicant.

Stat. Auth.: 689.205
Stats. Implemented: 689.225
Hist.: BP 8-2005, f. 12-14-05, cert. ef. 12-15-05; BP 1-2006, f. & cert. ef. 6-9-06

855-025-0005
Qualifications for Licensure as a Pharmacy Technician or Certified Pharmacy Technician

(1) Effective August 1, 2006, to qualify for licensure as a certified pharmacy technician, an applicant must demonstrate that the applicant is or will be at least 18 years of age and holds or will hold a high school diploma or GED at the time the Board issues the license.

(2) No person whose license to practice as a pharmacist has been denied, revoked, suspended or restricted by the Board may be licensed as a pharmacy technician or certified pharmacy technician unless the Board determines that licensure will pose no danger to patients or to the public interest.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 1-2006, f. & cert. ef. 6-9-06

855-025-0010
Renewal of Licensure as a Pharmacy Technician Requires Certification

(1) The purpose of this rule is to ensure that all pharmacy technicians in Oregon become certified pharmacy technicians by passing a certification examination accepted by the Board. This rule requires all current pharmacy technicians to become certified by October 1, 2008, and gives all new pharmacy technicians until October 1, 2008, one year after initial licensure, or prior to the pharmacy technician's 19th birthday, whichever is later, to obtain certification.

(2) The license of a pharmacy technician expires one year from the date upon which it is issued, and may be renewed only if:

(a) The applicant has become certified by taking and passing one of the examinations described in section three or

(b) The applicant is less than 18 years of age.

(3) For any pharmacy technician license that expires on or after September 30, 2008, an applicant to renew a pharmacy technician license must demonstrate that the applicant for renewal has taken and passed the national pharmacy technician certification examination given by either:

(a) The Pharmacy Technician Certification Board (PTCB) or

(b) The Institute for the Certification of Pharmacy Technicians (ICPT).

(4) The license of a certified pharmacy technician expires on September 30 of each year and must be renewed annually.

(5) Notwithstanding any other provision of these rules, a pharmacy technician who is less than 18 years of age need not take and pass a certified pharmacy technician examination.

(6) Applicants for licensure or renewal of licensure as a pharmacy technician must submit to a criminal background check.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 1-2006, f. & cert. ef. 6-9-06

855-025-0015
Renewal of Licensure as a Certified Pharmacy Technician

(1) Licensed pharmacy technicians who have taken and passed a certification examination listed in OAR 855-025-0010(3) may use the title "certified pharmacy technician," are referred to in these rules as a "certified pharmacy technician," and are licensed as a "certified pharmacy technician."

(2) An applicant for renewal of a certified pharmacy technician license must:

(a) Maintain certification by one of the organizations listed in OAR 855-025-0010(3) and

(b) During each period from September 1 through August 31, complete and report at least one hour of pharmacy law, appropriate to the applicant's work setting and functions. Fifty minutes equal one contact hour.

(c) Submit to a criminal background check.

(3) The Board may randomly select and audit applications for renewal to verify completion of the continuing education reported on the application for renewal. Certified pharmacy technicians whose applications for renewal are selected for audit must provide documentation of completion of the continuing education reported.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 1-2006, f. & cert. ef. 6-9-06

855-025-0020
Recordkeeping Responsibilities of Pharmacy Technicians and Certified Pharmacy Technicians

(1) Certified pharmacy technicians and pharmacy technicians must notify the Board in writing within 15 days of a change of home address.

(2) Certified pharmacy technicians and pharmacy technicians must notify the Board in writing within 15 days of employment of the name and address of the pharmacy by which they are employed. A certified pharmacy technician or pharmacy technician who is employed at more than one pharmacy need only report the name and address of the pharmacy at which the technician normally works the most hours.

(3) Certified pharmacy technicians must obtain certificates of completion that show the date and number of hours earned to document continuing education credit earned and must keep the certificates of completion for three years from the date of the program.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 1-2006, f. & cert. ef. 6-9-06

855-025-0025
Use of Pharmacy Technicians and Certified Pharmacy Technicians

(1) A pharmacist or pharmacy may use pharmacy technicians and certified pharmacy technicians only as authorized by the rules of the Board.

(2) Pharmacy technicians and certified pharmacy technicians must be supervised by a pharmacist.

(3) Pharmacists, pharmacist interns, pharmacy technicians and certified pharmacy technicians must be clearly identified as such to the public.

(4) Work performed by pharmacy technicians and certified pharmacy technicians assisting the pharmacist to prepare medications must be

verified by a pharmacist prior to release for patient use. Verification must be documented, available and consistent with the standard of practice.

(5) The pharmacist-in-charge must prepare and maintain in the pharmacy written procedures that describe the tasks performed by pharmacy technicians and certified pharmacy technicians, and the methods of verification and documentation of work performed by pharmacy technicians and certified pharmacy technicians. Written procedures must be available for inspection by the Board or its representatives. The pharmacist-in-charge must review written procedures annually and document that review on the annual pharmacist-in-charge inspection sheet.

(6) Training:

(a) The pharmacist-in charge must outline, and each pharmacy technician and certified pharmacy technician must complete initial training that includes on-the-job and related education commensurate with the tasks that the pharmacy technician or certified pharmacy technician will perform, prior to the performance of those tasks.

(b) The pharmacist-in-charge must ensure the continuing competency of pharmacy technicians and certified pharmacy technicians.

(c) The pharmacist-in-charge must document initial training of each pharmacy technician and certified pharmacy technician and make that documentation available to the Board or its representatives upon request.

(7) Upon written request, the Board may waive any of the requirements of this rule upon a showing that a waiver will further public health or safety or the health or safety of a patient or other person. A waiver granted under this section is effective only when issued by the Board in writing.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 1-2006, f. & cert. ef. 6-9-06

855-025-0030
Confidentiality

(1) No licensee of the Board who obtains any patient information shall disclose that information to a third-party without the consent of the patient except as provided in section two of this rule.

(2) A licensee may disclose patient information:

(a) To the Board;

(b) to a practitioner, pharmacist, pharmacy technician, or certified pharmacy technician, if disclosure is authorized by a pharmacist who reasonably believes that disclosure is necessary to protect the patient's health or well-being; or

(c) To a third-party when disclosure is authorized or required by law; or

(d) As permitted pursuant to federal and state patient confidentiality laws.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 1-2006, f. & cert. ef. 6-9-06

855-025-0035
Pharmacy and Pharmacist Responsibility for Supervising Pharmacy Technicians and Certified Pharmacy Technicians

(1) The supervising pharmacist and the pharmacist-in-charge are responsible for the actions of pharmacy technicians and certified pharmacy technicians. The use of pharmacy technicians or certified pharmacy technicians to perform tasks not included in written procedures maintained by the pharmacy constitutes unprofessional conduct on the part of the supervising pharmacist and the pharmacist-in-charge.

(2) The pharmacy must maintain on file and post the current license of each pharmacy technician and certified pharmacy technician.

(3) Before allowing any person to work as a pharmacy technician or certified pharmacy technician, the pharmacy and pharmacist shall verify that the person is currently licensed as a pharmacy technician or certified pharmacy technician.

(4) Prior to performing the duties of a pharmacy technician or a certified pharmacy technician, a person must provide to the pharmacist or pharmacist-in-charge a copy of the person's current pharmacy technician license or a current certified pharmacy technician license.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 1-2006, f. & cert. ef. 6-9-06

855-025-0040
Certified Pharmacy Technician and Pharmacy Technician Tasks and Guidelines

(1) Non-licensed pharmacy personnel may enter non-prescription information into a computer record system and may perform clerical duties such as filing prescriptions, delivery, housekeeping, and general record keeping, but the responsibility for the accuracy of the non-licensed pharmacy personnel's work lies with the pharmacist.

(2) Only persons licensed with the Board as a Pharmacy Technician or Certified Pharmacy Technician, acting in compliance with all applicable statutes and rules and under the supervision of a pharmacist, may assist in the practice of pharmacy by the following:

(a) Packing, pouring or placing in a container for dispensing, sale, distribution, transfer possession of, any drug, medicine, poison, or chemical which, under the laws of the United States or the State of Oregon, may be sold or dispensed only on the prescription of a practitioner authorized by law to prescribe drugs, medicines, poisons, or chemicals.

(b) Reconstituting prescription medications. The supervising pharmacist must verify the accuracy in all instances.

(c) Affixing required labels upon any container of drugs, medicines, poisons, or chemicals sold or dispensed upon prescription of a practitioner authorized by law to prescribe those drugs, medicines, poisons, or chemicals.

(d) Entering information into the pharmacy computer. The pharmacy technician or certified pharmacy technician shall not make any decisions that require the exercise of judgment and that could affect patient care. The supervising pharmacist must verify prescription information entered into the computer and is responsible for all aspects of the data and data entry.

(e) Initiating or accepting oral or electronic refill authorization from a practitioner or practitioner's agent, provided that nothing about the prescription is changed, and record the medical practitioner's name and medical practitioner's agent's name, if any;

(f) Prepackaging and labeling of multi-dose and unit-dose packages of medication. The pharmacist must establish the procedures, including selection of containers, labels and lot numbers, and must verify the accuracy of the finished task.

(g) Picking doses for unit dose cart fill for a hospital or for a nursing home patient. The pharmacist must verify the accuracy of the finished task.

(h) Checking nursing units in a hospital or nursing home for non-judgmental tasks such as sanitation and out of date medication. Any problems or concerns shall be documented and initialed by a pharmacist.

(i) Recording patient or medication information in computer systems for later verification by the pharmacist.

(j) Bulk Compounding. Solutions for small-volume injectables, sterile irrigating solutions, products prepared in relatively large volume for internal or external use by patients, and reagents or other products for the pharmacy or other departments of a hospital. The supervising pharmacist must verify the accuracy in all instances.

(k) Preparation of parenteral products as follows:

(A) Performing functions involving reconstitution of single or multiple dosage units that are to be administered to a given patient as a unit. The supervising pharmacist must verify the accuracy in all instances.

(B) Performing functions involving the addition of one manufacturer's single dose or multiple unit doses of the same product to another manufacturer's prepared unit to be administered to a patient. The supervising pharmacist must verify the accuracy in all instances.

(l) Performing related activities approved in writing by the Board.

(3) In order to protect the public, safety, health and welfare, pharmacy technicians or certified pharmacy technicians shall not:

(a) Communicate or accept by oral communication a new or transferred prescription of any nature;

(b) Receive or transfer a prescription to another pharmacy without the prior verification of a pharmacist.

(c) Provide a prescription or medication to a patient without a pharmacist's verification of the accuracy of the dispensed medication;

(d) Counsel a patient on medications or perform a drug utilization review;

(e) Perform any task that requires the professional judgment of a pharmacist; or

(f) Engage in the practice of pharmacy as defined in ORS 689.015.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 1-2006, f. & cert. ef. 6-9-06

855-025-0050
Grounds for Discipline of Pharmacy Technicians and Certified Pharmacy Technicians

The State Board of Pharmacy may refuse to issue or renew; or suspend; or revoke; or restrict the license of; or impose a civil penalty upon a pharmacy technician or certified pharmacy technician upon the following grounds including but not limited to:

(1) Repeated or gross negligence;

(2) Incapacity of a nature that prevents a pharmacy technician or certified pharmacy technician from assisting in the practice of pharmacy with reasonable skill, competence and safety to the public;

(3) Habitual or excess use of intoxicants, drugs or controlled substances;

(4) Being found guilty by the Board of a violation of the pharmacy or drug laws of this state or rules pertaining thereto or of statutes, rules or regulations of any other state or of the federal government;

(5) Being found guilty by a court of competent jurisdiction of a felony as defined by the laws of this state;

(6) Being found guilty by a court of competent jurisdiction of a violation of the pharmacy or drug laws of this state or rules pertaining thereto or of statutes, rules or regulations of any other state or of the federal government;

(7) Fraud or intentional misrepresentation in securing or attempting to secure the issuance or renewal of a pharmacy technician or certified pharmacy technician license;

(8) Engaging an individual to engage in the duties of a pharmacy technician or certified pharmacy technician without a license or falsely using the title of pharmacy technician or certified pharmacy technician;

(9) Aiding and abetting an individual to engage in the duties of a pharmacy technician or certified pharmacy technician without a license or falsely using the title of pharmacy technician or certified pharmacy technician;

(10) Being found by the Board to be in violation of any violation of any of the provisions of ORS 435.010 to 435.130, 453.025, 453.045, 475.035 to 475.190, 475.805 to 475.995 or 689.005 to 689.995 or the rules adopted pursuant thereto.

(11) Failure to appropriately perform the duties of a pharmacy technician or certified pharmacy technician as outlined in OAR 855-025-0040 while assisting a pharmacist in the practice of pharmacy as defined in ORS 689.015.

(12) Aiding and abetting an individual in performing the duties of a pharmacy technician or certified pharmacy technician or in using the title of pharmacy technician or certified pharmacy technician without a license.

(13) Incapacity of a nature that prevents a pharmacy technician or certified pharmacy technician from performing the duties of a pharmacy technician or certified pharmacy technician with reasonable skill, competence and safety to the public.

(14) Repeated or gross negligence in performing the duties of a pharmacy technician or certified pharmacy technician; or

(15) Fraud or misrepresentation in dealings relating to performing the duties of a pharmacy technician or certified pharmacy technician with:

(a) Customers, patients, or the public;

(b) Practitioners authorized to prescribe drugs, medications, or devices;

(c) Insurance companies;

(d) Wholesalers, manufacturers, or distributors of drugs, medications, or devices;

(e) Health care facilities;

(f) Government agencies;

(g) Drug outlets.

(16) Illegal use of drugs, medications, or devices without a practitioner's prescription, or otherwise contrary to federal or state law or regulations;

(17) Theft of drugs, medications, or devices or theft of any other property or services under circumstances which bear a demonstrable relationship to the performing the duties of a pharmacy technician or certified pharmacy technician;

(18) Any act or practice relating to performing the duties of a pharmacy technician or certified pharmacy technician which is prohibited by state or federal law or regulation;

(19) Authorizing or permitting any person to perform the duties of a pharmacist, pharmacy technician or certified pharmacy technician in violation of the Oregon Pharmacy Act or the rules of the Board; and

(20) Any conduct or practice by a pharmacy technician, certified pharmacy technician or pharmacy which the Board determines is contrary to the accepted standards of practice.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.151 & SB 512 (2005), Sec. 8
Hist.: BP 9-2005, f. 12-14-05, cert. ef. 12-15-05; BP 1-2006, f. & cert. ef. 6-9-06

855-025-0060
Petition for Reinstatement of a Certified Pharmacy Technician License

(1) A certified pharmacy technician's license that has been revoked, suspended or restricted will be reinstated only if the Board finds, upon a presentation made by the petitioner, that there is a reasonable assurance that the public interest will be protected if relicensure occurs.

(2) A presentation must consist of a showing by the petitioner of changed circumstances from those surrounding the revocation, suspension or restriction of license. The presentation must include:

(a) A showing that the petitioner has engaged in treatment, programs, or other endeavors or activities since the suspension, revocation or restriction of license which has caused the rehabilitation of the petitioner to the extent that the public's interest would be protected if relicensure should be granted.

(b) Medical, psychological, sociological or other physical, mental or moral appraisals, evaluations or recommendations relating to the petitioner to aid the Board in its determination whether the petitioner has been rehabilitated to the extent that the public's interest would be protected if relicensure should be granted.

(3) Petitions to the Board for reinstatement of licensure after suspension, revocation or restriction must be in writing and must contain:

(a) A written statement of those changed circumstances which the petitioner believes warrant the Board's finding that there is a reasonable assurance that the public interest will be protected if relicensure occurs. Such statement must include a recitation of the treatment, programs, or other endeavors or activities undertaken by the petitioner, more particularly referred to subsection (2)(a) of this rule.

(b) A summarization of the medical, psychological, sociological or other physical, mental, or moral appraisals or recommendations which the petitioner intends to present to the Board pursuant to subsection (2)(b) of this rule.

(4) If, after opportunity is afforded the petitioner to show otherwise, the Board determines that a petition fails to comply with section (3) of this rule, or has not been made within a reasonable interval from the suspension, revocation, or restriction of license or from a previous petition, the Board will dismiss the petition without further investigation and hearing before the Board.

(5) Petitions which comply with section (3) of this rule will be scheduled for presentation of proof before the Board, and the petitioner will be notified of the time and place.

(6) The completion of any treatment, program or activity which the Board may recommend does not establish a right to reinstatement. The Board must, in each and every case, make a finding based upon the presentation of the petitioner that there is a reasonable assurance that the public interest will be protected if relicensure occurs.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: BP 1-2006, f. & cert. ef. 6-9-06

855-110-0005
Licensing Fees

(1) Pharmacist license examination and re-examination fee - $50.

(2) Pharmacist jurisprudence re-examination fee — $25.

(3) Pharmacist licensing by reciprocity fee — $200.

(4) Pharmacist licensing by score transfer fee — $200.

(5) Intern License fee. Expires May 31 every four years — $30.

(6) Pharmacist license fee. Expires June 30 annually — $120 Delinquent renewal fee, (postmarked after May 31) — $50.

(7) Certification of approved providers of continuing education courses fee, none at this time.

(8) Technician license fee. Expires September 30 annually — $35. Delinquent renewal fee, (postmarked after August 31) — $20.

(10) Certified Pharmacy Technician license fee. Expires September 30 annually — $35.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.135
Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. &ef. 4-3-80; 1PB 3-1980, f. 5-3-80, ef. 5-3-80 & 7-1-80; 1PB 2-1982, f. 3-8-82, ef. 4-1-82; 1PB 1-1984, f. & ef. 2-16-84; 1PB 3-1985, f. & ef. 12-2-85; PB 3-1988, f. & cert. ef. 5-23-88; PB 7-1989, f. & cert. ef. 5-1-89; PB 15-1989, f. & cert. ef. 12-26-89; PB 10-1990, f. & cert. ef. 12-5-90; PB 3-1991, f. & cert. ef. 9-19-91; PB 1-1992, f. & cert. ef. 1-31-92 (and corrected 2-7-92); PB 4-1992, f. & cert. ef. 8-25-92; PB 1-1994, f. & cert. ef. 2-2-94; PB 1-1996, f. & cert. ef. 4-5-96; PB 2-1997(Temp), f. 10-2-97, cert. ef. 10-4-97; BP 2-1998, f. & cert. ef. 3-23-98; BP 1-2001, f. & cert. ef. 3-5-01; BP 2-2001(Temp), f. & cert. ef. 7-26-01 thru 1-22-02; BP 1-2002, f. & cert. ef. 1-8-02; BP 1-2003, f. & cert. ef. 1-14-03; BP 1-2006, f. & cert. ef. 6-9-06

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Rule Caption: Related to authority to accept returned drugs and devices, allows waiver.
Adm. Order No.: BP 2-2006
Filed with Sec. of State: 6-9-2006
Certified to be Effective: 6-9-06
Notice Publication Date: 3-1-06
Rules Amended: 855-041-0080
Subject: Pharmacies should be able to accept returned drugs and devices for destruction when public or patient safety concerns make that appropriate. Amends rule to apply to pharmacies, pharmacy technicians and certified pharmacy technicians, in addition, allows Board to waive rule or parts of rule upon request, if public or individual health or safety requires.
Rules Coordinator: Karen Maclean—(971) 673-0005

855-041-0080
Returned Drugs and Devices

(1) Pharmacists, pharmacies, pharmacy technicians, and certified pharmacy technicians may only accept the return of controlled substances upon receiving a waiver from the Board of Pharmacy.

(2) Pharmacists, pharmacies, pharmacy technicians, and certified pharmacy technicians may accept the return of drugs or devices as defined by ORS 689.005 once the drugs or devices have been removed from the pharmacy only if;

(a) The drugs or devices are accepted for destruction or disposal and;

(b) The drugs or devices were dispensed in error, were defective, adulterated, misbranded, dispensed beyond their expiration date, were unable to be delivered to the patient, or are subject of a drug or device recall; or

(c) After consultation, a pharmacist determines that, in the pharmacist's professional judgment, harm could result to the public or a patient if the drugs or devices were not accepted for return.

(3) Not withstanding section 2 of this rule, drugs or devices previously dispensed or distributed may be returned and redispensed or redistributed provided all the following conditions are met:

(a) The drug is in an unopened, tamper-evident unit;

(b) The drugs or devices have remained at all times in control of a person trained and knowledgeable in the storage and administration of drugs in long term care facilities or supervised living groups using the services of a consultant pharmacist;

(c) The drug or device has not been adulterated or misbranded and has been stored under conditions meeting United States Pharmacopeia standards.

(4) Upon written request, the Board may waive any of the requirements of this rule if a waiver will further public heath or safety or the health and safety of a patient. A waiver granted under this section shall only be effective when it is issued by the Board in writing.

Stat. Auth.: ORS 475 & 689
Stats. Implemented:
Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; 1PB 1-1981(Temp), f. & ef. 4-1-81; 1PB 2-1981, f. & ef. 8-20-81; PB 5-1989, f. & cert. ef. 1-30-89; PB 8-1990, f. & cert. ef. 12-5-90; BP 2-2006, f. & cert. ef. 6-9-06

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Rule Caption: Amends rules related to pharmacists administering vaccines and immunizations.
Adm. Order No.: BP 3-2006
Filed with Sec. of State: 6-9-2006
Certified to be Effective: 6-9-06
Notice Publication Date: 3-1-06
Rules Amended: 855-041-0500, 855-041-0510, 855-041-0520
Subject: The amendments incorporate statutory changes allowing pharmacists to administer flu vaccines to people fifteen years of age and older, and the word "immunizations" to reflect statutory language, and reduce reporting requirements related to vaccines and immunizations.
Rules Coordinator: Karen Maclean—(971) 673-0005

855-041-0500
Qualifications

(1) A pharmacist may administer vaccines and immunizations to persons who are at least 18 years of age as provided by these rules. For the purposes of this rule, a person is at least 18 years of age on the day of the person's eighteenth birthday.

(2) A pharmacist may administer influenza vaccines to persons who are at least 15 years of age. For the purposes of this rule, a person is at least 15 years of age on the day of the person's fifteenth birthday.

(3) A pharmacist may administer vaccines or immunizations under section one or section two of this rule only if:

(a) The pharmacist has completed a course of training accredited by the Centers for Disease Control and Prevention, the American Council on Pharmaceutical Education or a similar health authority or professional body approved by the Board and the Oregon Department of Human Services;

(b) The pharmacist holds a current basic Cardiopulmonary Resuscitation (CPR) certification issued by the American Heart Association or the American Red Cross and documentation of the certification is placed on file in the pharmacy;

(c) The vaccines and immunizations are administered in accordance with an administration protocol approved by the Oregon Department of Human Services; and

(d) The pharmacist has a current copy of the CDC reference, "Epidemiology and Prevention of Vaccine-Preventable Diseases."

(4) No pharmacist may delegate the administration of vaccines to another person.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.015
Hist.: BP 7-2000, f. & cert. ef. 6-29-00; BP 3-2006, f. & cert. ef. 6-9-06

855-041-0510
Protocols, Policies and Procedures

(1) Prior to administering vaccines or immunizations to persons who are at least years of age or influenza vaccines to persons who are at least 15 years of age, pharmacists must follow written protocols approved by the Oregon Department of Human Services for administration of vaccines and the treatment of severe adverse events following administration of a vaccine(s).

(2) The pharmacy must maintain written policies and procedures for handling and disposal of used or contaminated equipment and supplies.

(3) The pharmacy must give the appropriate Vaccine Information Statement (VIS) to the patient or legal representative with each dose of vaccine or immunization covered by these forms. The pharmacist must ensure that the patient or legal representative is available and has read, or has had read to them, the information provided and has had their questions answered prior to administering the vaccine or immunization.

(4) The pharmacy must report adverse events as required by the Vaccine Adverse Events Reporting System (VAERS) and to the primary care provider as identified by the patient.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.015
Hist.: BP 7-2000, f. & cert. ef. 6-29-00; BP 3-2006, f. & cert. ef. 6-9-06

855-041-0520
Record Keeping and Reporting

(1) A pharmacist who administers any vaccine or immunization shall maintain the following information in the pharmacy records regarding each administration for a minimum of three years:

(a) The name, address, and date of birth of the patient;

(b) The date of the administration and site of injection of the vaccine or immunization;

(c) The name, dose, manufacturer, lot number, and expiration date of the vaccine or immunization;

(d) The name and address of the patient's primary health care provider, as identified by the patient;

(e) The name or identifiable initials of the administering pharmacist;

(f) The date the pharmacist reported the vaccination or immunization information to the patient's primary health care provider, as identified by the patient, and, when requested, to the Department of Human Services if different from the date of administration;

(g) Documentation of provision of informed consent for administration of vaccines or immunizations if needed for transmission of records to a primary care provider. The pharmacist must also report to the Department of Human Services as requested for vaccines or immunizations specifically identified by the Department.

(h) Which Vaccine Information Statement (VIS) was provided;

(i) The date of publication of the VIS; and

(j) The date the VIS was provided.

(2) A pharmacist who administers any vaccine or immunization must report in writing to the patient's primary health care provider, as identified by the patient, the information required to be maintained by OAR 855-041-0520(1). The report shall be made within fourteen days of the date of administration.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.015
Hist.: BP 7-2000, f. & cert. ef. 6-29-00; BP 3-2006, f. & cert. ef. 6-9-06

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Rule Caption: Implements new restrictions on sale of some cold medications in response to legislation.
Adm. Order No.: BP 4-2006
Filed with Sec. of State: 6-9-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 3-1-06
Rules Amended: 855-050-0070, 855-080-0022, 855-080-0023, 855-080-0028, 855-080-0031, 855-080-0065, 855-080-0070, 855-080-0075, 855-080-0095, 855-080-0105
Rules Repealed: 855-050-0037, 855-050-0038, 855-050-0039, 855-050-0041, 855-050-0042, 855-050-0043
Subject: These rules implement legislation passed in the 2005 legislative session that required the Board of Pharmacy to place ephedrine, Pseudoephedrine and phenylpropanolamine on Controlled

Substances Schedule III. These three drugs will be available by prescription only effective July 1, 2006. In addition, these changes repeal existing rules that require pharmacies to keep a separate log of sales of Pseudoephedrine because pharmacies will now track those sales as sales of prescription drugs. These amendments also include some housekeeping revisions.

Rules Coordinator: Karen Maclean—(971) 673-0005

855-050-0070
Prescription Drugs

(1) The following are prescription drugs:

(a) Drugs required by federal law to be labeled with either of the following statements:

(A) "Caution: Federal law prohibits dispensing without prescription"

(B) "Caution: Federal law restricts this drug to be used by or on the order of a licensed veterinarian"; or

(C) "Rx only"

(b) Drugs designated as prescription drugs by the Oregon Board of Pharmacy

(2) The Oregon Board of Pharmacy designates the following drugs as prescription drugs:

(a) Preparations containing codeine or salts of codeine

(b) Preparations containing opium/paregoric

(3) No person shall sell, give away, barter, transfer, purchase, receive or possess prescription drugs except upon the prescription of a practitioner.

(4) Manufacturers, wholesalers, institutional and retail drug outlets and practitioners are exempt from the prohibition of subsection 3.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.155
Hist.: PB 3-1990, f. & cert. ef. 4-5-90; PB 9-1990, f. & cert. ef. 12-5-90; PB 4-1991, f. & cert. ef. 9-19-91; BP 1-2002, f. & cert. ef. 1-8-02; BP 7-2004, f. & cert. ef. 11-8-04; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

855-080-0022
Schedule II

Schedule II consists of the drugs and other substances by whatever official, common, usual, chemical, or brand name designated, listed in this rule:

(1) Substances, vegetable origin or chemical synthesis: Unless specifically excepted or unless listed in another schedule, any quantity of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(a) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate excluding apomorphine, dextrophan, nalbuphine, nalmefene, naloxone, and naltrexone, and their respective salts, but including the following:

(A) Raw opium.

(B) Opium extracts.

(C) Opium fluid.

(D) Powdered opium.

(E) Granulated opium.

(F) Tincture of opium.

(G) Codeine.

(H) Ethylmorphine.

(I) Etorphine hydrochloride.

(J) Hydrocodone.

(K) Hydromorphone.

(L) Metopon.

(M) 6-monoacetyl morphine.

(N) Morphine.

(O) Oxycodone.

(P) Oxymorphone.

(Q) Thebaine.

(b) Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subsection (a) of this section except that these substances shall not include the isoquinoline alkaloids of opium.

(c) Opium poppy and poppy straw.

(d) Cocaine, including its salts, isomers (whether optical or geometric) and salts of such isomers; coca leaves, and any salt, compound, derivative or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecognine.

(e) Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid or powder form which contains the phenanthrene alkaloids of the opium poppy).

(2) Opiates: Unless specifically excepted or unless listed in another schedule any quantity of the following substances, including its isomers, esters, ethers, salts and salts of isomers, esters and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation, dextrorphan and levopropoxyphene excepted:

(a) Alfentanil.

(b) Alphaprodine.

(c) Anileridine.

(d) Bezitramide.

(e) Bulk Dextropropoxyphene (non-dosage forms).

(f) Carfentanil.

(g) Dihydrocodeine.

(h) Diphenoxylate.

(i) Fentanyl.

(j) Isomethadone.

(k) Levo-alphacetylmethadol (levo-alphaacetylmethadol, levomethadyl acetate, LAAM).

(l) Levomethorphan.

(m) Levorphanol.

(n) Metazocine.

(o) Methadone.

(p) Methadone-Intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane.

(q) Moramide-Intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid.

(r) Pethidine (meperidine).

(s) Pethidine-Intermediate-A, 4-cyano-1-methyl-4, phenylpiperidine.

(t) Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate.

(u) Pethidine-Intermediate-C, 1 methyl-4-phenylpiperidine-4-carboxylic acid.

(v) Phenazocine.

(w) Piminodine.

(x) Racemethorphan.

(y) Racemorphan.

(z) Sufentanil.

(3) Stimulants: Unless specifically excepted or listed in another schedule, any quantity of the following substances:

(a) Amphetamine, its salts, optical isomers, and salts of its optical isomers.

(b) Methamphetamine, its salts, isomers, and salts of its isomers

(c) Phenmetrazine and its salts.

(d) Methylphenidate.

(4) Depressants: Unless specifically excepted or listed in another schedule, any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(a) Amobarbital.

(b) Glutethimide.

(c) Pentobarbital.

(d) Phencyclidine.

(e) Secobarbital.

(5) Hallucinogenic Substances: Unless specifically excepted or unless listed in another schedule, any quantity of the following substances, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation: Nabilone.

(6) Immediate precursors: Unless specifically excepted or listed in another schedule, any quantity of the following substances:

(a) Immediate precursor to amphetamine and methamphetamine: Phenylacetone.

(b) Immediate precursors to phencyclidine:

(A) 1-phenylcyclohexylamine.

(B) 1-piperidinocyclohexanecarbonitrile (PCC).

(7) Other Substances: Unless specifically excepted or listed in another schedule, any quantity of the following substances or their salts or stereoisomers:

(a) Anthranilic acid.

(b) Hydriodic acid.

(c) Methylamine.

(d) Methylformamide.

(e) Lead Acetate.

(f) Phenylacetic acid.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 475.035
Hist.: PB 4-1987, f. & ef. 3-30-87; PB 8-1987, f. & ef. 9-30-87; PB 10-1987, f. & ef. 12-8-87; PB 15-1989, f. & cert. ef. 12-26-89; PB 9-1990, f. & cert. ef. 12-5-90; PB 5-1991, f. & cert. ef. 9-19-91; PB 1-1992, f. & cert. ef. 1-31-92 (and corrected 2-7-92); PB 1-1994, f. &

cert. ef. 2-2-94; PB 1-1996, f. & cert. ef. 4-5-96; PB 1-1997, f. & cert. ef. 9-22-97; BP 3-1999(Temp), f. & cert. ef. 8-9-99 thru 1-17-00; BP 4-2000, f. & cert. ef. 2-16-00; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

855-080-0023
Schedule III

Schedule III consists of the drugs and other substances by whatever official, common, usual, chemical, or brand name designated, listed in this rule:

(1) Stimulants: Unless specifically excepted or unless listed in another schedule, any quantity of the following substances, including its salts, isomers (whether optical, position, or geometric), and salts of such isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(a) Those compounds, mixtures, or preparations in dosage unit form containing any stimulant substances listed in Schedule II which compounds, mixtures, or preparations are listed as excepted compounds under Section 1308.32 of Title 21 of the Code of Federal Regulations, and any other drug of the quantitative composition shown in that list for those drugs or which is the same except that it contains a lesser quantity of controlled substances;

(b) Benzphetamine;

(c) Chlorphentermine;

(d) Clortermine;

(e) Phendimetrazine.

(2) Depressants: Unless specifically excepted or listed in another schedule, any quantity of the following substances:

(a) In a compound, mixture or preparation containing:

(A) Amobarbital;

(B) Secobarbital;

(C) Pentobarbital;

(D) A salt thereof and one or more other active medicinal ingredients which are not listed in any schedule.

(b) In a suppository dosage form containing:

(A) Amobarbital;

(B) Secobarbital;

(C) Pentobarbital;

(D) Salts of any of these drugs which have been approved by the Food and Drug Administration for marketing as a suppository.

(c) Derivatives of barbituric acid or any salt thereof;

(d) Chlorhexadol;

(e) Lysergic acid;

(f) Lysergic acid amide;

(g) Methyprylon;

(h) Sulfondiethylmethane;

(i) Sulfonethylmethane;

(j) Sulfonmethane;

(k) Tiletamine and zolazapam or any salt thereof.

(3) Any quantity of the following substances, including its salts, isomers (whether optical, position, or geometric), and salts of such isomers, whenever the existence of such salts, isomers, and salts of isomer is possible:

(a) Nalorphine.

(4) Narcotic Drugs: Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing any of the following narcotic drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities as set forth below:

(a) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium.

(b) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, non-narcotic ingredients in recognized therapeutic amounts.

(c) Not more than 300 milligrams of dihydrocodeinone (hydrocodone) per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium.

(d) Not more than 300 milligrams of dihydrocodeinone (hydrocodone) per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active non-narcotic ingredients in recognized therapeutic amounts.

(e) Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active non-narcotic ingredients in recognized therapeutic amounts.

(f) Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, non-narcotic ingredients in recognized therapeutic amounts.

(g) Not more than 500 milligrams of opium per 100 milliliters or per 100 grams or not more than 25 milligrams per dosage unit, with one or more active non-narcotic ingredients in recognized therapeutic amounts.

(h) Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with one or more active non-narcotic ingredients in recognized therapeutic amounts.

(5) Anabolic Substances: Any quantity of the following substances or its isomer, ester, salt, or derivative except that anabolic substances in a dosage form approved by the Food and Drug Administration for administration through implants to cattle or other nonhuman species shall not be classified as controlled substances:

(a) Boldenone;

(b) Chlorotestosterone (4-chlortestosterone);

(c) Clostebol;

(d) Dehydrochlormethyltestosterone;

(e) Dihydrotestosterone (4-dihydrotestosterone);

(f) Dostanolone;

(g) Ethylestrenol;

(h) Fluoxymesterone;

(i) Formebulone (formebolone);

(j) Human growth hormone;

(k) Mesterolone;

(l) Methandienone;

(m) Methandranone;

(n) Methandriol;

(o) Methandrostenolone;

(p) Methenolone;

(q) Methyltestosterone;

(r) Milbolerone

(s) Nandrolone;

(t) Norethandrolone;

(u) Oxandrolone;

(v) Oxymesterone;

(w) Oxymetholone;

(x) Stanolone;

(y) Stanozolol;

(z) Testolactone;

(aa) Testosterone;

(bb) Trenbolone.

(6) Hallucinogenic Substances: Unless specifically excepted or unless listed in another schedule, any quantity of the following substances, its salts, isomer, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible: Dronabinol (synthetic) in sesame oil and encapsulated in a soft gelatin capsule in a U.S. Food and Drug Administration approved drug product.

(7) Other Substances: A drug containing gamma-hydroxybutyrate that has been approved by the Food and Drug Administration as a legend drug is a Schedule III controlled substance.

(8) Products containing pseudoephedrine, the salts, isomers or salts of isomers of pseudoephedrine as an active ingredient.

(9) Products containing ephedrine, the salts, isomers or salts of isomers of ephedrine as an active ingredient.

(10) Products containing phenylpropanolamine, the salts, isomers or salts of isomers of phenylpropanolamine as an active ingredient.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 475.035
Hist.: PB 4-1987, f. & ef. 3-30-87; PB 11-1989, f. & cert. ef. 7-20-89; PB 5-1991, f. & cert. ef. 9-19-91; PB 1-1992, f. & cert. ef. 1-31-92 (and corrected 2-7-92); BP 3-1999(Temp), f. & cert. ef. 8-9-99 thru 1-17-00; BP 4-2000, f. & cert. ef. 2-16-00; BP 9-2000, f. & cert. ef. 6-29-00; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

855-080-0028
Excluded Substances

The following drugs and their generic equivalents are excepted from the schedules in OAR 855-080-0021 through 855-080-0026:

(1) Estratest.

(2) Estratest HS.

(3) Premarin with Methyltestosterone.

(4) Estradiol Cypionate Injection.

(5) Estradiol Valerate Injection.

Stat. Auth.: ORS 689.155 & 689.205
Stats. Implemented:
Hist.: 1PB 6-1978(Temp), f. & ef. 7-1-78; 1PB 8-1978, f. & ef. 10-17-78; 1PB 6-1982, f. & ef. 8-6-82; PB 4-1987, f. & ef. 3-30-87; Renumbered from 855-080-0025; PB 5-1991, f. & cert. ef. 9-19-91; PB 1-1995, f. & cert. ef. 4-27-95; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

855-080-0031
Registration Requirements

Manufacturers, distributors, and pharmacies (the latter referred to in OAR 855-080-0030 through 855-080-0095 as “dispensers”) are required to register with the Board under the Uniform Controlled Substances Act.

Stat. Auth.: ORS 475 & 689
Stats. Implemented:
Hist.: 1PB 6-1982, f. & ef. 8-6-82; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

855-080-0065
Security

(1) Applicants for registration and registrants must comply with the security requirements of **21 CFR 1301.02**, **1301.71** through **1301.76** and **1301.90** through **1301.93**, which apply to their registration classification. The requirements of **21 CFR 1301.75** and **1301.76** relating to “practitioners” are applicable to applicants and registrants who are drug dispensers.

(2) The security requirements of subsection one of this rule apply to all “controlled substances,” as defined in OAR 855-080-0020, except ephedrine, pseudoephedrine and phenylpropanolamine.

(3) Applicants and registrants must guard against theft and diversion of ephedrine, pseudoephedrine and phenylpropanolamine.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 475 & 689
Stats. Implemented:
Hist.: 1PB 6-1978(Temp), f. & ef. 7-1-78; 1PB 8-1978, f. & ef. 10-17-78; 1PB 6-1982, f. & ef. 8-6-82; PB 5-1991, f. & cert. ef. 9-19-91; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

855-080-0070
Records and Inventory

All registered persons shall, as applicable to the registration classification, keep records and maintain inventories in conformance with **21 U.S.C. Section 827**; **21 CFR 1304.02** through **1304.19**; **1304.21** through **1304.29**; **1304.31** through **1304.38**; except that a written inventory of all controlled substances shall be taken by registrants annually within 365 days of the last written inventory. All such records shall be maintained for a period of three years.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 475.035 & 689.205
Stats. Implemented:
Hist.: 1PB 6-1978(Temp), f. & ef. 7-1-78; 1PB 8-1978, f. & ef. 10-17-78; 1PB 6-1982, f. & ef. 8-6-82; 1PB 1-1986, f. & ef. 6-5-86; PB 10-1987, f. & ef. 12-8-87; PB 5-1991, f. & cert. ef. 9-19-91; PB 1-1994, f. & cert. ef. 2-2-94; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

855-080-0075
Order Forms

Controlled substances in Schedules I and II shall be distributed by a registrant to another registrant only pursuant to an order form in conformance with **21 U.S.C. Section 828** and **21 CFR 1305.01** through **1305.29**.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 475 & 689
Stats. Implemented:
Hist.: 1PB 6-1978(Temp), f. & ef. 7-1-78; 1PB 8-1978, f. & ef. 10-17-78; PB 5-1991, f. & cert. ef. 9-19-91; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

855-080-0095
Verification of Research Registration

Persons conducting research with controlled substances in Sections I through V within this state who are not otherwise exempt from registration pursuant to ORS 475.125(3), may, upon furnishing the Board a copy of a current federal registration certificate issued for such a purpose, pursuant to ORS 475.135, receive written verification of such submission from the Board’s Executive Director.

Stat. Auth.: ORS 475
Stats. Implemented:
Hist.: 1PB 6-1978(Temp), f. & ef. 7-1-78; 1PB 8-1978, f. & ef. 10-17-78; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

855-080-0105
Disposal of Drugs

(1) Drugs that are outdated, damaged, deteriorated, misbranded, or adulterated shall be quarantined and physically separated from other drugs until they are destroyed or returned to their supplier.

(2) Controlled substances which are expired, deteriorated or unwanted shall be disposed of in conformance with **21 CFR 1307.21**.

(3) Expired, deteriorated, discontinued, or unwanted controlled substances in a long-term care facility shall be destroyed and the destruction jointly witnessed on the premises by any two of the following:

(a) The consultant pharmacist or registered nurse designee.

(b) The Director of Nursing Services or supervising nurse designee

(c) The administrator of the facility or an administrative designee

(d) A Registered Nurse employed by the facility

(4) The destruction shall be documented and signed by the witnesses and the document retained at the facility for a period of at least three years. Copies of the document shall be sent to the Drug Enforcement Administration and to the consultant pharmacist. Any destruction of controlled substances deviating from this procedure must be approved by the Board prior to implementation.

(5) Upon written request, the Board may waive any of the requirements of this rule if a waiver will further public heath or safety or the health and safety of a patient. A waiver granted under this section shall only be effective when it is issued by the Board in writing.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 475.035 & 689.205
Stats. Implemented: ORS 689.305
Hist.: 1PB 2-1984, f. & ef. 3-7-84; PB 1-1989, f. & cert. ef. 1-3-89; PB 1-1990, f. & cert. ef. 1-23-90; PB 1-1992, f. & cert. ef. 1-31-92 (and corrected 2-7-92); PB 1-1996, f. & cert. ef. 4-5-96; BP 4-2006, f. 6-9-06, cert. ef. 7-1-06

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Construction Contractors Board
Chapter 812

Rule Caption: Housekeeping changes and revises dishonest & fraudulent conduct definition.
Adm. Order No.: CCB 6-2006
Filed with Sec. of State: 5-25-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 5-1-06
Rules Adopted: 812-001-0180
Rules Amended: 812-001-0160, 812-002-0260, 812-002-0533, 812-003-0130, 812-003-0180, 812-003-0200, 812-003-0250, 812-003-0260, 812-003-0280, 812-006-0010, 812-006-0011, 812-006-0020, 812-006-0050, 812-008-0074
Subject: • 812-001-0160 is amended to delete criteria no longer used to answer public records requests since the information is available on the website.

• 812-001-0180 is adopted to create a separate rule for refunds. Formerly 812-001-0160(7).

• 812-002-0260 is amended to add ORS 701.135(2)(a)(D) to the definition of dishonest or fraudulent conduct. This amendment will allow the agency the ability to emergency suspend a license.

• 812-002-0533, 812-003-0130, 812-003-0260, 812-003-0280, 812-006-0010, 812-006-0011, 812-006-0020 & 812-006-0050 are amended to correct cite references.

• 812-003-0180 is amended to allow cancellation of a bond to go into effect more than 30 days from the date of receipt of cancellation notice from bonding company.

• 812-003-0200 is amended to correct a cite reference.

• 812-003-0250 is amended to include limited liability companies, which was inadvertently left off the previous amendment to this rule.

• 812-008-0074 is amended for clarity because in the past home inspector applicants have assumed that the “agency study guide items” referred to in OAR 812-008-0074(1) is the CCB 16 hour licensing class and that it will help them qualify to take the Home Inspector Certification test. Applicants have also assumed that the class can be used for part of the continuing education units (CEUs) needed to renew their certification. This change will help clarify that it is the home inspector study guide they need to refer to.

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

812-001-0160
Requests for Information; Charges for Records

(1) 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 dates in the license history and the action that took place on those dates.

(2) 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.

Stat. Auth.: ORS 293.445, 670.310 & 701.235
Stats. Implemented: ORS 192.430, 293.445, 701.235 & 701.250
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; Renumbered from 812-001-0015, CCB 7-2005, f. 12-7-05, cert. ef. 1-1-06; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-001-0180
Refunds

(1) 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.

(2) 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, 670, 310 & 701.235
Stats. Implemented: ORS 293.445 & 701
Hist.: CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-002-0260
Dishonest or Fraudulent Conduct

"Dishonest or fraudulent conduct", as used in ORS 701.135(1)(k) and (2)(a)(D) includes, but is not limited to, the following:

(1) Acting in a manner that, because of a wrongful or fraudulent act by the applicant or licensee, has resulted in injury or damage to another person; or

(2) Failing to pay monies when due for materials or services rendered in connection with the applicant's or licensee's operations as a contractor when the applicant or licensee has received sufficient funds as payment for the particular construction work project or operation for which the services or materials were rendered or purchased; or

(3) Accepting payment in advance on a contract or agreement and failing to perform the work or provide services required by the contract or agreement in a diligent manner and failing to return payment for unperformed work, upon reasonable and proper demand, within ten days of demand; or

(4) Displaying to the public false, misleading, or deceptive advertising whereby a reasonable person could be misled or injured; or

(5) Submitting a license application that includes false or misleading information; or

(6) Submitting a false gross business volume certification in order to qualify for a reduced bond amount as set forth in OAR 812-003-0280; or

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

(8) Failing to comply with the state Prevailing Wage Rate Law, ORS 279C.800 to 279C.870; or

(9) Failing to comply with the federal Davis-Bacon and related acts when the terms of the contract require such compliance.

(10) Failing to pay wages as determined by the Bureau of Labor & Industries, Wage and Hour Division.

(11) Failing to timely pay a civil penalty or fine imposed by a unit of local, state, or federal government.

(12) Presenting for payment to the Board a check that subsequently is returned to the agency due to non-sufficient funds or closure of the account.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701.135
Hist.: CCB 4-1998, f. & cert. ef. 4-30-98; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 11-2000(Temp), f. 9-21-00, cert. ef. 9-21-00 thru 3-19-01; 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 4-2003, f. & cert. ef. 6-3-03; CCB 9-2004, f. & cert. ef. 12-10-04; CCB 7-2005, f. 12-7-05, cert. ef. 1-1-06; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-002-0533
Officer

(1) "Officer", as used in ORS chapter 701 and these rules means:

(a) A person described as an "officer" in ORS 701.005;

(b) A partner in a partnership, or limited liability partnership;

(c) A responsible managing individual described in ORS 701.078; or

(d) A person who has a financial interest in a business and manages or shares in the management of the business; or

(2) "Officer", as used in ORS chapter 701 and these rules, includes an individual who has a financial interest in another business and who is an officer of that other business if that other business owns more than fifty percent of the particular business.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701.078
Hist.: CCB 7-2005, f. 12-7-05, cert. ef. 1-1-06; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-003-0130
License Categories

The following are license categories as provided in ORS 701.005:

(1) General Contractor — All structures. A person licensed in this category may:

(a) Bid or perform work on three or more unrelated building trades or crafts on all types of structures, and

(b) Bid or perform the work of a Specialty Contractor — All-Structures.

(2) General Contractor — Residential Only. A person licensed in this category may:

(a) Bid or perform work on three or more unrelated building trades or crafts on residential structures or small commercial properties only; and

(b) Bid or perform the work of a Specialty Contractor — Residential-Only.

(3) Special Contractor — All structures. A person licensed in this category may:

(a) Bid or perform work on two or less unrelated building trades or crafts with no dollar limit on all types of structures.

(b) If three or more unrelated trades or crafts are performed or subcontracted out, the entire contract price cannot exceed $2,500.

(4) Specialty Contractor — Residential Only. A person licensed in this category may:

(a) Bid or perform work on two or less unrelated building trades or crafts with no dollar limit on all residential structures or small commercial properties only.

(b) If three or more unrelated trades or crafts are performed or subcontracted out, the entire contract price cannot exceed $2,500.

(5) Limited Contractor. A person licensed in this category may:

(a) Bid or perform Specialty Contractor, General Contractor, residential, small commercial and large commercial construction work, as long as all of the following conditions are met:

(A) The licensee's annual gross business sales do not exceed $40,000.

(B) The licensee does not enter into a contract in which the contract price exceeds $5,000.

(C) If the contract price in a contract for work performed by the licensee is based on time and materials, the amount charged by the licensee shall not exceed $5,000.

(D) The licensee consents to inspection by the Construction Contractors Board of its Oregon Department of Revenue tax records to verify compliance with paragraph (5)(a)(A) of this rule.

(E) For purposes of this section, "contract" includes a series of agreements between the licensee and a person for work on any single work site within a one-year period.

(6) Inspector. A person licensed in this category may:

(a) Bid or perform inspections, but may not construct, alter, repair, add to, subtract from, improve, move, wreck or demolish for another, any building, highway, road, railroad, excavation or other structure, project, development or improvement attached to real estate or do any part thereof, or act as a contractor performing construction management on a project that involves any of these activities.

(7) Licensed Developer. A person licensed in this category may arrange for construction work on property they own or have an interest in as long as they meet the conditions in ORS 701.005(8).

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701.005, 701.055, 701.058 & 701.085
Hist.: CCB 9-2004, f. & cert. ef. 12-10-04; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-003-0180
Effective and Cancellation Dates of the Bond

(1) The surety bond's effective date is the date on which the licensee has first met all requirements for licensing, renewal or reissue as determined by the agency. The bond shall remain in effect and be continuous until cancelled by the surety or until the licensee no longer meets the requirements for licensing as determined by the agency, whichever comes first.

(2) A surety bond may be cancelled by the surety only after the surety has given 30 days' notice to the agency. Cancellation will be effective no less than 30 days after receipt of the cancellation notice.

(3) Immediately upon cancellation of the bond, the agency may send an emergency suspension notice to the contractor as provided for in ORS 701.135(2)(a)(A), informing the contractor that the license has been suspended.

(4) The bond shall be subject to final orders as described in OAR 812-004-0600.

(5) The surety will be responsible for ascertaining the bond's effective date.

Stat. Auth.: ORS 670.310, 701.085 & 701.235
Stats. Implemented: ORS 701.085 & 701.135
Hist.: CCB 9-2004, f. & cert. ef. 12-10-04; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-003-0200
Insurance Generally

(1) An applicant for a license, renewal or reissue shall certify that the applicant:

(a) Has procured insurance as required by ORS 701.105 and as provided in OAR 812-002-0380 from an insurer transacting insurance in Oregon; and

(b) Will continue to meet those insurance requirements for as long as the applicant is licensed.

(2) Licensees shall provide a certificate of insurance or other evidence of insurance as required by the agency upon request or prior to the expiration date of their insurance.

(3) A certificate of insurance must include:

(a) The name of the insurer;

(b) Policy or binder number;

(c) Effective dates of coverage;

(d) Coverage amount per occurrence;

(e) The agent's name, and agent's telephone number; and

(f) The CCB listed as the certificate holder.

(4) If the licensee, in performance of work subject to ORS chapter 701, through failure to comply with this rule, causes damage to another entity or to the property of another person for which that entity could have been compensated by an insurer had the required insurance been in effect, the agency may assess a civil penalty against the licensee in an amount up to $l,000 in addition to such other action as may be taken under ORS 701.135.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701.105
Hist.: CCB 9-2004, f. & cert. ef. 12-10-04; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

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;

(k) Trusts with more than two trustees if any of the trustees are not family members.

(l) Limited liability companies with one or more employees; or

(m) Limited liability companies with more than two members if any of the members 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 to 183.500, 670.310, 701.235 & 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; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

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 and passed the examination required under ORS 701.072 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, 701.072, 701.075, 701.085, 701.105, & 701.125

Hist.: CCB 9-2004, f. & cert. ef. 12-10-04; CCB 3-2005, f. & cert. ef. 8-24-05; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-003-0280

Renewal and Reissue of License

(1) A license may be renewed or reissued upon:

(a) The applicant's completion of the renewal form or application form prescribed by the agency;

(b) Payment of the fee or fees,

(c) Receipt of the required certification of insurance coverage, and

(d) A non-cancelled bond on file. If it appears to the agency that the required surety bond has been cancelled, the applicant must submit a reinstatement from the surety on the cancelled bond or a new, original, continuous until cancelled surety bond.

(2) A licensee may qualify for Limited Contractor license and reduce the bond to $5,000 upon certification that:

(a) The licensee will not enter into contracts that exceed $5,000;

(b) The licensee's gross business sales of work subject to ORS chapter 701 was less than $40,000 in the previous twelve months and is expected to be less than $40,000 during the next twelve months; and

(c) The licensee agrees that if the licensee's gross construction business volume exceeds $40,000 during the coming year the licensee will immediately increase the bond amount to the amount required under OAR 812-003-0170, and increase the insurance coverage if necessary, to meet the requirements of the appropriate license category.

(3) A bond may be reduced under section (2) of this rule by submitting a decrease rider to an existing bond or submitting a new bond. The effective date on either the decrease rider or the new bond must be the license renewal date or after.

(4) The agency may refuse to authorize a reduced bond amount under section (2) of this rule until any pending claim(s) against the licensee are resolved.

(5) If a licensee provides a decrease rider to an existing bond under section (3) of this rule prior to the license renewal date, the agency will determine the effective date to be the date of renewal or reissue.

Stat. Auth.: ORS 670.310, 701.235

Stats. Implemented: ORS 701.085, 701.105, 701.115, 701.125

Hist.: CCB 9-2004, f. & cert. ef. 12-10-04; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-006-0010

General

(1) The following rules apply to the implementation of prerequisite education and implementation of testing requirements under ORS 701.072 and are not applicable to those licensees exempt under those statutes.

(2) The purpose of ORS 701.072 and these rules is to improve the professional business competency of construction contractors by providing reasonable standards for prerequisite education and testing required under ORS 701.072.

(3) Hours of education refer to clock hours, not credit hours.

(4) Evidence of course completion and test passage shall consist of information supplied to the agency by the education provider and test administrator.

Stat. Auth.: ORS 670.310, 701.235 & 701.280

Stats. Implemented: ORS 701.280

Hist.: CCB 1-1992, f. 1-27-92, cert. ef. 2-1-92; CCB 3-1993, f. & cert. ef. 6-9-93; CCB 3-1997, f. & cert. ef. 10-3-97; CCB 1-1998, f. & cert. ef. 2-6-98; CCB 3-1998, f. & cert. ef. 2-26-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 1-1999, f. 3-29-99, cert. ef. 4-1-99; CCB 5-1999, f. & cert. ef. 9-10-99; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

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 and passing any test required by ORS 701.072. 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 701.072 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, 701.072 & 701.235

Stats. Implemented: ORS 701.072

Hist.: CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 3-2005, f. & cert. ef. 8-24-05; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-006-0020
Exemptions

(1) In lieu of the education courses required under ORS 701.072, an applicant may provide evidence satisfactory to the agency that the responsible managing individual:

(a) Has completed the licensing requirements of ORS 446.395 for manufactured dwelling installers;

(b) Is listed on the agency's current computer license records as having been licensed as a sole proprietor, partner, corporate officer, member, designated RMI, or trustee prior to July 1, 2000 and that the business has been lapsed with the agency for 24 months or less.

(2) In lieu of the test required under ORS 701.072, an applicant may provide evidence satisfactory to the agency that the responsible managing individual.

(a) Is listed on the agency's current computer license records as having been licensed as a sole proprietor, partner, corporate officer, member, or trustee prior to July 1, 2000, and that the business has been lapsed with the agency for 12 months or less; or

(b) Effective January 1, 2002, is listed on the agency's current computer license records as having been licensed as a sole proprietor, partner, corporate officer, member, designated RMI, or trustee prior to July 1, 2000 and that the business has been lapsed with the agency for 24 months or less.

(3) Education and testing that was completed prior to the 12-month lapse in OAR 812-006-0020(1)(b) shall not be used to fulfill this requirement.

(4) Effective January 1, 2002, education and testing that was completed prior to the 24-month lapse in OAR 812-006-0020(1)(b) shall not be used to fulfill this requirement.

Stat. Auth.: ORS 670.310, 701.072 & 701.235
Stats. Implemented: ORS 701.072
Hist.: CCB 1-1992, f. 1-27-92, cert. ef. 2-1-92; CCB 5-1992, f. 7-31-92, cert. ef. 8-1-92; CCB 3-1993, f. & cert. ef. 6-9-93; CCB 4-1993, f. 8-17-93, cert. ef. 8-18-93; CCB 5-1993, f. 12-7-93, cert. ef. 12-8-93; CCB 1-1994, f. 6-23-94, cert. ef. 7-1-94; CCB 2-1994, f. 12-29-94, cert. ef. 1-1-95; CCB 2-1995, f. 6-6-95, cert. ef. 6-15-95; CCB 1-1998, f. & cert. ef. 2-6-98; CCB 1-1999, f. 3-29-99, cert. ef. 4-1-99; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 4-2001(Temp), f. & cert. ef. 5-18-01 thru 11-13-01; Administrative correction 11-20-01; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 5-2002, f. 5-28-02, cert. ef. 6-1-02; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; CCB 11-2003, f. 12-5-03, cert. ef. 1-1-04; CCB 9-2004, f. & cert. ef. 12-10-04; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-006-0050
Education Subjects

(1) The agency may evaluate and approve courses based on written evaluation criteria approved by the Training and Education Committee and made available to providers. The agency may revoke a provider's right to offer classes if a provider's courses do not meet the approved criteria.

(2) The 16 hours of education shall consist of the following topics:

(a) Construction Contractors Board: role and authority, licensing requirements, application procedures, major divisions and functions; dispute resolution processes; business entities; mandatory consumer notices; rights and responsibilities of consumers and contractors; address change notification; enforcement program, and statutes and rules that govern contractors;

(b) Employer requirements and employee's rights: state agencies that regulate workplace issues; information and resources on employer requirements, employee's rights, workers' compensation insurance, and required workplace postings; civil rights; Title VII, child labor, and important state and federal wage and hour laws; current minimum wage rate requirements; prevailing wage rate law; employees and independent contractors;

(c) Taxes, record keeping and business practices: required employment forms; identification numbers; cost of employees; importance of good record keeping; ways to organize records; required tax forms and reporting times; professional help; profit and cash flow; requirements for business licenses;

(d) Building codes: applicable codes; building codes books; code revisions; specialty licenses and inspections; required and exempt permit work; permit applications permit violation penalties; required inspections; inspection procedures; final inspections and occupancy permits; red tag/stop work orders ;

(e) Oregon Occupational Safety and Health Division: OR-OSHA regulations, job site inspections and resources; equipment basics and maintenance; job site record keeping; general safety practices, responsibilities and relationships among contractors and subcontractors on a job site;

(f) Sound environmental practices and laws: environmental friendly materials; good recycling, reduction and reuse methods; hazardous waste and special waste found in new and old construction; laws and regulations governing environmental hazards, proper handling and disposal methods of environmental hazards and job site debris; governmental agencies that regulate environmental conditions at a job site; environmental violation penalties; site preparation including construction activities that impact rivers; recycling methods; soil erosion; wetlands, water quality, sewage and underground storage/heating oil tanks;

(g) Contract law: clear and concise contracts; four elements of contract law; three elements of a construction contract; breach of contract; minor and major breach of contract; written and verbal contracts and change orders; contractor responsibilities for work of self and others; partnering, negotiation, mediation, arbitration and litigation; Buyer's Right to Cancel;

(h) Oregon construction lien law: purpose; required notices; lien law procedures; steps and timelines to perfect a lien and foreclose; important lien law differences of other states; and

(i) Project management, estimating and scheduling: importance of project management and consequences for failing to do so; simple written budgets that include cost, overhead and profit; simple project schedules and consequences of improper job scheduling.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701.072
Hist.: CCB 1-1992, f. 1-27-92, cert. ef. 2-1-92; CCB 2-1992, f. & cert. ef. 4-15-92; CCB 1-1993, f. & cert. ef. 2-1-93; CCB 4-1993, f. 8-17-93, cert. ef. 8-18-93; CCB 5-1993, f. 12-7-93, cert. ef. 12-8-93; CCB 1-1994, f. 6-23-94, cert. ef. 7-1-94; CCB 2-1994, f. 12-29-94, cert. ef. 1-1-95; CCB 2-1995, f. 6-6-95, cert. ef. 6-15-95; CCB 3-1997, f. & cert. ef. 10-3-97; CCB 3-1998, f. & cert. ef. 2-26-98; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 2-2001, f. & cert. ef 4-6-01; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 2-2003, f. & cert. ef. 3-4-03; CCB 7-2004, f. 8-26-04, cert. ef. 9-1-04; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

812-008-0074
Approved Course Subjects and Education Providers

(1) The following subject areas are approved for continuing education: Report writing, communication skills, business practices, legal issues, ethics, home inspector study guide items, building codes, and home inspector standards of practice.

(2) Education provider applicants shall submit application form, instructor qualifications, course content outlines, course materials and other materials as required by the agency.

(3) The agency shall approve education providers' courses based on written evaluation criteria approved by the agency and made available to providers. Criteria include:

(a) Instructor has experience in subject matter.

(b) Instructor has licenses, certificates, and/or degrees in subject matter.

(c) Instructor has background in training or adult education.

(d) Instructor has knowledge of home inspection industry.

(e) Criteria used to approve and evaluate instructors are stringent and ongoing.

(f) Goals and objectives are clear and are appropriate for Oregon home inspectors.

(g) Course is in approved subject area stated in OAR 812-008-0074(1).

(h) Course content is relevant and appropriate for Oregon home inspectors.

(i) Course content is thorough.

(j) Course can be evaluated against CCB standards of practice and study guide.

(k) Course materials are accurate and current.

(l) Input is received from home inspection industry.

(4) The agency shall approve education providers' programs based on written evaluation criteria approved by the agency and made available to providers. Criteria include:

(a) Instructors are qualified.

(b) Criteria used to approve and evaluate instructors are stringent and ongoing.

(c) Goals and objectives are clear and appropriate for Oregon home inspectors.

(d) Course is in approved subject area stated in OAR 812-008-0074(1).

(e) Course content is relevant and appropriate for Oregon home inspectors.

(f) Course can be evaluated against CCB standards of practice and study guide.

(g) Course materials are accurate and current.

(h) Input is received from home inspection industry.

(5) Education providers' courses and programs approved by the agency shall be granted retroactive credit for certified home inspectors for two years.

(6) The agency may terminate a provider's right to offer a course or their program if the course(s) do not meet the agency's approved criteria.

Stat. Auth.: ORS 670.310, 701.235 & 701.350
Stats. Implemented: ORS 701.350 & 701.355

Hist.: CCB 5-1999, f. & cert. ef. 9-10-99; CCB 4-2003, f. & cert. ef. 6-3-03; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06

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Department of Administrative Services
Chapter 125

Rule Caption: Updating and clarifying public contracting rules.
Adm. Order No.: DAS 5-2006
Filed with Sec. of State: 5-31-2006
Certified to be Effective: 5-31-06
Notice Publication Date: 1-1-06
Rules Adopted: 125-246-0576, 125-247-0293, 125-247-0294, 125-247-0295, 125-247-0690, 125-247-0691, 125-247-0731, 125-249-0395, 125-249-0645, 125-249-0815
Rules Amended: 125-246-0100, 125-246-0110, 125-246-0130, 125-246-0140, 125-246-0150, 125-246-0170, 125-246-0210, 125-246-0220, 125-246-0300, 125-246-0310, 125-246-0321, 125-246-0322, 125-246-0323, 125-246-0330, 125-246-0335, 125-246-0345, 125-246-0350, 125-246-0353, 125-246-0355, 125-246-0360, 125-246-0400, 125-246-0410, 125-246-0420, 125-246-0430, 125-246-0440, 125-246-0450, 125-246-0460, 125-246-0500, 125-246-0555, 125-246-0560, 125-246-0570, 125-246-0575, 125-247-0010, 125-247-0165, 125-247-0170, 125-247-0200, 125-247-0255, 125-247-0256, 125-247-0260, 125-247-0261, 125-247-0270, 125-247-0275, 125-247-0280, 125-247-0285, 125-247-0287, 125-247-0288, 125-247-0296, 125-247-0430, 125-247-0450, 125-247-0600, 125-247-0610, 125-247-0630, 125-247-0700, 125-247-0710, 125-247-0730, 125-247-0740, 125-248-0100, 125-248-0110, 125-248-0120, 125-248-0130, 125-248-0200, 125-248-0210, 125-248-0220, 125-248-0230, 125-248-0240, 125-248-0250, 125-248-0260, 125-248-0300, 125-248-0310, 125-248-0330, 125-248-0340, 125-249-0100, 125-249-0120, 125-249-0130, 125-249-0140, 125-249-0150, 125-249-0160, 125-249-0200, 125-249-0210, 125-249-0280, 125-249-0290, 125-249-0300, 125-249-0310, 125-249-0320, 125-249-0360, 125-249-0370, 125-249-0380, 125-249-0390, 125-249-0400, 125-249-0440, 125-249-0450, 125-249-0460, 125-249-0610, 125-249-0620, 125-249-0630, 125-249-0640, 125-249-0650, 125-249-0660, 125-249-0670, 125-249-0680, 125-249-0820, 125-249-0860, 125-249-0870, 125-249-0900, 125-249-0910
Subject: The Department of Administrative Services (DAS) is mandated and permitted by the new Public Contracting Code, ORS 279ABC, to develop rules (Rules) for state agencies subject to DAS purchasing authority (Agencies). DAS developed and filed these Rules on November 23, 2004, to be effective on March 1, 2005, when the Public Contracting Code became operative. In 2005, the Legislature made specific changes in the Public Contracting Code, and the Department of Administrative Services and Agencies gained experience with the Rules. Now, the Department of Administrative Services needs to adopt additional Rules and amend some existing Rules to implement the Public Contracting Code and fulfill its responsibilities.
Rules Coordinator: Kristin Keith—(503) 378-2349, ext. 325

125-246-0100
Application; Commentary; Federal Law Prevails

(1) These Rules of the Department of Administrative Services (Department) are policy and procedure for the Public Contracting of Agencies subject to these Rules. Pursuant to ORS 279A.065(5), the Department adopts these Rules, including but not limited to selected and adapted Public Contract Model Rules. The Public Contract Model Rules adopted by the Attorney General do not apply to the Department or the Agencies. These Department Public Contracting Rules implement the Oregon Public Contracting Code and consist of the following four Divisions:

(a) Division 246, which applies to all Public Contracting;

(b) Division 247, which applies only to Public Contracting for Supplies and Services, and not to construction services or Architectural, Engineering and Land Surveying Services, and Related Services;

(c) Division 248, which applies only to Public Contracting for Architectural, Engineering and Land Surveying Services and Related Services; and

(d) Division 249, which applies only to Public Contracting for construction services.

(2) If a conflict arises between these Division 246 Rules and Rules in Division 247, 248 or 249, the Rules in Divisions 247, 248 or 249 takes precedence over these Division 246 Rules.

(3) Commentary on these Rules may be published by the Department to assist the Agencies by providing: examples, options, references, background, and other commentary. The Department's commentary is not a Rule or interpretation of any Rule and has no legally-binding effect.

(4) Federal statutes and regulations prevail and govern, except as otherwise expressly provided in ORS 279C.800 through 279C.870 (Prevailing Wage Rate) and notwithstanding other provisions of the Public Contracting Code, under these conditions:

(a) Federal funds are involved; and

(b) The federal statutes or regulations either:

(A) Conflict with any provision of ORS Chapters 279A, 279B, or 279C.005 through 279C.670; or

(B) Require additional conditions in Public Contracts not authorized by ORS Chapters 279A, 279B, or 279C.005 through 279C.670.

(5) Except for Section (6) of this Rule, the authority for Amendments pursuant to OAR 125-246-0170, and 125-246-0560(13), these Division 246 Rules apply to Public Contracts first advertised on or after March 1, 2005, and to unadvertised Public Contracts entered into on or after March 1, 2005.

(6) Transitional and Old Contracts.

(a) Pursuant to Oregon Laws 2005, chapter 103, Section 39, the rules repealed by section 332, chapter 794, Oregon Laws 2003 (Old Rules) will continue to apply to Transitional and Old Contracts, including: Solicitations, if any, as defined in Section 39 and Contract Administration as defined in the Old Rules, except for Amendments and the related authority for Amendments. (See OAR 125-246-0170 and 125-246-0560(13))

(b) Section (6) of this Rule applies retroactively to and is effective on and after March 1, 2005.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.020, 279A.030, 279A.065 & OL 2005, Ch. 103, Sec. 39
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 4-2005, f. 4-13-05, cert. ef. 6-6-05; DAS 7-2005, f. & cert. ef. 6-6-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0110
Definitions

The following terms are a compilation of definitions, including those found in the Public Contracting Code, in other statutes referenced by the Public Contracting Code, and elsewhere in these Rules. Partial definitions of the Public Contracting Code are for the use of the Agencies only. The following terms, when capitalized in these Rules, have the meaning given below:

(1) "Addendum" or "Addenda" means an addition to, deletion from, a material change in, or general interest explanation of a Solicitation Document.

(2) "Adequate" is defined in ORS 279C.305 and means sufficient to control the performance of the Work and to ensure satisfactory quality of construction by the contracting agency personnel.

(3) "Advantageous" means a judgmental assessment by the Agency of the Agency's best interests.

(4) "Advocate for Minority, Women and Emerging Small Business" means the individual appointed by the Governor to advise the Governor, Legislature and Director's Office on issues related to the integration of minority, women and emerging small business into the mainstream of the Oregon economy and business sector. The Advocate oversees the resolution of business concerns with Agencies impacting certified disadvantaged, minority, women and emerging small businesses (DMWESB). The Advocate is also charged with maintaining the Oregon Opportunity Register and Clearinghouse to facilitate the timely notice of business and contract opportunities to DMWESB firms certified by the Office of Minority, Women and Emerging Small Businesses pursuant to ORS 200.025.

(5) An "Administrator" or "Administering Agency" is defined in OAR 125-246-0400(3)(a).

(6) "Affected Person" or "Affected Offeror" means a Person whose ability to participate in a Procurement is adversely affected by an Agency decision.

(7) "Affirmative Action" is defined in ORS 279A.100 and means a program designed to ensure equal opportunity in employment and business for persons otherwise disadvantaged by reason of race, color, religion, sex, national origin, age or physical or mental disability.

(8) "Agency" means those agencies of the State of Oregon that are subject to the procurement authority of the Director of the Department pursuant to ORS 279A.050 and 279A.140. This term includes the Department

when the Department is engaged in Public Contracting. Under these Rules, an Agency is authorized only through a delegation of authority pursuant to OAR 125-246-0170.

(9) "Amendment" means a Written modification to the terms and conditions of a Public Contract, other than Changes to the Work as defined in OAR 125-249-0910, that meets the requirements of OAR 125-246-0560. For the purposes of these Rules, Amendments are included within the definitions of "Procurements" and "Contract Administration."

(10) "Architect" is defined in ORS 279C.100 and means a person who is registered and holds a valid certificate in the practice of architecture in the State of Oregon, as provided under ORS 671.010 to 671.220, and includes without limitation the terms "architect," "licensed architect" and "registered architect.

(11) "Architectural, Engineering and Land Surveying Services" is defined in ORS 279C.100 and collectively means professional services that are required to be performed by an architect, engineer or land surveyor. "Architectural, Engineering and Land Surveying Services" includes "Architectural, Engineering or Land Surveying Services," separately or any combination thereof, as appropriate within the context of a Rule.

(12) "Architectural, Engineering and Land Surveying Services, and Related Services" is defined in ORS 279C.100 and 279C.100(6) and collectively means professional services that are required to be performed by an architect, engineer or land surveyor and Related Services. "Related Services" means services that are related to the planning, design, engineering or oversight of Public Improvement projects or components thereof, including but not limited to landscape architectural services, facilities planning services, energy planning services, space planning services, environmental impact studies, hazardous substances or hazardous waste or toxic substances testing services, wetland delineation studies, wetland mitigation studies, Native American studies, historical research services, endangered species studies, rare plant studies, biological services, archaeological services, cost estimating services, appraising services, material testing services, mechanical system balancing services, commissioning services, project management services, construction management services and owner's representative services or land-use planning services. "Architectural, Engineering and Land Surveying Services, and Related Services" includes "Architectural, Engineering or Land Surveying Services, or Related Services, separately or in any combination thereof, as appropriate within the context of a Rule.

(13) "As-Is, Where-Is" applies to the sale of Goods and means that the Goods are of the kind, quality, and locale represented, even though they are in a damaged condition. It implies that the buyer takes the entire risk as to the quality of the Goods involved, based upon the buyer's own inspection. Implied and express warranties are excluded in sales of Goods "As-Is, Where-Is."

(14) "Authorized Agency" means any Person authorized pursuant to OAR 125-246-0170 to conduct a Procurement or take other actions on an Agency's behalf. This term, including its use in the Rules, does not convey authority to an Agency. For the authority of Agencies under the Code and these Rules, see OAR 125-246-0170 only.

(15) "Award" means, as the context requires, either identifying or occurrence of the Agency's identification of the Person with whom the Agency intends to enter into a Contract following the resolution of any protest of the Agency's selection of that Person, and the completion of all Contract Negotiations.

(16) "Bid" means a Written response to an Invitation to Bid.

(17) "Bidder" means a Person who submits a Bid in response to an Invitation to Bid.

(18) "Brand Name or Equal Specification" is defined in ORS 279B.200(1) and means a Specification that uses one or more manufacturers' names, makes, catalog numbers or similar identifying characteristics to describe the standard of quality, performance, functionality or other characteristics needed to meet the Agency's requirements and that authorizes Offerors to offer Supplies and Services that are equivalent or superior to those named or described in the Specification.

(19) "Brand Name Specification" is defined in ORS 279B.200(2) and means a Specification limited to one or more products, brand names, makes, manufacturer's names, catalog numbers or similar identifying characteristics.

(20) "Business Day" means 8:00 a.m. to 5:00 p.m., Pacific time, Monday through Friday, excluding State of Oregon holidays.

(21) "Chief Procurement Officer" means the individual designated and authorized by the Director of the Department to perform certain procurement functions described in these Rules.

(22) "Class Special Procurement" is defined in ORS 279B.085 and means a contracting procedure that differs from the procedures described in ORS 279B.055, 279B.060, 279B.065 and 279B.070 and is for the purpose of entering into a series of contracts over time for the acquisition of a specified class of goods or services.

(23) "Client" means any individual, family or Provider:

(a) For whom an Agency must provide Services and incidental or specialized Goods, in any combination thereof ("Services and Incidental Supplies"), according to state, federal law, rule, and policy. Those Services and Incidental Supplies include but are not limited to treatment, care, protection, and support without regard to the proximity of the services being provided;

(b) Who in fact receives and utilizes services provided by an Agency primarily for that individual's or family's benefit;

(c) Who is under the custody, care, or both of the Agency; or

(d) Who provides direct care or Services and is a proxy or representative of the non-Provider Client.

(24) "Client Services" means any Services and incidental or specialized Goods, in any combination thereof, that either directly or primarily support a Client, whether the Client is the recipient through the provision of voluntary or mandatory Services. Client Services may include but are not limited to (where these terms are used in another statute, they must have that meaning):

(a) Housing, including utilities, rent or mortgage or assistance to pay rent, mortgage or utilities;

(b) Sustenance, including clothing;

(c) Employment training or Skills training to improve employability;

(d) Services for people with disabilities;

(e) Foster care or foster care facilities;

(f) Residential care or residential care facilities;

(g) Community housing;

(h) In-home care including home delivered meals;

(i) Medical care, services and treatment, including but not limited to:

(A) Medical, Dental, Hospital, Psychological, Psychiatric, Therapy, Vision;

(B) Alcohol and drug treatment;

(C) Smoking cessation;

(D) Drugs, prescriptions and non-prescription;

(E) Nursing services and facilities;

(j) Transportation or relocation;

(k) Quality of life, living skills training; or

(l) Personal care; or

(m) Legal services and expert witnesses services;

(n) Religious practices, traditions and services, separately or in any combination thereof; and

(o) Educational services. The term "Client Services" does not include benefits or services provided as a condition of employment with an Agency.

(25) "Closing" means the date and time specified in a Solicitation Document as the deadline for submitting Offers.

(26) "Code" is the "Public Contracting Code," defined in ORS 279A.010(1)(z), and "Code" means ORS Chapters 279A, 279B and 279C.

(27) "Competitive Quotes" means the sourcing method pursuant to OAR 125-249-0160.

(28) "Competitive Range" means the Proposers with whom the Agency will conduct Discussions or Negotiations if the Agency intends to conduct Discussions or Negotiations in accordance with OAR 125-247-0261 or 125-249-0650.

(29) "Competitive Sealed Bidding" means the sourcing method pursuant to ORS 279B.055.

(30) "Competitive Sealed Proposals" means the sourcing method pursuant to ORS 279B.060.

(31) "Consultant" means the Person with whom an Agency enters into a Contract for the purposes of consulting, conferring, or deliberating on one or more subjects, and this Person provides advice or opinion; e.g., Consultants for Architectural, Engineering and Land Surveying Services, and Related Services as defined in ORS 279C.115 and information technology Consultants.

(32) "Contract" means an agreement between two or more Persons which creates an obligation to do or not to do a particular thing. Its essentials are competent parties, subject matter, a legal consideration, mutuality of agreement, and mutuality of obligation. For the purposes of these Rules, "Contract" means Public Contract.

(33) "Contract Administration" means all functions related to a given Contract between an Agency and a Contractor from the time the Contract is awarded until the Work is completed and accepted or the Contract is terminated, payment has been made, and disputes have been resolved. Contract Administration includes Amendments.

(34) "Contractor" means the Person with whom an Agency enters into a Contract and has the same meaning as "Consultant" or "Provider."

(35) "Contract Price" means, as the context requires, (i) the maximum monetary obligation that an Agency either will or may incur under a

Contract, including bonuses, incentives and contingency amounts, if the Contractor fully performs under the Contract.

(36) "Contract Review Authority" means the Director of the Department and the Director's delegatee, unless specified by statute as the Director of the Oregon Department of Transportation.

(37) "Contract-Specific Special Procurement" is defined in ORS 279B.085 and means a contracting procedure that differs from the procedures described in ORS 279B.055, 279B.060, 279B.065 and 279B.070 and is for the purpose of entering into a single Contract or a number of related Contracts for the acquisition of specified Supplies and Services on a one-time basis or for a single project.

(38) "Contracting Agency."

(a) "Contracting Agency" is defined in ORS 279A.010(1)(b) and, for Agencies operating under these Rules and the Code, means the Director of the Oregon Department of Administrative Services, authorized to act on their behalf pursuant to ORS 279A.140.

(b) The definition of "Contracting Agency" in ORS 279A.010(1)(b) does not give Agencies procurement authority. For procurement authority of Agencies, see OAR 125-246-0170.

(39) "Cooperative Procurement" is defined in OAR 125-246-0400(3)(c).

(40) "Cooperative Procurement Group" is defined in OAR 125-246-0400(3)(d).

(41) "Days" means calendar days.

(42) "Disqualification" means a disqualification, suspension or debarment of a Person pursuant to ORS 200.065, 200.075, and 279A.110 and OAR 125-246-0210(4).

(43) "Department" means the Oregon Department of Administrative Services.

(44) "Department Price Agreement" means a Price Agreement issued by the Department's State Procurement Office on behalf of all Agencies. Such Agreements may be mandatory for use by Agencies or voluntary for use by Agencies. Such Agreements may result from a Cooperative Procurement. Pursuant to OAR 125-246-0360 (Purchases through Federal Programs), an Authorized Agency may not purchase Supplies and Services through Federal Programs if a Department Price Agreement for those authorized Supplies and Services exists.

(45) "Designated Procurement Officer" means the individual designated and authorized by the head of an Authorized Agency to perform certain Procurement functions described in these Rules. If any head of an Authorized Agency does not designate and authorize an individual as a Designated Procurement Officer, "Designated Procurement Officer" also means that head of the Authorized Agency, who then acts in the place of the Designated Procurement Officer.

(46) "Descriptive Literature" means Written information submitted with the Offer that addresses the Supplies and Services included in the Offer.

(47) "Director" is defined in ORS 279A.010(1)(e) and means the Director of the Department or a person designated by the Director to carry out the authority of the Director under the Public Contracting Code and these Rules.

(48) "Discussions" means to exchange information, compare views, take counsel, and communicate with another for the purposes of achieving clarification and mutual understanding of an Offer. This typically occurs before the issuance of a Notice of Intent to award, or in the absence of such Notice, during the Procurement Process and prior to award.

(49) "Donee" is defined in ORS 279A.250(1) and means an entity eligible to acquire federal donation property based upon federal regulations or eligible to acquire Surplus Property in accordance with rules adopted by the Department. Entities eligible to acquire federal donation property may also acquire Surplus Property other than federal donation property.

(50) "Electronic Advertisement" means an Agency's Solicitation Document, Request for Quotes, request for information or other document inviting participation in the Agency's Procurements made available over the Internet via:

(a) The World Wide Web;

(b) ORPIN; or

(c) An Electronic Procurement System other than ORPIN approved by the State Procurement Office. An Electronic Advertisement may or may not include a Solicitation Document.

(51) "Electronic Offer" means a response to an Agency's Solicitation Document or request for Quotes submitted to an Agency via

(a) The World Wide Web or some other Internet protocol; or

(b) ORPIN.

(52) "Electronic Procurement System" means ORPIN or other system approved by the State Procurement Office, constituting an information system that Persons may access through the Internet, using the World Wide Web or some other Internet protocol, or that Persons may otherwise remotely access using a computer, that enables Persons to send Electronic Offers and an Agency to post Electronic Advertisements, receive Electronic Offers, and conduct any activities related to a Procurement.

(53) "Electronic Goods" means Goods which are dependent on electric currents or electromagnetic fields in order to Work properly and Goods for the generation, transfer and measurement of such currents and fields.

(54) "Emergency" means circumstances that:

(a) Could not have been reasonably foreseen;

(b) Create a substantial risk of loss, damage or interruption of services or a substantial threat to property, public health, welfare or safety; and

(c) Require prompt execution of a Contract to remedy the condition. An "Emergency Procurement" means a sourcing method pursuant to ORS 279B.080, 279C.335(5), 125-248-0200, or related Rules.

(55) "Energy Savings Performance Contract" means a Public Contract between an Agency and a qualified energy service company for the identification, evaluation, recommendation, design and construction of energy conservation measures, including a design-build contract, that guarantee energy savings or performance.

(56) "Engineer" is defined in ORS 279C.100 and means a Person who is registered and holds a valid certificate in the practice of engineering in the State of Oregon, as provided under ORS 672.002 to 672.325, and includes all terms listed in ORS 672.002(2).

(57) "Established Catalog Price" is defined in ORS 279B.005(1)(a) and means the price included in a catalog, price list, schedule or other form that:

(a) Is regularly maintained by a manufacturer or Contractor;

(b) Is either published or otherwise available for inspection by customers; and

(c) States prices at which sales are currently or were last made to a significant number of any category of buyers or to buyers constituting the general market, including public bodies, for the Supplies and Services involved.

(58) "Executive Department" is defined in ORS 174.112 and subject to ORS 174.108, means: all statewide elected officers other than judges, and all boards, commissions, departments, divisions and other entities, without regard to the designation given to those entities, that are within the Executive Department of government as described in section 1, Article III of the Oregon Constitution, and that are not:

(a) In the judicial department or the legislative department;

(b) Local governments; or

(c) Special government bodies.

(d) An entity created by statute for the purpose of giving advice only to the Executive Department and that does not have members who are officers or employees of the judicial department or Legislative Department;

(A) An entity created by the Executive Department for the purpose of giving advice to the Executive Department, if the document creating the entity indicates that the entity is a public body; and

(B) Any entity created by the Executive Department other than an entity described in Subsection (c), unless the document creating the entity indicates that the entity is not a governmental entity or the entity is not subject to any substantial control by the Executive Department.

(59) "Findings" is defined in ORS 279C.330 and means the justification for an Agency's conclusion that includes, but is not limited to, information regarding:

(a) Operational, budget and financial data;

(b) Public benefits;

(c) Value engineering;

(d) Specialized expertise required;

(e) Public safety;

(f) Market conditions;

(g) Technical complexity; and

(h) Funding sources.

(60) "Fire Protection Equipment" is defined in ORS 279A.190 and 476.005 and means any apparatus, machinery or appliance intended for use by a fire service unit in fire prevention or suppression activities, excepting forest fire protection equipment.

(61) "Flagger" is defined in ORS 279C.810 and means a person who controls the movement of vehicular traffic through construction projects using sign, hand or flag signals.

(62) "Formal Selection Procedure" means the procedure pursuant to OAR 125-248-0220.

(63) "Fringe Benefits" is defined in ORS 279C.800 and means the amount of:

(a) The rate of contribution irrevocably made by a Contractor or subcontractor to a trustee or to a third person under a plan, fund or program; and

(b) The rate of costs to the Contractor or subcontractor that may be reasonably anticipated in providing benefits to Workers pursuant to an

enforceable commitment to carry out a financially responsible plan or program that is committed in Writing to the Workers affected, for medical or hospital care, pensions on retirement or death, compensation for injuries or illness resulting from occupational activity, or insurance to provide any of the foregoing, for unemployment benefits, life insurance, disability and sickness insurance or accident insurance, for vacation and holiday pay, for defraying costs of apprenticeship or other similar programs or for other bona fide fringe benefits, but only when the Contractor or subcontractor is not required by other federal, state or local law to provide any of these benefits.

(64) "Good Cause" is defined in ORS 279C.585, and the Oregon Construction Contractors Board must define "Good Cause" by rule. "Good Cause" includes, but is not limited to, the financial instability of a subcontractor. The definition of "Good Cause" must reflect the least-cost policy for Public Improvements established in ORS 279C.305.

(65) "Good Faith Dispute" is defined in ORS 279C.580(5)(b) and means a documented dispute concerning:

(a) Unsatisfactory job progress;

(b) Defective work not remedied;

(c) Third-party claims filed or reasonable evidence that claims will be filed;

(d) Failure to make timely payments for labor, equipment and materials;

(e) Damage to the prime Contractor or subcontractor; or

(f) Reasonable evidence that the subcontract cannot be completed for the unpaid balance of the subcontract sum.

(66) "Goods" is derived from the definition in ORS 279B.005(b) and means supplies, equipment, or materials, and any personal property, including any tangible, intangible and intellectual property and rights and licenses in relation thereto, that an Agency is authorized by law to procure.

(67) "Goods and Services" or "Goods or Services" is defined in ORS 279B.005 and for purposes of these Rules falls within the meaning of "Supplies and Services" (see the definition of "Supplies of Services" in this Rule). "Goods and Services" or "Goods or Services" does not include Personal Services. "Supplies and Services" includes Personal Services.

(68) "Grant" is defined in ORS 279A.010(1)(i) and means:

(a) An agreement under which an Agency receives money, property or other assistance, including but not limited to federal assistance that is characterized as a Grant by federal law or regulations, loans, loan guarantees, credit enhancements, gifts, bequests, commodities or other assets, from a grantor for the purpose of supporting or stimulating a program or activity of the Agency and in which no substantial involvement by the grantor is anticipated in the program or activity other than involvement associated with monitoring compliance with the Grant conditions; or

(b) An agreement under which an Agency provides money, property or other assistance, including but not limited to federal assistance that is characterized as a grant by federal law or regulations, loans, loan guarantees, credit enhancements, gifts, bequests, commodities or other assets, to a recipient for the purpose of supporting or stimulating a program or activity of the recipient and in which no substantial involvement by the Agency is anticipated in the program or activity other than involvement associated with monitoring compliance with the grant conditions.

(c) "Grant" does not include a Public Contract:

(A) For a Public Improvement for Public Works, as defined in ORS 279C.800; or

(B) For emergency Work, minor alterations or ordinary repair or maintenance necessary to preserve a Public Improvement, when under the Public Contract:

(i) An Agency pays moneys that the Agency has received under a Grant; and

(ii) Such payment is made in consideration for Contract performance intended to realize or to support the realization of the purposes for which Grant funds were provided to the Agency.

(69) "Industrial Oil" means any compressor, turbine or bearing oil, hydraulic oil, metal-working oil or refrigeration oil.

(70) "Informal Selection" means the procedure pursuant to OAR 125-248-0210.

(71) "Intermediate Procurement" means a sourcing method pursuant to ORS 279B.070 or OAR 125-249-0160.

(72) "Interstate Cooperative Procurement" is defined in OAR 125-246-0400(3)(e).

(73) "Invitation to Bid" or "ITB" is defined in ORS 279B.005 and 279C.400 and means all documents, whether attached or incorporated by reference, used for soliciting Bids in accordance with either ORS 279B.055 or 279C.335.

(74) "Joint Cooperative Procurement" is defined in OAR 125-246-0400(3)(f).

(75) "Judicial Department" is defined in ORS 174.113 and means:

(a) The Supreme Court, the Court of Appeals, the Oregon Tax Court, the circuit courts and all administrative divisions of those courts, whether denominated as boards, commissions, committees or departments or by any other designation.

(b) An entity created by statute for the purpose of giving advice only to the Judicial Department and that does not have members who are officers or employees of the Executive Department or Legislative Department;

(c) An entity created by the Judicial Department for the purpose of giving advice to the judicial department, if the document creating the entity indicates that the entity is a public body; and

(d) Any entity created by the Judicial Department other than an entity described in paragraph (c) of this Subsection, unless the document creating the entity indicates that the entity is not a governmental entity or the entity is not subject to any substantial control by the Judicial Department.

(76) "Labor Dispute" is defined in ORS 662.010 and means any controversy concerning terms or conditions of employment, or concerning the association or representation of Persons in negotiating, fixing, maintaining, changing or seeking to arrange terms or conditions of employment, regardless of whether or not the disputants stand in the proximate relation of employer and employee.

(77) "Land Surveyor" is defined in ORS 279C.100(4) and means a Person who is registered and holds a valid certificate in the practice of land surveying in the State of Oregon, as provided under ORS 672.002 to 672.325, and includes all terms listed in ORS 672.002(4).

(78) "Legally Flawed" is defined in ORS 279B.405(1)(b) and means that a Solicitation Document contains terms or conditions that are contrary to law.

(79) "Legislative Department" is defined in ORS 174.114 and, subject to ORS 174.108, means:

(a) The Legislative Assembly, the committees of the Legislative Assembly and all administrative divisions of the Legislative Assembly and its committees, whether denominated as boards, commissions or departments or by any other designation.

(b) An entity created by statute for the purpose of giving advice only to the Legislative Department and that does not have members who are officers or employees of the executive department or judicial department;

(c) An entity created by the Legislative Department for the purpose of giving advice to the legislative department, but that is not created by statute, if the document creating the entity indicates that the entity is a public body; and

(d) Any entity created by the Legislative Department by a document other than a statute and that is not an entity described in paragraph (c) of this Subsection, unless the document creating the entity indicates that the entity is not a governmental entity or the entity is not subject to any substantial control by the Legislative Department.

(80) "Locality" is defined in ORS 279C.800(2) and means the following district in which the Public Works, or the major portion thereof, is to be performed:

(a) District 1, composed of Clatsop, Columbia and Tillamook Counties;

(b) District 2, composed of Clackamas, Multnomah and Washington Counties;

(c) District 3, composed of Marion, Polk and Yamhill Counties;

(d) District 4, composed of Benton, Lincoln and Linn Counties;

(e) District 5, composed of Lane County;

(f) District 6, composed of Douglas County;

(g) District 7, composed of Coos and Curry Counties;

(h) District 8, composed of Jackson and Josephine Counties;

(i) District 9, composed of Hood River, Sherman and Wasco Counties;

(j) District 10, composed of Crook, Deschutes and Jefferson Counties;

(k) District 11, composed of Klamath and Lake Counties;

(l) District 12, composed of Gilliam, Grant, Morrow, Umatilla and Wheeler Counties;

(m) District 13, composed of Baker, Union and Wallowa Counties; and

(n) District 14, composed of Harney and Malheur Counties.

(81) "Lowest Responsible Bidder" is defined in ORS 279A.010(1)(p) and means the lowest Bidder who:

(a) Has substantially complied with all prescribed Public Contracting procedures and requirements;

(b) Has met the standards of responsibility set forth in ORS 279B.110(2) or 279C.375;

(c) Has not been debarred or disqualified by the Agency under ORS 279B.130 or 279C.440; and

(d) Is not on the list created by the Oregon Construction Contractors Board under ORS 701.227, if the advertised contract is a Public Improvement Contract.

(82) "Lubricating Oil" means any oil intended for use in an internal combustion crankcase, transmission, gearbox or differential or an automobile, bus, truck, vessel, plane, train, heavy equipment or machinery powered by an internal combustion engine.

(83) "Mandatory Use Contract" means a Public Contract, Department Price Agreement, or other agreement that an Agency is required to use for the Procurement of Supplies and Services.

(84) "Multiple-tiered" or "Multistepped" means the type of process used in Competitive Sealed Bidding and Competitive Sealed Proposals pursuant to ORS 279B and OAR Division 247, where the process is staged in phases. For example, a multistepped proposal process includes more than one opportunity to submit proposals for the same project.

(85) "Negotiations" means to compare views, take counsel, and communicate with another so as to arrive at a voluntary, mutual agreement about a matter. Pursuant to ORS 279B and OAR Division 247 Negotiations typically occur after issuance of a Notice of Intent to award, or in the absence of such Notice, preceding an award of a Contract.

(86) "Nonprofit Organization" is defined in ORS 279C.810 and means an organization or group of organizations described in section 501(c)(3) of the Internal Revenue Code that is exempt from income tax under section 501(a) of the Internal Revenue Code.

(87) "Nonresident Offeror" means an Offeror who is not a resident Offeror. For the meaning of residency, see the definition of "Resident Offeror."

(88) "Not-for-Profit Organization" is defined in ORS 307.130(4)(c) and means a Nonprofit Corporation.

(89) "OAR" means the Oregon Administrative Rules.

(90) "Offer" means a response to a Solicitation, including: a Bid, Proposal, Quote or similar response to a Solicitation.

(91) "Offeror" means a Person who submits an Offer

(92) "Offering" means a Bid, Proposal, or Quote.

(93) "Office of Minority, Women, and Emerging Small Business" or "OMWESB" is defined in ORS 200.025 and 200.055 and means the office that administers the certification process for the Disadvantaged Business Enterprise (DBE), Minority Business Enterprise/Women Business Enterprise (MBE/WBE), and Emerging Small Business (ESB) Programs. OMWESB is the sole authority providing certification in Oregon for disadvantaged, minority, and woman-owned businesses, and emerging small businesses.

(94) "Old Contracts" means all Public Contracts entered into before March 1, 2005. See OAR 125-246-0100(5).

(95) "OPB Certified Professional" means an individual holding an active Oregon Procurement Basic Certification, issued by the State Procurement Office.

(96) "Opening" means the date, time and place specified in the Solicitation Document for the public opening of Written sealed Offers.

(97) "Ordering Instrument" or "Order" means a document used by an Authorized Agency in compliance with the Public Contracting Code, these Rules, and Department policies, for the general purpose of ordering Supplies and Services from one or more Providers.

(a) An Ordering Instrument or Order may also be known as a Purchase Order, Work Order, or other name assigned by an Agency.

(b) A Price Agreement may specify the use of Ordering Instruments.

(c) Absent a Price Agreement and subject to the Public Contracting Code, Rules, and Department policies, an Authorized Agency's appropriate use of an Ordering Instrument is an Offer to purchase Supplies and Services from one or more Providers, and a Provider's responsive and appropriate acceptance of the Offer creates a Public Contract.

(98) "Ordinary Construction Services" means those services that are not Public Improvements, are procured under ORS Chapter 279B, and are otherwise under ORS Chapter 279C, in accordance with OAR 125-249-0100(1) and 125-249-0140.

(99) "Original Contract" means the initial Contract or Price Agreement as solicited and awarded by the State Procurement Office or an Authorized Agency. See OAR 125-246-0400(3)(h) for the definition of "Original Contract" that the Public Contracting Code and Rules use for Cooperative Procurements only.

(100) "ORPIN" means the on-line electronic Oregon Procurement Information Network administered by the State Procurement Office, as further defined in OAR 125-246-0500.

(101) "ORS" means the Oregon Revised Statutes.

(102) "Participant," is defined in OAR 125-246-0400(3)(i).

(103) "Permissive Cooperative Procurement" is defined in OAR 125-246-0400(3)(j).

(104) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, governmental agency, public corporation or any other legal or commercial entity. "Person" is also defined in ORS 279C.500 and 279C.815 and means any employer, labor organization or any official representative of an employee or employer association.

(105) "Personal Services" means the services performed under a Personal Services Contract in accordance with Division 247 and related Rules in Division 246. "Personal Services" is also defined in ORS 279C.100, and that definition applies only to ORS 279C.100 to 279C.125, for Architectual, Engineering, Land Surveying Services or Related Services.

(106) "Personal Services Contract" or "Contract for Personal Services" means a Contract, or a member of a class of Contracts, other than a Contract for the services of an Architect, Engineer, Land Surveyor or Provider of Related Services as defined in ORS 279C.100, which primary purpose is to acquire specialized skills, knowledge and resources in the application of technical or scientific expertise, or the exercise of professional, artistic or management discretion or judgment, including, without limitation, a Contract for the services of an accountant, physician or dentist, educator, Consultant, broadcaster, or artist (including a photographer, filmmaker, painter, weaver or sculptor). Contracts for Architectural, Engineering and Land Surveying Services, and Related Services are a special class of Personal Services Contracts, defined in ORS 279C.100(5), and Providers under such Contracts are Consultants, as defined in OAR 125-248-0110(1).

(107) "Prevailing Rate of Wage" is defined in ORS 279C.800 and means the rate of hourly wage, including all fringe benefits, paid in the Locality to the majority of Workers employed on projects of similar character in the same trade or occupation, as determined by the Commissioner of the Bureau of Labor and Industries.

(108) "Price Agreement."

(a) "Price Agreement" is defined in ORS 279A.010(1)(t) and means a Public Contract for the Procurement of Supplies and Services at a set price with:

(A) No guarantee of a minimum or maximum purchase; or

(B) An initial order or minimum purchase combined with a continuing Contractor obligation to provide Supplies and Services in which the Authorized Agency does not guarantee a minimum or maximum additional purchase.

(b) The set price may exist at the outset or be determined later by an Ordering Instrument.

(c) A "Price Agreement"as a Public Contract may collectively consist of an initial agreement, together with later Ordering Instruments, if any.

(A) The initial agreement may be known as an agreement to agree, a master agreement, a Price Agreement for any Supplies and Services, a services agreement, or a retainer agreement, if such agreement meets the requirements of this Rule's definition.

(B) The Ordering Instrument may be known as a work order, purchase order, or task order, or by another name for ordering purposes and related to the initial agreement.

(109) "Procurement" means the act of purchasing, leasing, renting or otherwise acquiring: Supplies and Services; Architectural, Engineering and Land Surveying Services, and Related Services; and Public Improvements. Procurement includes each function and procedure undertaken or required to be undertaken by an Authorized Agency to enter into a Public Contract, administer a Public Contract and obtain the performance of a Public Contract under the Public Contracting Code and these Rules. Procurement includes Contract Administration, and Contract Administration includes Amendments.

(110) "Procurement Process" means the process related to these acts, functions, and procedures of Procurement.

(111) "Procurement Document" collectively means the inclusive Solicitation Document and all documents either attached or incorporated by reference, and any changes thereto, used for any of the methods pursuant to ORS 279A.200 through 279A.220, 279B.055 through 279B.085, 279C.100 through 279C.125, or 279C.300 through 2729C.450.

(112) "Procurement File" means any of the following files maintained by an Authorized Agency: a solicitation, contract, or contract administration file, separately or collectively.

(113) "Product Sample" means the exact Goods or a representative portion of the Goods offered in an Offer, or the Goods requested in the Solicitation Document as a sample.

(114) "Property" is defined in ORS 279A.250 and means personal property.

(115) "Proposal" means a Written response to a Request for Proposals.

(116) "Proposer" means a Person who submits a proposal in response to a Request for Proposals, except for Architectural, Engineering and Land Surveying Services, and Related Services pursuant to OAR 125-248-0110(4), whereby "Proposer" means a Consultant who submits a proposal to an Authorized Agency in response to a Request for Proposals.

(117) "Provider" means collectively or in the alternative: the supplier, Contractor or Consultant, providing Supplies and Services or Public Improvements.

(118) "Post-consumer Waste" means a finished material that would normally be disposed of as solid waste, having completed its life cycle as a consumer item. "Post-consumer waste" does not include manufacturing waste.

(119) "Public Agency" is defined in ORS 279C.800 and means the State of Oregon or any political subdivision thereof or any county, city, district, authority, public corporation or entity and any of their instrumentalities organized and existing under law or charter.

(120) "Public Body," is defined in ORS 174.109, subject to ORS 174.108, and means state government bodies, local government bodies and special government bodies.

(121) "Public Contract" is defined in ORS 279A.010(1)(x) and means a sale or other disposal, or a purchase, lease, rental or other acquisition, by an Authorized Agency of Supplies and Services, Public Improvements, Public Works, minor alterations, or ordinary repair or maintenance necessary to preserve a Public Improvement. "Public Contract" does not include Grants. For the purposes of these Rules, "Public Contract" means Contract.

(122) "Public Contracting" is defined in ORS 279A.010(1)(y) and means Procurement activities described in the Public Contracting Code relating to obtaining, modifying or administering Public Contracts or Price Agreements.

(123) "Public Contracting Code" or "Code" is defined in ORS 279A.010(1)(z) and means 279A, 279B and 279C.

(124) "Public Improvement Contract" means a Public Contract for a Public Improvement. "Public Improvement Contract" does not include a Public Contract for emergency Work, minor alterations, or ordinary repair or maintenance necessary to preserve a Public Improvement.

(125) "Public Improvement" is defined in ORS 279A.010(1)(aa) and means a project for construction, reconstruction or major renovation on real property by or for an Authorized Agency. "Public Improvement" does not include:

(a) Projects for which no funds of an Authorized Agency are directly or indirectly used, except for participation that is incidental or related primarily to project design or inspection; or

(b) Emergency Work, minor alteration, ordinary repair or maintenance necessary to preserve a Public Improvement.

(126) "Public Works" is defined in ORS 279C.800 and includes, but is not limited to: roads, highways, buildings, structures and improvements of all types, the construction, reconstruction, major renovation or painting of which is carried on or contracted for, by any public agency, to serve the public interest, but does not include the reconstruction or renovation of privately owned property that is leased by a Public Agency.

(127) "Purchase Order" means an Ordering Instrument or Order, as defined in this Rule.

(128) "Pursuant to" means "in accordance with" or "in harmony with" its object.

(129) "QBS" means the qualifications based selection process mandated by ORS 279C.110 for Architectural, Engineering and Land Surveying Services, and Related Services Contracts.

(130) "Quote" means a verbal or Written Offer obtained through an Intermediate Procurement pursuant to either OAR 125-247-0270 or 125-249-0160.

(131) "Recycled Material" means any material that would otherwise be a useless, unwanted or discarded material except for the fact that the material still has useful physical or chemical properties after serving a specific purpose and can, therefore, be reused or recycled.

(132) "Recycled Oil" means used oil that has been prepared for reuse as a petroleum product by refining, re-refining, reclaiming, reprocessing or other means, provided that the preparation or use is operationally safe, environmentally sound and complies with all laws and regulations.

(133) "Recycled Paper" means a paper product with not less than:

(a) Fifty percent of its fiber weight consisting of secondary waste materials; or

(b) Twenty-five percent of its fiber weight consisting of post-consumer waste.

(134) "Recycled PETE" means post-consumer polyethylene terephthalate material.

(135) "Recycled Product" means all materials, goods and supplies, not less than 50 percent of the total weight of which consists of secondary and post-consumer waste with not less than 10 percent of its total weight consisting of post-consumer waste. "Recycled Product" includes any product that could have been disposed of as solid waste, having completed its life cycle as a consumer item, but otherwise is refurbished for reuse without substantial alteration of the product's form.

(136) "Related Services" is defined in ORS 279C.100(6) and means personal services, other than architectural, engineering and land surveying services, that are related to the planning, design, engineering or oversight of Public Improvement projects or components thereof, including but not limited to landscape architectural services, facilities planning services, energy planning services, space planning services, environmental impact studies, hazardous substances or hazardous waste or toxic substances testing services, wetland delineation studies, wetland mitigation studies, Native American studies, historical research services, endangered species studies, rare plant studies, biological services, archaeological services, cost estimating services, appraising services, material testing services, mechanical system balancing services, commissioning services, project management services, construction management services and owner's representative services or land-use planning services.

(137) "Request for Proposals" or "RFP" is defined in ORS 279B.005 and means all documents, either attached or incorporated by reference, and any Addenda thereto, used for soliciting Proposals in accordance with either ORS.279B.060 or 279C.405 and related rules.

(138) "Request for Qualifications" or "(RFQ)" means a Written document issued by an Authorized Agency and describing: the Authorized Agency's circumstances; the type of service(s) or Work desired; significant evaluation factors; their relative importance; if appropriate, price; and competitive qualifications. Contractors respond in Writing to the Authorized Agency by describing their experience and qualifications. The RFQ will not result in a Contract. It establishes a list of qualified Contractors in accordance with OAR 125-247-0550, 125-248-0220 or 125-249-645.

(139) "Request for Quotes" means a Written or oral request for prices, rates or other conditions under which a potential Contractor would provide Supplies and Services or Public Improvements described in the request.

(141) "Resident Bidder" is defined in ORS 279A.120 and means a Bidder that has paid unemployment taxes or income taxes in this state during the 12 calendar months immediately preceding submission of the Bid, has a business address in this State, and has stated in the Bid whether the Bidder is a "resident Bidder."

(142) "Resident Offeror" means an Offeror that has paid unemployment taxes or income taxes in this state during the 12 calendar months immediately preceding submission of the Offer, has a business address in this State, and has stated in the Offer whether the Offeror is a "resident Offeror."

(143) "Responsible" means meeting the standards set forth in OAR 125-247-0640 or 125-249-0390(2), and not debarred or disqualified by the Authorized Agency under OAR 125-247-0575 or 125-249-0370.

(144) "Responsible Bidder" or "Responsible Proposer" is defined in ORS 279A.105 and 279B.005 and means a person who meets the standards of responsibility as described in ORS 279B.110.

(145) "Responsible Offeror"means, as the context requires, a Responsible Bidder, Responsible Proposer or a Person who has submitted an Offer and meets the standards set forth in OAR 125-247-0640 or 125-249-0390(2), and who has not been debarred or disqualified by the Agency under OAR 125-247-0575 or 125-249-0370, respectively.

(146) "Responsible Proposer" or "Responsible Bidder" is defined in ORS 279B.005 and means a Person who meets the standards of responsibility described in ORS 279B.110.

(147) "Responsive" means having the characteristic of substantial compliance in all material respects with applicable solicitation requirements.

(148) "Responsive Bid" or "Responsive Proposal" is defined in ORS 279B.005 and means a Bid or Proposal that substantially complies with the Invitation to Bid or Request for Proposals, respectively, and all prescribed Procurement procedures and requirements.

(149) "Responsive Offer" means, as the context requires, a Responsive Bid, Responsive Proposal or other Offer that substantially complies in all material respects with applicable solicitation requirements.

(150) "Responsive Proposal" or "Responsive Bid" is defined in ORS 279B.005 and means a bid or proposal that substantially complies with the Invitation to Bid or Request for Proposals and all prescribed procurement procedures and requirements.

(151) "Retainage" is defined in ORS 279C.550 and means the difference between the amount earned by a Contractor on a Public Contract and the amount paid on the contract by the Authorized Agency.

(152) "Rules" means these Public Contracting Rules of the Department including Divisions 246 through 249, unless otherwise indicated.

(153) "Scope" means the extent or range of view, outlook, application, operation, or effectiveness.

(154) "Secondary Waste Materials" means fragments of products or finished products of a manufacturing process that has converted a virgin resource into a commodity of real economic value. "Secondary Waste

Materials" includes post-consumer waste. "Secondary Waste Materials" does not include excess virgin resources of the manufacturing process. For paper, "Secondary Waste Materials" does not include fibrous waste generated during the manufacturing process such as fibers recovered from waste water or trimmings of paper machine rolls, mill broke, wood slabs, chips, sawdust or other wood residue from a manufacturing process.

(155) "Services" or "services," for the purpose of these Rules only, means Trade Services, Personal Services, or any combination thereof.

(156) "Signature" means any Written mark, word or symbol that is made or adopted by a Person with the intent to be bound and that is attached to or logically associated with a Written document to which the Person intends to be bound.

(157) "Signed" means, as the context requires, that a Written document contains a Signature or that the act of making a Signature has occurred.

(158) "Small Procurement" means a sourcing method pursuant to ORS 279B.065.

(159) "Sole-Source Procurement" means a sourcing method by which an Authorized Agency awards a Contract without competition to a single source for Supplies and Services, when Written justification demonstrates no other source is available, in accordance with ORS 279B.075 and OAR 125-247-0275.

(160) "Solicitation" means:

(a) A request by an Authorized Agency for the purpose of soliciting Offers. This request may take the form of an Invitation for Bid, a Request for Proposal, a Request for Quotation, a Request for Qualifications or a similar document; or

(b) The process of notifying prospective Offerors that the Authorized Agency requests such Offers; or

(c) The Solicitation Document itself. A Solicitation and award process uses methods identified in ORS 279A.200 through 279A.220 (Cooperative Procurement); ORS 279B.055 through 279B.060 (bidding and proposals); ORS 279B.070 (intermediate procurements); ORS 279B.085 (special procurements); ORS 279C.100 through 279C.125 (Architectural, Engineering and Land Surveying and Related Services); or ORS 279C.300 through 279C.450 (Public Improvements).

(161) "Solicitation Document," means an Invitation to Bid; a Request for Proposals; a Writing for a Small, Intermediate, Informal Selection, Competitive Quote, or Emergency Procurement; a Special Procurement Solicitation; or other document issued to invite Offers from prospective Contractors in accordance with ORS 279B or 279C. "Solicitation Document" includes related documents, either attached or incorporated by reference, and any changes thereto, issued by an Authorized Agency to establish an Original Contract that forms the basis for an Agency's participation in a Procurement.

(162) "Special Government Body" is defined in ORS 174.117 and

(a) means any of the following:

(A) A public corporation created under a statute of this State and specifically designated as a public corporation.

(B) A school district.

(C) A public charter school established under ORS chapter 338.

(D) An education service district.

(E) A community college district or community college service district established under ORS chapter 341.

(F) An intergovernmental body formed by two or more public bodies.

(G) Any entity that is created by statute, ordinance or resolution that is not part of state government or local government.

(H) Any entity that is not otherwise described in this section that is:

(i) Not part of state government or local government;

(ii) Created pursuant to authority granted by a statute, ordinance or resolution, but not directly created by that statute, ordinance or resolution; and

(iii) Identified as a governmental entity by the statute, ordinance or resolution authorizing the creation of the entity, without regard to the specific terms used by the statute, ordinance or resolution.

(b) Subject to ORS 174.117, "Special Government Body" includes:

(A) An entity created by statute for the purpose of giving advice only to a special government body;

(B) An entity created by a Special Government Body for the purpose of giving advice to the special government body, if the document creating the entity indicates that the entity is a public body; and

(C) Any entity created by a Special Government Body described in Subsection (a) of this section, other than an entity described in paragraph (B) of this Subsection, unless the document creating the entity indicates that the entity is not a governmental entity or the entity is not subject to any substantial control by the Special Government Body.

(163) "Special Procurement" means a sourcing method may be a class Special Procurement, a contract-specific Special Procurement or both, unless the context requires otherwise in accordance with ORS 279B.085 and OAR 125-247-0287.

(a) "Class Special Procurement" is defined in ORS 279B.085 and means a contracting procedure that differs from the procedures described in ORS 279B.055, 279B.060, 279B.065 and 279B.070 and is for the purpose of entering into a series of Contracts over time for the acquisition of a specified class of Supplies and Services.

(b) "Contract-specific Special Procurement" means a contracting procedure that differs from the procedures described in ORS 279B.055, 279B.060, 279B.065 and 279B.070 and is for the purpose of entering into a single Contract or a number of related contracts for the acquisition of specified Supplies and Services on a one-time basis or for a single project.

(164) "Specification" is defined in ORS 279B.200(3) and means any description of the physical or functional characteristics, or of the nature of the Supplies and Services to be procured by an Agency. "Specification" includes: any requirement for inspecting, testing, or preparing the Supplies and Services for delivery and the quantities or qualities of Supplies and Services to be furnished under the Contract. Specifications generally will state the result to be obtained and occasionally may describe the method and manner of performance.

(165) "State" means the State of Oregon.

(166) "State Government," subject to ORS 174.108, means the Executive Department, the Judicial Department and the Legislative Department.

(167) "State Procurement Office" means that office of the State Services Division of the Department designated by the Director to carry out the authority of the Department under the Public Contracting Code and these Rules. The authority of the State Procurement Office is described in OAR 125-246-0170, originating with the Director, delegated to the Chief Procurement Officer, and subdelegated in writing by the Chief Procurement Officer to any subdelegatee within the State Procurement Office. When a Rule refers to the approval of the State Procurement Office, any individual acting on behalf of the State Procurement Office must be authorized to give such approval in accordance with OAR 125-246-0170.

(168) "Substantial Completion" is defined in 279C.465 and pursuant to ORS 12.135 and HB 3022 means the date when the Contractee accepts in Writing the Construction, alteration or repair of the improvement to real property or any designated portion thereof as having reached that state of completion when it may be used or occupied for its intended purpose or, if there is no such Written acceptance, the date of acceptance of the completed construction, alteration or repair of such improvement by the Contractee.

(169) "Supplies and Services" includes "Supplies or Services" and collectively means Goods, Trade Services, Personal Services, and Ordinary Construction Services separately or in any combination of these terms thereof as appropriate within the context of the Rule. "Supplies and Services" includes the terms "goods and services," "goods or services," and "personal services" contained in ORS 279A and 279B. This term does not include Public Improvements or Architectural, Engineering and Land Surveying Services, and Related Services, governed under ORS 279C.

(170) "Surplus Property" means all personal property, vehicles and titled equipment property received by the Department as surplus from federal government units, state agencies, local governments, and special government bodies for sale to state agencies, political subdivisions of the State, and private not-for-profit organizations or the general public or any combination thereof.

(171) "Sustainability" is defined in ORS 184.421 and means using, developing and protecting resources in a manner that enables people to meet current needs and provides that future generations can also meet future needs, from the joint perspective of environmental, economic and community objectives.

(172) "Threshold" means a specific monetary limitation that distinguishes one Procurement method from another, triggers a requirement, or marks a point of reference or change in Rule. For example, the Thresholds of $5,000 to $150,000 distinguish Intermediate Procurements under ORS 279B from other methods.

(173) "Trade Services" means all remaining services that do not meet the definition for Personal Services.

(174) "Transitional Contracts" means all Public Contracts first advertised before March 1, 2005, but not entered into until on or after March 1, 2005. See OAR 125-246-0100(6).

(175) "Unnecessarily Restrictive" is defined in ORS 279B.405(1)(c) and means that Specifications limit competition arbitrarily, without reasonably promoting the fulfillment of the Procurement needs of an Agency.

(176) "Used Oil" is defined in ORS 459A.555 and means a petroleum-based oil which through use, storage or handling has become unsuitable for its original purpose due to the presence of impurities or loss of original properties.

(177) "Virgin Oil" means oil that has been refined from crude oil and that has not been used or contaminated with impurities.

(178) "Work" means the furnishing of all materials, equipment, labor, and incidentals necessary to successfully complete any individual item or the entire Contract and the carrying out and completion of all duties and obligations imposed by the Contract.

(179) "Work Order" means an Ordering Instrument.

(180) "Writing" means letters, characters and symbols inscribed on paper by hand, print, type or other method of impression, intend to represent or convey particular ideas or meanings. "Writing" when required or permitted by law, or required or permitted in a Solicitation Document, also means letters, characters and symbols made in electronic form and intended to represent or convey particular ideas or meanings.

(181) "Written" means existing in Writing.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065, 279A.200, 279B.005 & 279C.110
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0130
Application of the Code and Rules; Exceptions

(1) Code, Rules and Policies. Except as set forth in this Section, an Agency must exercise all rights, powers and authority related to Public Contracting in accordance with the Public Contracting Code, Rules, and applicable Department policies (Policies).

(2) Exceptions for Contracts and Grants. These Rules apply to the following:

(a) Contracts between Agencies;

(b) Contracts between Agencies and Public Bodies;

(c) Contracts between Agencies and the federal government;

(d) For Cooperative Procurements, the Code and these Rules do not apply to any contractual relationship described in subsections (2)(a) through (c) of this Rule. The Code, Rules, and policies apply to the contractual relationships between the Agencies and Providers, other states, tribes, other nations, and any of their public entities; or

(e) Grants. If an agreement includes the substantial involvement of the grantor in public contracting, it is not a "Grant" as described in ORS 279A.010(1)(i) and OAR 125-246-0110; and the Code, Rules, and Policies apply to such public contracting.

(3) Exceptions for Agencies. Neither the Code nor these Rules apply to the Public Contracting activities and entities listed in ORS 279A.025(2) and (3).

(4) Exception for a Federal Program. Authorized Agencies otherwise subject to the Code and these Rules may enter into Public Contracts under a federal program described in ORS 279A.180 and pursuant to OAR 125-246-0360, without following the procedures set forth in ORS 279B.050 through 279B.085 and 125-247-0250 through 125-247-0690.

(5) Exception for Qualified Rehabilitation Facilities. Agencies otherwise subject to the Code and these Rules are not subject to the methods set forth in ORS 279A.200 through 279A.225 (Cooperative Purchasing) or 279B.050 through 279B.085 (Sourcing Methods) and related Rules when the Agencies procure Supplies and Services pursuant to ORS 279.835 through 279.855 and OAR 125-055-0005 through 125-055-0045 (Acquisition of Supplies and Services from Qualified Rehabilitation Facilities). Agencies are subject to the remainder of the Code and these Rules, including but not limited to delegation of authority in accordance with OAR 125-246-0170.

(6) Exception for Correctional Industries. Agencies otherwise subject to the Code and these Rules may enter into Contracts with correctional industries pursuant to the Oregon Constitution, Article 1, Subsection 11, without being subject to the source selection procedures set forth in either ORS 279A.200 through 279A.225 (Cooperative Purchasing) or 279B.050 through 279B.085 (Sourcing Methods) and their respective rules.

(7) Exception for Price Agreements. Agencies otherwise subject to the Code and these Rules are not subject to the methods set forth in ORS 279A.200 through 279A.225 (Cooperative Purchasing) or 279B.050 through 279B.085 (Sourcing Methods) and related Rules when the Agencies procure Supplies and Services from a DAS Price Agreement or other Price Agreement. Agencies are subject to the remainder of the Code and these Rules, including but not limited to delegation of authority in accordance with OAR 125-246-0170.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.025, 279A.050, 279A.055 & 279A.180
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0140
Procurement Authority

Pursuant to ORS 279A.050, except as otherwise provided in the Public Contracting Code, for state agencies the Director of the Department has all of the rights, powers and authority necessary to carry out the provisions of the Public Contracting Code, and the Department must exercise all rights, powers and authority in accordance with the Public Contracting Code. For Agencies, the Department and its Director are the Contracting Agency described in the Public Contracting Code and represent the Agencies. Authorized Agencies receive delegated authority pursuant to OAR 125-246-0170.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050(1)(2)
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0150
Applicability of These Rules to Agencies

Agencies subject to the authority of the Director of the Department must follow these Rules. If an Agency is partially independent of the authority of the Department and partially subject to the authority of the Department, that Agency is responsible for obtaining any legal determination related to these Rules.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0170
Delegation of Authority

(1) Generally.

(a) Purpose. The purpose of this Rule is to specify the policy and procedures related to the delegation of authority pursuant to the Code, including but not limited to authority related to Procurements, approvals, orders, reports, and other procedures (Authority). This Rule and only this Rule delegates this Authority. This Rule consists of the following:

(A) Section (1) applies to all delegations and subdelegations of Authority (collectively, "Delegations"), modifications of Delegations, and revocations of Delegations;

(B) Section (2) applies to individuals in the Agencies; and

(C) Section (3) applies to the Chief Procurement Officer.

(b) Policy.

(A) Authority of the Director. Pursuant to ORS 279A.140, the Department must conduct all Procurements, including Contract Administration, for the Agencies. Other Sections of the Code authorize specific actions by the Director of the Department. Pursuant to ORS 279A.050(1) and (2), this Authority of the Department vests only in the Director of the Department. The Director is ultimately responsible for the Procurement of the Agencies.

(B) Policy of the Code. The policy of the Code is to clarify responsibilities, instill public confidence, promote efficient use of resources, implement socioeconomic programs, allow meaningful competition, and provide a structure that supports evolving procurement methods, pursuant to ORS 279A.015. These Rules support this policy of the Code.

(C) Individual Representation. Public Contracting impacting State assets require individual representation of the State's interests. Authority under these Rules may be delegated only to individuals acting on behalf of the Agencies and in accordance with this Rule. All individual delegatees must hold and use this Authority within the scope of their employment by the Agency and act on behalf of the Agency as the Agency's representative. Subdelegations may be in whole or in part pursuant to ORS 279A.075. Any individual may decline a subdelegation in whole or in part.

(c) Delegation of Authority by this Rule. The Director of the Department hereby delegates Authority to individuals in the Agencies, only as set forth in Section (2), and delegates Authority to the Chief Procurement Officer, including the discretionary power to revoke the Authority hereby given to individuals in the Agencies, only as set forth in Section (3). A delegator or delegatee may also be referred to in this Rule as an "Authorized Individual."

(d) Forms of Delegations and Revocations of Authority. ORS 279A.075 provides that the exercise of all authorities in the Code may be delegated and subdelegated in whole or in part. The form of a Delegation or revocation of Authority by an Authorized Individual may be by:

(A) This Rule by the Director of the Department;

(B) A Written external or internal policy by an authorized delegator or revoker;

(C) An Interagency Agreement, signed by the Chief Procurement Officer and the Authorized Agency; or

(D) A letter or memorandum signed by an authorized delegator or revoker.

(e) Changes in Individual Representation. If an Agency determines that an Authorized Individual has ceased to represent that Agency for Procurement (Absent Individual), then:

(A) The Authority of the Absent Individual automatically reverts back to the individual who originally delegated the Authority to the Absent

Individual. The Agency must determine who receives the reverted Authority in accordance with this Rule. If the Absent Individual is a head of an Agency or Designated Procurement Officer, the delegator of authority to that individual must notify the State Procurement Office within thirty (30) days after the change in representation.

(B) Subdelegations, if any, by an Absent Individual remain in effect unless and until the Authority of any subdelegatees is modified or revoked by an Authorized Individual.

(f) Requirements.

(A) Compliance. Authorized Agencies must maintain good contracting procedures in accordance with the Public Contracting Code, related Rules and policies of the Department. Delegation of Authority does not exempt anyone from the requirements of the Public Contracting Code, related Rules, and policies of the Department. To the extent applicable, any individual receiving delegated Authority is responsible for following the Public Contracting Code, related Rules, and policies of the Department.

(B) Modifications or Revocations.

(i) Authority. Subject to the conditions of Subsection (ii) below, any Delegation may be modified or revoked by:

(I) the Director of the Department,

(II) the Chief Procurement Officer in accordance with Section (3)(d)(F);

(III) the head of an Agency in accordance with Subsection (2)(a)(B); or

(IV) the original authorized delegator or successor of this delegator who made this Delegation being modified or revoked.

(ii) Conditions.

(I) This modification or revocation of a Delegation must be Writing;

(II) The delegatee must receive reasonable notice of the modification or revocation of the Delegation; and

(III) This modification or revocation of a Delegation must be based upon a determination, as set forth in the related policy of the Department.

(C) Maintenance of Documents. The Authorized Agency must maintain copies of letters, memoranda, or agreements granting a Delegation.

(g) Signature. When an Authorized Agency has delegated Authority pursuant to this Rule, the Authorized Agency's signature constitutes both the execution and approval of the Contract, except as described in Subsections (1)(h), (2)(a)(B), and (2)(b)(F).

(h) Commitment of Funds. ORS 291 and 293, together with the policies of the State Controller's Division of the Department, provide for public financial administration, including: appropriations, allotments by the Department, and an individual's authority to commit or encumber funds, financially obligate the Agency, and decide to expend funds. This type of authority may be referred to as commitment, expenditure, obligation, expenditure decision or signature authority (collectively, Commitment of Funds).

(2) Delegation to Individuals in Agencies.

(a) Chain of Delegation and Responsibilities.

(A) Head and Designated Procurement Officer of the Agency.

(i) Conditional Delegation. The Director delegates Authority, only as set forth in this Section (2), to the heads of Authorized Agencies, on the condition that the heads of Authorized Agencies subdelegate such Authority to their Agencies' Designated Procurement Officers, who may further subdelegate such Authority in accordance with policies of their Agencies (Chain of Delegation). Every Authorized Agency must appoint a Designated Procurement Officer to serve that Authorized Agency; if none is appointed, the head of the Agency is deemed to be the Designated Procurement Officer and assumes the Authority, duties and responsibilities of the Designated Procurement Officer (collectively, "Designated Procurement Officer"). The heads of the Agencies may not subdelegate Authority outside this Chain of Delegation, except as provided in Subsection (2)(a)(B).

(ii) Manner of Appointment. The Authorized Agency determines its procedure for appointing its Designated Procurement Officer, and this Rule does not require or imply any inherent Authority in individual(s) or the Agency in order to make this appointment. The Agency must send a Written notice of its appointment of the Designated Procurement Officer to the State Procurement Office.

(B) Exceptions: Head and Other Individuals of the Agency.

(i) Execution of Contracts. Heads of Authorized Agencies may subdelegate the Authority to execute Contracts, as described in subsection (2)(b)(F), to other individuals within their respective Agency, provided this subdelegation is in accordance with a Written alternative subdelegation plan, maintained on file with the Agency's Designated Procurement Officer.

(ii) Special Procurements of General or Special Counsel Authorized by the Attorney General, pursuant to OAR 125-247-0295. Heads of Authorized Agencies may subdelegate the Authority to procure general or special counsel authorized by the Attorney General, as described in subsection (2)(d)(Q), to other individuals within their respective Agency, provided the head of the Authorized Agency has determined that the individual receiving the subdelegation has the requisite skills and knowledge to carry out the subdelegation. Such subdelegations may be further subdelegated within that Authorized Agency, provided the subdelegator has determined that each individual receiving the Delegation has the requisite skills and knowledge to carry out the subdelegation.

(iii) Chain of Delegation. Authorized Individuals in accordance with subsections (2)(a)(B)(i) and (ii) are included in the Chain of Delegation.

(C) Responsibilities. Each individual in the Chain of Delegation remains responsible for the exercise of Authority by that individual's subdelegatees, and subdelegation does not waive this responsibility. Each delegator must determine and document that the delegatee is capable and accountable for the Procurement. The Designated Procurement Officer, appointed within each Authorized Agency, is responsible for all delegated procurement activity on behalf of the Authorized Agency, as described in this Section (2), except as provided in Subsection (2)(a)(B).

(b) Duties and Responsibilities of Designated Procurement Officers. The Authority, duties and responsibilities of the Designated Procurement Officer, pursuant to (2)(a)(A), are as follows:

(A) Serve as the exclusive supervisor and manager of the Authorized Agency's Procurement system;

(B) Conduct, supervise and manage the Procurement and the Procurement Process for the Authorized Agency in accordance with the Code and these Rules, except for those Procurements conducted by a delegatee to whom the Designated Procurement Officer has delegated Authority;

(C) Prepare or monitor the use of Specifications or statements of work for all Procurements of the Authorized Agency;

(D) Issue Solicitations and implement other non-Solicitation methods for all Procurements of the Authorized Agency in accordance with the Code and these Rules;

(E) Award Contracts only as authorized in accordance with this Rule;

(F) Execute Contracts, which means causing the signing of Contracts and performance of all necessary formalities to bring the Contracts into their final, legally enforceable forms. If the Designated Procurement Officer is unable to make a Commitment of Funds as described in Subsection (1)(h), then the head of the Authorized Agency may follow an alternative subdelegation plan in accordance with Subsection (2)(a)(B)(i).

(G) Comply with the reporting requirements of the Code, these Rules, and Department policies;

(H) Monitor sourcing decisions, Procurements, development of Contracts, awarded Contracts, Contract compliance, spend, Delegations, Special Procurements and exemptions. Monitoring Contract development, awards, and compliance applies to all Delegations;

(I) Based upon the monitoring described in Subsection (2)(b)(H), determine opportunities, establish targets, and utilize methods pursuant to ORS 279A.200 through 279A.220 and 279B.055 through 279B.085 to optimize savings consistent with strategic sourcing.

(c) Delegation by Rule Based Upon Thresholds. By this Rule, the Director of the Department delegates authority to the heads of all Authorized Agencies, subject to Section (2)(a)(A) and (B), for the following Procurements, including Contract Administration:

(A) Small Procurements of Supplies and Services up to and including the Threshold of $5,000, pursuant to ORS 279B.065 and related Rules;

(B) Direct appointments of Architectural, Engineering and Land Surveying Services and Related Services pursuant to OAR 125-248-0200;

(C) Intermediate Procurements of Supplies and Services greater than $5,000 and not exceeding $150,000, pursuant to ORS 279B.070 and OAR 125-247-0270, provided that the Authorized Agency follows the requirements as set forth in the policy of the Department;

(D) Informal Selection Procedures of Architectural, Engineering and Land Surveying Services and Related Services pursuant to ORS 279C.110 and OAR 125-248-0210, provided that the Authorized Agency follows the requirements as set forth in the policy of the Department;

(E) Competitive Quotes for Public Improvements estimated not to exceed $100,000, or not to exceed $50,000 in the case of Contracts for highways, bridges and other transportation projects, pursuant to OAR 125-249-0160, provided that the Authorized Agency follows the requirements as set forth in the policy of the Department;

(F) Competitively Sealed Bidding not exceeding $150,000 and pursuant to OAR 125-247-0255 or 125-247-0256;

(G) Competitively Sealed Proposals not exceeding $150,000 and pursuant to OAR 125-247-0260 or 125-247-0261;

(H) Sole-Source Procurements not exceeding $150,000 and pursuant to ORS 279B.075 and OAR 125-247-0275;

(I) Purchase of Used Personal Property Special Procurements not exceeding $150,000 and pursuant to OAR 125-247-0288(9);

(J) Reverse Auctions Special Procurements not exceeding $150,000 and pursuant to OAR 125-247-0288(11);

(K) Contract Administration as follows:

(i) For Contracts and Ordering Instruments authorized pursuant to this Section (2)(c) and (d), the Contract Administration of these Public Contracts and Ordering Instruments, including but not limited to: appropriate payment approvals, ordering in accordance with the terms of Department Price Agreements, and the oversight of the Provider(s); but excluding the Contract Administration described in Subsection (v) below;

(ii) The daily or routine Contract Administration of Ordering Instruments placed against Department Price Agreements and Contracts procured by the State Procurement Office on behalf of Agencies. This daily or routine Contract Administration includes but is not limited to: appropriate payment approvals, ordering in accordance with the terms of Department Price Agreements, and the oversight of the Provider(s);

(iii) Activities specified in Writing by the Chief Procurement Officer or delegatee;

(iv) Activities specified in a related policy of the Department; and

(v) Notwithstanding Subsection (2)(c)(K)(i) through (iv) above, this Delegation by Subsection (2)(c)(K) does not include:

(I) The Contract Administration of Department Price Agreements; or

(II) For Contracts procured by the State Procurement Office on behalf of Agencies, Amendments when the amended value of Contract exceeds $150,000; and terminations of such Contracts when the amended value of such Contract exceeds $150,000;

(d) Delegation by Rule Based Upon Type. By this Rule, the Director of the Department delegates authority to the heads of all Authorized Agencies, subject to Section (2)(a)(A) and (B), for the following Procurements, including Contract Administration:

(A) Emergency Procurements, in accordance with ORS 279B.080, 279C.335(5), OAR 125-248-0200, or related Rules;

(B) One-time, nonrepetitive Joint Cooperative Procurements in accordance with OAR 125-246-0430, provided that:

(i) No such Procurement results in:

(I) a Permissive Cooperative Procurement that is open to any Agency outside of those Agencies jointly named in the original Procurement or

(II) a Price Agreement for repetitive use by any Agency;

(ii) No such Procurement of Supplies and Services exceeds the Threshold of $150,000, including all Amendments, pursuant to OAR 125-246-0560;

(iii) No such Procurement of Public Improvements exceeds $100,000, or exceeds $50,000 in the case of Contracts for highways, bridges and other transportation projects, including Amendments pursuant to OAR 125-246-0560; and

(iv) The Authorized Agency must follow any related policy of the Department.

(C) Federal program Procurements not exceeding $150,000 or pursuant to a delegation agreement with the State Procurement Office, and in accordance with ORS 279A.180 and related Rules;

(D) Client Services Special Procurements pursuant to OAR 125-247-0288(1) and (2);

(F) “Client Services” procured under ORS 279B.055 through ORS 279B.085 and related Rules, including all amendments pursuant to OAR 125-246-0560;

(G) Renegotiations of Existing Contracts with Incumbent Contractors Special Procurements pursuant to OAR 125-247-0288(3) and as follows: the Authorized Agency is limited to the same authority delegated to that Agency with regard to the Original Contract and any Amendments and may not collectively exceed any Threshold related to its authority to procure the Original Contract, except this limit may be exceeded with the prior Written approval of the Chief Procurement Officer or delegatee of the State Procurement Office;

(H) Advertising Contracts Special Procurements pursuant to OAR 125-247-0288(4);

(I) Equipment Repair and Overhaul Special Procurements pursuant to OAR 125-247-0288(5);

(J) Contracts for Price Regulated Items Special Procurements pursuant to OAR 125-247-0288(6);

(K) Investment Contracts Special Procurements pursuant to OAR 125-247-0288(7);

(L) Food Contracts Special Procurements pursuant to OAR 125-247-0288(8);

(M) Business Assistance Services Special Procurements pursuant to OAR 125-247-0288(10);

(N) Interstate and International Agreements Special Procurements pursuant to OAR 125-247-0293 or an Interstate Agreements Special Procurement pursuant to OAR 125-247-0287;

(O) Tribal Agreements Special Procurements pursuant to OAR 125-247-0294 or an approved Tribal Agreements Special Procurement pursuant to OAR 125-247-0287;

(P) Special Procurements of General or Special Counsel Authorized by the Attorney General, pursuant to OAR 125-247-0295.

(e) Supplemental Requested Delegations. Any Agency may submit a request for a Delegation to the State Procurement Office for authority in accordance with the Public Contracting Code, this Rule, and the related policy of the Department.

(A) The Department will identify in policy the necessary requirements for requesting and obtaining delegated authority pursuant to this Rule.

(B) All Delegations must be approved in Writing by the Chief Procurement Officer and based upon a consideration of relevant factors set forth in the related policy of the Department.

(3) Delegation to the Chief Procurement Officer:

(a) Powers and Authorities. The Director of the Department delegates to the Chief Procurement Officer the rights, powers and authority vested in the Director of the Department to:

(A) Delegate and subdelegate these authorities in whole or in part pursuant to ORS 279A.075;

(B) Approve Special Procurement requests, pursuant to ORS 279B.085 and related Rules, and receive filed protests of approvals of Special Procurements, pursuant to ORS 279B.400(1);

(C) Conduct hearings, approve Agency findings, approve exemption requests, and issue exemption orders, pursuant to ORS 279C.335, 279C.345, 279C.390, and related Rules;

(D) Create all procedures and Specifications required by the Public Contracting Code and these Rules;

(E) Receive, maintain, and act upon information contained in reports, including but not limited to ORS 279A.140(h) and 279C.355, as required by the Public Contracting Code and these Rules;

(F) Receive and resolve protests pursuant to ORS 279B.400 to 279B.420 and Division 247 Rules, except for appeals from a decision of the Chief Procurement Officer or delegatee;

(G) Receive notices, conduct hearings, and make decisions regarding prequalifications, debarments, and Disqualifications pursuant to ORS 279A.110, 279B.425, 279C.450, 200.065(5), and 200.075(1), except for appeals from a decision of the Chief Procurement Officer or delegatee;

(H) Approve Unanticipated Amendments pursuant to OAR 125-246-0560(2);

(I) Approve expedited notices for Sole-Source Procurements pursuant to OAR 125-247-0275;

(J) Procure and administer Cooperative Procurements and receive, hear, and resolve related protests and disputes, pursuant to ORS 279A.200 through 279A.225 and OAR 125-246-0400 through 125-246-0460;

(K) Approve Brand Name Specifications pursuant to OAR 125-247-0288(3);

(L) Determine authorization for purchases through federal programs pursuant to ORS 279A.180 and OAR 125-246-0360; and

(M) Authorize public notice of bids, proposals, and public improvement Contracts to be published electronically and pursuant to ORS 279B.055(4)(c) and 279C.360(1);

(N) Approve the manner and character of retainage pursuant to ORS 279C.560(1)and (5); and

(O) Other actions of the State Procurement Office specifically required by these Rules.

(b) Duties and Responsibilities of the Chief Procurement Officer. The authority, duties and responsibilities of the Chief Procurement Officer are as follows:

(A) Conduct Procurements, including administration of Contracts, for Agencies.

(B) Develop and maintain State-wide Procurement rules, policies, procedures and standard contract terms and conditions as necessary to carry out the Public Contracting Code.

(C) Subdelegate authority in whole or part, based upon consideration and documentation of one or more of the following factors in making this decision:

(i) The procurement expertise, specialized knowledge and past experience of the individual;

(ii) The impact of the subdelegation of the Procurement on efficiency and effectiveness;

(iii) The individual’s adherence to the Code, these Rules, standards, procedures and manuals;

(iv) The ability and assent of the individual to be accountable for the delegated Procurement; or

(v) The short-term demands upon the staff and resources of the State Procurement Office, arising from unusual circumstances;

(D) Revoke authority delegated by the Chief Procurement Officer or in accordance with (3)(d)(F), in whole or part, based upon consideration and documentation of one or more of the following factors in making this decision:

(i) The procurement expertise, specialized knowledge and past experience of the individual;

(ii) The impact of the subdelegation of the Procurement on efficiency and effectiveness;

(iii) The individual's adherence to the Code, these Rules, standards, procedures and manuals; or

(iv) The ability and assent of the individual to be accountable for the delegated Procurement;

(E) Maintain a file of Written subdelegation authority granted and revoked under these Rules in accordance with the law;

(F) Provide guidance and leadership on Procurement matters to Agencies and their employees;

(G) Provide training and instruction opportunities to assure SPO staff and Agency staff are equipped with necessary knowledge and skills to comply with requirements of the Public Contracting Code, Rules, and Department policy related to Procurement;

(H) Monitor sourcing decisions, Procurements, development of Contracts, awarded Contracts, Contract compliance, spend, Delegations, Special Procurements and exemptions. Report these matters to the Authorized Agency and Director as appropriate. Monitoring Contract development, awards, and compliance applies to all Delegations;

(I) Based upon monitoring described in Subsection (3)(b)(H), determine opportunities, establish targets, and utilize methods pursuant to ORS 279A.200 through 279A.220 and 279B.055 through 279B.085 to optimize savings consistent with strategic sourcing.

(J) 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.

(c) Delegation by Rule Based Upon Threshold. By this Rule, the Director of the Department delegates authority to the Chief Procurement Officer for the following Procurements, including Contract Administration:

(A) Small Procurements of Supplies and Services on behalf of Agencies and pursuant to ORS 279B.065;

(B) Intermediate Procurements of Supplies and Services greater than $5,000 and not exceeding $150,000, on behalf of Agencies and pursuant to ORS 279B.070 and OAR 125-247-0270;

(C) Informal Selection procedures of Architectural, Engineering and Land Surveying Services and Related Services, on behalf of Agencies and pursuant to ORS 279C.110 and OAR 125-248-0210;

(D) Competitive Quotes of Public Improvements estimated not to exceed $100,000, or not to exceed $50,000 in the case of Contracts for highways, bridges and other transportation projects, pursuant to ORS 279C.410 notes and OAR 125-249-0160; and

(E) All Procurements exceeding the Thresholds for Intermediate Procurements, Informal Procurements, or Competitive Quotes, pursuant to ORS 279B.070 and OAR-125-247-0270 (Supplies and Services); ORS 279C.110 and OAR 125-248-0210 (Architectural, Engineering and Land Surveying and Related Services); and ORS 279C.410 and OAR 125-249-0210 (Public Improvements), respectively.

(d) Delegation by Rule Based Upon Type. By this Rule, the Director of the Department delegates authority to the Chief Procurement Officer for the following Procurements, including Contract Administration:

(A) Cooperative Procurements in accordance with ORS 279A.200 through 279A.225 and OAR 125-246-0400 through 125-246-0460, except as provided in Section (7)(a)(C) of this Rule; and the State Procurement Office may delegate this authority by agreement to an Authorized Agency, provided this Delegation to an Authorized Agency meets the following criteria:

(i) There is no pre-existing Department Price Agreement or Mandatory Use Agreement;

(ii) The proposed Procurement does not negatively impact DAS Price Agreements or other Contracts identified by the State Procurement Office;

(iii) A competitive process was used for the original agreement; and

(iv) The initial Solicitation was or will be advertised in Oregon.

(B) Special Procurements pursuant to ORS 279B.085 and related Rules;

(C) Sole-Source Procurements in accordance with ORS 279B.075 and OAR 125-247-0275;

(D) Emergency Procurements in accordance with ORS 279B.080, 279C.335(5), OAR 125-248-0200, or related Rules;

(E) Federal program Procurements in accordance with ORS 279A.180 and OAR 125-246-0360; and

(F) All Procurements otherwise delegated to an Authorized Agency pursuant to Section (2) if the Chief Procurement Officer, at her or his own discretion, revokes and assumes this delegated authority, based upon a determination that any Authorized Agency refuses or fails to comply with any Delegation described in Section (2).

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050, 279A.075 & 279A.140
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 15-2005(Temp), f. & cert. ef. 12-22-05 thru 5-21-06; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0210
Subcontracting to and Contracting with Emerging Small Businesses; Disqualification

(1) As set forth in ORS 279A.105, an Authorized Agency may require a Contractor to subcontract some part of a Contract to, or to obtain materials to be used in performing the Contract from:

(a) A business enterprise that is certified under ORS 200.055 as an emerging small business; or

(b) A business enterprise that is:

(A) Certified under ORS 200.055 as an emerging small business; and

(B) Is located in or draws its Workforce from economically distressed areas, as designated by the Oregon Economic and Community Development Department.

(2) For purposes of ORS 279A.105, a subcontractor certified under ORS 200.055 as an emerging small business is located in or draws its Workforce from economically distressed areas if:

(a) Its principal place of business is located in an area designated as economically distressed by the Oregon Economic and Community Development Department pursuant to administrative rules adopted by the Oregon Economic and Community Development Department; or

(b) The Contractor certifies in Writing to the Authorized Agency that a substantial number of the subcontractor's employees, or subcontractors that will manufacture or provide the Goods or perform the Services under the Contract, reside in an area designated as economically distressed by the Oregon Economic and Community Development Department pursuant to administrative rules adopted by the Oregon Economic and Community Development Department. For the purposes of making the foregoing determination, the Authorized Agency must determine in each particular instance what proportion of a Contractor's subcontractor's employees or subcontractors constitute a substantial number.

(3) Authorized Agencies must include in each Solicitation Document a requirement that Offerors certify in their Offers that the Offeror has not and will not discriminate against a subcontractor in the awarding of a subcontract because the subcontractor is a minority, women or emerging small business enterprise certified under ORS 200.055. Authorized Agencies must use a form approved by the State Procurement Office.

(4) Disqualification:

(a) An Authorized Agency may disqualify a Person from consideration of award of the Authorized Agency's Contracts under ORS 200.065(5), or suspend a Person's right to bid on or participate in any Public Contract pursuant to ORS 200.075(1) after providing the Person with notice and a reasonable opportunity to be heard in accordance with subsections (d) and (e) of this section.

(b) As provided in ORS 200.065 and 200.075 an Authorized Agency may disqualify or suspend a Person's right to submit an Offer or to participate in a Contract (e.g., act as a subcontractor) as follows:

(A) For a Disqualification under ORS 200.065, the Authorized Agency may disqualify a Person upon finding that the Person engaged in any of the activities made unlawful by ORS 200.065(1) or (2), or if the Person has been disqualified by another Authorized Agency pursuant to ORS 200.065.

(B) For a Disqualification under ORS 200.075, the Authorized Agency may suspend a Person upon finding that the Person engaged in any of the acts prohibited by ORS 200.075(a) through (c).

(c) An Authorized Agency may disqualify or suspend a Person's right to submit Offers or participate in Public Contracts only for the length of time permitted by ORS 200.065 or 200.075, as applicable.

(d) The Authorized Agency must provide Written notice to the Person of a proposed Disqualification. The Agency must deliver the Written notice by personal service or by registered or certified mail, return receipt requested. This notice must:

(A) State that the Authorized Agency intends to disqualify or suspend the Person;

(B) Set forth the reasons for the Disqualification;

(C) Include a statement of the Person's right to a hearing if requested in Writing within the time stated in the notice and that if the Authorized Agency does not receive the Person's Written request for a hearing within the time stated, the Person must have waived the right to a hearing;

(D) Include a statement of the authority and jurisdiction under which the hearing will be held;

(E) Include a reference to the particular sections of the statutes and rules involved;

(F) State the proposed Disqualification period; and

(G) State that the Person may be represented by legal counsel.

(e) Hearing. Upon the Authorized Agency's receipt of the Person's timely request, the Authorized Agency must promptly deliver written notification and this request to the Chief Procurement Officer. The State Procurement Office must schedule a hearing upon its receipt of the Person's timely request. The State Procurement Office must notify the Person of the time and place of the hearing and provide information on the procedures, right of representation and other rights related to the conduct of the hearing prior to hearing. The Chief Procurement Officer has the discretion to delegate authority under OAR 125-246-0170(3)(a)(G) and specify how the delegatee must review and hear Disqualifications.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.200.065, 200.075, 105 & 279A.110
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0220
Advocate's Office and OMWESB

(1) The "Governor's Advocate's Office for Minority, Women and Emerging Small Business (Advocate's Office)" was created in the Office of the Governor, and the "Advocate for Minority, Women and Emerging Small Business" is the individual appointed by the Governor to advise the Governor, Legislature and Director's Office on issues related to the integration of minority, women and emerging small business into the mainstream of the Oregon economy and business sector. The Advocate oversees the resolution of business concerns with Authorized Agencies impacting certified disadvantaged, minority, women and emerging small businesses (DMWESB). The Advocate is also charged with maintaining the Oregon Opportunity Register and Clearinghouse to facilitate the timely notice of business and contract opportunities to DMWESB firms certified by the Office of Minority, Women and Emerging Small Businesses pursuant to ORS 200.025.

(2) The "Office of Minority, Women and Emerging Small Business" (OMWESB), located in the Department of Consumer and Business Services, administers the certification process for the Disadvantaged Business Enterprise (DBE), Minority Business Enterprise/Women Business Enterprise (MBEWBE), and Emerging Small Business (ESB) Programs. As the sole certification authority in Oregon for disadvantaged, minority-and woman-owned businesses, and emerging small businesses, the Office of Minority, Women and Emerging Small Business (OMWESB) provides certification services for disadvantaged, minority, woman and emerging small businesses, pursuant to ORS 200.025 and 200.055.

(3) A "Disadvantaged Business Enterprise" means a small business concern which is at least 51 percent owned by one or more socially and economically disadvantaged individuals or, in the case of any corporation, at least 51 percent of the stock of which is owned by one or more socially and economically disadvantaged individuals and whose management and daily business operations are controlled by one or more of the socially and economically disadvantaged individuals who own it.

(4) An "Emerging Small Business" is a business with its principal place of business located in this State; a business with average annual gross receipts over the last three years not exceeding $1 million for construction firms and $300,000 for non-construction firms business which has fewer than 20 employees; an independent business (not a subsidiary, affiliate, or successor company of another business whose average gross receipts would exceed the stated limits); and a business properly licensed and legally registered in this State.

(5) A "Minority or Women Business Enterprise" is a small business concern which is at least 51 percent owned by one or more minorities or women, or in the case of a corporation, at least 51 percent of the stock of which is owned by one or more minorities or women, and whose management and daily business operations are controlled by one or more of such individuals, pursuant to ORS 200.005.

(6) The general policy of the Department and these Rules is to expand economic opportunities for Disadvantaged Business Enterprises, Minority Business Enterprises, Women Business Enterprises and Emerging Small Businesses by exposing them to contracting and subcontracting opportunities available through Public Contracts, pursuant to ORS 279A.105 and based upon the Legislative findings set forth in ORS 200.015.

(7) The Agency must support the participation of Minority, Women owned and Emerging Small Businesses in its purchasing processes by notifying the Advocate for Minority, Women and Emerging Small Business as required under ORS 200.035.

(8) When a Public Improvement Contract is less than $100,000 and the Offerors are being drawn exclusively from a list of Certified Emerging Small Businesses maintained by the Office of Minority, Women and Emerging Small Business, the Authorized Agency may let the Contract without formal competitive sourcing methods after a good faith effort to obtain a minimum of three competitive Quotes from Emerging Small Businesses. To obtain maximum exposure for all firms and guard against favoritism, care must be taken to obtain Quotes from different firms each time the list is used. The Authorized Agency must keep a Written record of the source and amount of the Quotes received and comply with the applicable requirements of this Rule.

(9) In carrying out the policy of affirmative action, an Authorized Agency may rely upon ORS 279A.100 and advice of legal counsel regarding its application.

(10) No Special Procurement pursuant to ORS 279B.085 and no exemption pursuant to ORS 279C.335 approved by the Chief Procurement Officer waives or excepts the requirement of notice to the Governor's Advocate for Minority, Women and Emerging Small Businesses in accordance with ORS 200.035 and any DAS policy. All Agencies must comply with ORS 200.035, notwithstanding the Public Contracting Code.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.100 & 279A.105
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0300
Preference for Oregon Supplies and Services; Tie-Offers

(1) Award When Offers Identical. When an Authorized Agency receives Offers identical in price, fitness, availability and quality, and chooses to award a Contract, the Authorized Agency must award the Contract based on the following order of precedence:

(a) The Authorized Agency must award the Contract to the Offeror among those submitting identical Offers, who is offering Supplies and Services or Architectural, Engineering or Land Surveying Services, or Related Services, that have been manufactured or produced in Oregon. For the purposes of this Rule only, Supplies and Services includes Architectural, Engineering or Land Surveying Services, or Related Services; see OAR 125-248-0230(2).

(b) If two or more Offerors submit identical Offers, and they all offer Supplies and Services manufactured or produced in Oregon, the Authorized Agency must award the Contract by drawing lots among the identical Offers.

(c) If the Authorized Agency receives identical Offers, and none of the identical Offers offer Supplies and Services manufactured or produced in Oregon, then the Authorized Agency must award the Contract by drawing lots among the identical Offers. The Offerors that submitted the identical Offers subject to the drawing of lots must be given notice and an opportunity to be present when the lots are drawn. The Authorized Agency must provide to the Offerors who submitted the identical Offers notice of the date, time and location of the drawing lots and an opportunity for these Offerors to be present when the lots are drawn.

(d) Offers received in response to an Intermedaite Procurement are identical if the Offers equally best serve the interests of the Authorized Agency in accordance with ORS 279B.070(4).

(2) Determining if Offers are Identical. An Authorized Agency must consider Offers identical in price, fitness, availability and quality as follows:

(a) Bids received in response to an Invitation to Bid are identical in price, fitness, availability and quality if the Bids are Responsive and offer the Supplies and Services described in the Invitation to Bid at the same price.

(b) Offers received in response to a Request for Proposals are identical in price, fitness, availability and quality if they are Responsive and achieve equal scores when scored in accordance with the evaluation criteria set forth in the Request for Proposals. While qualifications are the primary criteria, whenever an Authorized Agency determines that the Services offered by two or more individuals or firms are equally able to meet that Agency's needs and are of equal value, that Agency must award the Contract to the individual or firm offering the Service at the lowest price.

(c) Proposals received in response to a Special Procurement conducted pursuant to ORS 279B.085 are identical in price, fitness, availability and quality if, after completing the contracting procedure approved by the State Procurement Office, the Authorized Agency determines, in Writing, that two or more Proposals are equally Advantageous to the Authorized Agency.

(3) Determining if Supplies and Services are Manufactured or Produced in Oregon. For the purposes of complying with Section 1 of this Rule, Authorized Agencies must determine whether a Contract is predominantly for Goods, Trade Services or Personal Services and then use the

predominant purpose to determine if the Goods, Trade Services or Personal Services are manufactured or produced in Oregon. Authorized Agencies may request, either in a Solicitation Document, following Closing, or at any other time the Authorized Agency determines is appropriate, any information the Authorized Agency may need to determine if the Supplies and Services are manufactured or produced in Oregon. An Authorized Agency may use any reasonable criteria to determine if Supplies and Services are manufactured or produced in Oregon, provided that the criteria reasonably relate to that determination, and provided that the Authorized Agency applies those criteria equally to each Offer.

(4) Procedure for Drawing Lots. When the Rule calls for the drawing of lots, the Authorized Agency must draw lots by a procedure that affords each Offeror subject to the drawing a substantially equal probability of selection, and that does not allow the person making the selection the opportunity to manipulate the drawing of lots to increase the probability of selecting one Offeror over another.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.120
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0310
Reciprocal Preferences

When evaluating Offers pursuant to OAR 125-247-0255 through 125-247-0261, 125-249-0390 or 125-249-0640 through 125-249-0660, Authorized Agencies must add a percentage increase to the Offer of a Nonresident Offeror equal to the percentage, if any, of the preference that would be given to that Offeror in the state in which the Offeror resides. An Authorized Agency may rely on the list prepared and maintained by the Department pursuant to ORS 279A.120(4) to determine both:

(1) Whether the Nonresident Offeror's state gives preference to in-state Offerors; and

(2) The amount of such preference.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.120
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0321
Recycling Policy

(1) The Department promotes the Procurement by all Authorized Agencies of products made from Recycled Materials in accordance with ORS 279A.125 and 279A.270.

(2) When purchasing Goods, or pursuant to Subsection (2)(c), Personal Services that relate to the use of recovered resources and Recycled Materials, Authorized Agencies must:

(a) Review the procurement Specifications currently utilized in order to eliminate, wherever economically feasible, discrimination against the Procurement of recovered resources or Recycled Materials;

(b) Develop purchasing practices that, to the maximum extent economically feasible, assure purchase of materials which are recycled or which may be recycled or reused when discarded. The Department will make Recycled Products and materials available to Authorized Agencies whenever they can be obtained;

(c) Provide incentives for the maximum possible use of recovered resources and Recycled Materials, wherever economically feasible, in all procurement Specifications issued.

(3) Pursuant to ORS 279A.125, notwithstanding provisions of law requiring the Department to award a Contract to the lowest or best Offeror, the State Procurement Office must give preference to the procurement of Goods manufactured from Recycled Materials, if the Recycled Product's costs do not exceed the costs of nonrecycled products by more than 5%, or a higher percentage if a Written determination is made by the State Procurement Office. The requirements of ORS 279A.125 may be applied to Authorized Agencies by agreement or policy of the Department.

(4) The Offeror must indicate in the Offer, the materials considered relevant to the 5% preference. The 5% preference will only apply to the value of that portion of the Offer that offers non-paper products containing verifiable recycled contents.

(5) All Contracts must require Contractors to use, in the performance of the Contract Work, to the maximum extent economically feasible, Recycled Paper;

(a) All Contracts must require Contractors to use, in the performance of the Contract Work, to the maximum extent economically feasible, recycled PETE products, as well as other recycled plastic resin products. "Recycled PETE products" means a product containing post-consumer polyethylene terephthalate material. The Department must provide guidelines to Authorized Agencies and Contractors on the availability of necessary Goods that contain recycled PETE, as well as other recycled plastic resin supplies and materials; the Department must also identify suppliers able to provide necessary Goods containing recycled PETE, as well as other recycled plastic resin supplies and materials, pursuant to ORS 279A.150.

(b) All Authorized Agencies must include the following language in any Invitation to Bid or Request for Proposal: "Vendors must use recyclable products to the maximum extent economically feasible in the performance of the contract Work set forth in this document," pursuant to ORS 279B.270(2); and

(c) The Department must include Recycled Product purchasing information within publications and training programs provided to local governments requesting state government purchasing assistance, pursuant to ORS 279A.145.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.125, 279A.145, 279A.150, 279B.270 & 279B.280
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0322
Preference for Recycled Materials

(1) Notwithstanding provisions of law requiring an Authorized Agency to award a Contract to the lowest or best Offer of a Provider, and in accordance with ORS 279A.125 and Subsection (2) of this Section, an Authorized Agency charged with the Procurement of Goods for any public use must give preference to the Procurement of Goods manufactured from Recycled Materials whenever the Authorized Agency uses Competitive Sealed Bidding or Competitive Sealed Proposals pursuant to ORS 279B.055 or 279B.060, respectively, and as set forth in this Rule.

(2) In comparing Goods from two or more Offerors, if at least one Provider offers Goods manufactured from Recycled Materials and at least one Provider does not, an Authorized Agency must select the Provider offering Goods manufactured from Recycled Materials if each of the following four conditions exists:

(a) The Recycled Product is available;

(b) The Recycled Product meets applicable standards;

(c) The Recycled Product can be substituted for a comparable non-recycled product; and

(d) The Recycled Product's costs do not exceed the costs of non-recycled products by more than five percent (5%), or a higher percentage if a Written determination is made by the Authorized Agency and set forth in the Solicitation Document. When making this determination, the Authorized Agency must consider the costs of the Goods following any adjustments the Authorized Agency makes to the price of the Goods after evaluation pursuant to OAR 125-246-0310.

(3) For the purposes of this Section, an Authorized Agency must determine if Goods are manufactured from Recycled Materials in accordance with standards established by the State Procurement Office.

(4) Providers must certify in their Offers:

(a) The minimum, if not exact, percentage of Recycled Product in all materials and supplies offered; and

(b) Both the post-consumer and secondary waste content thereof. Providers may certify a zero percent Recycled Product content. This certification applies to Public Improvement products and all other Procurements.

(5) To be eligible for a preference under ORS 279A.125 and this Rule:

(a) The Provider must indicate which materials and supplies contain verifiable recycled content; and

(b) Such products must meet the requirements of ORS 279A.125 and this Rule.

(6) A preference under ORS 279A.125 will only be applied to those products in the Offer that contain verifiable recycled content.

(7) Offers that contain false information about (i) the percentage of Recycled Product, post-consumer and secondary waste content, or (ii) verifiable recycled content, must be rejected as nonresponsive, and the Provider offering false information may be deemed non-responsible.

(8) Contracts awarded as a result of a preference under ORS 279A.125 are subject to such investigation, including but not limited to, audits, plant visitations, examination of invoices, laboratory analysis, and other documents, etc., as the Department deems necessary to confirm that the products supplied therein contain the percentages of Recycled Product, post-consumer and secondary waste stated in the Offer.

(9) Failure to provide products containing the percentages of Recycled Product, post-consumer and secondary waste stated in the Offer may result in:

(a) The Provider reimbursing the State for the portion of the Contract Price that is attributable to the preference applied under ORS 279A.125;

(b) Contract termination; or

(c) Both (a) and (b), or such other remedies as the Department deems appropriate.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.125
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0323
Recycled Paper and Paper Products

(1) The Department promotes the use of Recycled Paper and paper products, and no less than 35% of Authorized Agency Procurements of paper products may be from Recycled Paper Products, pursuant to ORS 279A.155.

(2) The State Procurement Office or its delegatees must make available to Agencies paper and paper products that contain significant quantities of Recycled Materials in all grades where it can be obtained. The State Procurement Office and Authorized Agencies must purchase Recycled Paper and paper products when the cost of such Recycled Paper or paper products is no more than five (5%) higher than the cost of the same quality paper or paper products containing little or no Recycled Paper. The State Procurement Office and Authorized Agencies must give a preference of up to five percent (5%) pursuant to ORS 279A.125(2), to suppliers of Recycled Paper and paper products, over the lowest price of non Recycled Paper and paper products if the fitness and quality of the Recycled Paper content paper meet Specification requirements and the type of Recycled Paper content is equivalent to the same type of virgin material.

(3) Except as provided in this Rule and regardless of cost, the State Procurement Office or its delegatees must make Recycled Paper and paper products available to Authorized Agencies through a Recycled Paper agreement. Authorized Agencies that find it economically feasible to exceed the incentive in Section (2) of this Rule for Recycled Paper may do so either by use of agreements for Recycled Paper or by indicating on their purchase request the percentage of Recycled Paper incentive, which is economically feasible for them.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.125 & 270A.155
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0330
State Procurement

(1) The Department must conduct all Procurements and administer the contracting for Supplies and Services; Architectural, Engineering and Land Surveying Services, and Related Services; and Public Improvements for the Agencies, pursuant to ORS 279A.140 and 279C.105(1). Delegations of authority in accordance with OAR 125-246-0170 do not relieve the Department of this responsibility. To advance the conduct of Procurements including administration of Contracts, the State Procurement Office provides leadership and services for innovative, responsive, and accountable public Procurement. The following Sections (2) through (4) of this Rule applies only to Trade Services, Personal Services, and Architectural, Engineering and Land Surveying and Related Services (for the purposes of this Rule only, “Services”).

(2) Independent Contractor Status. The Authorized Agency must develop a Statement of Work for Trade or Personal Services, including Architectural, Engineering and Land Surveying Services, and Related Services, that will not result in an employee relationship with the potential Contractor. The Authorized Agency and Contractor(s) must complete the Independent Contractor Certification whether by contract provision or form approved by the State Procurement Office (Independent Contractor Certification). If the individual cannot certify Independent Contractor status, the Authorized Agency may not contract with the individual using a Trade or Personal Services Contract, including Architectural, Engineering and Land Surveying Services, and Related Services, except as otherwise allowed in Subsection (2)(f) of this Rule:

(a) An Independent Contractor Certification must be part of each Contract;

(b) If the Contractor is a corporation, the Independent Contractor Certification is still required.

(c) If the nature of the Services or project is such that an employee/employer relationship will exist, the Authorized Agency must hire the individual through normal personnel procedures.

(d) The Contract must include the Contractor’s legal name, address, and Social Security or federal tax identification number.

(e) 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.

(f) When a Contractor cannot certify that the Contractor meets the definition of “independent contractor,” is customarily engaged in an independently established business, and meets at least three of the requirements for such a business in accordance with ORS 670.600, then the Authorized Agency may contract with the Contractor only if the State Procurement Office, in consultation with the Department of Justice, approves the Contract upon a determination by the State Procurement Office that the Contractor is an Independent Contractor and the Contract will not result in undue risk to the State.

(3) Tax Compliance. No Contract or other agreement for more than $1,000 may be entered into, renewed or extended with any Person unless the Person certifies in Writing, under penalty of perjury, that the Person is not in violation of any tax laws described in ORS 305.385(6) and (7).

(4) Requirements to Transact Business in Oregon:

(a) A Contractor who is a corporation, partnership, or who has an assumed business name must be registered with the Secretary of State Office in accordance with ORS chapters 58, 60, 62, 63, 65, 67, 70, and 648. This registration is the obligation of the Contractor, not the Agency.

(b) In addition, for Contracts requiring the services of one or more architects, engineers, and land surveyors, these Consultants must be registered with the appropriate licensing boards under the provisions of ORS 671.020, 672.020, and 672.025.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070 & Sec. 335, Ch. 794, OL 2003 (HB 2341)
Stats. Implemented: ORS 279A.140 & 279C.105(1)
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0335
Authority and Standards for Personal Services Contracts

(1) Application. For the purposes of this Rule only, “Personal Services” includes Architectural, Engineering and Land Surveying Services, and Related Services.

(2) Identification of Personal Services Contracts.

(a) Pursuant to ORS 279A.140(2)(h), the State Procurement Office may designate Contracts or classes of Contracts as Personal Services Contracts for the purposes of reporting Personal Services Contracts in accordance with ORS 279A.140 and identifying the appropriate required procedures in accordance with ORS 279A.070 and 270A.140. In the event of uncertainty or disagreement as to the status of any particular Contract or class of Contracts, the State Procurement Office may determine whether a particular contract is a Personal Services Contract.

(b) The Authorized Agency must identify within the Contract that the Authorized Agency is contracting for Personal Services. A failure to adequately describe Personal Services within the Contract will not invalidate the Procurement or Contract if the Authorized Agency properly used a sourcing method pursuant to ORS 279B.055 through 279B.085 or 279C.100 through 279C.125 and substantially followed the related Rules regarding screening, selection, evaluation, award, and approval in accordance with these Rules, OAR 125-246-0345 through 125-246-0355 or 125-246-0100 through 125-246-0320.

(3) Independent Contractor. An Authorized Agency may, within the limits of its delegation under OAR 125-246-0170 and its legislatively approved budget, Contract for Personal Services with Providers who are Independent Contractors. “Independent Contractor” means a Person who provides services to an Authorized Agency in which the Authorized Agency neither controls nor has the right to control the means or manner by which Work is performed. The Authorized Agency may control the results of the services, but not control the means or manner of Contractor’s performance of the Work.

(4) Within the parameters of employment, Workers’ compensation, and other relevant state and federal laws, and after meeting any collective bargaining agreements, an Authorized Agency may contract for Personal Services when:

(a) The Authorized Agency has complied with any labor-related agreements;

(b) The Work cannot be done in a reasonable time with the Authorized Agency’s own Workforce;

(c) An independent and impartial evaluation is required; or

(d) It will be less expensive to contract for the Work.

(5) The Authorized Agency may not use Personal Services Contracts to obtain and pay for the services of an employee. If a Contractor is not an Independent Contractor, the Authorized Agency may not enter into a Personal Services Contract with the Contractor; instead, the Authorized Agency must follow personnel policies for employment options.

(6) Contracting Out for Services Provided by Employees.

(a) Where the Authorized Agency is contemplating contracting for Work performed by Authorized Agency employees represented by a labor organization, the Authorized Agency must review the relevant collective bargaining agreement to ensure the contract complies with the provisions and, if applicable, the requirements of ORS 279A.140.

(b) Whenever the Authorized Agency pays more in a given 12-month period to a Provider under a Personal Services Contract for services historically performed by state employees than would have been paid to the Authorized Agency employee performing the same Work, the Authorized Agency must report that fact, with a justifying statement to the Department. The report must be made at the conclusion of each fiscal year.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.140
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0345
Procedures for Personal Services Contracts.

(1) Contract Forms for Architectural, Engineering and Land Surveying Services, and Related Services. Authorized Agencies must comply with OAR 125-248-0300(1).

(2) Contract Forms for other Contracts for Personal Services. Authorized Agencies must use one of the forms provided or approved by the State Procurement Office for Contracts for Personal Services.

(a) If an Authorized Agency obtains approval in accordance with this Rule, it may enter into a Contract for Personal Services containing terms and conditions other than those in the approved form for one-time acquisitions of Personal Services. The Authorized Agency must provide the State Procurement Office with a copy of the proposed Contract for Personal Services that shows the specific terms or conditions that the Authorized Agency wishes to revise. The Authorized Agency must obtain State Procurement Office approval of any revisions to the terms and conditions of the form, other than revisions to exhibits included with the form before it enters into the Contract for Personal Services. The State Procurement Office may approve such a revision to its form Contract for Personal Services by facsimile, email, letter or any other method that provides an objective means to verify State Procurement Office approval.

(b) Upon an Authorized Agency's request, the State Procurement Office may approve a revised form Contract for repeated use for a specific class or classes of transactions.

(c) The Authorized Agency must review the approved Contract form at least every two years. If upon review the Authorized Agency revises the Contract form, the Authorized Agency must obtain State Procurement Office approval prior to using the revised Contract form.

(3) Screening, Selection, Evaluation and Award Procedures. An Authorized Agency must follow the procedures set forth in Division 248 of these Rules when contracting for Architectural, Engineering and Land Surveying Services, and Related Services. For all other Contracts for Personal Services, an Authorized Agency must select a sourcing method from the seven methods available pursuant to ORS 279B.055 through 279B.085 and follow the screening, selection, evaluation and award procedures set forth for the selected sourcing method in Division 247 of these Rules.

(4) Amendments and Reinstatements. The procedures for Amendments and reinstatements are found in OAR 125-246-0560 and 125-246-0570, respectively. Procedures for Amendments and reinstatements for Architectural, Engineering and Land Surveying Services, and Related Services are found in OAR 125-248-0340 and 125-248-0310, respectively.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.70 & 279A.140(h)(B)
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0350
Approval of Personal Services Contracts

(1) Application. For the purposes of this Rule only, "Personal Services" includes Architectural, Engineering and Land Surveying Services, and Related Services.

(2) State Procurement Office Approval. Except as provided in OAR 125-246-0170, the State Procurement Office must approve all Personal Services Contracts exceeding $150,000 before the Authorized Agency executes the Contract.

(3) Requisite Approvals First. All requisite approvals must be obtained, including the approval of the Attorney General, if required, before any Personal Services Contract entered into by an Authorized Agency becomes binding upon the State and before any service may be performed or payment made under the Contract, unless the Contract is exempt from the prohibition against services being performed before review for legal sufficiency is obtained under ORS 291.047(6).

(4) Legal Sufficiency Review. The State Procurement Office may not approve a Personal Services Contract calling for payment of more than $75,000 before the Attorney General approves this Personal Services Contract, if the review and approval of the Attorney General is required under ORS 291.047 or 291.049.

(5) Types of Approvals.

(a) When Attorney General legal sufficiency approval is required under ORS 291.047, the Authorized Agency must seek legal approval;

(b) When an Authorized Agency contracts for services normally provided by another Authorized Agency or for services for which another Authorized Agency has statutory responsibilities, the Authorized Agency is required to seek the other Authorized Agency's approvals, prior to final approval by the State Procurement Office. Examples of these special approvals include, but are not limited to:

(A) Department, Risk Management Division for providing tort liability coverage.

(B) Department, Information Resource Management Division (IRMD), Publishing and Distribution for printing services;

(C) Department, 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); and

(E) Department, Information Resources Management Division for information-system related and telecommunications services. The Authorized Agency is also encouraged to use this Division's Enterprise Planning and Policy Section as a resource in carrying out information system-related projects. This may include:

(i) Assistance to the Authorized Agency in developing Statements of Work related to information system projects;

(ii) Reviews to assure consistency with State standards and direction; and

(iii) A listing of vendors that provide information system-related services.

(c) The Authorized Agency's and Contractor's execution must be obtained;

(d) The State Procurement Office approval, when required, is last. The State Procurement Office must use its best efforts to approve all Personal Services Contracts within five (5) business days. A longer period might be necessary for Contracts that are incomplete or Contracts where additional information must be acquired.

(6) Attorney or Financial Auditing Services.

(a) The Attorney General has sole authority to contract for attorney services. Only the Attorney General may grant exceptions in Writing on a case-by-case basis;

(b) The Secretary of State Audits Division has sole authority to contract for financial auditing services. Only the Secretary of State Audits Division may grant exceptions in Writing on a case-by-case basis.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.140(2)
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0353
Reporting Requirements for Personal Services Contracts

(1) Application. For the purposes of this Rule only, "Personal Services" includes Architectural, Engineering and Land Surveying Services, and Related Services.

(2) The State Procurement Office maintains an electronic reporting system within ORPIN for the Authorized Agency and a report form for reporting Personal Services Contracts. The Authorized Agency must submit this report form to the State Procurement Office for each Contract and subsequent Contract Amendment. The report form must include the Authorized Agency name, not-to-exceed amount of the Contract, the name of the Contractor, the duration of the Contract, and its basic purpose. The State Procurement Office will provide a copy of the report form for an Authorized Agency without access to the ORPIN. Whenever an Authorized Agency pays more in a calendar year under a Personal Services Contract for services historically performed by state employees than the Authorized Agency would have paid to the Authorized Agency's employees performing the same Work, the Authorized Agency must so report to the Department and include in the report a statement of justification for the greater costs, pursuant to ORS 279A.140(2)(h)(A)(i).

(3) The State Procurement Office must submit a report to the Legislature concerning Authorized Agency use of Personal Services Contracts. This report must include the name of the Authorized Agency, the not-to-exceed amount of the Contracts, the name(s) of Contractor(s), the duration of Contract(s) and the basic purpose of the Contract(s). The report must also include the total dollar figure of all Personal Services Contracts for each fiscal year.

(4) The State Procurement Office maintains an electronic file of Personal Services Contracts report forms for public review. The electronic file includes a justification statement, when applicable, and documentation of the selection process for each Contract.

(5) The Authorized Agency must keep in the Procurement File all Personal Services Contracts, justification statements, when applicable, documentation of the selection process for each Contract, and the report forms in compliance with OAR 166-300-0015(7) and any other applicable laws.

(6) Personal Services Contracts submitted to the State Procurement Office for approval or filing must include the report form. The Authorized Agency's Procurement File should include detailed documentation of the process.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.140(h)(A)
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0355
Procurement Files

(1) Application. This Rule applies to Procurement Files, as defined in OAR 125-246-0110.

(2) Actions. All Written documents delivered to an Agency from the Department, Chief Procurement Officer, or State Procurement Office, whether the documents relate to approvals, revocations, orders, modifications, or other actions (Actions), must be maintained in a Procurement File related to the documents' subject matter and Action.

(3) Procurements Exceeding Thresholds. This Section (3) applies only to Procurements exceeding the Intermediate Procurement Threshold for Supplies and Services; the Informal Selection Threshold for Architectural, Engineering and Land Surveying Services; and the Competitive Quotes Threshold for Public Improvements pursuant to OAR 125-247-0270, 125-248-0210, and 125-249-0160, respectively, unless a policy established by the Department provides otherwise. Each Agency's 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 Provider and sourcing method pursuant to ORS 279A.200 through 279A.220 (Cooperative Procurement); 279B.055 through 085 (seven methods for Supplies and Services); 279C.100 through 279C.125 (Architectural, Engineering and Land Surveying and Related Services); or ORS 279C.300 through 279C.450 (Public Improvements); and

(e) Documentation of Contract Administration pursuant to OAR 125-246-0555.

(4) Each Authorized Agency's Procurement File may also contain, if required by the Code or these Rules:

(a) A list of prospective Providers notified of any Solicitation;

(b) The method used to advertise or notify prospective Providers;

(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 Providers pursuant to OAR 125-246-0635;

(g) All information describing how the Provider was selected, including the basis for awarding the Contract;

(h) A copy of the Request for Special Procurement, if any;

(i) Documentation for a Federal Program purchase pursuant to OAR 125-246-0360;

(j) Documentation related to Cooperative Procurements pursuant to OAR 125-246-0410 et. seq.; and

(k) Any Written documentation of an Action, as described in Section (2) above.

(5) The Agency must maintain Procurement Files, including all documentation, for a period in compliance with OAR 166-300-0015(7) and any other applicable laws. Procurement Files must be made immediately available for review upon the request of the State Procurement Office.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070 & 279A.140
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0360
Purchases Through Federal Programs

(1) Exemption. An Authorized Agency may purchase certain authorized Supplies and Services through General Service Administration (GSA) federal programs or federal Contracts (Federal Programs) without Competitive Sealed Bidding, Competitive Sealed Proposals or other competition required under ORS 279B.050 to 279B.085, provided that the Authorized Agency has federal authorization to purchase through the Federal Program and follows the procedures set forth in this rule.

(2) Federal Authorization:

(a) The Federal Programs named in ORS 279A.180 are accessible to Authorized Agencies for purchasing Supplies and Services. In addition, by this Rule, the Director of the Department (Director) hereby makes the determination pursuant to ORS 279A.180, that the GSA Order of 2000 and any subsequent revisions or updating of this GSA Order of 2000 (GSA Orders) describe other Federal Programs that, under federal law, are similar to 10 U.S.C. 381 or Section 211 of the Electronic Government Act of 2002 in effectuating or promoting transfers of property to Authorized Agencies; therefore, Authorized Agencies may purchase through those Federal Programs described in a GSA Order without making individual requests for determination to the Director.

(b) If an Authorized Agency desires to purchase through another Federal Program that is not expressly named in ORS 279A.180 or a GSA Order, the Authorized Agency must request in Writing a determination from the Director or the Director's designated representative. In the request, the Authorized Agency must document that the federal government has authorized states, including the Authorized Agency, to purchase through the proposed Federal Program. The request of the Authorized Agency and the determination by the Director or representative must be limited to those other Federal Programs described in ORS 279A.180 that, under federal law, are similar to 10 U.S.C. 381 or Section 211 of the Electronic Government Act of 2002 in effectuating or promoting transfers of property to Authorized Agencies.

(c) If no federal authorization exists as described in Sections (2)(a) and (b) of the Rule, then an Authorized Agency is not permitted to purchase through any Federal Program.

(3) Procedures. To purchase through a Federal Program, an Authorized Agency must document in its Procurement File that:

(a) The federal authority for the Authorized Agency to purchase through the Federal Program, referring to ORS 279A.180, a GSA Order, or the State Procurement Office's approval of an Authorized Agency's request.

(b) The acquisition meets the Authorized Agency's needs;

(c) The price and other terms of the acquisition are Advantageous to the State;

(d) No Department Price Agreement for the authorized Supplies and Services exists, based upon the Authorized Agency's inquiry through ORPIN;

(e) The Authorized Agency has considered the acquisition's impact upon local business as follows:

(A) If the Procurement is in excess of $5,000, the Authorized Agency has given timely notice through ORPIN of its needs, reasons, and intent to procure through a Federal Program;

(B) The Authorized Agency has provided a reasonable time period under the circumstances for individuals to respond to the notice and send Written comments to the Authorized Agency; and

(C) The Authorized Agency has considered any comments and replied, if appropriate, before proceeding with its Procurement through a Federal Program. This Rule provides for an informal opportunity to comment to and be considered by the Authorized Agency, in lieu of the formal notice requirements for Solicitations in excess of $5,000 pursuant to ORS 200.035.

(f) State and local preference programs, including but not limited to the Inmate Work Program of ORS 279.015, the Products of Disabled Individuals Program of ORS 279.835 to 850, and state requirements Contracts under OAR 125-247-0296, are not waived or otherwise adversely affected by an acquisition through a Federal Program;

(g) The Authorized Agency has complied with OAR 137-045-0010 to 137-045-0090, and if it is required, obtained a legal sufficiency review or exemption from the Department of Justice; and

(h) The Authorized Agency is informed of its Federal Program's Procurement Process, including:

(A) Voluntary and Direct Contract. The Authorized Agency and Contractors participate voluntarily. The Contractors make direct deliveries to the Authorized Agency and retain the right to decline orders on a case-by-case basis, for any reason, within a five-Day period of receipt of that order;

(B) Funding Fee. The price of a Federal Program Contract includes a GSA industrial funding fee to cover GSA administrative costs to operate the Federal Program;

(C) New Contract. When a Contractor accepts an order from an Authorized Agency, a new Contract is formed. The Contract's terms and conditions are incorporated by reference; and

(D) Additional Terms and Conditions. The Authorized Agency may add to its Contract such significant, substantial contract terms and conditions as are required by State statutes or rules, if such additions do not conflict with the Federal Program's Contract terms and conditions. Examples of such terms and conditions include, but are not limited to:

(i) Prompt Payment. The Authorized Agency may apply the terms and conditions of Oregon's prompt payment law to its Contracts, but if the Authorized Agency fails to make this addition, then the Authorized Agency may be subject to the Federal Prompt Payment Act, 31 U.S.C. sec. 3901 et seq., as implemented at subpart 32.9 of the Federal Acquisition Regulation (FAR);

(ii) Commercial Terms. Patent indemnity and other commercial terms and conditions may be added if they do not conflict with the Federal Program's terms and conditions; and

(iii) Conflict Resolution. The Authorized Agency may revise the Contract's dispute resolution provision to use Alternative Dispute Resolution (ADR) to the extent authorized by law.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070 & Sec.335, Ch. 794, OL 2003 (HB 2341)
Stats. Implemented: ORS 279A.180
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0400
Purpose, Policy, and Definitions

(1) Purpose. The purpose of these Rules for Cooperative Procurement is to specify the policy and procedures of the State Procurement Office or Authorized Agency for Procurement, using one of the three Cooperative Procurement methods; Joint Cooperative Procurements, Permissive Cooperative Procurements, and Interstate Cooperative Procurements. An Administrator's Original Contract or a Participant's Contract with a Provider in a Cooperative Procurement is subject to ORS 279A and these Rules, unlike agreements solely between Authorized Agencies pursuant to ORS 190 et seq. and excepted from the Code pursuant to OR 279A.025.

(2) Policy. It is the policy of the Department that Authorized Agencies will collaborate to leverage their purchases for Supplies and Services to achieve efficiency in state government by optimizing the benefits from these Cooperative Procurements.

(3) Definitions. For the purposes of these Cooperative Procurement Rules only, the following definitions apply to Cooperative Procurement:

(a) An "Administrator" means an entity that solicits and establishes the Original Contract for Procurement of Supplies and Services or Public Improvements in a Cooperative Procurement. "Administrator" means the State Procurement Office, or subject to the approval of the State Procurement Office: an Agency, another Public Body within the state of Oregon, or a governmental body outside the state of Oregon. An Administrator has the same rights and responsibilities as an Administering Contracting Agency in ORS 279A.200 through 279A.225.

(b) "Contract" for the purposes of these Cooperative Procurement Rules means a Public Contract or Price Agreement resulting from a Cooperative Procurement by an Administrator.

(c) "Cooperative Procurement" means a Procurement conducted by an Administrator or on behalf of one or more Participants. Cooperative Procurement includes but is not limited to multiparty Contracts and Price Agreements.

(d) "Cooperative Procurement Group" means:

(A) A group of Agencies, Public Bodies within the state of Oregon or any governmental body outside the state of Oregon, separately or in any combination;

(B) Approved by the State Procurement Office;

(C) Joined through an intergovernmental agreement; and

(D) For the purposes of facilitating a Cooperative Procurement.

(e) "Interstate Cooperative Procurement" means a Permissive Cooperative Procurement in which the Administrator is authorized under that governmental body's laws, rules, or regulations to enter into Public Contracts and in which one or more of the Participants are located outside of the State of Oregon.

(f) "Joint Cooperative Procurement" means a Cooperative Procurement that identifies:

(A) The Participants or the Cooperative Procurement Group; and

(B) The contract requirements or estimated contract requirements for the Original Contract.

(g) "Material Change" or "Material Alteration" means an alteration in a Public Contract or Solicitation that is different in effect from the original meaning or Scope. This includes changes in quality, price or type of Supplies and Services or Public Improvements.

(h) "Original Contract" means the initial Contract or Price Agreement as solicited and awarded during a Cooperative Procurement by an Administrator.

(i) A "Participant" means an entity that procures Supplies and Services or Public Improvements from a Provider based on the Original Contract established by an Administrator in a Cooperative Procurement. A Participant may be the State Procurement Office, or subject to the approval of the State Procurement Office: an Authorized Agency, a local Public Body, or a state agency with independence under ORS 279A.050. A Participant has the same rights and responsibilities as a Participating or Purchasing Contracting Agency in ORS 279A.200 through 279A.225.

(j) "Permissive Cooperative Procurement" means a Cooperative Procurement in which the Participants are not identified.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.205, 279A.210, 279A.215, 279A.220, 279A.225
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0410
Authority for Cooperative Procurements

(1) The State Procurement Office will enter into Cooperative Procurements on behalf of Agencies, unless an Authorized Agency receives a delegation of authority pursuant to OAR 125-246-0170 to act as an Administrator or Participant.

(2) Subject to a delegation of authority described in section (1) of this Rule, an Administrator or Participant may participate in, sponsor, conduct or administer Joint Cooperative Procurements, Permissive Cooperative Procurements and Interstate Cooperative Procurements in accordance with ORS 279A.200 through 279A.225 and these Rules.

(3) For Permissive Cooperative Procurements under OAR 125-246-0440 and 125-246-0450 only, each Participant that participates after the Award of the Original Contract must determine, in Writing, whether the Solicitation and award process for the Original Contract arising out of a Cooperative Procurement is substantially equivalent to those identified in ORS 279B.055, 279B.060 or 279B.085, consistent with 279A.200(2). This Written documentation must be maintained in the Participant's Procurement File.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.205, 279A.210, 279A.215 & 279A.220
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0420
Responsibilities

(1) The Administrator of a Cooperative Procurement may establish any terms and conditions necessary to allow other Participating Authorized Agencies or Cooperative Procurement Groups, of which the Participant is a member (hereinafter collectively known as "Participant"), to participate in a Cooperative Procurement. The Administrator may require Participants to enter into a Written agreement, which establishes the terms and conditions for participation in a Cooperative Procurement. These terms and conditions may include, but are not limited to: the establishment of any administrative fees for the Administrator, whether each Person must enter into a Written agreement with the Administrator, and any other matters related to the administration of the Cooperative Procurement source selection and the resulting Original Contract. The Administrator may, but is not required to, include provisions in the Solicitation Document for a Cooperative Procurement and advertise the Solicitation Document in a manner to assist Participants' compliance with the Code and these Rules.

(2) In administering or applying these Rules, the Administrator must collaboratively review and compare the procurement needs and requirements of both the Administrator and the respective Participant(s) for the purpose of using a Cooperative Procurement to achieve cost savings (for examples: lowest total cost of acquisition, least time to procure, process streamlining, Return on Investment calculation based on a comparison of the total costs of individual Authorized Agency Procurements versus a Cooperative Procurement).

(3) If a Participant enters into a Contract based on a Cooperative Procurement, the Participant must comply with the Code, these Rules, and any terms and conditions set out by the Administrator, including without limitation those sections of the Code and these Rules that govern:

(a) The extent to which the Participant may participate in the Cooperative Procurement;

(b) The advertisement of the Solicitation Document related to the Cooperative Procurement; and

(c) Public notice of the Participant's intent to establish Contracts based on a Cooperative Procurement.

(4) An Administrator must use a Solicitation and award process that is substantially equivalent to a source selection method identified in ORS 279B.055, 279B.060, 279B.085, or 279C.005 through 279C.870 when it has the characteristics set forth in ORS 279A.200(2).

(5) Interstate Procurement Solicitations must substantially comply with the public notice requirements for advertising pursuant to OAR 125-247-0305.

(6) The interval between the first date of notice of a Joint or Permissive Procurement Solicitation must be not less than fourteen (14) Days for an ITB and thirty (30) Days for an RFP. A Joint or Permissive Procurement Solicitation must comply with the requirements of OAR 125-247-0305.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.205
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0430
Joint Cooperative Procurements

(1) Applicability. An Administrator or Participant may participate in, sponsor, conduct or administer this type of Procurement for the purchase of Supplies and Services or Public Improvements. The Administrator and Participant must comply with the procedures set out in OAR 279A.210 and these Rules to procure Supplies and Services or Public Improvement using a Joint Cooperative Procurement. Only the Participants listed in the Solicitation and Original Contract documents may enter into Contract through a Joint Cooperative Procurement. A Joint Cooperative Procurement is not a Permissive Cooperative Procurement.

(2) Solicitation and Original Contract Documents. The Solicitation Document and Original Contract for a Joint Cooperative Procurement must include, but is not limited to:

(a) A list of the Participants that may enter into a Contract under the terms and conditions of the Original Contract;

(b) The Original Contract requirements, which may include, but are not limited to:

(A) The Original Contract's not-to-exceed value;

(B) The term of the Original Contract;

(C) The quantity or quantity range of purchases to be made;

(D) The minimum level of quality or quality range requirements for the Supplies and Services;

(E) The minimum Provider qualifications;

(F) The Scope of the Supplies and Services or Public Improvements to be purchased;

(G) Terms and conditions;

(H) Any special considerations; and

(I) Any insurance or bonding requirements.

(c) A Written requirement that the Participant will not Materially Change or alter the terms, conditions, and prices from the Original Contract between the Provider and the Administrator.

(d) A Written requirement that Amendments will be generally stated, in Writing, in the Solicitation Document and the Original Contract pursuant to OAR 125-246-0560.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.210
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0440
Permissive Cooperative Procurements

(1) Applicability. An Administrator or Participant may only participate in, sponsor, conduct or administer this type of Cooperative Procurement for the purchase of Supplies and Services. The Administrator and Participant must comply with the procedures set out in ORS 279A.215 and these Rules to procure Supplies and Services using a Permissive Cooperative Procurement. A Permissive Cooperative Procurement is not a Joint Cooperative Procurement.

(2) Solicitation and Original Contract Documents. The Solicitation Document and Original Contract for a Permissive Cooperative Procurement must include, but is not limited to:

(a) A Written requirement that other Participants may establish Contracts to purchase the Supplies or Service;

(b) A Written requirement that the Provider will extend the terms, conditions and prices to any Participant that establishes a Contract through a Permissive Cooperative Procurement;

(c) The Original Contract requirements, which may include, but is not limited to:

(A) The Original Contract's not-to-exceed value;

(B) The term of the Original Contract;

(C) The quantity or quantity range of purchases to be made;

(D) The minimum level of quality or quality range requirements for the Supplies and Services;

(E) The minimum Provider qualifications;

(F) The Scope of the Supplies and Services to be purchased;

(G) Terms and conditions;

(H) Any special considerations; and

(I) Any insurance or bonding requirements.

(d) A Written requirement that the Participant will not Materially Change or Alter the terms, conditions, and prices from the Original Contract between the Provider and the Administrator.

(e) A Written requirement that Amendments will be generally stated, in Writing, in the Solicitation Document and the Original Contract pursuant to OAR 125-246-0560.

(3) Public Notice of Intent to establish a Contract; Comment Period.

(a) A Participant that intends to enter into a Contract through a Permissive Cooperative Procurement must publish a notice of its intent to do so if the Participant estimates that it will spend in excess of $250,000 for the purchase of the Supplies and Services to be acquired under the Contract;

(b) For purposes of determining if a Participant must give a Notice of Intent to establish a Contract through a Permissive Cooperative Procurement as required by ORS 279A.215(a), the estimated amount of the Participant(s)'s purchases will exceed $250,000 for Supplies and Services if:

(A) The Participant's Contract arising out of the Permissive Cooperative Procurement expressly provides that the Participant intends to make purchases over the term of the Contract that will, in aggregate, exceed $250,000, whether or not the total amount or value of the payments is expressly stated in the Contract;

(B) The Participant's Contract arising out of the Permissive Cooperative Procurement expressly provides:

(i) For payment, whether in a fixed amount or up to a stated maximum amount that exceeds $250,000; or

(ii) For a guaranteed maximum price, or a maximum not-to-exceed amount that is in excess of $250,000; or,

(C) At the time the Participant enters into the Contract, the Participant reasonably contemplates, based on historical or other data available to the Participant, that the total purchases it will make for the Supplies and Services under the Contract will, in aggregate, exceed $250,000 over the anticipated duration of the Contract.

(c) The Notice of Intent must contain the following information:

(A) A description of the purchases to made;

(B) An estimated amount of the purchases;

(C) The name of the Administrator; and,

(D) A time, place and date by which comments must be submitted to the Participant regarding the Notice of Intent to establish a Contract.

(E) The Contract requirements, which may include, but are not limited to:

(i) The Contract's not-to-exceed value;

(ii) The term of the Contract;

(iii) The quantity or quantity range of purchases to be made;

(iv) The minimum level of quality or quality range requirements for the Supplies and Services;

(v) The minimum Provider qualifications;

(vi) The Scope of the Supplies and Services to be purchased;

(vii) Any special considerations;

(vii) Terms and conditions; and

(ix) Any insurance or bonding requirements.

(d) A Written requirement that Amendments will be generally stated, in Writing, in the Solicitation Document and the Original Contract pursuant to OAR 125-246-0560.

(e) Any Notice of Intent for a Permissive Cooperative Procurement must be published for no fewer than seven (7) calendar Days before the deadline for submission of comments regarding the Notice of Intent to establish a Contract.

(f) Providers must submit comments within seven (7) calendar Days after the Notice of Intent is published. If the Participant receives comments on its intent to establish a Contract, the Participant must respond to any comments on its intent, to include:

(A) The governing body of the Participant, its chief executive or another officer authorized by the Participant must make a Written determination that establishing a Contract is in the best interest of the Participant.

(B) The Participant must provide a copy of the Written determination to all Providers that submitted comments.

(g) The Notice of Intent must appear in the ORPIN system and, at the Participant's option, an additional Notice of Intent may be placed in at least one newspaper of general circulation, and in as many additional issues and publications as may be necessary or desirable to ensure Providers, who would otherwise be prospective Offerors on the Contract, are given an opportunity to comment.

(h) The Participant's Notice of Intent described in this Section and the Administrator's Permissive Cooperative Procurement Solicitation advertisement requirements described in OAR 125-0247-0305 may occur concurrently.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.215
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0450
Interstate Cooperative Procurements

(1) Applicability. An Administrator or Participant may only participate in this type of Cooperative Procurement for the purchase of Supplies and Services if the Solicitation was advertised in Oregon by the Administrator or Participant pursuant to OAR 125-247-0305. The Administrator or Participant must comply with the procedures set out in ORS 279A.220 and these Rules to procure Supplies and Services using an Interstate Cooperative Procurement.

(2) Solicitation and Original Contract Documents. The Solicitation Document and Original Contract for an Interstate Cooperative Procurement must include, but is not limited to:

(a) A Written requirement that other governmental bodies may establish Contracts to purchase the Supplies and Services;

(b) Either:

(A) A list of the Participant(s) that may enter into Contracts under the terms and conditions of the Original Contract, and a Written requirement that the Provider will extend the terms, conditions and prices to these Participants (Listed Participants); or

(B) A Written requirement that the Provider will extend the terms, conditions and prices to any Participant through the Interstate Cooperative Agreement.

(c) The Original Contract requirements, which may include, but are not limited to:

(A) The Original Contract's not-to-exceed value;

(B) The term of the Original Contract;

(C) The quantity or quantity range of purchases to be made;

(D) The minimum level of quality or quality range requirements for the Supplies or Service;

(E) The minimum Provider qualifications;

(F) The Scope of the Supplies and Services to be purchased;

(G) Any special considerations;

(H) Terms and conditions; and

(I) Any insurance and bonding requirements.

(d) A Written requirement that a Participant will not Materially Change or Alter the terms, conditions, and prices from the Original Contract between the Provider and the Administrator.

(e) A Written requirement that Amendments will be generally stated, in Writing, in the Solicitation Document and the Original Contract pursuant to OAR 125-246-0560.

(3) Advertisements of Interstate Cooperative Procurements

(a) If the Solicitation Document and Original Contract for an Interstate Cooperative Agreement contain a list of the Participants in accordance with Subsection (2)(b) and at least one of the Participants is an Agency, then the Solicitation Document for that Interstate Cooperative Procurement must be advertised in Oregon. This Solicitation Document is advertised in Oregon for purposes of ORS 279A.220(2)(a) if it is advertised in Oregon in compliance with ORS 279B.055(4) or 279B.060(4) by:

(A) The Administrator;

(B) The Participant;

(C) The Cooperative Procurement Group, or a member of the Cooperative Procurement Group, of which the Participant is a member; or

(D) Another Participant that is subject to the Code, so long as such advertisement would, if given by the Participant, comply with ORS 279B.055(4) or 279B.060(4) with respect to the Participant.

(b) A Participant or the Cooperative Procurement Group of which the Participant is a member satisfies the advertisement requirement under ORS 279A.220(2)(b) if the notice is advertised in the same manner as provided in ORS 279B.055(4)(b) and (c).

(4) Public Notice of Intent to establish a Contract;

(a) If a Participant is not listed in accordance with Subsection (2)(b)(A) and intends to enter into a Contract through an Interstate Cooperative Procurement at any time in accordance with Subsection (2)(b)(B), that Participant must publish a Notice of Intent to do so in Oregon.

(b) The Notice of Intent required in accordance with Subsection (4)(a) must appear in the ORPIN system and, at the Participant's option, an additional Notice of Intent may be placed in at least one newspaper of general circulation, and in as many additional issues and publications as may be necessary or desirable to ensure Providers, who would otherwise be prospective Offeror on the Contract, are given an opportunity to comment.

(c) The Notice of Intent must contain the following information:

(A) A description of the purchases to be made;

(B) An estimated amount of the purchases;

(C) The name of the Administrator; and,

(D) A time, place and date by which comments must be submitted to the Participant regarding the Notice of Intent to establish a Contract.

(E) The Contract requirements, which may include, but are not limited to:

(i) The Contract's not-to-exceed value;

(ii) The term of the Contract;

(iii) The quantity or quantity range of purchases to be made;

(iv) The minimum level of quality or quality range requirements for the Supplies and Services;

(v) The minimum Provider qualifications;

(vi) The Scope of the Supplies and Services to be purchased;

(vii) Any special considerations;

(viii) Terms and conditions; and

(ix) Any insurance and bonding requirements.

(d) A Written requirement that Amendments will be generally stated, in Writing, in the Solicitation Document and the Original Contract pursuant to OAR 125-246-0560.

(e) Providers must submit comments within seven (7) calendar Days after the Notice of Intent is published. If the Participant receives comments on its intent to establish a Contract, the Participant must respond to any comments on its intent, including:

(A) The Participant must make a Written determination that establishing a Contract is in the best interest of the Participant; and

(B) The Participant must provide a copy of the Written determination to any Provider that submitted comments.

(f) The Participant's Notice of Intent described in this Section and the Administrator's Interstate Cooperative Procurement Solicitation advertisement requirements described in OAR 125-0247-0305 may occur concurrently.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.220
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0460
Protest and Disputes

(1) Protests to an Administrator.

(a) Solicitation. If a prospective Offeror wishes to protest the procurement process or the contents of the original Solicitation of an Original Contract related to a Cooperative Procurement, the prospective Offeror must direct the protest to the Administrator, and the Offeror must make such protest pursuant to ORS 279B.405, unless the Administrator is not subject to the Code (see Subsection (c) below).

(b) Award. If an adversely affected Offeror wishes to protest the Award or proposed Award of an Original Contract related to a Cooperative Procurement, the Offeror must direct the protest to the Administrator, and the Offeror must make such protest pursuant to ORS 279B.410, unless the Administrator is not subject to the Code (see Subsection (c) below).

(c) If the Administrator is not subject to the Code, then the prospective Offeror under Subsection (a) or the Offeror under Subsection (b) must make the protest in accordance with the processes and procedures established by the Administrator.

(2) Any other protests related to a Cooperative Procurement, or disputes related to a Contract arising out of a Cooperative Procurement, must be made and resolved as set forth in ORS 279A.225.

(3) Protests to a Participant. If an Offeror wishes to protest the use by a Participant of a Cooperative Procurement after the execution of an Original Contract, the potential Offeror must direct the protest to the Participant, and the potential Offeror must make such protest pursuant to ORS 279B.400 to 279B.425. The protest to the Participant is limited in Scope to the Participant's authority to enter into a Cooperative Procurement Contract.

(4) Preservation of Rights and Remedies. Failure of an Administrator or Participant to exercise any rights or remedies it has under the Original Contract or Contract entered into through a Cooperative Procurement may not affect the rights or remedies of the any other Participant that participates in the Cooperative Procurement, including the Administrator, and may not prevent any other Participant from exercising any rights or seeking any remedies that may be available to it under its own Contract arising out of the Cooperative Procurement.

(5) Other Protests or Disputes. Any other protests related to a Cooperative Procurement, or disputes related to an Original Contract or Contract arising out of a Cooperative Procurement, must be made and resolved as set forth in ORS 279A.225.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.225
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0500
Oregon Procurement Information Network (ORPIN)

The Oregon Procurement Information Network, known as ORPIN, an Internet-based, on-line system, is the official publication forum for state Procurement notices and advertisements, as functionality allows, by the Department and all Agencies.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065, 279A.070 & 279A.140
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0555
Contract Administration; General Provisions

(1) Authority. Procurements include Contract Administration. The authority for an Authorized Agency to conduct Contract Administration is found in OAR 125-246-0170.

(2) Contract Administrator. The Authorized Agency must appoint, in Writing, a Contract Administrator to represent the Authorized Agency 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.

(a) Applicability. This Section (3) applies only to Procurements exceeding the Intermediate Procurement Threshold for Supplies and Services; the Informal Selection Threshold for Architectural, Engineering and Land Surveying Services, and Related Services; and the Competitive Quotes Threshold for Public Improvements pursuant to OAR 125-247-0270, 125-248-0210, and 125-249-0160, respectively, unless the policy established by the Department provides otherwise.

(b) Requirements. Documentation of Contract Administration is a part of the Procurement File in accordance with OAR 125-246-0355, and this documentation must include:

(A) An executed Contract;

(B) The record of the actions used to administer the Contract; and

(C) The Contract Administrator and any technical representative delegatees, together with a description of their delegated duties.

(c) Documentation of Contract Administration may also include, if any:

(A) Amendments, including but not limited to the approval of Amendments and the bases for determinations of the Designated Procurement Officer, as required in OAR 125-246-0560(c)(B);

(B) Claims related to the Contract;

(C) Release of claims documents;

(D) Contract close-out documents; and

(E) 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.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0560
Amendments

(1) Applicability and Definitions. This Rule on Amendments sets forth:

(a) A General Rule for Amendments in Section (2) applicable to Contracts for Supplies and Services pursuant to the Code and these Rules;

(b) Special Rules for Amendments in Sections (3) through (12), applicable to different types of Contracts. These Special Rules replace the General Rule, unless expressly stated otherwise;

(c) A Rule for Transitional and Old Contracts in Section (13), as those Contracts are defined in OAR 125-246-0100; and

(d) Definitions for the purposes of this Rule.

(A) "Anticipated Amendment" means:

(i) The Authorized Agency has stated in the Solicitation Document, if any, and the Original Contract ("Contract") that the Authorized Agency may amend the Contract; and

(ii) Required language in the Solicitation Document, if any, and the Contract includes:

(I) The general circumstances that might require an Anticipated Amendment to be issued under the Contract. "General circumstances" means broad or important aspects of the circumstances and not detailed. "Circumstances" means the anticipated conditions, state of affairs, or context that might require the Amendment. "Anticipated" means considered, realized, foreseen, or expected before its time. "Contract" means the specific Original Contract or class of Original Contracts being amended (specific Contract). This requirement is not satisfied by boilerplate language. "Boilerplate language" means standard language used commonly in documents without variation based upon specific circumstances; and

(II) A general description of certain or known changes to the requirements of the Contract that may be anticipated or planned for, but not necessarily quantified at the time of Contract execution. These changes may be specifically described in any Solicitation and Contract as: Additional Work; Work to be done if certain situations are encountered; or changes in terms, conditions, price, or type of Work. "General description" means broad or important aspects of the certain or known changes and not detailed. "Certain or known changes" that "may be anticipated or planned for" does not mean all possibilities; it means anticipated changes that might be required by the circumstances, as defined in Subsection (d)(A)(ii)(I). This general description of such changes must relate to the specific Contract and is not satisfied by boilerplate language, as defined in Subsection (d)(A)(ii)(I).

(iii) The Authorized Agency is not required to designate an Amendment in any Solicitation Document and Original Contract as an "Anticipated Amendment."

(B) "Unanticipated Amendment" means an Amendment that does not otherwise meet the requirements of being an Anticipated Amendment.

(2) General Rule for Amendments.

(a) Authorized Agency may make Amendments to Contracts as set forth in this Rule under the following conditions:

(A) Scope. The Amendment must be within the Scope of the original Solicitation Document, if any, and the Original Contract, in accordance with the definition of an Amendment under OAR 125-246-0110;

(B) Original Contract. The Original Contract was awarded either:

(i) Pursuant to ORS 279B.055, 279B.060, 279B.065, 279B.070, 279B.075, 279B.085, or 279A.200 through 279A.220;

(ii) For Transitional or Old Contracts only, in accordance with Old Rules, as the Contracts and Old Rules are defined in OAR 125-246-0100; or

(iii) Other statutory law.

(C) Legal Requirements. The Amendment is made consistent with applicable legal requirements;

(D) Writing. All Amendments to Contracts must be in Writing;

(E) Authority. All Amendments to Contracts must be signed by the authorized representatives of the parties to the Contracts, except that Amendments to Ordering Instruments may be accepted by the action of the Provider in accordance with the terms and conditions of the Ordering Instruments. All Amendments must receive all required approvals before the Amendments will be binding on the Authorized Agency, including but not limited to the Department of Justice legal sufficiency review pursuant to ORS 291.047.

(b) Authority for Anticipated Amendments. An Authorized Agency in accordance with OAR 125-246-0170 may make one or more Anticipated Amendments to a Contract without any additional competitive process and for an unlimited amount, in accordance with the definition of an Anticipated Amendment and this Rule.

(c) Authority for Unanticipated Amendments. An Authorized Agency in accordance with OAR 125-246-0170 may make one or more Unanticipated Amendments to a Contract without any additional competitive process, in accordance with the definition of an Unanticipated Amendment and this Rule.

(A) Limited Amount. The cumulative amounts of one or more Unanticipated Amendments to a Contract must not exceed 20% of the Original Contract amount; or

(B) Unlimited Amount. An Authorized Agency may make one or more Unanticipated Amendments to a Contract without any additional competitive process and for an unlimited amount pursuant to an Authorized Agency's delegated authority under OAR 125-246-0170, the Authorized Agency's Designated Procurement Officer gives Written approval of the Unanticipated Amendment, based upon a determination that:

(i) The change is legitimate and due to unforeseen circumstances which occurred as Work progressed, and that the reasons for the change were unforeseen at the time the Original Contract was established, as opposed to an effort to evade Procurement requirements;

(ii) The Unanticipated Amendment is within the Scope of the original Solicitation Document, if any, and the Original Contract, in accordance with the definition of an Amendment under OAR 125-246-0110;

(iii) The Original Contract contains clauses authorizing modification; and

(iv) The Unanticipated Amendment does not represent a material, general change, which alters the essential identity or main purpose of the Original Contract, or is of such importance as to constitute a new undertaking. The approval of the Designated Procurement Officer and the basis of this determination must be documented in the Procurement File pursuant to OAR 125-246-0355.

(3) Special Rules for Amendments Based on Dollar Threshold:

(a) Small Procurements. An Authorized Agency may amend a Contract awarded as a Small Procurement in accordance with OAR 125-247-0265 and the definition of an Amendment set forth in OAR 125-246-0110.

(b) Intermediate Procurements. An Authorized Agency may amend a Contract awarded as an Intermediate Procurement in accordance with OAR 125-247-0270, and the General Rule on Amendments applies to Intermediate Procurements not exceeding the Threshold of $150,000. If the Contract and all cumulative Amendments would result in an amended Contract amount exceeding $150,000, then the Authorized Agency must request and obtain prior approval of a Special Procurement in accordance with OAR 125-247-0287.

(c) Formal Procurements. The General Rule on Amendments applies to Procurements pursuant to ORS 279A.200 through 279A.220 (Cooperative Procurement), ORS 279B.055 through 279B.060 (Competitively Sealed Bidding and Proposals) and ORS 279B.085 (Special Procurements), if applicable, except as provided in this Rule.

(4) Special Rule for Amendments of Sole-Source Procurements. The General Rule on Amendments in Section (2) applies to Sole-Source Procurements pursuant to ORS 279B.075 and OAR 125-247-0275.

(5) Special Rule for Amendments of Contracts for Emergencies. Notwithstanding Sections (2) through (11) of this Rule, an Authorized Agency may amend a Contract awarded as an Emergency Procurement if the emergency justification for entering into the Contract still exists, and the Amendment is necessary to address the continuing emergency.

(6) Special Rule for Reinstatement of Expired Contracts. Notwithstanding the General Rule on Amendments in Section (2), the Rule for Reinstatement of Expired Contracts is found at OAR 125-246-0570.

(7) Special Rules for Payment Authorization for Cost Overruns and Retroactive Approvals and Payment Authorization for Cost Overruns for Services Contracts. Notwithstanding the General Rule on Amendments in Section (2), the Rules for Retroactive Approvals and Payment

Authorization for Cost Overruns are found at OAR 125-246-0575 and 125-246-0576, respectively.

(8) Special Rule for Renegotiated Contracts. Notwithstanding the General Rule on Amendments in Section (2) the Special Procurement Rule for Renegotiated Contracts is found at OAR 125-247-0288(3).

(9) Special Rule for Amendments of Contracts for Architectural, Engineering and Land Surveying Services, and Related Services. Notwithstanding the General Rule on Amendments in Section (2), the Rule for Amendments of Contracts for Architectural, Engineering and Land Surveying Services, and Related Services is found at OAR 125-248-0340.

(10) Special Rule for Amendments of Contracts for Public Improvements. Notwithstanding the General Rule on Amendments in Section (2), the Rule for Amendments of Contracts for Public Improvements is found at OAR 125-249-0160.

(11) Special Rule for Amendments of Price Agreements. Notwithstanding the General Rule on Amendments in Section (2), the State Procurement Office or its delegatee may amend a Price Agreement as follows:

(a) As permitted by the Price Agreement;

(b) As permitted by any applicable Special Rule for Amendments, Sections (3) through (10); or

(c) As permitted by applicable law.

(12) Special Rules for Amendments of Cooperative Procurements.

(a) An Administering Authorized Agency may amend an Original Contract only in accordance with ORS 279A.205 through 279A.225 and in a manner that is substantially equivalent to this Rule.

(b) A Participating Authorized Agency may amend its own Contract resulting from a Cooperative Procurement in a manner that complies with this Rule.

(13) Rule for Amendments of Transitional and Old Contracts.

(a) “Transitional Contracts” and “Old Contracts” are defined in OAR 125-246-0100.

(b) An Authorized Agency must have authority to amend the Transitional or Old Contract in accordance with OAR 125-246-0170, including but not limited to delegations by rule, agreement, letter and policy as described in OAR 125-246-0170(1).

(c) An Authorized Agency may amend a Transitional or Old Contract by complying with one of the following four (4) processes:

(A) New Amendment Process. An Authorized Agency may apply Sections (1) through (9) of this Amendment Rule; or

(B) New Special Procurement Process. An Authorized Agency may amend through the Special Procurement Rules for Supplies and Services, as set forth in OAR 125-247-0285 through 125-247-0287; or

(C) Exclusive Amendment Process. This Process is not available for Personal Services Contracts. An Authorized Agency may amend an Original Contract with a Provider without competitive bidding and for additional Work or product which is reasonably related to the Scope of Work under the Original Contract, including Changes to Work, extra Work, field orders, or other change in the original Specifications that increases the Original Contract price, subject to the following conditions:

(i) The Original Contract:

(I) Was let by a competitive bidding or alternative Procurement process;

(II) Unit prices or additive alternates were provided that established the cost basis for the additional Work or product; and

(III) A binding obligation exists on the parties covering the terms and conditions of the additional Work; or

(ii) The Original Contract was let pursuant to a declaration of emergency, in accordance with former ORS 279.015(4)(a) and 279.015(5) and former OAR 125-310-0030; or

(iii) The additional Work is required by reason of existing regulations or ordinances of federal, state or local agencies, dealing with the prevention of environmental pollution and the preservation of natural resources, that affect performance of the Original Contract and such regulations or ordinances, as provided in former ORS 279.318, either were not cited in the Original Contract or were enacted or amended after submission of the successful Bid or Proposal; or

(iv) The Original Contract was for the renovation or remodeling of a building.

(v) Except for Amendments entered into pursuant to Subsections (C)(i) to (iv), the aggregate increase resulting from all Amendments to a Contract must not exceed 20 percent of the initial Contract price. Contracts for the renovation or remodeling of buildings may have aggregate Amendments not exceeding 33 percent of the initial Contract price. Provided, however, that Amendments made pursuant to Subsection (C)(i) are not to be applied against either the 20 percent or the 33 percent aggregate limit on Contract Amendments. Provided, further, that Contracts amended pursuant to Subsections (C)(ii) or (iii) are not subject to either the 20 percent or the 33 percent aggregate limit on Contract Amendments.

(vi) If the Original Contract required the Contractor to provide a performance and payment bond, and the Authorized Agency has terminated the Contract and notified the surety of such termination, the Authorized Agency may allow the Contractor’s surety an opportunity to provide a substitute Contractor to complete performance of the Original Contract. Such substitute performance, and any Amendment of the Original Contract that makes a substitute Contractor a party to the Contract, and is not an award of a Public Contract for purposes of former ORS 279.015(1), must not be subject to the competitive procurement provisions of former ORS 279.005 through 279.111.

(D) Personal Services Amendment Process. This process is for Personal Services Contracts only.

(i) Contract Amendments must be made in writing.

(ii) Amendments to Contracts must fall within the Scope of the original Solicitation, unless the Original Contract was exempt under former OAR 125-020-0610, including whether the Contract consideration or term limit for performance may be increased (See former OAR 125-020-0310(4)(b)). Amendments may not be used to circumvent rules establishing approvals at certain monetary levels.

(iii) The State Procurement Office must approve an Amendment to a Contract unless approval of the amended Contract is not required under OAR 125-246-0170.

(iv) Except for Contracts related to Year 2000 services or Phased Development projects, Amendments to perform additional work related to information technology must not exceed 33% of the amount identified in the original Contract.

(v) The Attorney General must approve an amendment to a Personal Services Contract if the resulting Contract calls for payments of more than $75,000, unless exempted by the Attorney General under ORS 291.045 and 291.047.

(vi) The Authorized Agency must provide justification for any increase in time, compensation or other modification to the State Procurement Office.

(vii) A Contract Amendment form(s) will be provided by the State Procurement Office. The Authorized Agency may create Amendment form(s) as long as the Amendment form is approved by the State Procurement Office.

(viii) For Amendments, the Authorized Agency is required to:

(I) Prepare a Contract Amendment;

(II) Obtain necessary approvals before the Amendment is effective; and

(III) Issue the Award justification on ORPIN for Amendments that do not require State Procurement Office approval.

(ix) For Contract Amendments that require State Procurement Office approval, the Authorized Agency must submit the Contract Amendment package (one original and one copy of the Contract Amendment, a copy of the original Contract, copies of any previous Amendment(s), and the justification statement) to the State Procurement Office.

(x) The State Procurement Office will review and approve the Contract Amendment for compliance with applicable rules.

(d) Section (10) of this Rule applies retroactively to and is effective on March 1, 2005.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070 & 279A.140
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 4-2005, f. 4-13-05, cert. ef. 6-6-05; DAS 7-2005, f. & cert. ef. 6-6-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0570
Reinstatements of Expired Contracts

(1) Reinstatement by the Designated Procurement Officer. If the type or aggregated value (including all amendments) of the Contract after reinstatement falls under the Agency’s procurement authority in accordance with OAR 125-246-0170, then the Designated Procurement Officer of this Authorized Agency may reinstate and amend for time only an expired or terminated Contract (collectively, “expired Contract”), if the Authorized Agency meets the following conditions:

(a) Purpose. The reinstatement of the expired Contract is for the following purpose:

(A) Fulfillment of its term, up to the maximum time period provided in the Contract; or

(B) Completion of a deliverable, provided:

(i) The deliverable, including but not limited to Services, Work, Goods, or a Public Improvement project, was defined in the Contract as having a completion date or event; and

(ii) The Authorized Agency documents in the Procurement File what has not been completed, as of the date of the reinstatement of the expired Contract.

(b) Proper Execution. The expired Contract was previously properly executed containing all of the required signatures; and

(c) Unforseen or Unavoidable Conditions. The failure to extend or renew the Contract in a timely manner was due to unforeseen or unavoidable conditions.

(2) Reinstatement by the State Procurement Office. If the type or aggregated value (including all amendments) of the Contract after reinstatement will exceed the Agency's procurement authority in accordance with OAR 125-246-0170, then the State Procurement Office may reinstate and amend for time only an expired Contract, if the Agency submits a written justification to the State Procurement Office, demonstrating the satisfaction of the requirements for reinstatement, as set forth in Subsections (1)(a) through (c) above.

(3) Amendments. The Authorized Agency may amend an expired Contract for time only in accordance with Section (1) of this Rule. The Authorized Agency may amend the Contract for purposes other than time in accordance with OAR 125-246-0560.

(4) When an Authorized Agency reinstates and amends for time an expired Contract pursuant to this Rule, the Authorized Agency may compensate the Provider for Work performed in the interim between the expiration of the Original Contract and effective date of the reinstatement and amendment.

(5) Once a Contract is reinstated, it is in full force and effect, as if it had not expired.

(6) For Architectural, Engineering and Land Surveying and Related Services, the Authorized Agency must follow the Reinstatement Rule set forth in OAR 125-248-0310.

(7) No reinstatement of a Contract may modify the Original Contract, except the Original Contract may be modified with respect to the time for performance and any adjustment in the amount of the Contract as a consequence of the time extension.

(8) If the reinstatement and amendment for time of a Contract pursuant to this Rule requires Attorney General approval under ORS 291.045 and 291.047, the Authorized Agency must obtain such approval before the extension becomes binding.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070 & 279A.140
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0575
Retroactive Approvals of Existing Contracts

(1) Application. This Rule applies to existing Contracts that must have the approval of the State Procurement Office pursuant to ORS 279ABC or these Rules, including but not limited to Personal Services Contracts and Contracts for Architectural, Engineering and Land Surveying Services or Related Services.

(2) Approval by the State Procurement Office. If the aggregated value (including all amendments) of the Contract exceeds $150,000, then retroactive approval of a Contract means the action of the State Procurement Office, retroactively approving an existing Contract that was not previously properly executed and approved.

(3) Approval by a Designated Procurement Officer. If the aggregated value (including all amendments) of the Contract does not exceed $150,000 and the Agency is authorized under OAR 125-246-0170, then retroactive approval of a Contract means the action of the Designated Procurement Officer of that Authorized Agency, retroactively approving an existing Contract that was not previously properly executed and approved.

(4) This retroactive approval does not apply to payments made for work performed between the start of the Work of the Contract and the date of any retroactive approval (Time Period). The retroactive approval applies to work performed but not paid for, as of the date of such approval.

(5) Requirements. Before the State Procurement Office or authorized Designated Procurement Officer may retroactively approve a Contract in accordance with Sections (1) through (3) of this Rule, the requesting Agency must meet the following requirements:

(a) Submit a Written request to the State Procurement Office or Designated Procurement Officer in accordance with Section (2) or (3). The Authorized Agency must also submit a copy of this Written request to the head of that Agency.

(A) If this Written request is submitted to the State Procurement Office in accordance with Section (2), it must be executed by the Authorized Agency's Designated Procurement Officer.

(B) If this Written request is submitted to the Designated Procurement Officer in accordance with Section (3), it must be executed by another individual within the Authorized Agency who is responsible for oversight of the Contract.

(b) The Written request must contain the following information:

(A) An explanation of why the Contract was not submitted for all required approval signatures before performance began, including but not limited to the circumstances that existed that created any need for performance without all of the required approval signatures;

(B) A description of the steps being taken to prevent similar occurrences in the near future; and

(C) A proposed retroactive approval of the Contract;

(c) Obtain all other approvals required for the Public Contract, including the Department of Justice's Legal Sufficiency Ratification of a Public Contract pursuant to OAR 137-045-0090 for Contracts that exceed $75,000; and

(d) If an internal approval signature of the Contract is lacking, obtain that internal approval signature in accordance with the Authorized Agency's internal policy, if any.

(6) The Authorized Agency must maintain a copy of the retroactively approved Contract and the Authorized Agency's retroactive approval documentation (Records) in its Procurement File. The Authorized Agency must make these Records available to the State Procurement Office upon request.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070 & 279A.140
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-246-0576
Payment Authorization for Cost Overruns for Services Contracts

(1) Payments on Contracts for Trade or Personal Services that exceed the maximum contract consideration (Cost Overruns) require approval (Approval). If the aggregated value of the Contract, including Cost Overruns, does not exceed $150,000, the Designated Procurement Officer of the requesting Authorized Agency may approve the Cost Overruns in accordance with Section (2) of this Rule. If the aggregated value of the Contract, including Cost Overruns, exceeds $150,000, the State Procurement Office may approve the Cost Overruns in accordance with Section (2) of this Rule. The Cost Overruns may also require approval from the Department of Justice pursuant to OAR 137-045-0010 et seq.

(2) Approval may be provided if:

(a) The Original Contract was duly executed and, if required, approved by the Department and the Attorney General;

(b) Payments relate to Services that were provided during the term of the Contract;

(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: emergencies arising in the course of the Contract that require prompt action to protect the Work already completed, compliance with official or judicial commands or directives issued during contract performance or insurance 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) The aggregated value of the Contract, including the Cost Overrun, and the Contract's objective are within the procurement authority of the Authorized Agency pursuant to OAR 125-246-0170, and the Authorized Agency currently has funds available for payment under the Contract; and

(g) The Agency must prepare a Written report that describes the Authorized Agency's discovery of the Cost Overrun, the reasons for the Cost Overrun, and the Agency's satisfaction of the conditions set forth in this Section (2) (Report). The Authorized Agency must maintain this Report in its Procurement File and make this Report available to the State Procurement Office upon request.

(h) The Designated Procurement Officer of the Authorized Agency approves in Writing the payment of the overrun, or such portion of the overrun amount as the Designated Procurement Officer of the Authorized Agency determines may be paid consistent with the conditions of this Rule. If the Designated Procurement Officer of the Authorized Agency 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.

(3) The Authorized Agency must obtain any Attorney General's approval of the Contract Amendment, if such approval is required by ORS 291.047, before making any Cost Overrun payment.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070, 279A.140
Hist.: DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0010
Policies

(1) ORS 279B and this Division 247 apply the policies of ORS 279A.015 to the Procurement of Supplies and Services. The seven sourcing methods for procurement, procedures, and legal remedies set forth in ORS 279B and these Rules simplify, clarify and modernize procurement practices so that they reflect the market place and industry standards. ORS 279B and this Division 247 provide a Public Contracting structure that can take full advantage of evolving procurement methods as they emerge within various industries, pursuant to ORS 279A.015(6).

(2) Specific procedures accompany each method, followed by a Section of general procedures. Authorized Agencies must comply with both the specific procedures of a method and general procedures.

(3) The responsibility of the Designated Procurement Officer and any delegatee of an Authorized Agency is to choose the appropriate sourcing methods in accordance with the Code, Rules, and policy, and arrive at offers that represent optimal value to the Agency and the State.

(4) Meaningful competition can be achieved through various strategies and sourcing methods when procuring Supplies and Services, and this competition must be reasonably calculated and demonstrated to satisfy the Authorized Agency's and the State's needs.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.010
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0165
Practices Regarding Electronic Goods Procurement

(1) ORS 279B.025 requires the Department to establish procurement practices that ensure, to the maximum extent economically feasible, Procurement of Goods that may be recycled or reused when discarded.

(2) The State Procurement Office and Authorized Agencies must procure Electronic Goods in a manner that includes consideration of the impact of the electronic goods upon the environment and public health, in addition to consideration of economic and community interests, in accordance with goals of sustainability pursuant to ORS 184.423. The State Procurement Office and Authorized Agencies, separately or together, may:

(a) Consult with stakeholders to develop procedures or guidelines for Procurement of Electronic Goods; and

(b) Address policy and procedure decisions including but not limited to: recycling, relationship to Rules for State Surplus Property as set forth in OAR 125-246-0700 through 125-246-0730, Energy Star certifications, promote toxic use reduction, and the use of certain components such as mercury or lead that have detrimental impacts.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.025, 279B.270 & 279B.280
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0170
Life Cycle Costing

(1) Policy. Life Cycle Costing provides an acquisition method that is consistent with the concept of sustainability as defined in ORS 184.421 and also drives the concept of lowest cost of ownership and best value of the products and equipment (Goods) purchased. When planning the award method of an Invitation to Bid or Request for Proposal for Goods, an Agency must 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) Definitions:

(a) "Life-Cycle Cost" means the total cost to the State 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 and related Services.

(3) Concept. Insofar as this Rule is concerned, the concept of Life Cycle Costing will be limited to begin with the acquisition of the Goods, 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. 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 costs associated with acquiring an item for State 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 the following:

(A) Switching costs are costs associated with changing from current Goods to another model or brand of Goods. Typically such costs may include: removal, shipping, training, replacement of supporting Goods, and related Services. The Agency may also consider increased project management or additional transition time.

(B) Operating and support costs 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 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. 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 an ITB, an RFP, an Intermediate Procurement, or a Special Procurement as described in this Division 247. 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.

(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 the Agency.

(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.

(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 includes a separate Life Cycle Cost Factor that is assessed a 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) When Life Cycle Costs continue over a period of years, Solicitations may provide for adjustments to the cost stream 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 the Authorized Agency 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.) An Agency 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. For one-step Solicitations, factors not described in the Solicitation may not be used in the evaluation. For Multistep and multi-round Solicitations, factors must be described in advance of the evaluation in order to be used in the evaluation.

(6) Elements that may be used in Awards. Solicitations must describe what elements the Offeror will be required to provide in the Offer, including relevant costs, along with appropriate information to support life costs. 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 the State 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 State 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.

(a) Award of an Invitation to Bid using Life Cycle Cost methods must be made to the Responsible Offeror whose Responsive Offer provides the lowest overall cost of ownership in accordance with the Life Cycle Cost evaluation factors listed in the Solicitation Document.

(b) In the case of a Life Cycle Cost Request for Proposal, award must be made to the Responsible Offeror whose Responsive Offer, after consid-

eration 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 the State.

(c) In the case of an Intermediate or Special Procurement, the award requirements are the same as found in these methods, and Life Cycle Costing is incorporated into the methods.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.025, 279B.270 & 279B.280
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0200
Methods of Source Selection

An Authorized Agency must award a Contract for Supplies and Services by one of the following seven sourcing methods in accordance with the Code and related Rules:

(1) Competitive Sealed Bidding (also known as Bidding or ITB) pursuant to ORS 279B.055;

(2) Competitive Sealed Proposals (also known as Proposals or RFP) pursuant to ORS 279B.060;

(3) Small Procurement pursuant to ORS 279B.065;

(4) Intermediate Procurement pursuant to ORS 279B.070;

(5) Sole-Source Procurement pursuant to ORS 279B.075;

(6) Emergency Procurement pursuant to ORS 279B.080; or

(7) Special Procurement pursuant to ORS 279B.085.

A Cooperative Procurement in accordance with OAR 125-246-0400 through 125-246-0470 substantially uses a Competitive Sealed Bidding or Competitive Sealed Proposals method.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.050
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0255
Competitive Sealed Bidding; One Step Solicitations

(1) Generally. An Authorized Agency may procure Supplies and Services by Competitive Sealed Bidding as set forth in ORS 279B.055. An Invitation to Bid is used to initiate a Competitive Sealed Bidding Solicitation and must contain the information required by ORS 279B.055(2) and by Section (2) of this Rule. The Authorized Agency must provide public notice of the Competitive Sealed Bidding Solicitation as set forth in OAR 125-247-0305.

(2) Invitation to Bid. In addition to the provisions required by ORS 279B.055(2), the Invitation to Bid must include the following:

(a) General Information.

(A) Notice of any pre-Offer conference as follows:

(i) The time, date and location of any pre-Offer conference;

(ii) Whether attendance at the conference will be mandatory or voluntary; and

(iii) A provision that provides that statements made by the Authorized Agency's representatives at the conference are not binding upon the Authorized Agency unless confirmed by Written Addendum.

(B) The form and instructions for submission of Bids and any other special information, e.g., whether Bids may be submitted by electronic means (See OAR 125-247-0330 for required provisions of electronic Bids);

(C) The time, date and place of Opening;

(D) The office where the Solicitation Document may be reviewed;

(E) A statement that each Bidder must identify whether the Bidder is a "resident Bidder," as defined in ORS 279A.120(1);

(F) Contractor's certification of nondiscrimination in obtaining required subcontractors in accordance with ORS 279A.110(4). (See OAR 125-246-0210(3));

(G) How the Authorized Agency will notify Bidders of Addenda and how the Authorized Agency will make Addenda available (See OAR 125-247-0430); and

(H) The requirement, if applicable, for the awarded Bidder to obtain or subcontract labor, materials, or labor and materials from a supplier registered as an Emerging Small Business.

(b) Authorized Agency Need. The character of the Supplies and Services the Authorized Agency is purchasing including, if applicable, a description of the acquisition, Specifications, delivery or performance schedule, inspection and acceptance requirements.

(c) Bidding and Evaluation Process.

(A) The anticipated Solicitation schedule, deadlines, protest process, and evaluation process;

(B) The Authorized Agency must set forth objective evaluation criteria in the Solicitation Document in accordance with the requirements of ORS 279B.055(6)(a); and

(C) If the Authorized Agency intends to award Contracts to more than one Bidder pursuant to OAR 125-247-0600(4)(d), the Authorized Agency must identify in the Solicitation Document the manner in which it will determine the number of Contracts it will Award. This may be left to the Authorized Agency's discretion at the time of the Award, provided it is so described in the Solicitation.

(d) Applicable preferences pursuant to ORS 279B.055(6)(b):

(A) Preference for Oregon Supplies and Services, pursuant to ORS 279A.120 and OAR 125-246-0300 and 125-246-0310;

(B) Preference for recycled materials, pursuant to ORS 279A.125 and OAR 125-246-0320 through 125-246-0324; and

(C) Performance with the State of public printing, binding and stationery Work, pursuant to ORS 282.210.

(e) Certification if required. For Authorized Agencies subject to ORS 305.385, Contractor's certification of compliance with the Oregon tax laws in accordance with ORS 305.385.

(f) Terms and Conditions. All Contract terms and conditions, including a provision indicating whether the Contractor can assign the Contract, delegate its duties, or subcontract the delivery of the Supplies and Services without prior Written approval from the Authorized Agency.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.055
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0256
Competitive Sealed Bidding; Multistep Solicitations

(1) Generally. An Authorized Agency may procure Supplies and Services by using one of the following methods of selection for Multistep Sealed Bidding pursuant to ORS 279B.055(12):

(a) Multistep Invitation to Bid; or

(b) Revised Rounds of Bidding. A step and a round have the same meaning for purposes of implementing ORS 279B.055(12). All of the methods described in ORS 279B.055(12) and this Rule may be collectively referred to in Division 247 as a "Multistep Sealed Bidding."

(2)(a) Multistep Invitation to Bid. A Multistep Invitation to Bid is a phased procurement process that seeks necessary information or unpriced submittals in Phase One, followed by a Phase Two of competitive sealed bidding, inviting Bidders who submitted eligible Bids in Phase One to submit competitive sealed price Bids on the unpriced submittals in Phase Two. The Authorized Agency initially issues a Multistep Invitation to Bid, requesting the submission of unpriced submittals. This Phase One may include multiple steps, at the discretion of the Authorized Agency, in order to obtain necessary information or unpriced submittals. At the conclusion of Phase One, the Authorized Agency evaluates those unpriced submittals to determine the eligibility of the Bidders to submit priced Bids. After this determination, the Authorized Agency may begin Phase Two by issuing subsequent Invitations to Bid, limited to those Bidders eligible to submit priced Bids. The Contract must be awarded to the lowest Responsible Bidder or to multiple Responsible Bidders in accordance with ORS 279B.055(10).

(b) Public Notice. Whenever an Authorized Agency uses a Multistep Invitation to Bid, the Authorized Agency must give public notice for Phase One in accordance with OAR 125-247-0305. Public notice is not required for subsequent steps in Phase One, unless a step in Phase One expands the number of Bidders, and then public notice is required. Public notice is not required for Phase Two. However, an Authorized Agency must give notice to all Bidders from Phase One (Bidders). If an Authorized Agency elects to provide a protest opportunity for Addenda issued after the Closing of Phase One pursuant to OAR 125-247-0430, then the Authorized Agency must give notice to the Bidders of this right to protest such Addenda. If an Authorized Agency elects to provide an opportunity to protest exclusion from Phase Two pursuant to OAR 125-247-0720, then the Authorized Agency must give notice to the Bidders of this right to protest such exclusion.

(c) Procedures Generally. In addition to the procedures set forth in OAR 125-247-0300 through 125-247-0490, an Authorized Agency must employ the following procedures set forth in this Section (2) from Multistep ITB:

(A) Solicitation Protest. Prior to the Closing of Phase One, an Authorized Agency must provide an opportunity to protest the Solicitation under ORS 279B.405 and OAR 125-247-0730.

(B) Addenda Protest. An Authorized Agency may provide an opportunity to protest any Addenda issued after closing of Phase Two pursuant to OAR 125-247-0430(3)(b).

(C) Exclusion Protest. An Authorized Agency may provide an opportunity for a Bidder to protest exclusion from Phase Two as set forth in OAR 125-247-0720.

(D) Administrative Remedy. Bidders may submit a protest to any Addenda or to any action by the Authorized Agency that has the effect of excluding the Bidder from a Phase Two to the extent such protests are provided for in the Solicitation Document or required by this Section (2). Failure to so protest must be considered the Bidder's failure to pursue an

administrative remedy made available to the Bidder by the Authorized Agency.

(E) Award Protest. An Authorized Agency must provide an opportunity to protest its intent to award a Contract pursuant to ORS 279B.410 and OAR 125-247-0740. An Affected Bidder may protest, for any of the bases set forth in OAR 125-247-0720(2), its exclusion from Phase Two or an Addendum issued following Closing of Phase One if the Authorized Agency did not previously provide Bidders the opportunity to protest such exclusion or Addendum.

(d) Procedure for Phase One.

(A) Form. Authorized Agency must initiate a Multistep Invitation to Bid by the issuance of an Invitation to Bid in the form and manner required for Competitive Sealed Bidding, except as hereinafter provided. In addition to the requirements set forth in OAR 125-247-0255(1 and 2), the Invitation to Bid must state:

(i) That unpriced submittals are requested;

(ii) Whether price Bids are to be submitted at the same time as unpriced submittals; if they are, that such price Bids must be submitted in a separate sealed envelope;

(iii) That the Solicitation is a multistep Invitation to Bid, and priced Bids will be considered only in Phase Two and only from those Bidders whose unpriced submittals are found eligible in Phase One;

(iv) The criteria to be used in the evaluation of unpriced submittals;

(v) That the Authorized Agency, to the extent that it finds necessary, may conduct oral or Written Discussions for the purposes of clarification of the unpriced submittals;

(vi) That the Supplies and Services being procured must be furnished generally in accordance with the Bidder's unpriced submittal as found to be finally eligible and must meet the requirements of the Invitation to Bid; and

(vii) Whether Bidders excluded from Phase Two have a right to protest the exclusion before the notice of intent to award. Such information must be given in the Bid Solicitation or changed by Addenda.

(B) Addenda to the Invitation to Bid. After receipt of unpriced submittals in Phase One, Addenda to the Invitation to Bid must be distributed only to Bidders who submitted unpriced submittals.

(C) Receipt and Handling of Unpriced Submittals. Unpriced submittals in Phase One need not be opened publicly.

(D) Evaluation of Unpriced Submittals. Unpriced submittals submitted by Bidders in Phase One must be evaluated solely in accordance with the criteria set forth in the Invitation to Bid. Unpriced submittals must be categorized as:

(i) Eligible;

(ii) Potentially eligible; that is, reasonably susceptible of being made eligible; or

(iii) Ineligible. The Authorized Agency must record in Writing the basis for determining an unpriced submittal ineligible and make it part of the Procurement File in accordance with OAR 125-246-0355. The Authorized Agency may initiate the Phase Two of the procedure if, in the Authorized Agency's opinion, there are sufficient eligible unpriced submittals to assure effective price competition in Phase Two without Discussions. If the Authorized Agency finds that such is not the case, the Authorized Agency may issue an Addendum to the Invitation to Bid or engage in Discussions as set forth in Subsection (2)(e) of this Rule.

(E) Discussion of Unpriced Submittals. The Authorized Agency may seek clarification of an unpriced submittal by any eligible or potentially eligible Bidder. During the course of such Discussions, the Authorized Agency may not disclose any information derived from one unpriced submittal to any other Bidder. Once Discussions have begun, any Bidder who has not been notified that its unpriced submittal has been finally found ineligible, may submit supplemental information amending its unpriced submittal, at any time until the Closing of the Phase Two. Such submission may be made at the request of the Authorized Agency or upon the Bidder's own initiative.

(F) Notice of Ineligible Unpriced Submittal. When the Authorized Agency determines a Bidder's unpriced submittal to be ineligible, such Bidder may not be afforded an additional opportunity to supplement its unpriced submittal.

(G) Mistakes During a Multistep Invitation to Bid. Mistakes may be corrected or unpriced submittals may be withdrawn during Phase One in accordance with OAR 125-247-0470; and

(i) Before unpriced submittals are considered;

(ii) After any Discussions have commenced under Subsection (2)(e); or

(iii) When responding to any Addenda of the Invitation to Bid.

(H) Revisions to Solicitation Specifications. After the Closing of Phase One, the Authorized Agency may issue Addenda that modify the Specifications for the Goods or Services being procured or that modify other terms and conditions of the Invitation to Bid. The Authorized Agency must provide such Addenda to all Bidders who initially submitted Unpriced Submittals. The Authorized Agency may then require Bidders to submit revised Unpriced Submittals.

(e) Procedure for Phase Two of Multistep Sealed Bidding.

(A) Initiation. Upon the completion of Phase One, the Authorized Agency must invite each eligible Bidder to submit a price Bid.

(B) Conduct. An Authorized Agency must conduct Phase Two as any other Competitive Sealed Bidding Procurement except:

(i) As specifically set forth in this Rule; and

(ii) No public notice need be given of this invitation to submit price Bids because such notice was previously given.

(3)(a) Revised Rounds of Bidding. Revised Rounds of Bidding means a process that begins with an initial round of Competitive Sealed Bidding pursuant to OAR 125-247-0255 and may, at the discretion of the Authorized Agency, include successive rounds of Bidding in order for the Authorized Agency to gain the best Offer for purposes of Award. An Authorized Agency may revise the Solicitation's Specifications, terms and conditions, and pricing structure for successive rounds to best meet the State's needs. Bidders will be allowed adequate time to revise and resubmit their Bids in accordance with the requirements set forth in the newly revised Solicitation Document. At each successive round, Authorized Agency may disregard its scoring of prior Bids and commence new scoring for the new Bids. The Authorized Agency must comply with the following procedures for this type of Solicitation:

(b) Revisions. An Authorized Agency may reject any Bid, after any round, because the Bid did not meet a minimum score or minimum set of requirements. An Authorized Agency may then proceed with a subsequent round that requires additional Bids to be submitted, based on different Specifications, terms and conditions, pricing structure, scoring model, and set of award criteria, separately or in any combination thereof, in order to best meet the State's interests (Revisions). If any Revision is made by an Authorized Agency in any subsequent round, the Authorized Agency has the right, in its sole discretion, to permit any Bidder whose Bid was previously rejected to submit a new Bid, if the reason(s) for the rejection of the prior Bid by that Bidder no longer applies.

(c) Public Notice. An Authorized Agency must give public notice pursuant to OAR 125-247-0305. The initial Solicitation Document must disclose that a Revised Rounds of Bidding process will or may be used. An Authorized Agency must give notice to all initial Bidders of any Revision(s) in the Specifications, terms and conditions, pricing structure, scoring model, and set of award criteria, separately or in any combination thereof. If an Authorized Agency discloses any prices, terms or conditions offered by other Bidders, the Authorized Agency will give notice of these disclosures to the initial Bidders. At the end of the process, the Authorized Agency must give a Notice of Intent to award at least seven (7) calendar Days prior to making the Award. Following clarifications and additional investigations, an Offeror may be reinstated or disqualified at any stage of the evaluation process.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.055
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0260
Competitive Sealed Proposals; One Step Solicitations

(1) Generally. An Authorized Agency may procure Supplies and Services and negotiate by Competitive Sealed Proposals as set forth in ORS 279B.060. A Request for Proposal is used to initiate a Competitive Sealed Proposals Solicitation and must contain the information required by ORS 279B.060(2) and by Section (2) of this Rule. The Authorized Agency must provide public notice of the Competitive Sealed Proposals as set forth in OAR 125-247-0305.

(2) Request for Proposal. In addition to the provisions required by ORS 279B.060(2), the Request for Proposal must include the following:

(a) General Information.

(A) Notice of any pre-Offer conference as follows:

(i) The time, date and location of any pre-Offer conference; and

(ii) Whether attendance at the conference will be mandatory or voluntary; and

(iii) A provision that provides that statements made by the Authorized Agency's representatives at the conference are not binding upon the Authorized Agency unless confirmed by Written Addendum.

(B) The form and instructions for submission of Proposals and any other special information, e.g., whether Proposals may be submitted by electronic means (See OAR 125-247-0330 for required provisions of electronic Proposals);

(C) The time, date and place of Opening;

(D) The office where the Solicitation Document may be reviewed;

(E) Contractor's certification of nondiscrimination in obtaining required subcontractors in accordance with ORS 279A.110(4). (See OAR 125-246-0210(3)); and

(F) How the Authorized Agency will notify Proposers of Addenda and how the Authorized Agency will make Addenda available. (See OAR 125-247-0430).

(b) Authorized Agency Need. The character of the Supplies and Services the Authorized Agency is purchasing, including if applicable, a description of the acquisition, Specifications, delivery or performance schedule, inspection and acceptance requirements.

(c) Proposal and Evaluation Process.

(A) The anticipated Solicitation schedule, deadlines, protest process, and evaluation process;

(B) The Authorized Agency must set forth selection criteria in the Solicitation Document in accordance with the requirements of ORS 279B.060(2)(h)(E). Evaluation criteria need not be precise predictors of actual future costs and performance, but to the extent possible, such factors must be reasonable estimates of actual future costs based on information available to the Authorized Agency;

(C) If the Authorized Agency's solicitation process calls for the Authorized Agency to establish a Competitive Range, the Authorized Agency must state the size of the Competitive Range in the Solicitation Document. The Authorized Agency may increase or decrease the number of the Proposers in the Competitive Range in accordance with OAR 125-247-0261(2); and

(D) If the Authorized Agency intends to award Contracts to more than one Proposer pursuant to OAR 125-247-0600(4)(d), the Authorized Agency must identify in the Solicitation Document the manner in which it will determine the number of Contracts it will award. This may be left to the Authorized Agency's discretion at the time of the Award, provided it is so described in the Solicitation.

(d) Applicable Preferences described in ORS 279A.120, 279A.125(2) and 282.210:

(A) Preference for Oregon Supplies and Services, pursuant to ORS 279A.120 and OAR 125-246-0300 and 125-246-0310;

(B) Preference for recycled materials, pursuant to ORS 279A.125 and OAR 125-246-0320 through 125-246-0324; and

(C) Performance with the State of public printing, binding and stationery Work, pursuant to ORS 282.210.

(e) Certification if requested. For Authorized Agencies subject to ORS 305.385, Contractor's certification of compliance with the Oregon tax laws in accordance with ORS 305.385.

(f) Terms and conditions. All Contract terms and conditions, including a provision indicating whether the Contractor can assign the Contract, delegate its duties, or subcontract the Supplies and Services without prior Written approval from the Authorized Agency.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.060
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0261
Competitive Sealed Proposals; Multistep Solicitations

(1) Generally. An Authorized Agency may procure Supplies and Services by using any combination of the following methods for Competitive Sealed Proposals pursuant to ORS 279B.060(6)(b).

(a) Competitive Range;

(b) Discussions and Revised Proposals;

(c) Best and Final Offers;

(d) Multistep Proposals;

(e) Revised Rounds of Negotiations; and

(f) Negotiations.

An Authorized Agency may also use a Request for Qualifications pursuant to OAR 125-247-0550 in combination with any of the methods described in ORS 279B.060(6)(b) and this Rule. All of the methods described in ORS 279B.060(6)(b) and this Rule may be collectively referred to in Division 247 as "Multistep Sealed Proposals." A "step," "tier" and "round" have the same meaning for purposes of implementing ORS 279B.060.

(2) Competitive Range. When an Authorized Agency's solicitation process conducted pursuant to ORS 279B.060(6)(b) calls for the Authorized Agency to establish a Competitive Range at any stage in the Procurement Process, the Authorized Agency must comply with the following procedures:

(a) Determining Competitive Range:

(A) The Authorized Agency must establish a Competitive Range after evaluating all Responsive Proposals in accordance with the evaluation criteria set forth in the Request for Proposals. After evaluation of all Proposals in accordance with the criteria set forth in the Request for Proposals, the Authorized Agency must determine and rank the Proposers in the Competitive Range.

(B) The Authorized Agency may increase the number of Proposers in the Competitive Range if the Authorized Agency's evaluation of Proposals establishes a natural break in the scores of Proposers indicating a number of Proposers greater than the initial Competitive Range are closely competitive, or have a reasonable chance of being determined the most Advantageous Proposer. The Authorized Agency may decrease the number of Proposers in the initial Competitive Range only if the excluded Proposers have no reasonable chance to be the most Advantageous Proposer.

(b) Protesting Competitive Range. The Authorized Agency must provide Written notice to all Proposers identifying Proposers in the Competitive Range. An Authorized Agency may provide an opportunity for Proposers excluded from the Competitive Range to protest the Authorized Agency's evaluation and determination of the Competitive Range in accordance with OAR 125-247-0720.

(c) Intent to Award; Discuss or Negotiate. After determination of the Competitive Range and after any protest period provided in accordance with Subsection (2)(b) expires, or after the Authorized Agency has provided a final response to any protest, whichever date is later, the Authorized Agency may either:

(A) Provide Written notice to all Proposers in the Competitive Range of its intent to award the Contract to the highest-ranked Proposer in the Competitive Range:

(i) An unsuccessful Proposer may protest the Authorized Agency's intent to award in accordance with OAR 125-247-0740 and ORS 279B.410.

(ii) After the protest period provided in accordance with OAR 125-247-0740 expires, or after the Authorized Agency has provided a final response to any protest, whichever date is later, the Authorized Agency must commence Negotiations in accordance with this Rule with Proposers in the Competitive Range; or

(B) Engage in Discussions with Proposers in the Competitive Range and accept revised Proposals from them as set forth in this Rule and following such Discussions and receipt and evaluation of revised Proposals, conduct Negotiations as set forth in this Rule with the Proposers in the Competitive Range.

(3) Discussions and Revised Proposals. If an Authorized Agency chooses to use the Competitive Range method and then enter into Discussions, the Authorized Agency must proceed as follows:

(a) Initiating Discussions. If the Authorized Agency initiates any Discussion, the Authorized Agency must initiate oral or Written Discussions with all Proposers submitting Responsive Proposals or all Proposers in the Competitive Range (collectively "eligible Proposers") regarding their Proposals with respect to the provisions of the RFP that the Authorized Agency identified in the RFP as the subject of Discussions. The Authorized Agency may conduct Discussions for the following purposes:

(A) Informing eligible Proposers of deficiencies in their initial Proposals;

(B) Notifying eligible Proposers of parts of their Proposals for which the Authorized Agency would like additional information; or

(C) Otherwise allowing eligible Proposers to develop revised Proposals that will allow the Authorized Agency to obtain the best Proposal based on the requirements and evaluation criteria set forth in the Request for Proposals.

(b) Conducting Discussions. The Authorized Agency may conduct Discussions with each eligible Proposer necessary to fulfill the purposes of this Section (3), but need not conduct the same amount of Discussions with each eligible Proposer. The Authorized Agency may terminate Discussions with any eligible Proposer at any time. However, the Authorized Agency must offer all eligible Proposers the same opportunity to discuss their Proposals with the Authorized Agency before the Authorized Agency notifies eligible Proposers of the date and time pursuant to Section (4) that best and final Proposals will be due.

(A) In conducting Discussions, the Authorized Agency:

(i) Must treat all eligible Proposers fairly and may not favor any eligible Proposer over another;

(ii) Must only disclose other eligible Proposer's Proposals or Discussions in accordance with 279B.060(6)(b)(B) or (C);

(iii) May adjust the evaluation of a Proposal as a result of a Discussion under this Section. The conditions, terms, or price of the Proposal may be altered or otherwise changed during the course of the Discussions provided the changes are within the Scope of the Request for Proposals.

(B) At any time during the time allowed for Discussions, the Authorized Agency may:

(i) Continue Discussions with a particular eligible Proposer;

(ii) Terminate Discussions with a particular eligible Proposer and continue Discussions with other eligible Proposers; or

(iii) Conclude Discussions with all remaining eligible Proposers and provide notice pursuant to this Rule to the eligible Proposers.

(4) Best and Final Offers. If an Authorized Agency chooses to require Best and Final Offers, an Authorized Agency must establish a common date and time by which Proposers must submit best and final Offers. Best and final Offers must be submitted only once; provided, however, the Authorized Agency may make a Written determination that it is in the Authorized Agency's best interest to conduct additional Discussions and Negotiations or change the Authorized Agency's requirements and require another submission of best and final Offers. Otherwise, no Discussion of or changes in the best and final Offers may be allowed prior to award. Proposers must also be informed if they do not submit notice of withdrawal or another best and final Offer, their immediately previous Offer will be construed as their best and final Offer. The Authorized Agency must evaluate Offers as modified by the best and final Offer. The Authorized Agency must conduct evaluations conducted as described in OAR 125-247-0600. The Authorized Agency may not modify evaluation factors or their relative importance after the date and time that best and final Offers are due.

(5) Multistep Sealed Proposals

(a) Process. The Multistep Sealed Proposals process is a phased procurement process that seeks necessary information or unpriced submittals in Phase One and invites Proposers who submitted qualified unpriced submittals in Phase One to submit competitive sealed price Proposals in Phase Two. The Contract must be awarded to the Responsible Proposer, or in the case of multiple awards, the Responsible Proposers pursuant to ORS 279B.060(10), submitting the most Advantageous Proposal in accordance with the terms of the Solicitation Document applicable to Phase Two. A "Phase" may include one or more "steps"

(b) Public Notice. Whenever an Authorized Agency uses Multistep Proposals, the Authorized Agency must give Public Notice in accordance with OAR 125-247-0305. Public Notice is not required for Phase Two. However, an Authorized Agency must give notice to all Proposers from Phase One (Proposers). If an Authorized Agency elects to provide a protest opportunity for Addenda issued after the Closing of Phase One pursuant to OAR 125-247-0430, then the Authorized Agency must give notice to the Proposers of this right to protest such Addenda. If an Authorized Agency elects to provide an opportunity to protest exclusion from Phase Two pursuant to OAR 125-247-0720, then the Authorized Agency must give notice to the Proposers of this right to protest such exclusion.

(c) Procedures Generally. In addition to the procedures set forth in OAR 125-247-0300 through 125-247-0490, an Authorized Agency must employ the following procedures set forth in this Section for Multistep Sealed Proposals:

(A) Solicitation Protest. Prior to the Closing of Phase One, an Authorized Agency must provide an opportunity to protest the Solicitation under ORS 279B.405 and OAR 125-247-0730.

(B) Addenda Protest. An Authorized Agency may provide an opportunity to protest any Addenda issued after closing of Phase Two pursuant to OAR 125-247-0430(3)(b).

(C) Exclusion Protest. An Authorized Agency may provide an opportunity for a Proposer to protest exclusion from Phase Two as set forth in OAR 125-247-0720.

(D) Administrative Remedy. Proposers may submit a protest to any Addenda or to any action by the Authorized Agency that has the effect of excluding the Proposer from a Phase Two to the extent such protests are provided for in the Solicitation Document or required by this Section. Failure to so protest must be considered the Proposer's failure to pursue an administrative remedy made available to the Proposer by the Authorized Agency.

(E) Award Protest. An Authorized Agency must provide an opportunity to protest its intent to award a Contract pursuant to ORS 279B.410 and OAR 125-247-0740. An Affected Proposer may protest, for any of the bases set forth in OAR 125-247-0720(2), its exclusion from Phase Two or an Addendum issued following Closing of Phase One if the Authorized Agency did not previously provide Bidders the opportunity to protest such exclusion or Addendum.

(d) Procedure for Phase One.

(A) The Form of the Request for Proposals. Multistep Proposals must be initiated by the issuance of a Request for Proposal in the form and manner required for Competitive Sealed Proposals in accordance with OAR 125-247-0260, except as provided in this Rule. In addition to the requirements set forth in OAR 125-247-0260(2), this Request for Proposal must state:

(i) That unpriced submittals are requested;

(ii) That the Solicitation is a unpriced submittal Procurement, and priced Proposals will be considered only in Phase Two and only from those Proposers whose unpriced submittals are found acceptable in Phase One;

(iii) The criteria to be used in the evaluation of unpriced submittals;

(iv) That the Authorized Agency, to the extent that it finds necessary, may conduct oral or Written Discussions for the purposes of clarification of the unpriced submittals;

(v) That the Supplies and Services being procured must be furnished generally in accordance with the Proposer's unpriced submittals as found to be finally qualified and must meet the requirements of the Request for Proposals;

(vi) Whether Proposers excluded from subsequent steps or Phase Two have a right to protest the exclusion. Such information must be given in the Solicitation or changed by Addenda; and

(vii) If time is a factor, the Authorized Agency may require Proposers to submit a separate sealed price Proposal during Phase One to be opened after the evaluation of unpriced submittals.

(B) Addenda to the Request for Proposal. After receipt of unpriced submittals in Phase One, Addenda to the Request for Proposal must be distributed only to those Proposers who submitted unpriced submittals.

(C) Receipt and Handling of Unpriced Proposals. The Authorized Agency is not required to publicly open unpriced submittals.

(D) Evaluation of Unpriced Proposals. The unpriced submittals submitted by Proposers must be evaluated solely in accordance with the criteria set forth in the Request for Proposals. The unpriced submittals must be categorized as:

(i) Qualified;

(ii) Potentially qualified; that is, reasonably susceptible of being made qualified; or

(iii) Unqualified. The Authorized Agency must record in Writing the basis for determining a Proposal unqualified and make it part of the Procurement File in accordance with OAR 125-246-0355. The Authorized Agency may initiate Phase Two of the procedure if, in the Authorized Agency's opinion, there are sufficient qualified unpriced submittals to assure effective price competition in Phase Two without Discussions. If the Authorized Agency finds that such is not the case, the Authorized Agency may issue an Addendum to the Request for Proposals or engage in Discussions as set forth in this Rule.

(E) Discussion of Unpriced Submittals. The Authorized Agency may seek clarification of any Proposal of any Proposer who submits a qualified, or potentially qualified unpriced submittal. During the course of such Discussions, the Authorized Agency may not disclose any information derived from one unpriced submittal to any other Proposer. Once Discussions begin, any Proposer may submit supplemental information amending the unpriced submittal at any time until the Closing of Phase Two set by the Authorized Agency. A submission may be in response to a request of the Authorized Agency or be initiated by the Proposer.

(F) Notice of Unqualified Unpriced Submittals. When the Authorized Agency determines a Proposer's unpriced submittal to be unqualified, such Proposer must not be afforded an additional opportunity to supplement its unpriced submittal.

(G) Mistakes During Multistep Sealed Proposals. Mistakes may be corrected or Proposals may be withdrawn during Phase One:

(i) Before unpriced submittals are considered;

(ii) After any Discussions have commenced under this Rule;

(iii) When responding to any Addenda of the Request for Proposals; or

(iv) In accordance with OAR 125-247-0470.

(e) Procedure for Phase Two.

(A) Initiation. Upon the completion of Phase One, the Authorized Agency must invite each qualified Proposer to submit price Proposals.

(B) Conduct. An Authorized Agency must conduct Phase Two as any other Competitive Sealed Proposal pursuant to OAR 125-247-0260, except:

(i) As specifically set forth in this Rule; and

(ii) No public notice need be given of the request to submit price Proposals because such notice was previously given.

(6) Revised Rounds of Negotiations Multistep Revised Negotiations means a process that begins with the standard Solicitation procedures for an RFP and may include successive rounds of Proposals achieved through Negotiations to gain the best Proposal for purposes of Award. These Negotiations may concern the price, Specifications, and final terms and conditions, separately or in any combination thereof. The Authorized Agency must treat all Proposers fairly. Before the start of each round of Negotiations, the Authorized Agency must disclose the parameters of that round of Negotiations. At that time, the Authorized Agency may revise the Solicitation's Specifications, terms and conditions, evaluation criteria and weight, and pricing structure in order to best meet the State's interests (Revisions). At each successive round, the Authorized Agency may disre-

gard its scoring of prior Proposals and commence new scoring for the new Proposals. The Authorized Agency may eliminate any Proposal after a round because the Proposal did not meet a minimum score, or the Proposal was not susceptible to award, and then proceed with a subsequent round that requires additional Proposals based on the Revision(s). If any Revision is made by the Authorized Agency in any subsequent round, the Authorized Agency reserves the right, in its sole discretion, to permit any Proposer whose Proposal was previously eliminated to submit a new Proposal, if the reason(s) for the elimination of the prior Proposal by that Proposer no longer applies. For each Solicitation, on a case-by-case basis, the Authorized Agency may determine whether prequalification of suppliers is needed. If prequalification is used, the Authorized Agency must prequalify suppliers and provide an appeal process in accordance with ORS 279B.120 and related rules.

(7) Negotiations.

(a) The Authorized Agency may negotiate serially with the highest-ranked eligible Proposer or simultaneously with all eligible Proposers as follows:

(A) After an initial determination of which Proposals are Responsive;

(B) After an initial determination of the Competitive Range in accordance with this Rule; or

(C) After conclusion of Discussions with all eligible Proposers and evaluation of revised Proposals.

(b) Conducting Negotiations.

(c) Scope. The Authorized Agency may negotiate:

(A) The statement of work;

(B) The Contract Price as it is affected by negotiating the statement of work; and

(C) Any other terms and conditions reasonably related to those expressly authorized for Negotiation in the Request for Proposals or Addenda thereto. Accordingly, the Proposers must not submit, and the Authorized Agency must not accept, for Negotiation any alternative terms and conditions that are not reasonably related to those expressly authorized for Negotiation in the Request for Proposals or Addenda thereto.

(d) Terminating Negotiations. At any time during Discussions or Negotiations that the Authorized Agency conducts in accordance with this Rule, the Authorized Agency may terminate Discussions or Negotiations with the highest-ranked Proposer, or the Proposer with whom it is currently discussing or negotiating, if the Authorized Agency reasonably believes that:

(A) The Proposer is not discussing or negotiating in good faith; or

(B) Further Discussions or Negotiations with the Proposer will not result in the parties agreeing to the terms and conditions of a final Contract in a timely manner.

(e) Continuing Serial Negotiations. If the Authorized Agency is conducting serial Negotiations and the Authorized Agency terminates Negotiations with a Proposer in accordance with this Rule, the Authorized Agency may then commence Negotiations with the next highest scoring Proposer in the Competitive Range, and continue the process described in this Rule until the Authorized Agency has determined either:

(A) To award the Contract to the Proposer with whom it is currently discussing or negotiating; or

(B) Has completed one step of Discussions or Negotiations with all Proposers in the Competitive Range, unless the Authorized Agency provided for more than one round of Discussions or Negotiations in the Request for Proposals.

(f) Competitive Simultaneous Negotiations. If the Authorized Agency chooses to conduct competitive Negotiations, the Authorized Agency may negotiate simultaneously with competing Proposers. The Authorized Agency:

(A) Must treat all Proposers fairly and must not favor any Proposer over another;

(B) Must only disclose other Proposer's Proposals or the substance of Negotiations with other Proposers if the Authorized Agency notifies all of the Proposers with whom the Authorized Agency will engage in Negotiations before engaging in Negotiations with any Proposer; and

(C) Any oral modification of a Proposal resulting from Negotiations under this Section must be reduced to Writing by the Proposer.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.060
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0270
Intermediate Procurements

(1) Generally. For Procurements of Supplies and Services greater than $5,000 and less than or equal to $150,000, an Authorized Agency may award a Contract as an Intermediate Procurement pursuant to ORS 279B.070. Authorized Agencies must procure Intermediate Procurements for Supplies and Services in accordance with ORS 279A and 279B.070.

(a) When conducting an Intermediate Procurement, an Authorized Agency must seek at least three informally solicited competitive price Quotes. Bids or Proposals from prospective Offerors. The Authorized Agency must keep a written record of the sources of the Quotes, Bids or Proposals received. If three Quotes, Bids or Proposals are not reasonably available, fewer will suffice, but the Authorized Agency must make a written record of the effort made to obtain the Quotes, Bids or Proposals.

(b) If a Contract is awarded, the Authorized Agency must award the Contract to the Offeror whose Quote, Bid or Proposal will best serve the interests of the Authorized Agency, taking into account price as well as considerations including, but not limited to, experience, expertise, product functionality, suitability for a particular purpose and Contractor responsibility under ORS 279B.110.

(2) Written Solicitation. For Intermediate Procurements from $5,000 to $75,000, Authorized Agencies are not required to use a Written Solicitation, but if an Agency elects to use a Written Solicitation, then the requirements of this Section (2) apply. For Intermediate Procurements exceeding $75,000 and up to $150,000, Authorized Agencies must use a Written Solicitation. The Written Solicitation must include fair, efficient, competitive Award evaluation criteria. This Written Solicitation may allow revisions to the Solicitation and opportunity for protests, at the discretion of the Agency. The process, potential revisions to the Solicitation, if any, and opportunity for protests, if any, must be disclosed in the Solicitation. Authorized Agencies must document:

(a) The Agency's methodology under this subsection (2),

(b) The Agency's compliance with legal sufficiency review requirements of the Attorney General under ORS 291.047; and

(c) Communications between the Agency and Providers regarding:

(A) The subject matter of OAR 125-246-0635 and ORS 279B.210;

(B) Offers;

(C) The Award; and

(D) Protests, if a protest opportunity is provided by the Agency, at its discretion.

(3) Borderline Procurements. If an Authorized Agency's Designated Procurement Officer or delegatee (DPO) in good faith estimated that the Procurement would be equal to or less than $75,000, and learned thereafter that all of the Quotes, Bids, or Proposals were minimally exceeding $75,000, this Procurement is deemed to have complied with Section (2) of this Rule upon the following conditions:

(a) The DPO must document in the Procurement File the basis for the original estimate under $75,000 and the process used; and

(b) The Agency must still comply with the remainder of this Rule.

(4) Inclusion of MWESBs. The Solicitations of Agencies must be inclusive, in accordance with Department policy and ORS 200.035.

(5) Notices and ORPIN.

(a) The Agency must post on ORPIN a notice of its verbal or Written Solicitation of at least three Quotes, Bids, or Proposals. In addition, the Agency may informally solicit Quotes, Bids, or Proposals by any other appropriate means (collectively, Notice).

(b) For Intermediate Procurements exceeding $75,000, the Notice must provide:

(A) Where, when, how, and for how long the Written Solicitation may be obtained;

(B) A general description of the Supplies and Services to be acquired;

(C) A reasonable interval between the first date of Notice of the Written Solicitation and the Closing (Time Period);

(i) For all Intermediate Procurements, the Agency must provide a reasonable and sufficient Time Period in order to meet the objectives of ORS 200.035 (Objectives); Agencies may adjust the Time Period to account for the type of Procurement and needs of the Agencies, so long as the Objectives are not undermined;

(ii) For Intermediate Procurements exceeding $75,000, the Time Period must be at least seven (7) calendar Days;

(D) The name, title and address of the individual authorized by the Agency to receive Offers; and

(E) Any other information the Agency deems to be appropriate.

(6) Negotiations. An Authorized Agency may negotiate with a Proposer to clarify its Quote, Bid, or Proposal or to effect modifications that will make the Quote, Bid, or Proposal acceptable or make the Quote, Bid, or Proposal more Advantageous to the Authorized Agency.

(7) No Fragmentation. A Procurement may not be artificially divided or fragmented so as to constitute an Intermediate Procurement, pursuant to ORS 279B.070(2).

(8) Agencies must post all Awards over $5,000 on ORPIN.

(9) Amendments. An Authorized Agency may amend a Contract awarded as an Intermediate Procurement in accordance with OAR 125-246-0560.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.070
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0275
Sole-Source Procurements

(1) Generally. An Authorized Agency with delegated authority pursuant to OAR 125-246-0170 may award a Contract without a competitive process through a Sole-Source Procurement pursuant to the requirements of ORS 279B.075, this Rule, and the policy of the Department. The Authorized Agency must make a determination of a sole source based upon Written findings of fact that the Supplies and Services are available from only one source.

(2) Requirements:

(a) Findings of fact required under OAR 125-247-0275(1) may include:

(A) Compatibility. The efficient utilization of existing Supplies and Services requires the acquisition of compatible Supplies and Services from only one source. For example, compatibility may be implicated when: Supplies are required to directly interface with or attach to equipment of the same manufacturer and no other manufacturer's Supplies will correctly interface with existing equipment; or when Services such as maintenance, warranty, project management, or systems integration are required to interface or integrate with existing Supplies and Services.

(B) Exchange of software or data. Specific Supplies and Services, which are available from only one source, may be required for the exchange of software or data with other public or private agencies. This finding may be particularly applicable when the Supplies and Services involve assets such as copyrights, patents, trademarks, and trade secrets.

(C) Pilot or experimental project. Supplies and Services are for the use in such projects, which may include but are not limited to research and economic development projects.

(D) Other findings that support the conclusion that Supplies and Services are available from only one source may include but are not limited to considerations of: unique design, availability, geographic location, exclusive authorized representative, cost of conversion, and warranty services.

(b) For all Contracts awarded through Sole-Source Procurements exceeding $5,000 but not exceeding $150,000:

(A) The Authorized Agency must place a public notice on ORPIN of its determination that the Supplies and Services or class of Supplies and Services are available from only one source.

(B) The public notice must describe the Supplies and Services to be acquired through a Sole-Source Procurement and identify the prospective Contractor and include the date, time and place that protests are due.

(C) The Authorized Agency must give such public notice at least seven calendar (7) Days before the Award of the Contract to allow for protests pursuant to OAR 125-247-0710. If the State Procurement Office is conducting the Sole-Source Procurement, then the State Procurement Office is the Authorized Agency for purposes of this Rule;

(D) For all Public Contracts exceeding $75,000 but not exceeding $150,000, the Authorized Agency must also obtain the prior Written approval of the Chief Procurement Officer or delegatee before the Authorized Agency may award a Public Contract as a Sole-Source Procurement under this Rule.

(c) For all Public Contracts exceeding $150,000:

(A) The Authorized Agency must place a public notice on ORPIN in accordance with Subsection (2)(b)(A) and (B); and if the State Procurement Office is conducting the Sole-Source Procurement, then the State Procurement Office is the Authorized Agency for purposes of this Rule;

(B) The Authorized Agency must give such public notice at least seven calendar (7) Days before the Award of the Contract to allow for protests pursuant to OAR 125-247-0710; and

(C) The Authorized Agency must obtain the prior Written approval of the Chief Procurement Officer or delegatee before the Authorized Agency may award a Public Contract as a Sole-Source Procurement under this Subsection (2)(b).

(d) Pursuant to ORS 279B.075 and to the extent reasonably practical, the Authorized Agency must negotiate with the sole source to obtain contract terms advantageous to the Authorized Agency.

(3) Protest. An Affected Person may protest the Authorized Agency's determination that the Supplies and Services or class of Supplies and Services are available from only one source in accordance with OAR 125-247-0710.

(4) Brand Name Requirements. If the findings of fact required under this Rule include a specification of a Brand Name, that specification must be in accordance with ORS 279B.215 and OAR 125-247-0691.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.075
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0280
Emergency Procurements

(1) An Authorized Agency may award a Contract as an Emergency Procurement pursuant to the requirements of ORS 279B.080. An Authorized Agency has delegated authority to enter into an Emergency Contract pursuant to OAR 125-246-0170. 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, the Authorized Agency, 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, the Authorized Agency entering into an Emergency Contract must:

(a) Make a Written declaration of emergency, including findings as follows:

(A) A brief description of the Supplies and Services to be provided under the Contract, together with its anticipated cost;

(B) A brief explanation of how the Contract, in terms of duration or Supplies and Services provided under it, was restricted to the Scope reasonably necessary to adequately deal only with the risk created or anticipated to be created by the Emergency circumstances; and

(C) A description of the emergency circumstances that require the prompt performance 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 (3)(b) 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 Authorized Agency, or person designated under ORS 279A.075, must declare the existence of the emergency, as required by Subsection (3)(a), which must authorize the Authorized Agency to enter into an Emergency Contract.

(5) Any Contract awarded under this Rule must be awarded within sixty (60) days following the declaration of the emergency unless the head of the Authorized Agency or Person designated has granted an extension.

(6) Agencies must also comply with OAR 137-045-0070, Emergency Public Contract Exemption, if applicable. The Authorized Agency must maintain a copy of any required report in the Authorized Agency's Emergency Procurement File.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.080
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0285
Special Procurements; Purpose and Application

(1) Generally. An Authorized Agency may award a Contract as a Special Procurement pursuant to the requirements of ORS 279B.085.

(2) Purpose. Pursuant to ORS 279B.085, these Rules establish the criteria for procuring Supplies and Services through Special Procurements by the State Procurement Office and Authorized Agencies. Authorized Agencies must have delegated authority pursuant to OAR 125-246-0170.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.085
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0287
Special Procurements; Request Procedures

(1) Approval. An Authorized Agency may request approval from the Chief Procurement Officer to use a Special Procurement for a particular Contract or Contracts or for a specific class of Contracts using the designated State Procurement Office form.

(2) Requests. Special Procurement Requests must contain the following:

(a) Request must include reason(s) why Authorized Agency has elected to use Special Procurement and how it will benefit the Authorized Agency or the public.

(b) The Request must include findings, market research, or other documentation that the Special Procurement:

(A) Will be unlikely to encourage favoritism in the awarding of Public Contracts or to substantially diminish competition for Public Contracts, and

(B) Will either:

(i) Result in substantial cost savings to the Authorized Agency or to the public; or

(ii) Otherwise substantially promote the public interest in a manner that could not practicably be realized by complying with requirements that are applicable under ORS 279B.055, 279B.060, 279B.065 or 279B.070 or under any related Rules.

(c) The alternative process designed by the Authorized Agency must be clear and complete, including a description of the Supplies and Services to be acquired, provisions for advertisement, a proposed Solicitation process, including provisions for Amendment and criteria for selection, and the proposed contract document.

(d) The State Procurement Office may require any additional information deemed necessary to evaluate the Authorized Agency's request for approval of a Special Procurement.

(3) Effect. The Special Procurement approval is effective only after the Chief Procurement Officer's approval of the findings and Request and completion of the Public Notice required under Section (4) of this Rule.

(4) Public Notice. The Public Notice process and requirements are as follows:

(a) General. The requesting Authorized Agency must give public notice of the approval of its Special Procurement as required under ORS 279B.085(4) and in accordance with this Rule, unless otherwise directed by the Chief Procurement Officer (Public Notice). As a Written condition to approval of the proposed Special Procurement, the Chief Procurement Officer may require that the State Procurement Office instead of the requesting Agency give the Public Notice.

(b) Content. The Public Notice must at least describe the Supplies and Services or class of Supplies and Services to be acquired through the Special Procurement.

(c) Time Periods.

(A) If the Special Procurement involves one or more Solicitations, then Public Notice of the approval of the proposed Special Procurement must be given at least seven (7) calendar Days before the Award. The Solicitation Document must either contain the attached request and approval of the Special Procurement or incorporate the request and approval by reference with the documents easily accessible to Affected Persons; or

(B) If the Special Procurement does not involve a Solicitation, then Public Notice of the approval of the Special Procurement must be given at least seven (7) Days prior to the commencement of the Special Procurement.

(b) An Authorized Agency may request certain information to be withheld from the public notice requirement of this Rule in cases where confidentiality or security may be jeopardized only pursuant to an exception under the Public Records Law (ORS 192.410 through 192.505).

(5) Protest. An Affected Person may protest the approval of a Special Procurement in accordance with ORS 279B.400 and OAR 125-247-0700.

(6) Reference. Any Solicitation or Contract resulting from a Special Procurement approval must contain a reference to the number of the approved Special Procurement.

(7) Conditions. If the Chief Procurement Officer provides Written approval of the proposed Special Procurement (Approval), the Authorized Agency must award any Contract under the Special Procurement in accordance with the conditions of this Approval and any subsequent amendments to the Approval. The Approval may include conditions, including but not limited to expiration, Public Notice and dollar limitations, and may be revoked at any time by the Chief Procurement Officer.

(8) If an Authorized Agency competitively solicits, it must comply with the the process described in the Special Procurement or the Rules for that method of Solicitation pursuant to ORS 279B.055 through 279B.075 and 279A.200 et seq.

(9) Nothing in this Rule exempts the Authorized Agency from obtaining the approval of the Attorney General for legal sufficiency pursuant to ORS 291.047.

(10) All Authorized Agencies must comply with ORS 200.035 and related Department policy, notwithstanding this Rule.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.085
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0288
Special Procurements; by Rule

(1) Client Placement and Client Health Care Services.

(a) Authorization and Application. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule to enter Written agreements for Client Placement and Client Health Care services, as described in this Rule. When an Authorized Agency determines that a need exists to secure or maintain Client Placement Services or to secure Client Health Care Services, the Authorized Agency may contract subject to the following definitions and conditions of this Section (1).

(A) "Client Placement Services" means securing, enhancing, or continuing the placement of a Client in a structured family-like setting or residential setting operated by a qualified Provider.

(B) "Client Health Care Services" means health care services or provision of incidental or specialized supplies related to the health of a Client. Client Health Care Services include but are not limited to: preventive, diagnostic, therapeutic, behavioral, rehabilitative, maintenance, or palliative care and counseling services, assessment, or procedure with respect to the physical or mental condition, or functional status of a Client, or that affect the structure or function of the body; and the sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

(C) Services that may prevent a placement or placement disruption but that cannot definitively be classified as Client Placement Services by the Authorized Agency are deemed to be Client Placement Services and are subject to the Class Special Procurement approved under this Rule. This Class Special Procurement for Client Placement Services may include training only if it is provided directly to the Client, excluding Providers.

(b) Authorized Agencies must execute a Contract or amendment to an existing Contract within sixty (60) days of obtaining the Client Placement Services or Client Health Care Services as defined herein. Should the Authorized Agency fail to execute the Contract within this specified period, then the Authorized Agency may execute the Contract if:

(A) A Written statement of justification that describes the unforeseen or unavoidable circumstances that were reasonably unanticipated and preclude the Authorized Agency from executing the Contract within the initial sixty (60) day period; and

(B) A copy of the Written justification is maintained in the Procurement File.

(c) The Authorized Agency may not make any payments for Client Placement Services or Client Health Care Services before obtaining all requisite approvals of the Contract.

(d) The Authorized Agency must adhere to all requirements of the Code and related Rules and must follow all procedures, and guidelines of the Department when procuring Client Placement Services or Client Health Care Services.

(e) The Authorized Agency must ensure that all Procurement personnel responsible for procuring Placement Services or Client Health Care Services are provided training on the conditions and limitations of this Rule.

(f) Contract Forms. Authorized Agencies must use a Contract form approved by the State Procurement Office when acquiring Client Placement Services or Client Health Care Services pursuant to this Rule. The State Procurement Office may approve the Contract form by facsimile, email, letter or any other method that provides an objective means to verify State Procurement Office approval. The Authorized Agency must review the approved Contract form at least every two years. If the Authorized Agency revises the Contract form, the Authorized Agency must obtain State Procurement Office approval prior to using the revised Contract form.

(c) Nothing in this Rule exempts the Authorized Agency from obtaining the approval of the Attorney General for legal sufficiency pursuant to ORS 291.047.

(2) Client Services Source Selection.

(a) An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement Rule.

(b) The Chief Procurement Officer waives the source selection requirements as found in OAR 125-247-0200(1) through (6) for Authorized Agencies to procure Client Services, as defined in OAR 125-246-0110.

(c) The Authorized Agency must solicit to the maximum extent possible for Client Services, except those Client Services covered by Section (1), when there is known competition and may use one of the defined source selection methods as found in OAR 125-247-0200 or an alternative source selection method as determined by the Authorized Agency.

(3) Renegotiations of Existing Contracts with Incumbent Contractors.

(a) Authorization. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule to renegotiate and amend existing Contracts with incumbent Contractors, and then only if it is in the best interest of the State.

(b) Process and Criteria. The Authorized Agency may renegotiate various items of the Contract, including but not limited to: price, term, delivery and shipping, order size, item substitution, warranties, discounts, on-line ordering systems, price adjustments, product availability, product

quality, and reporting requirements. The Authorized Agency must meet the following conditions in its Renegotiations with incumbent Contractors:

(A) Favorable Result. The Authorized Agency must determine that, with all things considered, the renegotiated Contract is at least as favorable to the State as the Original Contract and document this in the Procurement File. For example, the Authorized Agency and the Contractor may adjust terms and conditions within the Original Contract to meet different needs;

(B) Within the Scope. The Supplies and Services provided under the renegotiated Contract must be reasonably related to the Original Contract's Solicitation. For example, the Authorized Agency may accept functionally equivalent substitutes for any Supplies and Services in the Original Contract's Solicitation;

(C) Optional Term or Condition. If a Contractor offered to the Authorized Agency during the original Solicitation a term or condition that was reject at that time,(for the purpose of this subsection only, Rejected Term or Condition), the Authorized Agency may not renegotiate for a lower price based on this Rejected Term or Condition as a mandatory term or condition in the renegotiated Contract. If, however, a Contractor offers a lower price pursuant to a Rejected Term or Condition without additional consideration from the Authorized Agency and as only an option to the Authorized Agency, then the Authorized Agency may accept the option of a lower price under the Rejected Term or Condition. For example, if the Authorized Agency initially rejected a Contractor's proposed Condition that the price required a minimum order, any renegotiated Contract may not mandate this Condition; but the Authorized Agency may agree to the option to order lesser amounts or receive a reduced price based upon a minimum order; and

(D) Market. In order to avoid encouraging favoritism or diminishing competition, the Authorized Agency may research the accepted competitive practices and expectations of Offerors within the market for the specific Contract(s) or Classes of Contracts to be renegotiated (Market Norm). If the Authorized Agency researches the Market Norm, then the Authorized Agency must document its results in the Procurement File. Based upon this information, the Authorized Agency may confirm that, if the Authorized Agency follows the Market Norm, favoritism is not likely to be encouraged, competition is not likely to be diminished, and substantial cost savings may be realized. Under no condition may the Authorized Agency accept or follow any Market Norm that likely encourages favoritism or diminishes competition, even if it is accepted or expected in the market.

(4) Advertising Contracts.

(a) Authorization. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule to purchase media advertising, regardless of dollar value, without competitive bidding, pursuant to OAR 125-246-0170.

(b) Process and Criteria. Authorized Agencies must use competitive methods wherever possible to achieve best value and must document in Agency policy or the Procurement File the reasons why a competitive process was deemed to be impractical. If the anticipated purchase exceeds $5,000 and a competitive method is used, the Authorized Agency must post notice on ORPIN. The resulting Contract must be in Writing and the Authorized Agency 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 if applicable under ORS 291.047.

(5) Equipment Repair and Overhaul.

(a) Authorization. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule for equipment repair and overhaul, as described in this Rule.

(b) Conditions. An Authorized Agency, having delegated purchasing authority pursuant to OAR 125-246-0170, 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

(C) The Authorized Agency purchases within the limits and pursuant to the methods in (5)(c) of this Rule.

(c) Process and Criteria. Authorized Agencies must use competitive methods wherever possible to achieve best value and must document in Agency policy or the Procurement File the reasons why a competitive process was deemed to be impractical. If the anticipated purchase exceeds $5,000 and a competitive method is used, the Authorized Agency must post notice on ORPIN. The resulting Contract must be in Writing and the Authorized Agency 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 if applicable under ORS 291.047.

(6) Contracts for Price Regulated Items.

(a) Authorization. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule for the Procurement of price regulated items, and the Authorized Agency must comply with the conditions of this Rule. An Authorized Agency having delegated purchasing authority pursuant to OAR 125-246-0170 may, regardless of dollar value and without competitive bidding, contract for the direct purchase of Supplies and Services where the rate or price for the Supplies and Services being purchased is established by federal, state, or local regulatory authority.

(b) Process and Criteria. Authorized Agencies must use competitive methods wherever possible to achieve best value and must document in Agency policy or the Procurement File the reasons why a competitive process was deemed to be impractical. If the anticipated purchase exceeds $5,000 and a competitive method is used, the Authorized Agency must post notice on ORPIN. The resulting Contract must be in Writing and the Authorized Agency 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 if applicable under ORS 291.047.

(7) Investment Contracts.

(a) Authorization. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule for investment Contracts, including related Contracts arising from or giving rise to investment opportunities (collectively, investment Contracts), as described in this Rule. An Authorized Agency may, without competitive bidding, and regardless of dollar amount, contract for the purpose of the investment of public funds or the borrowing of funds by the Authorized Agency when such investment or borrowing is contracted pursuant to duly enacted statute, or constitution.

(b) Process and Criteria. Authorized Agencies must use competitive methods wherever possible to achieve best value and must document in Agency policy or the Procurement File the reasons why a competitive process was deemed to be impractical. If the anticipated purchase exceeds $5,000 and a competitive method is used, the Authorized Agency must post notice on ORPIN. The resulting Contract must be in Writing and the Authorized Agency 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 if applicable under ORS 291.047.

(8) Food Contracts.

(a) Intent. The intent of this Rule is to provide a method for Authorized Agencies to procure food products, which are available for a limited period of time at "lower than normal" prices (also referred to as "spot buys") (Food Contracts).

(b) Authorization. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule for the Procurement of Food Contracts, and the Authorized Agency must comply with the conditions of this Rule.

(c) Conditions. An Authorized Agency may procure an unlimited dollar value of food using a competitive bid or quote process when all of the following conditions are present:

(A) A non-exclusive Mandatory Use Contract or regularly scheduled bid process already exists for the item being purchased;

(B) The proposed unit price of the item(s) to be purchased is significantly less than a comparable item's price on an existing Mandatory Use Contract or recent bid (as described in Subsection (8)(d) of this Rule) and the amount saved exceeds any additional administrative costs incurred to purchase using this Special Procurement;

(C) The product being purchased has limited availability (i.e., the product may no longer be available upon completion of normal bid processes);

(D) Any Mandatory Use Contract currently in place for the item being purchased contain clauses allowing for the use of this Special Procurement; and

(E) The purchase does not jeopardize fulfillment of a guaranteed minimum volume under an existing Mandatory Use Contract.

(d) Documentation. Purchases may only be made under this Special Procurement after the Authorized Agency documents the following in its Procurement File in accordance with OAR 125-246-0355: the Authorized Agency's attempt and method to obtain Quotes from at least three sources; the Written Quote or Bid, if obtained; item Specifications; quantity; unit pricing; delivery; and other pertinent information. Contract or bid pricing used for comparison must be representative of current pricing available and must have been obtained or confirmed no more than six (6) months prior to the current purchase. When practical, Written Quotes are recommended.

(e) Process and Criteria. Authorized Agencies must use competitive methods wherever possible to achieve best value and must document in

Agency policy or the Procurement File the reasons why a competitive process was deemed to be impractical. If the anticipated purchase exceeds $5,000 and a competitive method is used, the Authorized Agency must post notice on ORPIN, except when the competitive method involves verbal Quotes for perishable food. The resulting Contract must be in Writing and the Authorized Agency 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 if applicable under ORS 291.047.

(9) Purchase of Used Personal Property.

(a) Authorization. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule Subject to the provisions of this Rule, an Authorized Agency may purchase used property or equipment without competitive bidding and without obtaining Quotes, if, at the time of purchase, the Agency has determined and documented that the purchase will (i) be unlikely to encourage favoritism or diminish competition; and (ii) result in substantial cost savings or promote the public interest. "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 the Authorized Agency purchase. "Used personal property or equipment" generally does not include property or equipment if the Authorized Agency was the previous user, whether under a lease, as part of a demonstration, trial or pilot project, or similar arrangement.

(b) Process and Criteria.

(A) For purchases of used personal property or equipment not exceeding $150,000, Authorized Agencies having delegated authority pursuant to OAR 125-246-0170, must, where feasible, obtain three Quotes, unless the Authorized Agency has determined and documented that a purchase without obtaining Quotes will result in cost savings to the Authorized Agency and will not diminish competition or encourage favoritism.

(B) For purchases of used personal property or equipment exceeding $150,000, the State Procurement Office must obtain and keep a Written record of the source and amount of Quotes received. If three Quotes are not available, a Written record must be made of the attempt to obtain Quotes.

(C) If the total purchase is estimated to exceed $150,000, an Authorized Agency must submit a Written request for a Written delegation of authority from the State Procurement Office prior to making the purchase.

(D) Authorized Agencies must use competitive methods wherever possible to achieve best value and must document in Agency policy or the Procurement File the reasons why a competitive process was deemed to be impractical. If the anticipated purchase exceeds $5,000 and a competitive method is used, the Authorized Agency must post notice on ORPIN. The resulting Contract must be in Writing and the Authorized Agency 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 if applicable under ORS 291.047.

(10) Business Assistance Services.

(a) Authorization. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule for Business Assistance Services, as described in this Rule. An Authorized Agency with delegated authority pursuant to OAR 125-246-0170 may, without any competitive process and regardless of dollar amount, procure Business Assistance Services. "Business Assistance Services" mean services that:

(A) Are delivered directly and expediently to small or troubled businesses in Oregon, and

(B) Assist businesses with start-up, growth, revitalization or stabilization.

(b) Process and Criteria. Authorized Agencies must use competitive methods wherever possible to achieve best value and must document in Agency policy or the Procurement File the reasons why a competitive process was deemed to be impractical. If the anticipated purchase exceeds $5,000 and a competitive method is used, the Authorized Agency must post notice on ORPIN. The resulting Contract must be in Writing and the Authorized Agency 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 if applicable under ORS 291.047.

(11) Reverse Auctions.

(a) Authority. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule.

(b) Process. A Reverse Auction means a process for the purchase of Supplies and Services by a buyer from the lowest Bidder. The Authorized Agency as the buyer must conduct Reverse Auctions by first publishing a Solicitation that describes its requirements, Contract terms and conditions. Then, the Authorized Agency 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 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 the Authorized Agency chooses to use a scoring model that weighs non-price factors in addition to price; or

(D) Any combination of (A), (B) and (C) above. Before the Reverse Auction commences, Bidders must be required by the Authorized Agency 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 the Authorized Agency. 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. The Authorized Agency may cancel this Solicitation if this Agency determines that it is in this Agency's or the State's best interest. At the end of this Bidding process, the Authorized Agency must award any potential Contract to the lowest Responsible Bidder or in the case of multiple awards, lowest Responsible Bidders pursuant to ORS 279B.055(10)(b). This process allows the Authorized Agency to test and determine the suitability of the Supplies and Services before making the Award. The Authorized Agency must comply with the following procedures for this type of Solicitation:

(c) Policy and Approval. The Authorized Agency must follow the policy of the Department and obtain prior Written approval from the State Procurement Office before using this Reverse Auction Special Procurement.

(d) Public Notice. The Authorized Agency must disclose the Reverse Auction process in the Solicitation Documents. The Authorized Agency must provide initial notice of this Solicitation through ORPIN. The Authorized Agency 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. The Authorized Agency must issue a Notice of Intent to award at least seven (7) calendar Days prior to making the Award.

(e) Prequalification. For each Solicitation, on a case-by-case basis, the Authorized Agency may determine whether prequalification of suppliers is needed. If prequalification is used, the Authorized Agency must prequalify suppliers and provide an appeal process in accordance with ORS 279B.120 and related Rules.

(f) E-Procurement. The requirements of OAR 125-247-0330 apply to Reverse Auctions. In the event of conflict or ambiguity, the more specific requirements of this Section (11) take precedence over the more general requirements of OAR 125-247-0330.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.085
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0293
Special Procurements: Interstate and International Agreements

(1) Authority. An Authorized Agency with delegated authority in accordance with OAR 125-246-0170 may use this Class Special Procurement by Rule to enter into written Interstate or International agreements for Supplies and Services.

(2) Definitions.

(a) "Interstate Agreements," as used in ORS 190.410 to 190.440, means agreements between or among Public Agencies in this state and in another state for joint or cooperative action. See ORS 190.420(2).

(b) "Public Agency," as defined in ORS 190.410, includes:

(A) "Any county, city, special district or other public corporation, commission, authority or entity organized and existing under laws of this state, or any other state, or under the city or county charter of any county or city of this or any other state";

(B) "Any agency of this state or any other state, and

(C) "Oregon Health and Science University."

(c) "International Agreements," as used in ORS 190.480 to 190.490, means agreements between or among a State Agency and another nation or Public Agency of another nation for joint and cooperative action. See ORS 190.485.

(d) "State Agency," as defined in ORS 190.480, "means every state officer, board, commission, department, institution, branch or agency of state government whose costs are paid wholly or in part from funds held in the State Treasury."

(3) Process.

(a) Agencies may procure and contract for Supplies and Services with other states and related entities outside of the state of Oregon according to the provisions of ORS 190.410 to 190.440.

(b) Agencies may procure and contract with other nations and related entities outside of the United States for Supplies and Services according to the provisions of ORS 190.480 to 190.490.

(c) All Interstate and International Agreements, when required, are subject to review and approval by the Attorney General.

(4) Contracting Procedures. Each Authorized Agency may enter into Interstate and International Agreements for Supplies and Services through negotiation, direct award, direct appointment, or in any other manner or procedure reasonably calculated to result in such Agreements that satisfies the legal requirements and limitations that constrain the contracting entities that are parties to these Agreements.

(5) Application Date. This Rule applies on and after March 1, 2005.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279B.085
Hist.: DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0294
Special Procurements: Tribal Agreements

(1) Application and Authority. This Rule applies to Agreements with American Indian Tribes and Agencies of American Indian Tribes. An Authorized Agency that has delegated authority under OAR 125-246-0170 may use this Class Special Procurement to enter into Written agreements for Supplies and Services with American Indian tribes and with agencies of American Indian tribes.

(2) Contracting Procedures. Each Authorized Agency may enter into written agreements for Supplies and Services with American Indian tribes and their agencies through negotiation, direct award, direct appointment, or in any other manner or procedure reasonably calculated to result in an agreement that satisfies the legal requirements and limitations that constrain the contracting entities that are parties to the agreement.

(3) Application Date. This Rule applies on and after March 1, 2005.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279B.085
Hist.: DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0295
Special Procurements: General or Special Counsel Authorized by the Attorney General

(1) Authority and Application. An Authorized Agency with delegated authority under OAR 125-246-0170 may use this Class Special Procurement by Rule. Under ORS 180.235, the Oregon Attorney General may authorize a public officer or Agency to retain its own general or special counsel, including but not limited to conflict counsel, other than the Department of Justice. This Rule governs the process for obtaining such counsel.

(2) Definitions For purposes of this Rule only, these terms have the following meanings:

(a) “Attorney General” means the Attorney General of the State of Oregon.

(b) “Authorized Agency” means a public officer or Agency that the Attorney General authorized to retain its own general or special counsel other than the Department of Justice under ORS 180.235.

(c) “Authorized Legal Services” means the legal services as authorized by the Attorney General for the particular matter or class of matters and as required by the Authorized Agency.

(d) “Outside Counsel” means general or special counsel selected by the Authorized Agency under this Rule.

(e) “Firm” means the proprietorship, partnership or professional legal corporation engaged in the practice of law of which Outside Counsel is a partner, a shareholder, an associate, a member, or a lawyer serving as “of counsel.”

(f) “Solicitation” means a written or oral request for offers, proposals, statements of qualifications, or other information from individuals or entities.

(3) Selection Criteria:

(a) The Authorized Agency must select the Firm it considers most advantageous based on the following factors:

(A) The knowledge, skills and ability of the Firm that will provide Authorized Legal Services. The Firm’s ability to provide Authorized Legal Services includes the training and expertise of the Firm attorneys, including Outside Counsel. Outside Counsel must be a member of the Oregon State Bar pursuant to ORS 180.235(2);

(B) The Firm’s experience, level of expertise and suitability to perform the Authorized Legal Services;

(C) Whether the Firm’s available personnel possess any required licenses or certifications required to perform the legal services for the Authorized Legal Services, such as licenses to practice law in the appropriate jurisdiction, or to appear in a certain forum;

(D) The Outside Counsel’s availability and capability to perform the Authorized Legal Services and meet the Agency’s needs;

(E) The commitment the Outside Counsel and Counsel’s Firm can make to the Authorized Agency to meet the Agency’s needs;

(F) The value of the Firm’s legal services, taking into account the cost of the Firm’s legal services; and

(G) Other factors the Authorized Agency considers relevant to accomplish an optimal, timely outcome.

(b) In weighing the evaluation factors, no single factor is determinative.

(4) Scope of Firms Considered The Solicitation process may range from direct negotiation and contracting with a single firm to publication of a request for proposals. The Authorized Agency must extend Solicitations to those firms that it considers reasonable and practical to solicit under the circumstances, and must take into consideration the following factors:

(a) When the subject matter of the Authorized Legal Services requires specialized knowledge in a particular field of law, the Authorized Agency may limit the Solicitation to prospective Firms that have a reputation of subject matter expertise in that field of law;

(b) The Authorized Agency must limit the number of Firms considered under the Solicitation as appropriate if the interests of the Authorized Agency would likely be adversely affected by delay in obtaining a Firm or through broad distribution of the Solicitation; and

(c) Other factors the Authorized Agency considers relevant to accomplish an optimal, timely outcome.

(5) Documentation of Selection

(a) The Authorized Agency must prepare a record of selection signed by the public officer or Agency designated to be responsible for the selection process. The record of selection must include the public officer’s or Agency’s summary of:

(A) The Solicitation process used and the Firms considered in the Solicitation process;

(B) Why the selected firm is considered most advantageous to the Authorized Agency; and

(C) Why the Scope of the Solicitation was reasonable and practical under the circumstances.

(b) As used in (5)(a) above, the public officer may include a member of the Authorized Agency’s board or commission.

(c) The record of solicitation must be retained by the Authorized Agency within the Procurement File for the Firm.

(6) The Agency may procure Amendments to existing Contracts under this Rule. In lieu of complying with Sections (4) through (5) of this Rule, the Agency must document why amending the Contract is necessary and in the best interest of the State.

(7) Effective Date. This Rule applies on and after March 1, 2005.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279B.075, 279B.085
Hist.: DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0296
Mandatory Use Contracts and Price Agreements

(1) Mandatory Use Contracts, for the purposes of this Rule and including Department Price Agreements, service agreements, and sales agreements, may be established for the purposes of minimizing paper work, achieving continuity of product, securing a source of supply, reducing inventory, combining Agency requirements for volume discounts, standardization among Agencies, and reducing lead time for ordering. A Mandatory Use Contract requires the Authorized Agency to purchase Supplies and Services for an anticipated need at a predetermined price, provided the Mandatory Use Contract is let by a competitive Procurement Process pursuant to the requirements of ORS 279ABC and these Rules.

(2) Authorized Agencies may purchase the Supplies and Services from a Contractor awarded a Mandatory Use Contract without first undertaking additional competitive Solicitation.

(3) Authorized Agencies must use Mandatory Use Contracts established by the Department unless otherwise specified in the Contract, allowed by law or these Rules, or specifically authorized by the State Procurement Office.

(4) Notwithstanding Section (3) above, Authorized Agencies are exempted from Mandatory Use Contracts for acquisition of the following, regardless of dollar amount:

(a) Supplies and Services from another Oregon Public Agency, provided that a formal, Written agreement is entered into between the parties;

(b) Personal property for resale through student stores operated by public educational Agencies; and

(c) Emergency purchases declared by an Authorized Agency pursuant to ORS 279B.

(5) Authorized Agencies may be exempted from a Mandatory Use Contract upon a request to and approval by the State Procurement Office.

(6) 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.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0430
Addenda to Solicitation Document

(1) Issuance; Receipt. The Authorized Agency may change a Solicitation Document only by Written Addenda. An Offeror must provide Written acknowledgment of receipt of all issued Addenda with its Offer, unless the Authorized Agency otherwise specifies in the Addenda.

(2) Notice and Distribution. The Authorized Agency must notify prospective Offerors of Addenda in a manner intended to foster competition and to make prospective Offerors aware of the Addenda. The Solicitation Document must specify how the Authorized Agency will provide notice of Addenda and how the Authorized Agency will make the Addenda available before Closing, and at each subsequent step or Phase of evaluation if the Authorized Agency will engage in a Multistep Competitive Sealed Bidding process in accordance with OAR 125-247-0256, or a Multi-tiered or Multistep Competitive Sealed Proposals process in accordance with OAR 125-247-0261.

(3) Timelines; Extensions:

(a) The Authorized Agency must issue Addenda within a reasonable time to allow prospective Offerors to consider the Addenda in preparing their Offers. The Authorized Agency may extend the Closing if the Authorized Agency determines prospective Offerors need additional time to review and respond to Addenda. Except to the extent required by a countervailing public interest, the Authorized Agency must not issue Addenda less than 3 Business Days before the Closing unless the Addendum also extends the Closing.

(b) Notwithstanding Subsection (3)(a) of this Rule, an Addendum that modifies the evaluation criteria, selection process or procedure for any step or Phase of competition under a Multistep Sealed Bidding or Multistep Sealed Proposals, issued in accordance with OAR 125-247-0256 or 125-247-0261, must be issued no fewer than five (5) Days before the beginning of that step or Phase of competition, unless the Authorized Agency determines that a shorter period is sufficient to allow the Offerors to prepare for that step or Phase of competition. The Authorized Agency must document the factors it considered in making that determination, which may include, without limitation, the Scope of the changes to the Solicitation Document, the location of the remaining eligible Proposers, or whether shortening the period between issuing an Addendum and the beginning of the next step or Phase of competition favors or disfavors any particular Proposer or Proposers.

(4) Request for Change or Protest. Unless a different deadline is set forth in the Addendum, an Offeror may submit a Written request for change or protest to the Addendum, as provided in OAR 125-247-0730, by the close of the Authorized Agency's next business day after issuance of the Addendum, or up to the last day allowed to submit a request for change or protest under OAR 125-247-0730, whichever date is later. If the date established in the previous sentence falls after the deadline for receiving protests to the Solicitation Document in accordance with OAR 125-247-0730, then the Authorized Agency may only consider an Offeror's request for change or protest to the Addendum, and the Authorized Agency must not consider a request for change or protest to matters not added or modified by the Addendum. Notwithstanding any provision of this Subsection (4) of this Rule, an Authorized Agency is not required to provide a protest period for Addenda issued after initial Closing during a or multistep Procurement Process conducted pursuant to ORS 279B.055 or 279B.060 and their respective rules.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.050 - 279B.090
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0450
Receipt, Opening, and Recording of Offers

(1) Receipt. An Authorized Agency must electronically or mechanically time-stamp or hand-mark each Offer and any modification upon receipt. The Authorized Agency must not open the Offer or modification, but must maintain it as confidential and secure until Opening. If the Authorized Agency inadvertently opens an Offer or a modification prior to the Opening, the Authorized Agency must return the Offer or modification to its secure and confidential state until Opening. The Authorized Agency must document the resealing for the Procurement File in accordance with OAR 125-246-0355 (e.g., "Authorized Agency inadvertently opened the Offer due to improper identification of the Offer").

(2) Opening and Recording. An Authorized Agency must publicly open Offers including any modifications made to the Offer pursuant to OAR 125-247-0440(1). In the case of Invitations to Bid, to the extent practicable, the Authorized Agency must read aloud the name of each Bidder, and such other information as the Authorized Agency considers appropriate. However, the Authorized Agency may withhold from disclosure information in accordance with ORS 279B.055(5)(c) and 279B.060(5). In the case of Requests for Proposals or voluminous Bids, if the Solicitation Document so provides, the Authorized Agency will not read Offers aloud.

(3) Public Record Requests. See OAR 125-247-0630.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.050 - 279B.090
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0600
Offer Evaluation and Award

(1) Authorized Agency Evaluation. The Authorized Agency must evaluate Offers only as set forth in the Solicitation Document, pursuant to ORS 279B.055(6)(a) and 279B.060(6)(b), and in accordance with applicable law. The Authorized Agency must not evaluate Offers using any other requirement or criterion.

(a) Evaluation of Bids:

(A) Nonresident Bidders. In determining the lowest Responsive Bid, the Authorized Agency must apply the reciprocal preference set forth in ORS 279A.120(2)(b) and OAR 125-246-0310 for nonresident Bidders.

(B) Public Printing. The Authorized Agency must, for the purpose of evaluating Bids, apply the public printing preference set forth in ORS 282.210.

(C) Award When Bids are Identical. If the Authorized Agency determines that one or more Bids are identical under OAR 125-246-0300, the Authorized Agency must award a Contract in accordance with the procedures set forth in OAR 125-246-0300.

(b) Evaluation of Proposals:

(A) Award When Proposals are Identical. If the Authorized Agency determines that one or more Proposals are identical under OAR 125-246-0300, the Authorized Agency must award a Contract in accordance with the procedures set forth in OAR 125-246-0300.

(B) Public Printing. The Authorized Agency must for the purpose of evaluating Proposals apply the public printing preference set forth in ORS 282.210.

(c) Recycled Materials. When procuring Goods, the Authorized Agency must give preference for Recycled Materials as set forth in ORS 279A.125 and OAR 125-246-0322.

(2) Clarification of Bids. After the Bid Opening, an Authorized Agency may conduct Discussions with apparent Responsive Bidders for the purpose of clarification and to assure full understanding of the Bid. All Bids, at the Authorized Agency's sole discretion, needing clarification must be afforded such an opportunity. The Authorized Agency must document clarification of any Bidder's Bid in the Procurement File in accordance with OAR 125-246-0355.

(3) Negotiations Prohibited or Allowed:

(a) Prohibition in Competitive Sealed Bidding. Except as permitted by this Section 3(b) of this Rule, an Authorized Agency must not negotiate with any Bidder in a competitive sealed bidding pursuant to ORS 279B.060 and related Rule. After Award of the Contract, the Authorized Agency and Contractor may only modify the Contract in accordance with OAR 125-246-0560. An Authorized Agency may conduct Discussions in accordance with OAR 125-247-0256.

(b) Allowance in Other Procurement Methods. An Authorized Agency may conduct Discussions or Negotiations with one or more Offerors in Competitive Sealed Proposals, Small Procurements, Intermediate Procurements, Emergency Procurements if applicable, and Special Procurements if applicable, in accordance with ORS 279B.060(6)(b), OAR 125-247-0260, 125-247-0261, 125-247-0270, 125-247-0287, and 125-247-0288. To the extent practical, an Authorized Agency must negotiate in Sole-Source Procurements in accordance with OAR 125-247-0275. After Award of the Contract, the Authorized Agency and Contractor may only modify the Contract in accordance with OAR 125-246-0560.

(c) Other Procurements. This section (3) does not apply to Small Procurements, Emergency Procurements, or Special Procurements which do not use Solicitations.

(4) Award:

(a) General. If awarded, the Authorized Agency must award the Contract to the Responsible Bidder submitting the lowest, Responsive Bid or the Responsible Proposer submitting the most Advantageous, Responsive Proposal. The Authorized Agency may award by item, groups of items or the entire Offer provided such Award is consistent with the Solicitation Document and in the public interest.

(b) Multiple Items. An Invitation to Bid or Request for Proposals may call for pricing of multiple items of similar or related type with the Award based on individual line item, group total of certain items, a "market basket" of items representative of the Authorized Agency's expected purchases, or grand total of all items.

(c) Multiple Awards; Bids:

(A) Notwithstanding Subsection 4(a) of this Rule, an Authorized Agency may award multiple Contracts under an Invitation to Bid in accordance with the criteria set forth in the Invitation to Bid. A multiple Award may be made if the Award to two or more Bidders is beneficial for adequate availability, delivery, service, competition, pricing, product capabilities, or other factors deemed significant by the Authorized Agency. Multiple Awards may not be allowed for user preference unrelated to utility or economy. A notice to prospective Bidders that multiple Contracts may be awarded for any Invitation to Bid must not preclude the Authorized Agency from awarding a single Contract for such Invitation to Bid.

(B) If an Invitation to Bid permits the Award of multiple Contracts, the Authorized Agency must specify in the Invitation to Bid the criteria it will use to choose from the multiple Contracts when purchasing Supplies and Services.

(d) Multiple Awards; Proposals:

(A) Notwithstanding Subsection 4(a) of this Rule, an Authorized Agency may award multiple Contracts under a Request for Proposals in accordance with the criteria set forth in the Request for Proposals. A multiple Award may be made if the Award to two or more Proposers is beneficial for adequate availability, delivery, service, competition, pricing, product capabilities, or other factors deemed significant by the Authorized Agency. Multiple Awards may not be allowed for user preference unrelated to utility or economy. A notice to prospective Proposers that multiple Contracts may be awarded for any Request for Proposals must not preclude the Authorized Agency from awarding a single Contract for such Request for Proposals.

(B) If a Request for Proposals permits the Award of multiple Contracts, the Authorized Agency must specify in the Request for Proposals the criteria it will use to choose from the multiple Contracts when purchasing Supplies and Services.

(e) Partial Awards. If after evaluation of Offers, the Authorized Agency determines that an acceptable Offer has been received for only parts of the requirements of the Solicitation Document:

(A) The Authorized Agency may award a Contract for the parts of the Solicitation Document for which acceptable Offers have been received; or

(B) The Authorized Agency may reject all Offers and may issue a new Solicitation Document on the same or revised terms, conditions and Specifications.

(f) All or None Offers. An Authorized Agency may award all or no Offers if the evaluation shows an all or no Award to be the lowest cost for Bids or the most Advantageous for Proposals of those submitted.

(g) Life Cycle Costing. The Authorized Agency must follow OAR 125-247-0170.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.050 - 279B.090
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0610
Notice of Intent to Award

(1) Notice of Intent to Award. The Authorized Agency must provide Written notice of its intent to award to all Offerors pursuant to ORS 279B.135 at least seven (7) Days before the Award of a Contract, unless the Authorized Agency determines that circumstances require prompt execution of the Contract, in which case the Authorized Agency may provide a shorter notice period. The Authorized Agency must document the specific reasons for the shorter notice period in the Procurement File in accordance with OAR 125-246-0355.

(2) Finality. The Authorized Agency's Award must not be final until the later of the following:

(a) The expiration of the protest period provided pursuant to OAR 125-247-0740; or

(b) The Authorized Agency provides Written responses to all timely-filed protests denying the protests and affirming the Award.

(3) The Authorized Agency may provide this notice through any reasonable means and, if functionality exists, through ORPIN in accordance with OAR 125-246-0500.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.050 - 279B.090 & 279B.135
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0630
Availability of Award Decisions

(1) Contract Documents. To the extent required by the Solicitation Document, the Authorized Agency must deliver to the successful Offeror a Contract, a Signed Purchase Order, Price Agreement, or other Contract documents as applicable.

(2) Availability of Award Decisions. A Person may obtain tabulations of awarded Bids or evaluation summaries of Proposals for a minimal charge, in person or by submitting to the Authorized Agency a Written request accompanied by payment. The requesting Person must provide the Solicitation Document number and enclose a self-addressed, stamped envelope. In addition, the Authorized Agency may make available tabulations of Bids and Proposals through ORPIN or the Authorized Agency's website.

(3) Availability of Procurement Files. After the notice of intent to award, the Authorized Agency must make Procurement Files available in accordance with applicable law, except where applicable law requires the Authorized Agency to make information contained in the Procurement Files available prior to any notice of intent to award. See OAR 125-247-0720, 125-247-0730, and the Public Records Law.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.050 - 279B.090
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0690
Policy

(1) As provided in ORS 279B.205 and consistent with ORS 279A.015, specifications must seek to promote optimal value and suitability for the purposes intended and to reasonably encourage competition in satisfying an Agency's needs. Subject to ORS 279B.405, the specification content must be determined in the sole discretion of the Agency.

(2) As provided in ORS 279B.210, it is the policy of the State of Oregon to encourage the development of clear, precise and accurate Specifications in Solicitations for Public Contracts. To that end, in developing Specifications, Agencies may consult, under contract or otherwise, with technical experts, suppliers, prospective contractors and representatives of the industries with which the Agencies contract. However, an Agency must take reasonable measures to ensure that no Person who prepares or assists in the preparation of Solicitation Documents, Specifications, plans or Scopes of Work, and no business with which the Person is associated, realizes a material competitive advantage in a Procurement that arises from the Agency's use of the Solicitation Documents, Specifications, plans or Scopes of Work. The policy against the realization of a material competitive advantage from the character of the Specifications developed in conjunction with Persons outside the Agency does not proscribe advantages that result incidentally from an Agency's specification of the characteristics of a product or Work to meet the Agency's needs.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279B.205; 279B.210
Hist.: DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0691
Brand Name or equal Specification

(1) Applicability and Use. This Rule applies to Specifications for a Solicitation or class of Solicitations. For a Solicitation or class of Solicitations under ORS 279B.060, 279B.065, 279B.070, 279B.085, or 279A.200 through 279A.225, as provided in 279B.215:

(a) A brand name or equal Specification may be used when the use of a brand name or equal Specification is advantageous to the Agency, because the brand name describes the standard of quality, performance, functionality and other characteristics of the product needed by the Agency.

(b) The Agency is entitled to determine what constitutes a product that is equal or superior to the product specified, and any such determination is final.

(c) Nothing in this subsection may be construed as prohibiting an Agency from specifying one or more comparable products as examples of the quality, performance, functionality or other characteristics of the product needed by the Agency.

(2) Determination. A brand name Specification may be prepared and used only if the Agency determines for a Solicitation or a class of Solicitations that only the identified brand name Specification will meet the needs of the Agency based on one or more of the following written determinations:

(a) That use of a brand name Specification is unlikely to encourage favoritism in the awarding of Public Contracts or substantially diminish competition for Public Contracts;

(b) That use of a brand name Specification would result in substantial cost savings to the Agency;

(c) That there is only one manufacturer or seller of the product of the quality, performance or functionality required; or

(d) That efficient utilization of existing Goods requires the acquisition of compatible Goods or Services.

(3) An Agency's use of a brand name Specification may be subject to review only as provided in ORS 279B.400.

(4) Single Manufacturer, Multiple Sellers. An Authorized Agency may prepare and use a brand name or equal Specification for Supplies and Services available from only one manufacturer, but available through multiple sellers, if the Authorized Agency complies with Sections (1) and (2) of this Rule and the following requirements:

(a) If the total purchase is $5,000 or more but does not exceed $150,000 and comparable Supplies and Services are not available under an existing Mandatory Use Contract, the Authorized Agency must obtain informal, competitive Quotes, Bids, or Proposals and document this process in the Procurement File pursuant to ORS 279B.070 and OAR 125-247-0270;

(b) If the purchase exceeds $150,000, and the comparable Supplies and Services are not available under an existing Mandatory Use Contract, an Authorized Agency must first request and obtain prior written authorization from the Chief Procurement Officer to proceed with the acquisition.

(5) Single Manufacturer, Multiple Purchases. If an Authorized Agency intends to make several purchases of brand name-specified Supplies and Services from a particular manufacturer or seller for a period not to exceed five (5) years, the Authorized Agency must so state this information in: the Procurement File; the Solicitation Document, if any; and a Public Notice on ORPIN. Such documentation and Public Notice constitute sufficient notice as to subsequent purchases. If the Authorized Agency estimates the total purchase amount to exceed $150,000, this estimate must also be stated in the Public Notice.

(6) Nothing in this Rule exempts the Authorized Agency from obtaining the approval of the Attorney General for legal sufficiency pursuant to ORS 291.047.

(7) All Authorized Agencies must comply with ORS 200.035 and related Department policy, notwithstanding this Rule.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279B.215
Hist.: DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0700
Protests and Judicial Review of Approvals of Special Procurements

(1) Purpose. An Affected Person may protest the approval of a Special Procurement. Pursuant to ORS 279B.400(1), before seeking judicial review of the approval a Special Procurement, an Affected Person must file a Written protest with the Chief Procurement Officer and exhaust all administrative remedies.

(2) Delivery. Notwithstanding the requirements for filing a writ of review under ORS chapter 34 pursuant to ORS 279B.400(4)(a), an Affected Person must deliver a Written protest to the Chief Procurement Officer within seven Days after the first date of public notice of the approval of a Special Procurement by the Chief Procurement Officer, unless a different protest period is provided in the public notice of the approval of a Special Procurement:

(3) Content of Protest. The Written protest must include:

(a) A detailed statement of the legal and factual grounds for the protest;

(b) A description of the resulting harm to the Affected Person; and

(c) The relief requested.

(4) Chief Procurement Officer Response. The Chief Procurement Officer must not consider an Affected Person's protest of the approval of a Special Procurement submitted after the timeline established for submitting such protest under this Rule or such different time period as may be provided in the public notice of the approval of a Special Procurement. The Chief Procurement Officer must issue a Written disposition of the protest in a timely manner. If the Chief Procurement Officer upholds the protest, in whole or in part, the Chief Procurement Officer may with sole discretion implement the sustained protest in the approval of the Special Procurement, or revoke the approval of the Special Procurement.

(5) Judicial Review. An Affected Person may seek judicial review of the Chief Procurement Officer's decision relating to a protest of the approval of a Special Procurement in accordance with ORS 279B.400.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.400
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0710
Protests and Judicial Review of Sole-Source Procurements

(1) Purpose. For Sole-Source Procurements requiring public notice under OAR 125-247-0275, an Affected Person may protest the determination of the Chief Procurement Officer, or delegatee, that the Supplies and Services or class of Supplies and Services are available from only one source. Pursuant to ORS 279B.420(3)(f), before seeking judicial review, an Affected Person must file a Written protest with the Chief Procurement Officer or delegatee and exhaust all administrative remedies.

(2) Delivery. Unless otherwise specified in the public notice of the Sole-Source Procurement, an Affected Person must deliver Written protest to the Chief Procurement Officer or delegatee within seven (7) Days after the first date of public notice of the Sole-Source Procurement, unless a different protest period is provided in the public notice of a Sole-Source Procurement.

(3) Content of Protest. The Written protest must include:

(a) A detailed statement of the legal and factual grounds for the protest;

(b) A description of the resulting harm to the Affected Person; and

(c) The relief requested.

(4) Chief Procurement Officer Response. The Chief Procurement Officer or delegatee must not consider an Affected Person's Sole-Source Procurement protest submitted after the timeline established for submitting such protest under this Rule, or such different time period as may be provided in the public notice of the Sole-Source Procurement. The Chief Procurement Officer or delegatee must issue a Written disposition of the protest in a timely manner. If the Chief Procurement Officer or delegatee upholds the protest, in whole or in part, the Authorized Agency must not enter into a sole-source Contract.

(5) Judicial Review. Judicial review of the Chief Procurement Officer's or delegatee's disposition of a Sole-Source Procurement protest must be in accordance with ORS 279B.420.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.405
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0730
Protests and Judicial Review of Solicitations

(1) Purpose. A prospective Offeror may protest the Procurement Process or the Solicitation Document for a Contract solicited under ORS 279B.055, 279B.060 and 279B.085 as set forth in ORS 279B.405(2)(a). Pursuant to ORS 279B.405(3), before seeking judicial review, a prospective Offeror must file a Written protest with the Authorized Agency and exhaust all administrative remedies.

(2) Delivery. Unless otherwise specified in the Solicitation Document, a prospective Offeror must deliver a Written protest to the Authorized Agency not less than seven (7) Days prior to Closing.

(3) Content of Protest. In addition to the information required by ORS 279B.405(4), a prospective Offeror's Written protest must include a statement of the desired changes to the Procurement Process or the Solicitation Document that the prospective Offeror believes will remedy the conditions upon which the prospective Offeror based its protest.

(4) Authorized Agency Response. The Authorized Agency may not consider a Prospective Offeror's Solicitation protest submitted after the timeline established for submitting such protest under this Rule, or such different time period as may be provided in the Solicitation Document. The Authorized Agency must consider the protest if it is timely filed and meets the conditions set forth in ORS 279B.405(4). The Authorized Agency must issue a Written disposition of the protest no less than three (3) business days before Bids, Proposals or Offers are due, unless a Written determination is made by the Authorized Agency that circumstances exist that require a shorter time limit, in accordance with the timeline set forth in ORS 279B.405(6). If the Authorized Agency upholds the protest, in whole or in part, the Authorized Agency may in its sole discretion either issue an Addendum reflecting its disposition under OAR 125-247-0430 or cancel the Procurement or Solicitation under OAR 125-247-0660.

(5) Extension of Closing. If the Authorized Agency receives a protest from a prospective Offeror in accordance with this Rule, the Authorized Agency may extend Closing if the Authorized Agency determines an extension is necessary to consider and respond to the protest.

(6) Clarification. Prior to the deadline for submitting a protest, a prospective Offeror may request that the Authorized Agency clarify any provision of the Solicitation Document. The Authorized Agency's clarification to an Offeror, whether orally or in Writing, does not change the Solicitation Document and is not binding on the Authorized Agency unless the Authorized Agency amends the Solicitation Document by Addendum.

(7) Judicial Review. Judicial review of the Authorized Agency's decision relating to a Solicitation protest must be in accordance with ORS 279B.405.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.115 & 279B.405
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0731
Protests and Judicial Review of Qualified Products List Decisions

(1) Purpose. A prospective Offeror may protest the Authorized Agency's decision to exclude the prospective Offeror's Goods from the Authorized Agency's qualified products list under ORS 279B.115. A prospective Offeror must file a Written protest and exhaust all administrative remedies before seeking judicial review of the Authorized Agency's qualified products list decision.

(2) Delivery. Unless otherwise stated in the Authorized Agency's notice to prospective Offerors of the opportunity to submit Goods for inclusion on the qualified products list, a prospective Offeror must deliver a Written protest to the Authorized Agency within seven (7) Days after issuance of the Authorized Agency's decision to exclude the prospective Offeror's Goods from the qualified products list.

(3) Content of Protest. The prospective Offeror's protest must be in Writing and must specify the grounds upon which the protest is based.

(4) The Authorized Agency Response. The Authorized Agency may not consider a prospective Offeror's qualified products list protest submitted after the timeline established for submitting such protest under this Rule, or such different time period as may be provided in the Authorized Agency's notice to prospective Offerors of the opportunity to submit Goods for inclusion on the qualified products list. The Authorized Agency must issue a Written disposition of the protest in a timely manner. If the Authorized Agency upholds the protest, it must include the successful protestor's Goods on the qualified products list.

(5) Judicial Review. Judicial review of the Authorized Agency's decision relating to a qualified products list protest must be in accordance with ORS 279B.425.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279B.115
Hist.: DAS 5-2006, f. & cert. ef. 5-31-06

125-247-0740
Protests and Judicial Review of Contract Award

(1) Purpose. An Offeror may protest the Award of a Contract, or the Intent to Award a Contract, whichever occurs first, if the conditions set forth in ORS 279B.410(1) are satisfied. An Offeror must file a Written protest with the Authorized Agency and exhaust all administrative remedies before seeking judicial review of the Authorized Agency's Contract Award decision.

(2) Delivery. Unless otherwise specified in the Solicitation Document, an Offeror must deliver a Written protest to the Authorized Agency within seven (7) Days after the Award of the Contract or the issuance of the notice of intent to award the Contract, whichever occurs first.

(3) Content of Protest. An Offeror's Written protest must specify the grounds for the protest to be considered by the Authorized Agency pursuant to ORS 279B.410(2).

(4) Authorized Agency Response. The Authorized Agency must not consider an Offeror's Contract Award protest submitted after the timeline established for submitting such protest under this Rule, or such different time period as may be provided in the Solicitation Document. The Authorized Agency must issue a Written disposition of the protest in a timely manner as set forth in ORS 279B.410(4). If the Authorized Agency upholds the protest, in whole or in part, the Authorized Agency may in its sole discretion either award the Contract to the successful protestor or cancel the Procurement or Solicitation.

(5) Judicial Review. Judicial review of the Authorized Agency's decision relating to a Contract Award protest must be in accordance with ORS 279B.415.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.410 & 270B.415
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0100
Application; Effective Date

(1) In addition to the general requirements set forth in Division 246 of these Rules, the Rules in this Division 248 apply to:

(a) The screening and selection of Architects, Engineers, Land Surveyors, and Providers of Related Services under Contracts, and set forth the procedures through which Authorized Agencies select Consultants to perform Architectural, Engineering and Land Surveying Services or Related Services; and

(b) Two-tiered procedures for selection of Architects, Engineers, Land Surveyors and Providers of Related Services for certain Public Improvements owned and maintained by a Local Government.

(2) In the event of conflict or ambiguity, the more specific requirements of the Rules in this Division 248 take precedence over the more general requirements of the Rules in Division 246.

(3) The Rules as a whole implement the Oregon Public Contracting Code, as defined in ORS 279A.010, and this Division 248 of the Rules specifically addresses matters covered in ORS Chapter 279C.110 through 279C.125.

(4) Delegation of authority for these contracts must be pursuant to OAR 125-246-0170.

(5) The dollar Threshold amounts that are applicable to the Direct Appointment Procedure, OAR 125-248-0200, the Informal Selection Procedure, OAR 125-248-0210, and the Formal Selection Procedure, OAR 125-248-220, are independent from and have no effect on the dollar Threshold amounts that trigger the legal sufficiency review requirement for Agencies under ORS 291.047.

(6) Effective Date. These Division 248 Rules apply only to the above-described Contracts first advertised on or after March 1, 2005, and to unadvertised Public Contracts entered into on or after March 1, 2005.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0110
Definitions

The definitions for this Division 248 are found in OAR 125-246-0110, except the following definitions apply only to this Division 248:

(1) "Consultant" for the purposes of these Division 248 Rules means an Architect, Engineer, Land Surveyor or Provider of Related Services. A Consultant includes a business entity that employs Architects, Engineers, Land Surveyors or providers of Related Services, or any combination of the foregoing.

(2) "Estimated Fee" means an Authorized Agency's reasonably projected fee to be paid for a Consultant's services under the anticipated Contract, excluding all anticipated reimbursable or other non-professional fee expenses. The Estimated Fee is used solely to determine the applicable Contract Solicitation method and is distinct from the total amount payable under the Contract. The Estimated Fee must not be used as a basis to resolve other Public Contracting issues, including without limitation, direct purchasing authority or Public Contract review and approval under ORS 291.047.

(3) "Project" means all components of an Authorized Agency's planned undertaking that gives rise to the need for a Consultant's Architectural, Engineering and Land Surveying Services, and Related Services under a Contract.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0120
List of Interested Consultants; Performance Record

(1) Consultants who are engaged in the lawful practice of their profession and who are interested in providing Architectural, Engineering and Land Surveying Services or Related Services may annually submit a statement describing their qualifications and related performance information to Authorized Agencies' office addresses. Authorized Agencies may use this information to create a list of prospective Consultants and which will be updated at least once every two years.

(2) Authorized Agencies may compile and maintain a record of each Consultant's performance under contracts with the particular Authorized Agency, including information obtained from Consultants during an exit interview. Upon request and in accordance with the Oregon Public Records Law (ORS 192.410 through 192.505) Authorized Agencies may make available copies of the records.

(3) Authorized Agencies must keep a record of all Contracts and must make these records available to the public consistent with the requirements of the Oregon Public Records Law (ORS 192.410 through 192.505). Authorized Agencies must include the following information in the record:

(a) Locations throughout the State where the Contracts are performed;

(b) Consultants' principal office address and all office addresses in the State of Oregon;

(c) Consultants' direct expenses on each Contract whether or not those direct expenses are reimbursed. "Direct expenses" include all amounts that are directly attributable to Consultants' services performed under each Contract, including personnel travel expenses, and that would not have been incurred but for the services being performed. The record must include all personnel travel expenses as a separate and identifiable expense on the Contract; and

(d) The total number of Contracts awarded to each Consultant over the immediately preceding 10-year period from the date of the record.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.110
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0130
Applicable Selection Procedures; Pricing Information

(1) When selecting the most qualified Consultants to perform Architectural, Engineering or Land Surveying Services, Authorized Agencies that are contracting with Consultants under the conditions listed in ORS 279C.110(2) must follow the applicable selection procedure under either OAR 125-248-0200 (Direct Appointment Procedure), 125-248-0210 (Informal Selection Procedure) or 125-248-0220 (Formal Selection Procedure). Authorized Agencies subject to this Section (1) must not solicit or use pricing policies and proposals or other pricing information to determine a Consultant's compensation until after the Authorized Agency has selected the most qualified Consultant in accordance with the applicable selection procedure.

(2) Authorized Agencies selecting Consultants to perform Related Services must follow one of the following selection procedures:

(a) When selecting a Consultant on the basis of qualifications alone, Authorized Agencies must follow the applicable selection procedure under OAR 125-248-0200 (Direct Appointment Procedure) if the requirements of OAR 125-248-0200(1) apply, 125-248-0210 (Informal Selection Procedure) or 125-248-0220 (Formal Selection Procedure); and

(b) When selecting a Consultant on the basis of price competition alone, Authorized Agencies must follow either the provisions under OAR chapter 125, division 247 for obtaining and evaluating Bids, or OAR 125-248-0200 (Direct Appointment Procedure) if the requirements of OAR 125-248-0200(1) apply; and

(c) When selecting a Consultant on the basis of price and qualifications, Authorized Agencies must follow either the provisions under OAR chapter 125, division 247 for obtaining and evaluating Proposals, or OAR 125-248-0200 (Direct Appointment Procedure) if the requirements of OAR 125-248-0200(1) apply. Authorized Agencies subject to this Section (2) may request and consider a Proposer's pricing policies, proposals and other pricing information submitted with a Proposal as part of the evaluation.

(3) Authorized Agencies may use electronic methods to screen and select a Consultant in accordance with the procedures described in sections (1) and (2) of this rule. If an Authorized Agency uses electronic methods to screen and select a Consultant, the Authorized Agency must conduct the screening and selection procedure by electronic means, substantially in conformance with OAR 125-247-0330 (Electronic Procurement).

(4) In applying these Rules, Authorized Agencies must support the State's goal of promoting a sustainable economy in the rural areas of the State.

(5) All Agencies must provide timely notice to the Advocate for Minority, Women and Emergency Small Business, pursuant to ORS 200.035.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.110
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0200
Direct Appointment Procedure

(1) Authorized Agencies may enter into a Contract directly with a Consultant without following the selection procedures set forth elsewhere in these Rules if:

(a) Emergency. The Authorized Agency finds that an Emergency exists; or

(b) Small Estimated Fee. The Estimated Fee to be paid under the Contract does not exceed $25,000; or

(c) Continuation of Project With Intermediate Estimated Fee. Where a Project is being continued, as more particularly described below, and where the Estimated Fee will not exceed $150,000, the Architectural, Engineering and Land Surveying Services or Related Services to be performed under the Contract must meet the following requirements:

(A) The services consist of or are related to Architectural, Engineering and Land Surveying Services or Related Services that have been substantially described, planned or otherwise previously studied in an earlier Contract with the same Consultant and are rendered for the same Project as the Architectural, Engineering and Land Surveying Services or Related Services rendered under the earlier Contract;

(B) The Estimated Fee to be made under the Contract does not exceed $150,000; and

(C) The Authorized Agency used either the formal selection procedure under OAR 137-048-0220 (Formal Selection Procedure) or the formal selection procedure applicable to selection of the Consultant at the time of selection, to select the Consultant for the earlier Contract; or

(d) Continuation of Project With Extensive Estimated Fee. Where a Project is being continued, as more particularly described below, and where the Estimated Fee is expected to exceed $150,000, the Architectural, Engineering and Land Surveying Services or Related Services to be performed under the Contract must meet the following requirements:

(A) The services consist of or are related to Architectural, Engineering and Land Surveying Services or Related Services that have been substantially described, planned or otherwise previously studied in an earlier Contract with the same Consultant and are rendered for the same Project as the Architectural, Engineering and Land Surveying Services or Related Services rendered under the earlier Contract;

(B) The Authorized Agency used either the formal selection procedure under OAR 137-048-0220 (Formal Selection Procedure) or the formal selection procedure applicable to selection of the Consultant at the time of selection, to select the Consultant for the earlier Contract; and

(C) The Authorized Agency makes written findings that entering into a Contract with the Consultant, whether in the form of an amendment to an existing Contract or a separate Contract for the additional Scope of services, will:

(i) Promote efficient use of public funds and resources and result in substantial cost savings to Authorized Agency;

(ii) Protect the integrity of the public contracting process and the competitive nature of the procurement by not encouraging favoritism or substantially diminishing competition in the award of the Contract.

(2) The Authorized Agencies may select Consultants for Contracts under this Rule from the following sources:

(a) The Authorized Agency's list of Consultants that is created under OAR 125-248-0120 (List of Interested Consultants; Performance Record);

(b) Another Authorized Agency's list of Consultants that the Authorized Agency has created under OAR 125-248-0120 (List of Interested Consultants; Performance Record), with Written consent of that Authorized Agency; or

(c) All Consultants offering the required Architectural, Engineering and Land Surveying Services or Related Services that Authorized Agencies reasonably can identify under the circumstances.

(3) The Authorized Agency must direct Negotiations with Consultants selected under this Rule toward obtaining Written agreement on:

(a) Consultant's performance obligations and performance schedule;

(b) Payment methodology and a maximum amount payable to Contractor for the Architectural, Engineering and Land Surveying Services or Related Services required under the Contract that is fair and reasonable to the Authorized Agency as determined solely by the Authorized Agency, taking into account the value, Scope, complexity and nature of the Architectural, Engineering and Land Surveying Services or Related Services; and

(c) Any other provisions the Authorized Agency believes to be in the Authorized Agency's best interest to negotiate.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C110 & 279C.115
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0210
Informal Selection Procedure

(1) Authorized Agencies may use the informal selection procedure described in this Rule to obtain a Contract if the Estimated Fee is expected to not exceed $150,000.

(2) Authorized Agencies using the informal selection procedure must:

(a) Create a Request for Proposals that includes at a minimum the following:

(A) A description of the Project for which Consultant's Architectural, Engineering and Land Surveying Services or Related Services are needed and a description of the Architectural, Engineering and Land Surveying Services or Related Services that will be required under the resulting Contract;

(B) Anticipated Contract performance schedule;

(C) Conditions or limitations, if any, that may constrain or prohibit the selected Consultant's ability to provide additional services related to the Project, including construction services;

(D) Date and time Proposals are due and other directions for submitting Proposals;

(E) Criteria upon which most qualified Consultant will be selected. Selection Criteria may include:

(i) Amount and type of resources and number of experienced staff Consultant has available to perform the Architectural, Engineering and Land Surveying Services or Related Services described in the Request for Proposals within the applicable time limits, including the current and projected Workloads of such staff and the proportion of time such staff would have available for the Architectural, Engineering and Land Surveying Services or Related Services;

(ii) Proposed management techniques for the Architectural, Engineering and Land Surveying Services or Related Services described in the Request for Proposals;

(iii) Consultant's capability, experience and past performance history and record in providing similar Architectural, Engineering and Land

Surveying Services or Related Services, including but not limited to quality of Work, ability to meet schedules, cost control methods and Contract Administration practices;

(iv) Approach to Architectural, Engineering and Land Surveying Services or Related Services described in the Request for Proposals and design philosophy, if applicable;

(v) Proposer's geographic proximity to and familiarity with the physical location of the Project;

(vi) Volume of Work, if any, previously awarded to Proposer, with the objective of effecting equitable distribution of Contracts among qualified Consultants, provided such distribution does not violate the principle of selecting the most qualified Consultant for the type of professional services required;

(vii) Ownership status and employment practices regarding women, minorities and emerging small businesses or historically underutilized businesses;

(F) A Statement that Proposers responding to the RFP do so solely at their expense, and the Authorized Agency is not responsible for any Proposer expenses associated with the RFP;

(G) A statement directing Proposers to the protest procedures set forth in these Rules; and

(H) For Related Services only, pricing policies, proposals and other pricing information.

(b) Provide a Request for Proposals to a minimum of five (5) prospective Consultants drawn from:

(A) The Authorized Agency's list of Consultants that is created and maintained under OAR 125-248-0120 (List of Interested Consultants; Performance Record);

(B) Another Authorized Agency's list of Consultants that is created and maintained under OAR 125-248-0120 (List of Interested Consultants; Performance Record); or

(C) All Consultants the Authorized Agency can reasonably locate that offer the desired Architectural, Engineering and Land Surveying Services or Related Services, separately or in any combination thereof.

(c) Review and rank all Proposals received according to the criteria set forth in the Request for Proposals, and select the three highest ranked Proposers.

(3) If the Authorized Agency does not cancel the RFP after it reviews and ranks each Proposer, the Authorized Agency will begin negotiating a Contract with the highest ranked Proposer. The Authorized Agency must direct Negotiations toward obtaining Written agreement on:

(a) Consultant's performance obligations and performance schedule;

(b) Payment methodology and a maximum amount payable to Contractor for the Architectural, Engineering and Land Surveying Services or Related Services required under the Contract that is fair and reasonable to the Authorized Agency as determined solely by the Authorized Agency, taking into account the value, S]cope, complexity and nature of the Architectural, Engineering and Land Surveying Services or Related Services; and

(c) Any other provisions the Authorized Agency believes to be in the Authorized Agency's best interest to negotiate.

(4) The Authorized Agency must, either orally or in Writing, formally terminate Negotiations with the highest ranked Proposer if the Authorized Agency and Proposer are unable for any reason to reach agreement on a Contract within a reasonable amount of time. The Authorized Agency may thereafter negotiate with the second ranked Proposer, and if necessary, with the third ranked Proposer, in accordance with Section (3) of this Rule, until Negotiations result in a Contract. If Negotiations with any of the top three Proposers do not result in a Contract within a reasonable amount of time, the Authorized Agency may end the particular informal Solicitation and thereafter may proceed with a new informal Solicitation under this Rule or proceed with a formal Solicitation under OAR 125-248-0220 (Formal Selection Procedure).

(5) The Authorized Agency must terminate the informal selection procedure and proceed with the formal selection procedure under OAR 125-248-0220 if the Scope of the anticipated Contract is revised during Negotiations so that the Estimated Fee will exceed $150,000. Notwithstanding the foregoing, the Authorized Agency may continue Contract Negotiations with the Proposer selected under the informal selection procedure if the Authorized Agency makes Written findings that contracting with that Proposer will:

(a) Promote efficient use of the public funds, and resources and result in substantial cost savings to the Authorized Agency; and

(b) Protect the integrity of the Public Contracting process and the competitive nature of the procurement by not encouraging favoritism or substantially diminishing competition in the award of the Contract.

(6) The Authorized Agency must comply with applicable preferences for recycled materials, pursuant to ORS 279A.125 and OAR 125-246-0320 through 125-246-0324.

(7) Minority, Women and Emerging Small Business. In accordance with ORS 200.035, an Authorized Agency must provide timely notice of all Procurements to the Advocate for Minority, Women and Emerging Small Business if the estimated Contract Price exceeds $5,000.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.110
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0220
Formal Selection Procedure

(1) General. Subject to OAR 125-248-0130 (Applicable Selection Procedures; Pricing Information), Authorized Agencies must use the formal selection procedure described in this Rule to select Consultants if the Consultants cannot be selected under either OAR 125-248-0200 (Direct Appointment Procedure) or under 125-248-0210 (Informal Selection Procedure). The Formal Selection Procedure may otherwise be used at Authorized Agencies' discretion.

(2) Advertisement. Authorized Agencies using the formal selection procedure must obtain Contracts through public advertisement of Requests for Proposals or Requests for Qualifications followed by Requests for Proposals.

(a) The Authorized Agency must advertise each RFP and RFQ at least once in at least one newspaper of general circulation in the area where the Project is located and in as many other issues and publications as may be necessary or desirable to achieve adequate competition. Other issues and publications may include, but are not limited to: local newspapers, trade journals, and publications targeted to reach the minority, women and emerging small business enterprise audiences. In addition, an Authorized Agency must use ORPIN pursuant to OAR 125-246-0500, provided the Authorized Agency follows a procedure for electronic advertisement approved by the State Procurement Office or its delegatee.

(A) The Authorized Agency must publish the advertisement within a reasonable time before the deadline for the Proposal submission or response to the RFQ but in any event no fewer than fourteen (14) calendar Days before the closing date set forth in the RFP or RFQ.

(B) The Authorized Agency must include a brief description of the following items in the advertisement:

(i) The Project;

(ii) A description of the Architectural, Engineering and Land Surveying Services or Related Services the Authorized Agency seeks;

(iii) How and where Consultants may obtain a copy of the RFP or RFQ; and

(iv) The deadline for submitting a Proposal or response to the RFQ.

(b) The Authorized Agency may also send notice of the RFP or RFQ directly to all Consultants on the Authorized Agency's list of Consultants that is created and maintained under OAR 125-248-0120 (List of Interested Consultants; Performance Record).

(3) Request for Qualifications Procedure. Authorized Agencies may use the RFQ procedure to evaluate potential Consultants and establish a short list of qualified Consultants to whom the Authorized Agency may issue an RFP for some or all of the Architectural, Engineering and Land Surveying Services or Related Services described in the RFQ.

(a) The Authorized Agency must include the following, at a minimum, in each RFQ:

(A) A brief description of the Project for which the Authorized Agency is seeking Consultants;

(B) A description of the Architectural, Engineering and Land Surveying Services or Related Services the Authorized Agency seeks for the Project;

(C) Conditions or limitations, if any, that may constrain or prohibit the selected Consultant's ability to provide additional services related to the Project, including construction services;

(D) The deadline for submitting a response to the RFQ;

(E) A description of required Consultant qualifications for the Architectural, Engineering and Land Surveying Services or Related Services the Authorized Agency seeks;

(F) The RFQ evaluation criteria, including weights, points, or other classifications applicable to each criterion;

(G) A statement whether or not the Authorized Agency will hold a pre-qualification meeting for all interested Consultants to discuss the Project and the Architectural, Engineering and Land Surveying Services or Related Services described in the RFQ and if a pre-qualification meeting will be held, the location of the meeting and whether or not attendance is mandatory; and

(H) A Statement that Proposers responding to the RFQ do so solely at their expense, and the Authorized Agency is not responsible for any Proposer expenses associated with the RFQ.

(b) The Authorized Agency may include a request for any or all of the following in each RFQ:

(A) A statement describing Consultant's general qualifications and related performance information;

(B) A description of Consultant's specific qualifications to perform the Architectural, Engineering and Land Surveying Services or Related Services described in the RFQ including Consultant's available resources and recent, current and projected workloads;

(C) A list of similar Architectural, Engineering and Land Surveying Services or Related Services and references concerning past performance, and a copy of all records, if any, of Consultant's performance under Contracts with any other Authorized Agency;

(D) The number of Consultant's experienced staff available to perform the Architectural, Engineering and Land Surveying Services, and Related Services described in the RFQ, including such personnel's specific qualifications and experience and an estimate of the proportion of their time that such personnel would spend on those services;

(E) Approach to Architectural, Engineering and Land Surveying Services or Related Services described in the RFQ and design philosophy, if applicable;

(F) Proposer's geographic proximity to and familiarity with the physical location of the Project;

(G) Ownership status and employment practices regarding women, minorities and emerging small businesses or historically underutilized businesses;

(H) Any other information the Authorized Agency deems reasonable and necessary to evaluate Consultants' qualifications; and

(I) For Related Services only, pricing policies, proposals and other pricing information.

(c) RFQ Evaluation Committee. The Authorized Agency must establish an RFQ evaluation committee of at least two individuals to review, score, and rank the responding Consultants according to the Solicitation criteria. The Authorized Agency may appoint to the evaluation committee, Authorized Agency employees, or employees of other public Authorized Agencies, with experience in architecture, engineering and land surveying, Related Services, construction or Public Contracting. If an Authorized Agency procedure permits, the Authorized Agency may include on the evaluation committee private practitioners of architecture, engineering and land surveying or related professions. The Authorized Agency must designate one member of the evaluation committee as the evaluation committee chairperson.

(d) The Authorized Agency may use any reasonable screening or evaluation method to establish a short list of qualified Consultants, including but not limited to the following:

(A) Requiring Consultants responding to an RFQ to achieve a Threshold score before qualifying for placement on the short list;

(B) Placing a pre-determined number of the highest scoring Consultants on a short list;

(C) Placing on a short list only those Consultants with certain essential qualifications; or experience, whose practice is limited to a particular subject area, or who practice in a particular geographic locale or region, provided that such factors are material, would not unduly restrict competition, and were announced as dispositive in the RFP.

(e) After the evaluation committee reviews, scores and ranks the responding Consultants, the Authorized Agency must establish a short list of at least three qualified Consultants, provided however, that if four or fewer Consultants responded to the RFQ, then:

(A) The Authorized Agency may establish a short list of fewer than three qualified Consultants; or

(B) The Authorized Agency may cancel the RFQ and issue an RFP.

(f) No Consultant will be eligible for placement on the Authorized Agency's short list established under Section (3) of this Rule if the Consultant or any of Consultant's principals, partners or associates is a member of the Authorized Agency's RFQ evaluation committee.

(g) Except when the RFQ is cancelled, the Authorized Agency must provide a copy of the subsequent RFP to each Consultant on the short list.

(4) Formal Selection of Consultants Through Request for Proposals. Authorized Agencies must use the procedure described in Section (4) of this Rule when issuing an RFP for a Contract described in Section (1) of this Rule.

(a) RFP Required Contents. Authorized Agencies using the formal selection procedure must include at least the following in each Request for Proposals, whether or not the RFP is preceded by an RFQ:

(A) General background information, including a description of the Project and the specific Architectural, Engineering and Land Surveying Services or Related Services sought for the Project, the estimated Project cost, the estimated time period during which the Project is to be completed, and the estimated time period in which the specific Architectural, Engineering and Land Surveying Services or Related Services sought will be performed.

(B) The RFP evaluation process and the criteria which will be used to select the most qualified Proposer, including the weights, points or other classifications applicable to each criterion. If the Authorized Agency does not indicate the applicable number of points, weights or other classifications then each criterion is of equal value. Evaluation criteria may include, but are not limited to, the following:

(i) Proposer's availability and capability to perform the Architectural, Engineering and Land Surveying Services or Related Services described in the RFP;

(ii) Experience of Proposer's key staff persons in providing similar Architectural, Engineering and Land Surveying Services or Related Services on comparable Projects;

(iii) The amount and type of resources, and number of experienced staff persons Proposer has available to perform the Architectural, Engineering and Land Surveying Service or Related Services described in the RFP;

(iv) The recent, current and projected workloads of the staff and resources referenced in this Section;

(v) The proportion of time Proposer estimates that the staff referenced in this Section, would spend on the Architectural, Engineering and Land Surveying Services or Related Services described in the RFP;

(vi) Proposer's demonstrated ability to successfully complete similar Architectural, Engineering and Land Surveying Services or Related Services on time and within budget, including whether or not there is a record of satisfactory performance under OAR 125-248-0120 (List of Interested Consultants; Performance Record);

(vii) References and recommendations from past clients;

(viii) Proposer's performance history in meeting deadlines, submitting accurate estimates, producing high quality Work, and meeting financial obligations;

(ix) Status and quality of any required license or certification;

(x) Proposer's knowledge and understanding of the Project and Architectural, Engineering and Land Surveying Services or Related Services described in the RFP as shown in Proposer's approach to staffing and scheduling needs for the Architectural, Engineering and Land Surveying Services or Related Services and proposed solutions to any perceived design and constructability issues;

(xi) Results from interviews, if conducted;

(xii) Design philosophy, if applicable, and approach to the Architectural, Engineering and Land Surveying Services or Related Services described in the RFP;

(xiii) Any other criteria that the Authorized Agency seems relevant to the Project and Architectural, Engineering and Land Surveying Services, and Related Services described in the RFP, including, where the nature and budget of the Project so warrant, a design competition between competing Proposers;

(C) Conditions or limitations, if any, that may constrain or prohibit the selected Consultant's ability to provide additional services related to the Project, including construction services;

(D) Whether interviews are possible and if so, the weight, points, or other classifications applicable to the potential interview;

(E) The date and time Proposals are due, and the delivery location for Proposals;

(F) Reservation of the right to seek clarifications of each Proposal;

(G) Reservation of the right to negotiate a final Contract that is in the best interest of the Authorized Agency;

(H) Reservation of the right to reject any or all Proposals and reservation of the right to cancel the RFP at anytime if doing either would be in the public interest as determined by the Authorized Agency;

(I) A Statement that Proposers responding to the RFP do so solely at their expense, and the Authorized Agency is not responsible for any Proposer expenses associated with the RFP;

(J) A statement directing Proposers to the protest procedures set forth in these Rules;

(K) Special Contract requirements, including but not limited to disadvantaged business enterprise ("DBE"), minority business enterprise ("MBE"), women business enterprise ("WBE") and emerging small business enterprise ("ESB") participation goals or good faith efforts with respect to DBE, MBE, WBE and ESB participation, and federal requirements when federal funds are involved;

(L) A statement whether or not the Authorized Agency will hold a pre-Proposal meeting for all interested Consultants to discuss the Project and the Architectural, Engineering and Land Surveying Services or Related

Services described in the RFP and if a pre-Proposal meeting will be held, the location of the meeting and whether or not attendance is mandatory;

(M) A request for any information the Authorized Agency deems reasonably necessary to permit the Authorized Agency to evaluate, rank and select the most qualified Proposer to perform the Architectural, Engineering and Land Surveying Services or Related Services described in the RFP;

(N) A sample form of the Contract; and

(O) For Related Services only, pricing policies, proposals and other pricing information.

(b) RFP Evaluation Committee. The Authorized Agency must establish a committee of at least three individuals to review score and rank Proposals according to the evaluation criteria set forth in the RFP. If the RFP has followed an RFQ, the Authorized Agency may include the same members who served on the RFQ evaluation committee. The Authorized Agency may appoint to the evaluation committee, Authorized Agency employees, or employees of other public Authorized Agencies, with experience in architecture, engineering and land surveying, related services, construction or Public Contracting. At least one member of the evaluation committee must be an Authorized Agency employee. If the Authorized Agency procedure permits, the Authorized Agency may include on the evaluation committee private practitioners of architecture, engineering and land surveying or related professions. The Authorized Agency must designate one of its employees who also is a member of the evaluation committee as the evaluation committee chairperson.

(A) No Proposer will be eligible for award of the Contract under the RFP if the Proposer or any of Proposer's principals, partners or associates is a member of the Authorized Agency's RFP evaluation committee for the Contract.

(B) If the RFP provides for the possibility of Proposer interviews, the evaluation committee may elect to interview Proposers if the evaluation committee considers it necessary or desirable. If the evaluation committee conducts interviews, it must award weights, points or other classifications indicated in the RFP for the anticipated interview.

(C) The evaluation committee must provide to the Authorized Agency the results of the scoring and ranking for each Proposer.

(c) Initial Negotiations. If the Authorized Agency does not cancel the RFP after it receives the results of the scoring and ranking for each Proposer, the Authorized Agency will begin negotiating a Contract with the highest ranked Proposer. The Authorized Agency must direct Negotiations toward obtaining Written agreement on:

(A) Consultant's performance obligations and performance schedule;

(B) Payment methodology and a maximum amount payable to Contractor for the Architectural, Engineering and Land Surveying Services or Related Services required under the Contract that is fair and reasonable to the Authorized Agency as determined solely by the Authorized Agency, taking into account the value, Scope, complexity and nature of the Architectural, Engineering and Land Surveying Services or Related Services; and

(C) Any other provisions the Authorized Agency believes to be in the Authorized Agency's best interest to negotiate.

(d) Subsequent Negotiations. The Authorized Agency must, either orally or in Writing, formally terminate Negotiations with the highest ranked Proposer if the Authorized Agency and Proposer are unable for any reason to reach agreement on a Contract within a reasonable amount of time. The Authorized Agency may thereafter negotiate with the second ranked Proposer, and if necessary, with the third ranked Proposer, and so on, in accordance with Section 4(c) of this Rule, until Negotiations result in a Contract. If Negotiations with any Proposer do not result in a Contract within a reasonable amount of time, the Authorized Agency may end the particular formal Solicitation. Nothing in this Rule precludes the Authorized Agency from proceeding with a new formal Solicitation for the same Architectural, Engineering and Land Surveying Services or Related Services described in the RFP that failed to result in a Contract.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.110
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0230
Ties Among Proposers

(1) If an Authorized Agency is selecting a Consultant on the basis of qualifications alone and determines after the ranking of Proposers that two or more Proposers are equally qualified, the Authorized Agency may select a candidate through any process that the Authorized Agency believes will result in the best value for the Authorized Agency, taking into account the Scope, complexity and nature of the Architectural, Engineering and Land Surveying Services or Related Services. The process must instill public confidence through ethical and fair dealing, honesty and good faith on the part of the Authorized Agency and Proposers and must protect the integrity of the Public Contracting process. Once a tie is broken, the Authorized Agency and the selected Proposer must proceed with Negotiations under OAR 125-248-0210(3) or 125-248-0220(4)(c), as applicable.

(2) If an Authorized Agency is selecting a Consultant on the basis of price alone, or on the basis of price and qualifications, and determines after the ranking of Proposers that two or more Proposers are equal in terms of price or are equal in terms or price and qualifications, then the Authorized Agency must follow the procedure set forth in OAR 125-246-0300 (Preferences for Oregon Supplies and Services) to select the Consultant.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.110
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0240
Protest Procedures

(1) RFP Protest and Request for Change. Consultants may submit a Written protest of anything contained in an RFP and may request a change to any provision, Specification or Contract term contained in an RFP, no later than seven (7) calendar Days prior to the date Proposals are due unless a different deadline is indicated in the RFP. Each protest and request for change must include the reasons for the protest or request, and any proposed changes to the RFP provisions, Specifications or Contract terms. The Authorized Agency will not consider any protest or request for change that is submitted after the submission deadline.

(2) Protest of Consultant Selection.

(a) In the event of an Award to a single Proposer, the Authorized Agency must provide to all Proposers a copy of the selection notice that the Authorized Agency sent to the highest ranked Proposer. A Proposer who claims to have been adversely affected or aggrieved by the selection of the highest ranked Proposer may submit a Written protest of the selection to the Authorized Agency no later than seven (7) calendar Days after the date of the selection notice unless a different deadline is indicated in the RFP. A Proposer submitting a protest must claim that the protesting Proposer is the highest ranked Proposer because the Proposals of all higher ranked Proposers failed to meet the requirements of the RFP or because the higher ranked Proposers otherwise are not qualified to perform the Architectural, Engineering and Land Surveying Services or Related Services described in the RFP.

(b) Multiple Award. In the event of an award to more than one Proposer, the Authorized Agency must provide to all Proposers copies of the selection notices that the Authorized Agency sent to the highest ranked Proposers. A Proposer who claims to have been adversely affected or aggrieved by the selection of the highest ranked Proposers may submit a Written protest of the selection to the Authorized Agency no later than seven (7) calendar Days after the date of the selection notices, unless a different deadline is indicated in the RFP. A Proposer submitting a protest must claim that the protesting Proposer is one of the highest ranked Proposers because the Proposals of all higher ranked Proposers failed to meet the requirements of the RFP, or because a sufficient number of Proposals of higher ranked Proposers to include the protesting Proposer in the group of highest ranked Proposers failed to meet the requirements of the RFP. In the alternative, a Proposer submitting a protest must claim that the Proposals of all higher ranked Proposers, or a sufficient number of higher ranked Proposers to include the protesting Proposer in the group of highest ranked Proposers, otherwise are not qualified to perform the Architectural, Engineering and Land Surveying Services or Related Services described in the RFP.

(c) Effect of Protest Submission Deadline. The Authorized Agency may not consider any protest that is submitted after the submission deadline.

(3) Resolution of Protests. A duly authorized representative of the Authorized Agency must resolve all timely submitted protests within a reasonable time following the Authorized Agency's receipt of the protest and once resolved, must promptly issue a Written decision on the protest to the Proposer who submitted the protest. If the protest results in a change to the RFP, the Authorized Agency must revise the RFP accordingly and must re-advertise the RFP in accordance with these Rules.

(4) Judicial Review. Proposers may be able to obtain judicial review of the Authorized Agency's protest disposition pursuant to ORS 183.484.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065 & 279C.110
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0250
Solicitation Cancellation; Consultant Responsibility for Costs

An Authorized Agency may cancel a Direct Appointment or Solicitation, whether an informal or formal procedure, or reject all Proposals or responses to RFQs, or any combination of the foregoing, without liability to the Authorized Agency at anytime after issuing a solicitation

or RFQ, if the Authorized Agency believes it is in the public interest to do so. Consultants responding to either solicitations or RFQs are responsible for all costs they may incur in connection with submitting Proposals and responses to RFQs.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0260
Two-Tiered Selection Procedure for Local Contracting Agency Public Improvement Projects

(1) Definition. For purposes of this Rule, "Local Contracting Agency" is defined in ORS 279A.010(1)(n) and means a local government or special government body authorized by law to conduct a Procurement. "Local Contracting Agency" includes any Person authorized by a Local Contracting Agency to conduct a Procurement on behalf of the Local Contracting Agency.

(2) Generally. If a Local Contracting Agency requires an Architect, Engineer, or Land Surveyor to provide Architectural, Engineering and Land Surveying Services, and Related Services for a Public Improvement owned and maintained by that Local Contracting Agency, and an Authorized Agency will serve as the lead Authorized Agency and will enter into Contracts with Consultants for Architectural, Engineering and Land Surveying Services, and Related Services for that Public Improvement, the Authorized Agency must utilize the two-tiered selection process described below to obtain these Contracts with Architects, Engineers or Land Surveyors.

(3) Tier One. The Authorized Agency must, when feasible, identify no fewer than the three (3) most qualified Proposers responding to an RFP that was issued under the applicable selection procedures described in OAR 125-248-0210 (Informal Selection Procedure) and 125-248-0220 (Formal Selection Procedure), or from among Architects, Engineers or Land Surveyors identified under OAR 125-248-0200 (Direct Appointment Procedure), and must notify the Local Contracting Agency of the Architects, Engineers or Land Surveyors selected.

(4) Tier Two. In accordance with the qualifications based selection requirements of ORS 279C.110, the Local Contracting Agency must either:

(a) Select an Architect, Engineer or Land Surveyor from the State Authorized Agency's list of Proposers provided from the Authorized Agency to perform the Architectural, Engineering and Land Surveying Services, and Related Services for Local Contracting Agency's Public Improvement; or

(b) Select an Architect, Engineer or Land Surveyor to perform the Architectural, Engineering and Land Surveying Services, and Related Services for the Local Contracting Agency's Public Improvement through an alternative process adopted by the Local Contracting Agency, consistent with the provisions of the applicable RFP, if any, and these Division 248 Rules. The Local Contracting Agency's alternative process must be described in the applicable RFP, may be structured to take into account the unique circumstances of the particular Local Contracting Agency, and may include provisions to allow the Local Contracting Agency to perform its tier two responsibilities efficiently and economically, alone or in cooperation with other Local Contracting Agencies. The Local Contracting Agency's alternative process may include, but is not limited to, one or more of the following methods:

(A) A general written direction from the Local Contracting Agency to the Authorized Agency, prior to the advertisement of a Procurement or series of Procurements or during the course of the Procurement or series of Procurements, that the Local Contracting Agency's tier two selection must be the highest-ranked firm identified by the Authorized Agency during the tier one process, and that no further coordination or consultation with the Local Contracting Agency is required. However, the Local Contracting Agency may provide written notice to the Authorized Agency that the Local Contracting Agency's general written direction is not to be applied for a particular Procurement and describe the process that the Local Contracting Agency will utilize for the particular procurement. In order for a written direction from the Local Contracting Agency consistent with this Subsection to be effective for a particular Procurement, it must be received by the Authorized Agency with adequate time for the Authorized Agency to revise the RFP in order for Proposers to be notified of the tier two process to be utilized in the Procurement. In the event of a multiple award under the terms of the applicable Procurement, the written direction from the Local Contracting Agency may apply to the highest ranked firms that are selected under the terms of the procurement document.

(B) An intergovernmental agreement between the Local Contracting Agency and the Authorized Agency outlining the alternative process that the Local Contracting Agency has adopted for a Procurement or series of Procurements.

(C) Where multiple Local Contracting Agencies are involved in a two-tiered selection procedure, the Local Contracting Agencies may name one or more authorized representative(s) to act on behalf of all the Local Contracting Agencies, whether the Local Contracting Agencies are acting collectively or individually, to select the Architect, Engineer or Land Surveyor to perform the Architectural, Engineering and Land Surveying Services or Related Services under the tier two selection process. In the event of a multiple Award under the terms of the applicable Procurement, the authorized representative(s) of the Local Contracting Agencies may act on behalf of the Local Contracting Agencies to select the highest ranked firms that are required under the terms of the procurement document, as part of the tier two selection process.

(5) The Authorized Agency must thereafter begin contract Negotiations with the selected Architect, Engineer or Land Surveyor in accordance with the negotiation provisions in OAR 125-248-0200 (Direct Appointment Procedure), 125-248-0210 (Informal Selection Procedure) or 125-248-0220 (Formal Selection Procedure) as applicable.

(5) Nothing in these Division 248 Rules may be construed to deny or limit a Local Contracting Agency's ability to contract directly with Architects, Engineers or Land Surveyors pursuant to ORS 279C.125(4), through a selection process established by that Local Contracting Agency.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.110 & 279C.115
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0300
Contract Form; Prohibited Payment Methodology; Purchase Restrictions

(1) Contract Forms. The State Procurement Office or its delegatee must develop and maintain a standard Contract form and an Amendment form, which must be used by the Authorized Agencies in completing all Architectural, Engineering and Land Surveying and Related Services Contracts. These forms can be obtained from the State Procurement Office. Authorized Agencies must review the approved Contract form and Amendment form at least every two years. If upon review the Authorized Agency revises either form, the Authorized Agency must obtain State Procurement Office approval prior to using the revised Contract or Amendment form. In using the standard Contract form and standard Amendment form, Authorized Agencies must abide by the following Contract provisions:

(2) Except as otherwise allowed by law, the Authorized Agency must not enter into any Contract in which the compensation provisions expressly provide for payment of:

(a) Consultant's costs under the Contract plus a percentage of those costs; or

(b) A percentage of the Project construction costs or total Project costs.

(3) Except as otherwise allowed by law, an Authorized Agency must not enter into any Contract in which:

(a) The compensation paid under the Contract is solely based on or limited to the Consultant's hourly rates for the Consultant's personnel Working on the Project and reimbursable expenses incurred during the performance of Work on the Project (sometimes referred to as a "time and materials" Contract); and

(b) The Contract does not include a maximum amount payable to Contractor for the Architectural, Engineering and Land Surveying, and Related Services required under the Contract.

(4) Except in cases of Emergency or in the particular instances noted in the Subsections below, the Authorized Agency must not purchase any building materials, supplies or equipment for any building, structure or facility constructed by or for the Authorized Agency from any Consultant under a Contract with an Authorized Agency to perform Architectural, Engineering and Land Surveying, and Related Services, for the building, structure or facility. This prohibition does not apply if either of the following circumstances exists:

(a) Consultant is providing Architectural, Engineering and Land Surveying, or Related Services under a Contract with to perform Design-Build services as defined in OAR 125-249-0010(3) or Energy Savings Performance Contract services (see OAR 125-249-0670 and 125-249-0680); or

(b) That portion of the Contract relating to the acquisition of building materials, supplies or equipment was awarded to Consultant pursuant to applicable law governing the award of such Contracts.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0310
Expired or Terminated Contracts

(1) If an Authorized Agency enters into a Contract for Architectural, Engineering, and Land Surveying Services or Related Services and that Contract subsequently expires or is terminated, the Authorized Agency may proceed as follows, subject to the requirements of Subsection (2) of this Rule:

(a) Expired Contracts. If the Contract has expired as the result of Project delay caused by the Authorized Agency or caused by any other occurrence outside the reasonable control of the Authorized Agency or the Consultant, and if no more than one year has passed since the Contract expiration date, the Authorized Agency may amend the Contract to extend the Contract expiration date, revise the description of the Architectural, Engineering and Land Surveying Services or Related Services required under the Contract to reflect any material alteration of the Project made as a result of the delay, and revise the applicable performance schedule. Beginning on the effective date of the Amendment, the Authorized Agency and the Consultant must continue performance under the Contract as amended; or

(b) Terminated Contracts. If the Authorized Agency or both parties to the Contract have terminated the Contract for any reason and if no more than one year has passed since the Contract termination date, then the Authorized Agency may enter into a new Contract with the same Consultant to perform the remaining Architectural, Engineering and Land Surveying Services or Related Services not completed under the original Contract, or to perform any remaining Architectural, Engineering and Land Surveying Services or Related Services not completed under the Contract as adjusted to reflect a material alteration of the Project.

(2) The Authorized Agency may proceed under either Subsection (1)(a) or (1)(b) of this Rule only after making Written findings that amending the existing Contract or entering into a new Contract with Consultant will:

(a) Promote efficient use of public funds and resources and result in substantial cost savings;

(b) Protect the integrity of the Public Contracting process and the competitive nature of the procurement process by not encouraging favoritism or substantially diminishing competition in the award of Contracts; and

(c) Result in a Contract that is still within the Scope of the final form of the original procurement document.

Stat. Auth.: ORS 279A.050, 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065, 279A.070, 279C.110 & 279A.140
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0330
Special Contract Processes

(1) Consultants for Agreements-To-Agree must be selected, and the Authorized Agency must obtain Architectural, Engineering and Land Surveying and Related Services by selecting a Consultant or Consultants in the following manner:

(a) The Authorized Agency selects one or more Consultants under the applicable provisions of OAR 125-248-0200, 125-248-0210, or 125-248-0220.

(b) The Authorized Agency develops a document that includes the general provisions required under OAR 125-248-300 and a specific Statement of Work for each anticipated Contract under the Agreement-To-Agree document.

(c) When the Authorized Agency selects more than one Consultant under the Agreement-To-Agree Solicitation process, the Authorized Agency must identify a standard in the Solicitation Document and the Agreement-to-Agree to be used in assigning particular Architectural, Engineering and Land Surveying and or Related Services under the Agreements-To-Agree.

(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 248 rules, so long as the requirements of OAR 125-248-0300 are not violated. Otherwise, the selection process will require an exemption from competitive bidding under OAR 125-249-0335, unless the Design-Build Contract is to be awarded to the Responsible Bidder submitting the lowest Responsive Bid.

Stat. Auth.: ORS 279A.050, 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.110 & 279C.115
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-248-0340
Contract Amendments

(1) An Authorized Agency may amend any Contract for Architectural, Engineering and Land Surveying and Related Services if the Authorized Agency, in its sole discretion, determines that the Amendment is within the Scope of the final form of the original procurement document the Request for Proposals and that the Amendment would not materially impact the field of competition for the Architectural, Engineering and Land Surveying Services or Related Services described in the final form of the original procurement document. In making this determination, the Authorized Agency must consider potential alternative methods of procuring the services contemplated under the proposed Amendment. An Amendment would not materially impact the field of competition for the services described in the final form of the original procurement document if the Authorized Agency reasonably believes that the number of Proposers would not significantly increase if the procurement document were re-issued to include the additional services.

(2) The Authorized Agency may amend any Contract if the additional services are required by reason of existing or new regulations or ordinances of federal, state or local agencies, and these existing or new regulations or ordinances affect performance of the Original Contract and were not cited in the original Request for Proposals or Contract or were enacted or amended after issuance of the original Request for Proposals or execution of the Original Contract.

(3) All Amendments to Contracts must be in Writing, must be signed by an authorized representative of the Consultant and the Authorized Agency and must receive all required approvals before the Amendments will be binding on the Authorized Agency.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0100
Application; Federal Override; Effective Date

(1) In addition to the general requirements set forth in Division 246 of these Rules, the Rules in this Division 249 apply to Public Improvement Contracts as well as Public Contracts for ordinary construction Services that are not Public Improvements. Rules that apply specifically to Public Improvement Contracts are so identified. In the event of conflict or ambiguity, the more specific requirements of the Rules in this division 249 take precedence over the more general requirements of the Rules in division 246.

(2) The Rules as a whole implement the Oregon Public Contracting Code (Code), as defined in ORS 279A.010. This Division 249 of the Rules specifically addresses matters covered in ORS 279C.005, 279C.010, 279C.300 through 279C.870. Rules related to Architectural, Engineering, Land Surveying, and Related Services are found in Division 248.

(3) Pursuant to OAR 125-246-0100 and except as otherwise expressly provided in ORS 279C.800 through 279C.870, applicable federal statutes and regulations govern when federal funds are involved and the federal statutes or regulations require additional conditions or conflict with the Code or with these Rules.

(4) These Division 249 Rules apply only to the above-described Public Contracts first advertised on or after March 1, 2005, and to unadvertised Public Contracts entered into on or after March 1, 2005.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0120
Definitions

The definitions for this division 249 are found in OAR 125-246-0110, except the following Rule and definitions apply only to this division 249: Capitalized terms used in this division 249 of the Rules must have the meaning set forth below or within the Sections in which they appear (such as the Section on Alternative Contracting Methods beginning at OAR 125-249-0600, and if not defined there, then the meaning set forth in Division 246 of the Rules, and if not defined there, then the meaning set forth in the Code at ORS 279A.010 (general definitions) or 279C.330 (for the term Findings).

(1) “Competitive Range” means the number of Proposers with whom the Authorized Agency will conduct Discussions or Negotiations if the Authorized Agency intends to conduct Discussions or Negotiations in accordance with OAR 125-249-0390. The size of the Competitive Range must be stated in the Solicitation Document, but will be decreased if the number of Proposers that submit Proposals is less than the specified number, or may be increased by the Authorized Agency in accordance with OAR 125-249-0390.

(2) "Conduct Disqualification" means a Disqualification pursuant to ORS 279C.440.

(3) "Disqualification" means the preclusion of a Person from contracting with an Authorized Agency for a period of time. Disqualification may be a Conduct Disqualification or DBE Disqualification. An Authorized Agency is authorized to disqualify a Person in accordance with OAR 125-249-0370.

(4) "Foreign Contractor" means a Contractor that is not domiciled in or registered to do business in the State of Oregon. See OAR 125-249-0490.

(5) "Notice" means any of the alternative forms of public announcement of Procurements, as described OAR 125-249-0210.

(6) "Responsible Offeror" (also, Responsible Bidder or Responsible Proposer, as applicable) means a Person that has submitted an Offer and meets the standards set forth in OAR 125-249-0390(2) and that has not been disqualified by the Authorized Agency under OAR 125-249-0370. When used alone, "Responsible" means meeting the aforementioned standards.

(7) "Responsive Offer" (also, Responsive Bid or Responsive Proposal, as applicable) means an Offer that substantially complies in all material respects with applicable Solicitation procedures and requirements and the Solicitation Document. When used alone, "Responsive" means having the characteristic of substantially complying in all material respects with applicable Solicitation procedure and requirements and the Solicitation Document.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0130
Competitive Bidding Requirement

An Authorized Agency must solicit Bids for Public Improvement Contracts by Invitation to Bid ("ITB"), except as otherwise allowed or required pursuant to ORS 279C.335 on competitive bidding exceptions and exemptions, ORS 279A.030 on federal law overrides, or ORS 279A.100 on affirmative action. Also see OAR 125-249-0600 to 125-249-0690 regarding the use of Alternative Contracting Methods and the exemption process.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.335
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0140
Contracts for Construction Other Than Public Improvements

(1) Procurement Under ORS chapter 279B. Pursuant to ORS 279C.320, Public Contracts for construction Services that are not Public Improvement Contracts, other than Emergency Contracts regulated under ORS 279C.335(6) and OAR 125-249-0150, may be procured and amended as general Trade Services under the provisions of ORS chapter 279B rather than under the provisions of ORS chapter 279C and these division 249 Rules.

(2) Application of ORS chapter 279C. Non-procurement provisions of ORS chapter 279C and these division 249 Rules may still be applicable to the resulting Contracts. See, for example, particular statutes on Disqualification (ORS 279C.440, 445 and 450); Legal Actions (ORS 279C.460 and 465); Required Contract Conditions (ORS 279C.505, 510, 515, 520, 525, and 530); Hours of Labor (ORS 279C.540 and 545); Retainage (ORS 279C.550, 555, 560 and 565); Subcontracts (ORS 279C.580 and 279C.585); Action on Payment Bonds (ORS 279C.600, 610, 615, 620 and 625); Termination (ORS 279C.650, 655, 660, 665 and 670); and all of the Prevailing Wage Rates requirements (ORS 279C.800 through 870) for Public Works Contracts.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.320
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0150
Emergency Contracts; Bidding and Bonding Exemptions

(1) Emergency Declaration. Pursuant to ORS 279C.335(6) and this Rule, an Authorized Agency may declare that Emergency circumstances exist that require prompt execution of a Public Contract for Emergency construction or repair Work. The declaration must be made at an administrative level consistent with the Authorized Agency's internal policies, by a Written declaration that describes the circumstances creating the Emergency as that term is defined at ORS 279A.010(1)(f), and the anticipated harm from failure to enter into an Emergency Contract. The Emergency declaration must exempt the Public Contract from the competitive bidding requirements of ORS 279C.335(1) and must thereafter be kept on file as a public record.

(2) Competition for Contracts. The Authorized Agency must ensure competition for an Emergency Contract as reasonable and appropriate under the Emergency circumstances, and may include Written requests for Offers, oral requests for Offers, or direct appointment without competition in cases of extreme necessity, in whatever Solicitation time periods the Authorized Agency considers reasonable in responding to the Emergency.

(3) Contract Scope. Although no dollar limitation applies to Emergency Contracts, the Scope of the Contract must be limited to Work that is necessary and appropriate to remedy the conditions creating the Emergency as described in the declaration.

(4) Contract Modification. Emergency Contracts may be modified by change order or Amendment to address the conditions described in the original declaration or an amended declaration that further describes additional Work necessary and appropriate for related Emergency circumstances.

(5) Excusing Bonds. Pursuant to ORS 279C.380(4) and this Rule, the Emergency declaration may also state that the Authorized Agency waives the requirement of furnishing a performance bond and payment bond for the Emergency Contract. After making such an Emergency declaration those bonding requirements are excused for the Procurement.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.335(5) & 279C.380(4)
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0160
Intermediate Procurements; Competitive Quotes and Amendments

(1) General. Public Improvement Contracts estimated by the Authorized Agency not to exceed $100,000, or not to exceed $50,000 in the case of Contracts for highways, bridges and other transportation projects (Threshold), may be Awarded in accordance with intermediate level procurement procedures for Competitive Quotes established by this Rule.

(2) Selection Criteria. The selection criteria may be limited to price or some combination of price, experience, specific expertise, availability, project understanding, Contractor capacity, responsibility and similar factors.

(3) Request for Quotes. Authorized Agencies must utilize Written requests for Quotes whenever reasonably practicable. Written request for Quotes must include the selection criteria to be utilized in selecting a Contractor and, if the criteria are not of equal value, their relative value or ranking. When requesting quotations orally, prior to requesting the price quote the Authorized Agency must state any additional selection criteria and, if the criteria are not of equal value, their relative value. For Public Works Contracts, oral quotations may be utilized only in the event that Written copies of the prevailing wage rates are not required by the Bureau of Labor and Industries.

(4) Number of Quotes; Record Required. Authorized Agencies must seek at least three (3) competitive Quotes, and keep a Written record of the sources and amounts of the Quotes received. If three (3) Quotes are not reasonably available the Authorized Agency must make a Written record of the effort made to obtain those Quotes.

(5) Award. If awarded, the Authorized Agency must Award the Contract to the prospective Contractor whose quote will best serve the interests of the Authorized Agency, taking into account the announced selection criteria. If Award is not made to the Offeror offering the lowest price, the Authorized Agency must make a Written record of the basis for Award.

(6) Price Increases. Intermediate level Public Improvement Contracts obtained by Competitive Quotes may be increased above the original amount of Award by the Authorized Agency issuance of a Change to the Work or Amendment, pursuant to OAR 125-249-0910, within the following limitations:

(a) Up to an aggregate Contract Price increase of 25% over the Original Contract amount, when an Authorized Agency's Designated Procurement Officer determines that a price increase is warranted for additional reasonably related Work;

(b) Up to an aggregate Contract Price increase of 50% over the Original Contract amount, when an Authorized Agency's Designated Procurement Officer determines that a price increase is warranted for additional reasonably related Work and the head of the Authorized Agency or supervisor of the Designated Procurement Officer approves the increase; and

(c) An unlimited increase over the Original Contract amount, when the aggregate amount of the Contract, including all Changes to the Work and Amendments, does not exceed the Threshold stated in Section (1).

(7) Amendments. Amendments of intermediate level Public Improvement Contracts that exceed the Threshold stated in Section (1) are specifically authorized by the Code, when made in accordance with this Rule and OAR 125-249-0910. Accordingly, such Amendments are not considered new Procurements and do not require an exemption from competitive bidding.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070

Stats. Implemented: Temporary provisions relating to competitive quotes were not codified but compiled as Legislative Counsel notes following ORS 279C.410
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0200
Solicitation Documents; Required Provisions; Assignment or Transfer

(1) Solicitation Document. Pursuant to ORS 279C.365 and this Rule, the Solicitation Document must include the following:

(a) General Information:

(A) Identification of the Public Improvement project, including the character of the Work, and applicable plans, Specifications and other contract documents;

(B) Notice of any pre-Offer conference as follows:

(i) The time, date and location of any pre-Offer conference;

(ii) Whether attendance at the conference will be mandatory or voluntary; and

(iii) That statements made by the Authorized Agency's representatives at the conference are not binding upon the Authorized Agency unless confirmed by Written Addendum.

(C) The deadline for submitting mandatory prequalification applications and the class or classes of Work for which Offerors must be prequalified if prequalification is a requirement;

(D) The name and title of the Authorized Agency Person designated for receipt of Offers and contact Person (if different);

(E) Instructions and information concerning the form and submission of Offers, including the address of the office to which Offers must be delivered, any Bid or Proposal security requirements, and any other required information or special information, e.g., whether Offers may be submitted by Facsimile or electronic means (See OAR 125-249-0300 regarding Facsimile Bids or Proposals and OAR 125-249-0310 regarding electronic Procurement);

(F) The time, date and place of Opening;

(G) The time and date of Closing after which an Authorized Agency will not accept Offers, which time must be not less than five (5) Days after the date of the last publication of the advertisement. Although a minimum of five (5) Days is proscribed, Authorized Agencies are encouraged to use at least a (fourteen) 14 Day Solicitation period when feasible. If the Authorized Agency is issuing an ITB that may result in a Public Improvement Contract with a value in excess of $100,000, the Authorized Agency must designate a time of Closing consistent with the first-tier subcontractor disclosure requirements of ORS 279C.370(1)(b) and OAR 125-249-0360. For timing issues relating to Addenda, see OAR 125-249-0250;

(H) The office where the Specifications for the Work may be reviewed;

(I) A statement that each Bidder to an ITB must identify whether the Bidder is a "resident Bidder", as defined in ORS 279A.120;

(J) If the Contract resulting from a Solicitation will be a Contract for a Public Work subject to ORS 279C.800 to 279C.870 or the Davis-Bacon Act (40 U.S.C. 276a), a statement that no Offer will be received or considered by the Authorized Agency unless the Offer contains a statement by the Offeror as a part of its Offer that "Contractor agrees to be bound by and will comply with the provisions of ORS 279C.840 or 40 U.S.C. 276a";

(K) A statement that the Authorized Agency will not receive or consider an Offer for a Public Improvement Contract unless the Offeror is registered with the Construction Contractors Board, or is licensed by the State Landscape Contractors Board, as specified in OAR 125-249-0230;

(L) Whether a Contractor or a subcontractor under the Contract must be licensed under ORS 468A.720 regarding asbestos abatement projects;

(M) Contractor's certification of nondiscrimination in obtaining required subcontractors in accordance with ORS 279A.110(4). (See OAR 125-249-0440(3));

(N) How the Authorized Agency will notify Offerors of Addenda and how the Authorized Agency will make Addenda available (See OAR 125-249-0250); and

(O) When applicable, instructions and forms regarding First-Tier Subcontractor Disclosure requirements, as set forth in OAR 125-249-0360.

(b) Evaluation Process:

(A) A statement that the Authorized Agency may reject any Offer not in compliance with all prescribed Public Contracting procedures and requirements, and may reject for good cause all Offers upon the Authorized Agency's finding that it is in the public interest to do so;

(B) The anticipated Solicitation schedule, deadlines, protest process, and evaluation process, if any;

(C) Evaluation criteria, including the relative value applicable to each criterion, that the Authorized Agency will use to determine the Responsible Bidder with the lowest Responsive Bid (where Award is based solely on price) or the Responsible Proposer or Proposers with the best Responsive Proposal or Proposals (where use of Competitive Proposals is authorized under ORS 279C.335 and OAR 125-249-0620), along with the process the Authorized Agency will use to determine acceptability of the Work;

(i) If the Solicitation Document is an Invitation to Bid, the Authorized Agency must set forth any special price evaluation factors in the Solicitation Document. Examples of such factors include, but are not limited to, conversion costs, transportation cost, volume weighing, trade-in allowances, cash discounts, depreciation allowances, cartage penalties, and ownership or life-cycle cost formulas. Price evaluation factors need not be precise predictors of actual future costs; but, to the extent possible, such evaluation factors must be objective, reasonable estimates based upon information the Authorized Agency has available concerning future use;

(ii) If the Solicitation Document is a Request for Proposals, the Authorized Agency must refer to the additional requirements of OAR 125-249-0650.

(c) Contract Provisions. The Authorized Agency must include all contract terms and conditions, including warranties, insurance and bonding requirements, that the Authorized Agency considers appropriate for the Public Improvement project. The Authorized Agency must also include all applicable contract provisions required by Oregon law as follows:

(A) Prompt payment to all Persons supplying labor or material; contributions to Industrial Accident Fund; liens and withholding taxes (ORS 279C.505(1));

(B) Demonstrate that an employee drug testing program is in place (ORS 279C.505(2));

(C) If the Contract calls for demolition Work described in ORS 279C.510(1), a condition requiring the Contractor to salvage or recycle construction and demolition debris, if feasible and cost-effective;

(D) If the Contract calls for lawn or landscape maintenance, a condition requiring the Contractor to compost or mulch yard waste material at an approved site, if feasible and cost effective (ORS 279C.510(2);

(E) Payment of claims by public officers (ORS 279C.515(1));

(F) Contractor and first-tier subcontractor liability for late payment on Public Improvement Contracts pursuant to ORS 279C.515(2), including the rate of interest;

(G) Person's right to file a complaint with the Construction Contractors Board for all Contracts related to a Public Improvement Contract (ORS 279C.515(3));

(H) Hours of labor in compliance with ORS 279C.520;

(I) Environmental and natural resources regulations (ORS 279C.525);

(J) Payment for medical care and attention to employees (ORS 279C.530(1);

(K) Maximum hours, holidays and overtime (ORS 279C.540);

(L) Time limitation on claims for overtime (ORS 279C.545);

(M) Prevailing wage rates (ORS 279C.800 to 279C.870);

(i) Fee paid to BOLI (ORS 279C.830);

(ii) BOLI Public Works bond (ORS 279C.830(3));

(N) Retainage (ORS 279C.550 to 279C.570);

(i) Prompt payment policy, progress payments, rate of interest (ORS 279C.570);

(O) Contractor's relations with subcontractors (ORS 279C.580);

(P) Notice of claim (ORS 279C.605);

(Q) Contractor's certification of compliance with the Oregon tax laws in accordance with ORS 305.385; and

(R) Contractor's certification that all subcontractors performing Work described in ORS 701.005(2) (i.e., construction Work) will be registered with the Construction Contractors Board or licensed by the State Landscape Contractors Board in accordance with ORS 701.035 to 701.055 before the subcontractors commence Work under the Contract.

(2) Assignment or Transfer Restricted. Unless otherwise provided in the Contract, the Contractor must not assign, sell, dispose of, or transfer rights, or delegate duties under the Contract, either in whole or in part, without the Authorized Agency's prior Written consent. Unless otherwise agreed by the Authorized Agency in Writing, such consent must not relieve the Contractor of any obligations under the Contract. Any assignee or transferee must be considered the agent of the Contractor and be bound to abide by all provisions of the Contract. If the Authorized Agency consents in Writing to an assignment, sale, disposal or transfer of the Contractor's rights or delegation of Contractor's duties, the Contractor and its surety, if any, must remain liable to the Authorized Agency for complete performance of the Contract as if no such assignment, sale, disposal, transfer or delegation had occurred unless the Authorized Agency otherwise agrees in Writing.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.110(4), 279A.120, 279C.365, 279C.370, 279C.390, 279C.505 - 580, 279C.605, 305.385, 468A.720, 701.005 & 701.055
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0210
Notice and Advertising Requirements; Posting

(1) Notice and Distribution Fee. An Authorized Agency must furnish "Notice," as set forth below in Section (2), to a number of Persons sufficient for the purpose of fostering and promoting competition. The Notice must indicate where, when, how, and for how long the Solicitation Document may be obtained and generally describe the Public Improvement project or Work. The Notice may contain any other appropriate information. The Authorized Agency may charge a fee or require a deposit for the Solicitation Document.

(2) Advertising. Pursuant to ORS 279C.360 and this Rule, an Authorized Agency must advertise on ORPIN every Solicitation for competitive Bids or competitive Proposals for a Public Improvement Contract, unless the Chief Procurement Officer has exempted the Solicitation from the advertisement requirement as part of a competitive bidding exemption under ORS 279C.335.

(a) The Authorized Agency must furnish Notice using ORPIN and may use any additional method determined to foster and promote competition, including:

(A) Mailing notice of the availability of the Solicitation Document to Persons that have expressed an interest in the Authorized Agency's Procurements;

(B) Placing a Notice on the Authorized Agency's Internet World Wide Web site; or

(C) Publishing a Notice in a newspaper of general circulation as described in ORS 279C.360(1).

(b) Authorized Agencies must publish advertisements utilizing ORPIN as required under Sections (2)(a). Authorized Agencies may also publish advertisements utilizing other forms of Electronic Advertisement, such as Authorized Agency and general circulation web sites, as permitted under Section (2)(a). Authorized Agencies may also publish advertisements utilizing at least one (1) newspaper of general circulation in the area where the Contract is to be performed and in as many additional issues and publications as the Authorized Agency determines to be necessary or desirable to foster and promote competition.

(c) An Authorized Agency may publish by Electronic Advertisement if the Authorized Agency posts in its business office a notice that the Authorized Agency will publish advertisements for Offers by Electronic Advertisement. The notice must include the World Wide Web location (i.e., Uniform Resource Locator or URL) where the Authorized Agency publishes Electronic Advertisements or alternatively, to the Web location where the Authorized Agency publishes information on accessing the Electronic Advertisement via Telnet; and

(d) In addition to the Authorized Agency's publication required under Subsection 2(a) or 2(b), the Authorized Agency must also publish advertisement for Offers in at least one (1) trade newspaper of general statewide circulation if the Contract is for a Public Improvement with an estimated cost in excess of $125,000.

(e) All advertisements for Offers must set forth:

(A) The Public Improvement project;

(B) The office where Contract terms, conditions and Specifications may be reviewed;

(C) The date that Persons must file applications for prequalification under ORS 279C.430, if prequalification is a requirement, and the class or classes of Work for which Persons must be prequalified;

(D) The scheduled Closing, that must not be less than five (5) Days after the date of the last publication of the advertisement;

(E) The name, title and address of the Authorized Agency Person authorized to receive Offers;

(F) The scheduled Opening; and

(G) If applicable, that the Contract is for a Public Work subject to ORS 279C.800 to 279C.870 or the Davis-Bacon Act (40 U.S.C. 276(a)).

(3) Availability of Written Advertisement for Offers. Upon the request of any member of the public, the Authorized Agency must provide a copy of each advertisement for Offers and all supporting documents, to be located in the Procurement File or an identified repository.

(4) Minority, Women Emerging Small Business. State Authorized Agencies must provide timely notice of all Solicitations to the Advocate for Minority, Women and Emerging Small Business if the estimated Contract Price exceeds $5,000. See ORS 200.035.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.360 & 200.035
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0280
Offer Submissions

(1) Offer and Acceptance. The Bid or Proposal is the Bidder's or Proposer's offer to enter into a Contract.

(a) In competitive bidding, the Offer is always a "Firm Offer," i.e., the Offer must be held open by the Offeror for the Authorized Agency's acceptance for the period specified in OAR 125-249-0410. The Authorized Agency's Award of the Contract to a Bidder constitutes acceptance of the Offer and binds the Offeror to the Contract.

(b) In competitive Proposals, the Solicitation Document must describe whether Offers are to be made and considered as "Firm Offers" that may be accepted without Negotiation, as in the case of competitive bidding, or whether Offers are subject to Discussion, Negotiation or otherwise are not to be considered as final Offers. See OAR 125-249-0650 on Requests for Proposals and OAR 125-249-0290 on Bid or Proposal Security.

(2) Responsive Offer. An Authorized Agency may award a Contract only to a Responsible Offeror with a Responsive Offer.

(3) Contingent Offers. Except to the extent that an Offeror is authorized to propose certain terms and conditions pursuant to OAR 125-249-0650, an Offeror must not make an Offer contingent upon the Authorized Agency's acceptance of any terms or conditions (including Specifications) other than those contained in the Solicitation Document.

(4) Offeror's Acknowledgement. By signing and returning the Offer, the Offeror acknowledges they have read and understand the terms and conditions contained in the Solicitation Document and that they accept and agree to be bound by the terms and conditions of the Solicitation Document. If the Request for Proposals permits proposal of alternative terms under OAR 125-249-0650, the Offeror's Offer includes the non-negotiable terms and conditions and any proposed terms and conditions offered for Negotiation upon and to the extent accepted by the Authorized Agency in Writing.

(5) Instructions. Offerors must submit and Sign their Offers in accordance with the Solicitation Document. Offerors must initial and submit any corrections or erasures to their Offers prior to the Opening in accordance with the requirements for submitting an Offer under the Solicitation Document.

(6) Forms. Offerors must submit their Offers on the form(s) provided in the Solicitation Document, unless Offerors are otherwise instructed in the Solicitation Document.

(7) Documents. Offerors must provide the Authorized Agency with all documents and Descriptive Literature required under the Solicitation Document.

(8) Facsimile or Electronic Submissions. If the Authorized Agency permits facsimile or electronic Offers in the Solicitation Document, the Offeror may submit facsimile or electronic Offers in accordance with the Solicitation Document. The Authorized Agency must not consider facsimile or electronic Offers unless authorized by the Solicitation Document.

(9) Product Samples and Descriptive Literature. An Authorized Agency may require Product Samples or Descriptive Literature if it is necessary or desirable to evaluate the quality, features or characteristics of the offered items. The Authorized Agency will dispose of Product Samples, or return or make available for return Product Samples to the Offeror in accordance with the Solicitation Document.

(10) Identification of Offers:

(a) To ensure proper identification and handling, Offers must be submitted in a sealed envelope appropriately marked or in the envelope provided by the Authorized Agency, whichever is applicable.

(b) The Authorized Agency is not responsible for Offers submitted in any manner, format or to any delivery point other than as required in the Solicitation Document.

(11) Receipt of Offers. The Offerors are responsible for ensuring that the Authorized Agency receives their Offers at the required delivery point prior to the Closing, regardless of the method used to submit or transmit the Offer.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.365 & 279C.375
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0290
Bid or Proposal Security

(1) Security Amount. If an Authorized Agency requires Bid or Proposal security, it must be not more than 10% or less than 5% of the Offeror's Bid or Proposal, consisting of the base Bid or Proposal together with all additive alternates. An Authorized Agency must not use Bid or Proposal security to discourage competition. The Authorized Agency must clearly state any Bid or Proposal security requirements in its Solicitation Document. The Offeror must forfeit Bid or Proposal security after Award if the Offeror fails to execute the Contract and promptly return it with any required any required proof of insurance. See ORS 279C.365(4) and 279C.385.

(2) Requirement for Bid Security (Optional for Proposals). Unless an Authorized Agency has otherwise exempted a Solicitation or class of

Solicitations from Bid security pursuant to ORS 279C.390, the Authorized Agency must require Bid security for its Solicitation of Bids for Public Improvements. This requirement applies only to Public Improvement Contracts with a value, estimated by the Authorized Agency, of more than $100,000 or, in the case of Contracts for highways, bridges and other transportation projects, more than $50,000. See ORS 279C.365(5). The Authorized Agency may require Bid security even if it has exempted a class of Solicitations from Bid security. Authorized Agencies may require Proposal security in RFPs when Award of a Public Improvement Contract may be made without Negotiation following receipt of a Firm Offer as described in OAR 125-249-0280(1)(b). See ORS 279C.400(5).

(3) Form of Bid or Proposal Security. An Authorized Agency may accept only the following forms of Bid or Proposal security:

(a) A surety bond from a surety company authorized to do business in the State of Oregon;

(b) An irrevocable letter of credit issued by an insured institution as defined in ORS 706.008; or

(c) A cashier's check or Offeror's certified check.

(4) Return of Security. An Authorized Agency must return or release the Bid or Proposal security of all unsuccessful Offerors after a Contract has been fully executed and all required bonds and insurance have been provided, or after all Offers have been rejected. The Authorized Agency may return the Bid or Proposal security of unsuccessful Offerors prior to award if the return does not prejudice Contract Award and the security of at least the Bidders with the three (3) lowest Bids, or the Proposers with the three (3) highest scoring Proposals, is retained pending execution of a Contract.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.365 & 279C.375
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0300
Facsimile Bids and Proposals

(1) The Authorized Agency Authorization. An Authorized Agency may authorize Offerors to submit facsimile Offers. If the Authorized Agency determines that Bid or Proposal security is or will be required, the Authorized Agency must not authorize facsimile Offers unless the Authorized Agency has established a method for receipt of such security. Prior to authorizing the submission of facsimile Offers, the Authorized Agency must determine that the Authorized Agency's equipment and personnel are capable of receiving the size and volume of anticipated Offers within a short period of time. In addition, the Authorized Agency must establish administrative procedures and controls:

(a) To receive, identify, record and safeguard facsimile Offers;

(b) To ensure timely delivery of Offers to the location of Opening; and

(c) To preserve the Offers as sealed.

(2) Provisions To Be Included in Solicitation Document. In addition to all other requirements, if the Authorized Agency authorizes a facsimile Offer for Bids or Proposals, the Authorized Agency must include in the Solicitation Document (other than in a request for Quotes) the following:

(a) A provision substantially in the form of the following: "A 'facsimile Offer', as used in this Solicitation Document, means an Offer, modification of an Offer, or withdrawal of an Offer that is transmitted to and received by the Authorized Agency via a facsimile machine";

(b) A provision substantially in the form of the following: "Offerors may submit facsimile Offers in response to this Solicitation Document. The entire response must arrive at the place and by the time specified in this Solicitation Document";

(c) A provision that requires Offerors to Sign their facsimile Offers;

(d) A provision substantially in the form of the following: "The Authorized Agency reserves the right to award the Contract solely on the basis of the facsimile Offer. However, upon the Authorized Agency's request the apparent successful Offeror must promptly submit its complete original Signed Offer";

(e) The data and compatibility characteristics of the Authorized Agency's receiving facsimile machine as follows:

(A) Telephone number; and

(B) Compatibility characteristics, e.g., make and model number, receiving speed, communications protocol; and

(f) A provision that the Authorized Agency is not responsible for any failure attributable to the transmission or receipt of the facsimile Offer including, but not limited to the following:

(A) Receipt of garbled or incomplete documents;

(B) Availability or condition of the receiving facsimile machine;

(C) Incompatibility between the sending and receiving facsimile machine;

(D) Delay in transmission or receipt of documents;

(E) Failure of the Offeror to properly identify the Offer documents;

(F) Illegibility of Offer documents; and

(G) Security and confidentiality of data.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.365
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0310
Electronic Procurement

(1) General. Authorized Agencies may utilize Electronic Advertisement of Public Improvement Contracts in accordance with ORS 279C.360(1), provided that advertisement of such Contracts with an estimated Contract Price in excess of $125,000 must also be published in a trade newspaper of general statewide circulation, and may post notices of intent to award electronically as provided by ORS 279C.410(7).

(2) Alternative Procedures. In the event that an Authorized Agency desires to direct or permit the submission and receipt of Offers for a Public Improvement Contract, by electronic means, as allowed under ORS 279C.365(1)(d), it must first promulgate supporting procedures substantially in conformance with OAR 125-247-0330 (Electronic Procurement under ORS chapter 279B), taking into account ORS chapter 279C requirements for Written bids, opening bids publicly, bid security, first-tier subcontractor disclosure and inclusion of prevailing wage rates.

(3) Interpretation. Nothing in this Rule must be construed as prohibiting Authorized Agencies from making Procurement Documents for Public Improvement Contracts available in electronic format as well as in hard copy when Bids are to be submitted only in hard copy.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.365
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0320
Pre-Closing Modification or Withdrawal of Offers

(1) Modifications. An Offeror may modify its Offer in Writing prior to the Closing. An Offeror must prepare and submit any modification to its Offer to the Authorized Agency in accordance with OAR 125-249-0280, unless otherwise specified in the Solicitation Document. Any modification must include the Offeror's statement that the modification amends and supersedes the prior Offer. The Offeror must mark the submitted modification as follows:

(a) Bid (or Proposal) Modification; and

(b) Solicitation Number (or Other Identification as specified in the Solicitation Document).

(2) Withdrawals.

(a) An Offeror may withdraw its Offer by Written notice submitted on the Offeror's letterhead, Signed by an authorized representative of the Offeror, delivered to the location specified in the Solicitation Document (or the place of Closing if no location is specified), and received by the Authorized Agency prior to the Closing. The Offeror or authorized representative of the Offeror may also withdraw its Offer in Person prior to the Closing, upon presentation of appropriate identification and satisfactory evidence of authority;

(b) The Authorized Agency may release an unopened Offer withdrawn under Subsection 2(a) to the Offeror or its authorized representative, after voiding any date and time stamp mark;

(c) The Offeror must mark the Written request to withdraw an Offer as follows:

(A) Bid (or Proposal) Withdrawal; and

(B) Solicitation Number (or Other Identification as specified in the Solicitation Document).

(3) Documentation. The Authorized Agency must include all documents relating to the modification or withdrawal of Offers in the appropriate Solicitation file.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.360(2), 279C.365, 279C.375 & 279C.395
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0360
First-Tier Subcontractors; Disclosure and Substitution; ITB

(1) Required Disclosure. Within two (2) Working hours after the Bid Closing on an ITB for a Public Improvement having a Contract Price anticipated by the Authorized Agency to exceed $100,000, all Bidders must submit to the Authorized Agency a disclosure form as described by ORS 279C.370(2), identifying any first-tier subcontractors (those Entities that would be contracting directly with the prime Contractor) that will be furnishing labor or labor and materials on the Contract, if Awarded, whose subcontract value would be equal to or greater than:

(a) Five percent (5%) of the total Contract Price, but at least $15,000; or

(b) $350,000, regardless of the percentage of the total Contract Price.

(2) Bid Closing, Disclosure Deadline, and Bid Opening. For each ITB to which this rule applies, the Authorized Agency must:

(a) Set the Bid Closing on a Tuesday, Wednesday or Thursday, and at a time between 2 p.m. and 5 p.m., except that these Bid Closing restrictions do not apply to an ITB for maintenance or construction of highways, bridges or other transportation facilities, and provided that the two (2) hour disclosure deadline described by this Rule would not then fall on a legal holiday;

(b) Open Bids publicly immediately after the Bid Closing; and

(c) Consider for Contract Award only those Bids for which the required disclosure has been submitted by the announced deadline on forms prescribed by the Authorized Agency.

(3) Bidder Instructions and Disclosure Form. For the purposes of this Rule, an Authorized Agency in its Solicitation must:

(a) Prescribe the disclosure form that must be utilized, substantially in the form set forth in ORS 279C.370(2); and

(b) Provide instructions in a notice substantially similar to the following: "Instructions for First-Tier Subcontractor Disclosure." Bidders are required to disclose information about certain first-tier subcontractors when the contract value for a Public Improvement is greater than $100,000 (see ORS 279C.370). Specifically, when the contract amount of a first-tier subcontractor furnishing labor or labor and materials would be greater than or equal to: (i) 5% of the project Bid, but at least $15,000, or (ii) $350,000 regardless of the percentage, the Bidder must disclose the following information about that subcontract either in its Bid submission, or within two (2) hours after Bid Closing:

(A) The subcontractor's name,

(B) The category of Work that the subcontractor would be performing, and

(C) The dollar value of the subcontract. If the Bidder will not be using any subcontractors that are subject to the above disclosure requirements, the Bidder is required to indicate "NONE" on the accompanying form.

"THE AUTHORIZED AGENCY MUST REJECT A BID IF THE BIDDER FAILS TO SUBMIT THE DISCLOSURE FORM WITH THIS INFORMATION BY THE STATED DEADLINE."

(4) Submission. A Bidder must submit the disclosure form required by this Rule either in its Bid submission, or within two working hours after Bid Closing in the manner specified by the ITB.

(5) Responsiveness. Compliance with the disclosure and submittal requirements of ORS 279C.370 and this Rule is a matter of Responsiveness. Bids which are submitted by Bid Closing, but for which the disclosure submittal has not been made by the specified deadline, are not Responsive and must not be considered for Contract Award.

(6) Authorized Agency Role. Authorized Agencies must obtain, and make available for public inspection, the disclosure forms required by ORS 279C.370 and this Rule. Authorized Agencies must also provide copies of disclosure forms to the Bureau of Labor and Industries as required by ORS 279C.835. Authorized Agencies are not required to determine the accuracy or completeness of the information provided on disclosure forms.

(7) Substitution. Substitution of affected first-tier subcontractors must be made only in accordance with ORS 279C.585. Authorized Agencies must accept Written submissions filed under that statute as public records. Aside from issues involving inadvertent clerical error under ORS 279C.585, Authorized Agencies do not have a statutory role or duty to review, approve, or resolve disputes concerning such substitutions. See ORS 279C.590 regarding complaints to the Construction Contractors Board on improper substitution.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.370, 279C.585, 279C.590 & 279C.835
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0370
Disqualification of Persons

(1) Authority. An Authorized Agency may disqualify a Person from consideration of Award of the Authorized Agency's Contracts after providing the Person with notice and a reasonable opportunity to be heard in accordance with Sections (2) and (4) of this Rule.

(a) Standards for Conduct Disqualification. As provided in ORS 279C.440, an Authorized Agency may disqualify a Person for:

(A) Conviction for the commission of a criminal offense as an incident in obtaining or attempting to obtain a public or private Contract or subcontract, or in the performance of such Contract or subcontract.

(B) Conviction under state or federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, or any other offense indicating a lack of business integrity or business honesty that currently, seriously and directly affects the Person's responsibility as a Contractor.

(C) Conviction under state or federal antitrust statutes.

(D) Violation of a contract provision that is regarded by the Authorized Agency to be so serious as to justify Disqualification. A violation under this Subsection 2(d) may include but is not limited to material failure to perform the terms of a Contract or an unsatisfactory performance in accordance with the terms of the Contract. However, a Person's failure to perform or unsatisfactory performance caused by acts beyond the Person's control is not a basis for Disqualification.

(b) Standards for DBE Disqualification. As provided in ORS 200.065, 200.075 or 279A.110, an Authorized Agency may disqualify a Person's right to submit an Offer or to participate in a Contract (e.g. subcontractors) as follows:

(A) For a DBE Disqualification under ORS 200.065, the Authorized Agency may disqualify a Person upon finding that:

(i) The Person fraudulently obtained or retained or attempted to obtain or retain or aided another Person to fraudulently obtain or retain or attempt to obtain or retain certification as a disadvantaged, minority, women or emerging small business enterprise; or

(ii) The Person knowingly made a false claim that any Person is qualified for certification or is certified under ORS 200.055 for the purpose of gaining a Contract or subcontract or other benefit; or

(iii) The Person has been disqualified by another Authorized Agency pursuant to ORS 200.065.

(B) For a DBE Disqualification under ORS 200.075, the Authorized Agency may disqualify a Person upon finding that:

(i) The Person has entered into an agreement representing that a disadvantaged, minority, women, or emerging small business enterprise, certified pursuant to ORS 200.055 ("Certified Enterprise"), will perform or supply materials under a Public Improvement Contract without the knowledge and consent of the Certified Enterprise; or

(ii) The Person exercises management and decision-making control over the internal operations, as defined by ORS 200.075(1)(b), of any Certified Enterprise; or

(iii) The Person uses a Certified Enterprise to perform Work under a Contract to meet an established Certified Enterprise goal, and such enterprise does not perform a commercially useful function, as defined by ORS 200.075(3), in performing its obligations under the Contract.

(iv) If a Person is Disqualified for a DBE Disqualification under ORS 200.075, the affected Authorized Agency must not permit such Person to participate in that Authorized Agency's Contracts.

(C) For a DBE Disqualification under ORS 279A.110, an Authorized Agency may disqualify a Person if the Authorized Agency finds that the Person discriminated against minority, women, or emerging small business enterprises in awarding a subcontract under a Contract with that Authorized Agency.

(2) Notice of Intent to Disqualify. The Authorized Agency must notify the Person in Writing of a proposed Disqualification personally or by registered or certified mail, return receipt requested. This notice must:

(a) State that the Authorized Agency intends to disqualify the Person;

(b) Set forth the reasons for the Disqualification;

(c) Include a statement of the Person's right to a hearing if requested in Writing within the time stated in the notice and that if the Authorized Agency does not receive the Person's Written request for a hearing within the time stated, the Person must have waived its right to a hearing;

(d) Include a statement of the authority and jurisdiction under which the hearing will be held;

(e) Include a reference to the particular Sections of the statutes and rules involved;

(f) State the proposed Disqualification period; and

(g) State that the Person may be represented by legal counsel.

(3) Hearing. The Authorized Agency must schedule a hearing upon the Authorized Agency receipt of the Person's timely request. The Authorized Agency must notify the Person of the time and place of the hearing and provide information on the procedures, right of representation and other rights related to the conduct of the hearing prior to hearing.

(4) Notice of Disqualification. The Authorized Agency will notify the Person in Writing of its Disqualification, personally or by registered or certified mail, return receipt requested. The notice must contain:

(a) The effective date and period of Disqualification;

(b) The grounds for Disqualification; and

(c) A statement of the Person's appeal rights and applicable appeal deadlines. For a Conduct Disqualification or a DBE Disqualification under ORS 279A.110, the Disqualified Person must notify the Authorized Agency in Writing within three (3) business days after receipt of the Authorized Agency's notice of Disqualification if the Person intends to appeal the Authorized Agency's decision.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 200.065, 200.075, 279A.110, 279C.440, 279C.445 & 279C.450
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0380
Bid or Proposal Evaluation Criteria

(1) General. A Public Improvement Contract, if Awarded, must be Awarded to the Responsible Bidder submitting the lowest Responsive Bid, or to the Responsible Proposer submitting the best Responsive Proposal. See OAR 125-249-0390, and Rules for Alternative Contracting Methods at OAR 125-249-0600 to 125-249-0690.

(2) Bid Evaluation Criteria. Invitations to Bid may solicit lump-sum Offers, unit-price Offers, or a combination of the two.

(a) Lump Sum. If the ITB requires a lump-sum Bid, without additive or deductive alternates, or if the Authorized Agency elects not to award additive or deductive alternates, Bids must be compared on the basis of lump-sum prices, or lump-sum base Bid prices, as applicable. If the ITB calls for a lump-sum base Bid, plus additive or deductive alternates, the total Bid price must be calculated by adding to or deducting from the base Bid those alternates selected by the Authorized Agency, for the purpose of comparing Bids.

(b) Unit Price. If the Bid includes unit pricing for estimated quantities, the total Bid price must be calculated by multiplying the estimated quantities by the unit prices submitted by the Bidder, and adjusting for any additive or deductive alternates selected by the Authorized Agency, for the purpose of comparing Bids. Authorized Agencies must specify within the Solicitation Document the estimated quantity of the Procurement to be used for determination of the low Bidder. In the event of mathematical discrepancies between unit price and any extended price calculations submitted by the Bidder, the unit price must govern. See OAR 125-249-0350(2)(b).

(3) Proposal Evaluation Criteria. If the State Procurement Office has exempted the Procurement of a Public Improvement from the competitive bidding requirements of ORS 279C.335(1), and has directed the Authorized Agency to use an Alternative Contracting Method under ORS 279.335(4), the Authorized Agency must set forth the evaluation criteria in the Solicitation Documents. See OAR 125-249-0650, ORS 279C.335 and 279C.405.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.335
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0390
Offer Evaluation and Award; Determination of Responsibility

(1) General. If awarded, the Authorized Agency must award the Contract to the Responsible Bidder submitting the lowest, Responsive Bid or the Responsible Proposer or Proposers submitting the best, Responsive Proposal or Proposals, provided that such Person is not listed by the Construction Contractors Board as disqualified to hold a Public Improvement Contract (see ORS 279C.375(2)(a)) or is ineligible for award as a nonresident education service district (see Oregon Laws 2005, Chapter 413). The Authorized Agency may award by item, groups of items or the entire Offer provided such Award is consistent with the Solicitation Document and in the public interest.

(2) Determination of Responsibility. Offerors are required to demonstrate their ability to perform satisfactorily under a Contract. Before Awarding a Contract, the Authorized Agency must have information that indicates that the Offeror meets the standards of responsibility set forth in ORS 279C.375(2)(b). To be a Responsible Offeror, the Authorized Agency must determine that the Offeror:

(a) Has available the appropriate financial, material, equipment, facility and Personnel resources and expertise, or ability to obtain the resources and expertise, necessary to meet all contractual responsibilities;

(b) Has a satisfactory record of contract performance. An Authorized Agency should carefully scrutinize an Offeror's record of contract performance if the Offeror is or recently has been materially deficient in contract performance. In reviewing the Offeror's performance, the Authorized Agency should determine whether the Offeror's deficient performance was expressly excused under the terms of Contract, or whether the Offeror took appropriate corrective action. The Authorized Agency may review the Offeror's performance on both private and Public Contracts in determining the Offeror's record of contract performance. The Authorized Agency must make its basis for determining an Offeror not Responsible under this paragraph part of the Solicitation file;

(c) Has a satisfactory record of integrity. An Offeror may lack integrity if an Authorized Agency determines the Offeror demonstrates a lack of business ethics such as violation of state environmental laws or false certifications made to an Authorized Agency. An Authorized Agency may find an Offeror not Responsible based on the lack of integrity of any Person having influence or control over the Offeror (such as a key employee of the Offeror that has the authority to significantly influence the Offeror's performance of the Contract or a parent company, predecessor or successor Person). The standards for Conduct Disqualification under OAR 125-249-0370 may be used to determine an Offeror's integrity. The Authorized Agency must make its basis for determining that an Offeror is not Responsible under this paragraph part of the Solicitation file;

(d) Is qualified legally to contract with the Authorized Agency; and

(e) Has supplied all necessary information in connection with the inquiry concerning responsibility. If the Offeror fails to promptly supply information requested by the Authorized Agency concerning responsibility, the Authorized Agency must base the determination of responsibility upon any available information, or may find the Offeror not Responsible.

(3) Documenting Agency Determinations. Authorized Agencies must document their compliance with ORS 279C.375(2) and the above sections of this Rule on a Responsibility Determination Form substantially as set forth in ORS 279C.375(2)(c).

(4) Authorized Agency Evaluation. The Authorized Agency must evaluate an Offer only as set forth in the Solicitation Document and in accordance with applicable law. The Authorized Agency must not evaluate an Offer using any other requirement or criterion.

(5) Offeror Submissions:

(a) The Authorized Agency may require an Offeror to submit Product Samples, Descriptive Literature, technical data, or other material and may also require any of the following prior to award:

(A) Demonstration, inspection or testing of a product prior to award for characteristics such as compatibility, quality or Workmanship;

(B) Examination of such elements as appearance or finish; or

(C) Other examinations to determine whether the product conforms to Specifications.

(b) The Authorized Agency must evaluate product acceptability only in accordance with the criteria disclosed in the Solicitation Document to determine that a product is acceptable. The Authorized Agency must reject an Offer providing any product that does not meet the Solicitation Document requirements. An Authorized Agency's rejection of an Offer because it offers nonconforming Work or materials is not Disqualification and is not appealable under ORS 279C.445.

(6) Evaluation of Bids. The Authorized Agency must use only objective criteria to evaluate Bids as set forth in the ITB. The Authorized Agency must evaluate Bids to determine which Responsible Offeror offers the lowest Responsive Bid.

(a) Nonresident Bidders. In determining the lowest Responsive Bid, the Authorized Agency must add a percentage increase to the Bid of a nonresident Bidder equal to the percentage, if any, of the preference given to that Bidder in the state in which the Bidder resides.

(b) Clarifications. In evaluating Bids, an Authorized Agency may seek information from a Bidder only to clarify the Bidder's Bid. Such clarification must not vary, contradict or supplement the Bid. A Bidder must submit Written and Signed clarifications and such clarifications must become part of the Bidder's Bid.

(c) Negotiation Prohibited. The Authorized Agency must not negotiate Scope of Work or other terms or conditions under an Invitation to Bid process prior to award.

(7) Evaluation of Proposals. See OAR 125-249-0650 regarding rules applicable to Requests for Proposals.

(8) Independent Contractor Status, Tax Compliance, and Requirements to Transact Business in Oregon. For these responsibilities of Offerors, see OAR 125-246-0330.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.335, 279C.365, 279C.375 & 279C.395
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0395
Notice of Intent to Award

(1) Notice. At least seven (7) days before the Award of a Public Improvement Contract, the Authorized Agency must issue to each Offeror, or post electronically or otherwise, a notice of the Authorized Agency's intent to Award the Contract. See ORS 279C.375(2). This requirement does not apply to an Award of a Public Improvement Contract with a value of less than $5,000, certain Veterans' Affairs Contracts under ORS 279C.335(1)(d) and Contracts for Emergency Work under ORS 279C.335(6) and OAR 125-249-0150.

(2) Form and Manner of Posting. The form and manner of posting notice must conform to customary practices within the Authorized Agency's procurement system, and may be made electronically.

(3) Finalizng Award. The Authorized Agency's Award is not final until the later of the following:

(a) Seven (7) Days after the date of the notice, unless the Solicitation Document provided a different period for protest; or

(b) The Authorized Agency provides a Written response to all timely-filed protests that denies the protests and affirms the Award.

(4) Prior Notice Impractical. Posting of notice of intent to award is not required when the Authorized Agency determines that it is impractical due to unusual time constraints in making prompt Award for its immediate

procurement needs, documents the Procurement file as to the reasons for that determination, and posts notice of that action as soon as reasonably practical.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.335
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0400
Documentation of Award; Availability of Award Decisions

(1) Basis of Award. After Award, the Authorized Agency must make a record showing the basis for determining the successful Offeror part of the Authorized Agency's Solicitation file.

(2) Contents of Award Record for Bids. The Authorized Agency's record must include:

(a) Bids.

(b) Completed Bid tabulation sheet; and

(c) Written justification for any rejection of lower Bids.

(3) Contents of Award Record for Proposals. Where the use of Requests for Proposals is authorized as set forth in OAR 125-249-0650, the Authorized Agency's record must include:

(a) Proposals.

(b) The completed evaluation of the Proposals;

(c) Written justification for any rejection of higher scoring Proposals or for failing to meet mandatory requirements of the Request for Proposal; and

(d) If the Authorized Agency permitted Negotiations in accordance with OAR 125-249-0650, the Authorized Agency's completed evaluation of the initial Proposals and the Authorized Agency's completed evaluation of final Proposals.

(4) Contract Document. The Authorized Agency must deliver a fully executed copy of the final Contract to the successful Offeror.

(5) Bid Tabulations and Award Summaries. Upon request of any Person the Authorized Agency must provide tabulations of Awarded Bids or evaluation summaries of Proposals for a nominal charge which may be payable in advance. Requests must contain the Solicitation Document number and, if requested, be accompanied by a self-addressed, stamped envelope. Authorized Agencies may also provide tabulations of Bids and Proposals Awarded on designated Web sites.

(6) Availability of Solicitation Files. The Authorized Agency must make completed Solicitation files available for public review at the Authorized Agency.

(7) Copies from Solicitation Files. Any Person may obtain copies of material from Solicitation files upon payment of a reasonable copying charge.

(8) Minority, Women, Emerging Small Business. Agencies must provide timely notice of Contract Award to the Advocate for Minority, Women, Emerging Small Business if the estimated Contract Price exceeds $5,000. See ORS 200.035 and any applicable Department Policy.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065(5)(a) & 279A.070
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0440
Rejection of Offers

(1) Rejection of an Offer.

(a) An Authorized Agency may reject any Offer upon finding that to accept the Offer may impair the integrity of the Procurement Process or that rejecting the Offer is in the public interest.

(b) The Authorized Agency must reject an Offer upon the Authorized Agency's finding that the Offer:

(A) Is contingent upon the Authorized Agency's acceptance of terms and conditions (including Specifications) that differ from the Solicitation Document, or

(B) Takes exception to terms and conditions (including Specifications), or

(C) Attempts to prevent public disclosure of matters in contravention of the terms and conditions of Solicitation Document or in contravention of applicable law; or

(D) Offers Work that fails to meet the Specifications of the Solicitation Document; or

(E) Is late; or

(F) Is not in substantial compliance with the Solicitation Documents; or

(G) Is not in substantial compliance with all prescribed public Solicitation procedures.

(c) The Authorized Agency must reject an Offer upon the Authorized Agency's finding that the Offeror:

(A) Has not been prequalified under ORS 279C.430 and the Authorized Agency required mandatory prequalification; or

(B) Has been Disqualified; or

(C) Has been declared ineligible under ORS 279C.860 by the Commissioner of Bureau of Labor and Industries and the Contract is for a Public Work; or

(D) Is listed as not qualified by the Construction Contractors Board, if the Contract is for a Public Improvement; or

(E) Has not met the requirements of ORS 279A.105 if required by the Solicitation Document; or

(F) Has not submitted properly executed Bid or Proposal security as required by the Solicitation Document; or

(G) Has failed to provide the certification required under Section 3 of this Rule; or

(H) Is not Responsible. See OAR 125-249-0390(2) regarding Authorized Agency determination that the Offeror has met statutory standards of responsibility.

(2) Form of Business. For purposes of this Rule, the Authorized Agency may investigate any Person submitting an Offer. The investigation may include that Person's officers, Directors, owners, affiliates, or any other Person acquiring ownership of the Person to determine application of this Rule or to apply the Disqualification provisions of ORS 279C.440 to 279C.450 and OAR 125-249-0370.

(3) Certification of Non-Discrimination. The Offeror must certify and deliver to the Authorized Agency Written certification, as part of the Offer that the Offeror has not discriminated against minority, women or emerging small business enterprises in obtaining any required subcontracts. Failure to do so must be grounds for disqualification.

(4) Rejection of all Offers. An Authorized Agency may reject all Offers for good cause upon the Authorized Agency's Written finding it is in the public interest to do so. The Authorized Agency must notify all Offerors of the rejection of all Offers, along with the good cause justification and finding.

(5) Criteria for Rejection of All Offers. The Authorized Agency may reject all Offers upon a Written finding that:

(a) The content of or an error in the Solicitation Document, or the Solicitation process unnecessarily restricted competition for the Contract;

(b) The price, quality or performance presented by the Offerors is too costly or of insufficient quality to justify acceptance of the Offer;

(c) Misconduct, error, or ambiguous or misleading provisions in the Solicitation Document threaten the fairness and integrity of the competitive process;

(d) Causes other than legitimate market forces threaten the integrity of the competitive Procurement Process. These causes include, but are not limited to, those that tend to limit competition such as restrictions on competition, collusion, corruption, unlawful anti-competitive conduct, and inadvertent or intentional errors in the Solicitation Document;

(e) The Authorized Agency cancels the Solicitation in accordance with OAR 125-249-0270; or

(f) Any other circumstance indicating that Awarding the Contract would not be in the public interest.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.105, 279A.110, 279C.375, 279C.380 & 279C.395
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0450
Protest of Contractor Selection, Contract Award

(1) Purpose. An adversely affected or aggrieved Offeror must exhaust all avenues of administrative review and relief before seeking judicial review of the Authorized Agency's Contractor selection or Contract Award decision.

(2) Notice of Competitive Range. Unless otherwise provided in the RFP, when the competitive proposal process is authorized under OAR 125-249-0650, the Authorized Agency must provide Written notice to all Proposers of the Authorized Agency's determination of the Proposers included in the Competitive Range. The Authorized Agency's notice of the Proposers included in the Competitive Range must not be final until the later of the following:

(a) Ten (10) Days after the date of the notice, unless otherwise provided therein; or

(b) Until the Authorized Agency provides a Written response to all timely-filed protests that denies the protest and affirms the notice of the Proposers included in the Competitive Range.

(3) Notice of Intent to Award. The Authorized Agency must provide Written notice to all Offerors of the Authorized Agency's intent to award the Contract as provided by OAR 125-249-0395.

(4) Right to Protest Award.

(a) An adversely affected or aggrieved Offeror may submit to the Authorized Agency a Written protest of the Authorized Agency's intent to award within seven (7) Days after issuance of the notice of intent to award

the Contract, unless a different protest period is provided under the Solicitation Document.

(b) The Offeror's protest must be in Writing and must specify the grounds upon which the protest is based.

(c) An Offeror is adversely affected or aggrieved only if the Offeror is eligible for Award of the Contract as the Responsible Bidder submitting the lowest Responsive Bid or the Responsible Proposer submitting the best Responsive Proposal and is next in line for Award, i.e., the protesting Offeror must claim that all lower Bidders or higher-scored Proposers are ineligible for Award:

(A) Because their Offers were non-responsive; or

(B) The Authorized Agency committed a substantial violation of a provision in the Solicitation Document or of an applicable procurement statute or administrative rule, and the protesting Offeror was unfairly evaluated and would have, but for such substantial violation, been the Responsible Bidder offering the lowest Bid or the Responsible Proposer offering the highest-ranked Proposal.

(d) The Authorized Agency must not consider a protest submitted after the time period established in this Rule or such different period as may be provided in the Solicitation Document. A Proposer may not protest an Authorized Agency's decision not to increase the size of the Competitive Range above the size of the Competitive Range set forth in the RFP.

(5) Right to Protest Competitive Range:

(a) An adversely affected or aggrieved Proposer may submit to the Authorized Agency a Written protest of the Authorized Agency's decision to exclude the Proposer from the Competitive Range within seven (7) Days after issuance of the notice of the Competitive Range, unless a different protest period is provided under the Solicitation Document. (See procedural requirements for the use of RFPs at OAR 125-249-0650.)

(b) The Proposer's protest must be in Writing and must specify the grounds upon which the protest is based.

(c) A Proposer is adversely affected only if the Proposer is responsible and submitted a Responsive Proposal and is eligible for inclusion in the Competitive Range, i.e., the protesting Proposer must claim it is eligible for inclusion in the Competitive Range if all ineligible higher-scoring Proposers are removed from consideration, and that those ineligible Proposers are ineligible for inclusion in the Competitive Range because:

(A) Their Proposals were not responsive; or

(B) The Authorized Agency committed a substantial violation of a provision in the RFP or of an applicable procurement statute or administrative rule, and the protesting Proposer was unfairly evaluated and would have, but for such substantial violation, been included in the Competitive Range.

(d) The Authorized Agency must not consider a protest submitted after the time period established in this Rule or such different period as may be provided in the Solicitation Document. A Proposer may not protest an Authorized Agency's decision not to increase the size of the Competitive Range above the size of the Competitive Range set forth in the RFP.

(6) Authority to Resolve Protests. The head of the Authorized Agency, or such Person's delegatee, may settle or resolve a Written protest submitted in accordance with the requirements of this Rule.

(7) Decision. If a protest is not settled, the head of the Authorized Agency, or such Person's delegatee, must promptly issue a Written decision on the protest. Judicial review of this decision will be available if provided by statute.

(8) Award. The successful Offeror must promptly execute the Contract after the Award is final. The Authorized Agency must execute the Contract only after it has obtained all applicable required documents and approvals.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.375, 279C.380, 279C.385 & 279C.460
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0460
Performance and Payment Security; Waiver

(1) Public Improvement Contracts. Unless the required performance bond is waived under ORS 279C.380(1)(a), excused in cases of emergency under ORS 279C.380(4), or unless the State Procurement Office exempts a Contract or classes of Contracts from the required performance bond and payment bond pursuant to ORS 279C.390, the Contractor must execute and deliver to the Authorized Agency a performance bond and a payment bond each in a sum equal to the Contract Price for all Public Improvement Contracts. This requirement applies only to Public Improvement Contracts with a value, estimated by the Authorized Agency, of more than $100,000 or, in the case of Contracts for highways, bridges and other transportation projects, more than $50,000. See ORS 279C.380(5). Under ORS 279C.390(3)(b) the Director of the Oregon Department of Transportation may reduce the performance bond amount for Contracts financed from the proceeds of bonds issued under ORS 367.620(3)(a). Also see OAR 125-249-0815 and BOLI rules in OAR chapter 839, division 25, regarding the separate requirement for Public Works bond.

(2) Other Construction Contracts. An Authorized Agency may require performance security for other construction Contracts that are not Public Improvement Contracts. Such requirements must be expressly set forth in the Solicitation Document.

(3) Requirement for Surety Bond. The Authorized Agency must accept only a performance bond furnished by a surety company authorized to do business in Oregon unless otherwise specified in the Solicitation Document (i.e. the Authorized Agency may accept a cashier's check or certified check in lieu of all or a portion of the required performance bond if specified in the Solicitation Document). The payment bond must be furnished by a surety company authorized to do business in Oregon, and in an amount equal to the full Contract Price.

(4) Time for Submission. The apparent successful Offeror must promptly furnish the required performance security upon the Authorized Agency's request. If the Offeror fails to furnish the security as requested, the Authorized Agency may reject the Offer and award the Contract to the Responsible Bidder with the next lowest Responsive Bid or the Responsible Proposer with the next highest-scoring Responsive Proposal, and, at the Authorized Agency's discretion, the Offeror must forfeit its Bid or Proposal security.

(5) Public Improvement Contracts Under $100,000. An Authorized Agency having delegated purchasing authority pursuant to OAR 125-246-0170 may, in its discretion, waive the bid security requirements and performance and payment requirements if the amount of the Contract for the Public Improvement is less than $100,000.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.375, 279C.380 & 279C.390
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0610
Definitions for Alternative Contracting Methods

The following definitions must apply to these OAR 125-249-0600 to 125-249-0690 Rules, unless the context requires otherwise:

(1) "Alternative Contracting Methods" mean innovative procurement techniques for obtaining Public Improvement Contracts, utilizing processes other than the traditional method of Design-Bid-Build (with Award based solely on price, in which a final design is issued with formal Bid documents, construction services are obtained by sealed Bid Awarded to the lowest Responsive, Responsible Bidder, and the project is built in accordance with those documents). In industry practice, such methods commonly include variations of Design-Build contracting, CM/GC forms of contracting and ESPCs, which are specifically addressed in these OAR 125-249-0600 to 125-249-0690 Rules, as well as other developing techniques such as general "performance contracting" and "cost plus time" contracting, for which procedural requirements are identified under these OAR 125-249-0600 to 125-249-0690 Rules.

(2) "Construction Manager/General Contractor" (CM/GC) means a form of Procurement that results in a Public Improvement Contract for a Construction Manager/General Contractor to undertake project team involvement with design development; constructability reviews; value engineering, scheduling, estimating and subcontracting services; establish a Guaranteed Maximum Price to complete the Contract Work; act as General Contractor; hold all subcontracts, self-perform portions of the Work as may be allowed by the Authorized Agency under the CM/GC Contract; coordinate and manage the building process; provide general Contractor expertise; and act as a member of the project team along with the Authorized Agency, architect/engineers and other Consultants. CM/GC also refers to a Contractor under this form of Contract, sometimes known as the "Construction Manager at Risk."

(3) "Design-Build" means a form of Procurement that results in a Public Improvement Contract in which the construction Contractor also provides or obtains specified design Services, participates on the project team with the Authorized Agency, and manages both design and construction. In this form of Contract, a single Person provides the Authorized Agency with all of the Personal Services and Work necessary to both design and construct the project.

(4) "Energy Conservation Measures" (ECMs, also known as Energy Efficiency Measures) means, as used in ESPC Procurement, any equipment, fixture or furnishing to be added to or used in an existing building or structure, and any repair, alteration or improvement to an existing building or structure that is designed to reduce energy consumption and related costs, including those costs related to electrical energy, thermal energy, water consumption, waste disposal, and future contract-labor costs and materials costs associated with maintenance of the building or structure. For purposes of these OAR 125-249-0600 to 125-249-0690 Rules, use of either or both of the terms "building" or "structure" must be deemed to include existing energy, water and waste disposal systems connected or

related to or otherwise used for the building or structure when such system(s) are included in the project, either as part of the project together with the building or structure, or when such system(s) are the focus of the project. Maintenance Services are not Energy Conservation Measures, for purposes of these OAR 125-249-0600 to 125-249-0690 Rules.

(5) "Energy Savings Guarantee" means the energy savings and performance guarantee provided by the ESCO under an ESPC Procurement, which guarantees to the Authorized Agency that certain energy savings and performance will be achieved for the project covered by the RFP, through the installation and implementation of the agreed-upon ECMs for the project. The Energy Savings Guarantee must include, but must not be limited to, the specific energy savings and performance levels and amounts that will be guaranteed, provisions related to the financial remedies available to the Authorized Agency in the event the guaranteed savings and performance are not achieved, the specific conditions under which the ESCO will guarantee energy savings and performance (including the specific responsibilities of the Authorized Agency after final completion of the design and construction phase), and the term of the energy savings and performance guarantee.

(6) "Energy Savings Performance" Contract (ESPC) means a Public Improvement Contract between an Authorized Agency and a Qualified Energy Service Company for the identification, evaluation, recommendation, design and construction of Energy Conservation Measures, including a Design-Build Contract, that guarantee energy savings or performance.

(7) "Guaranteed Maximum Price" (GMP) means the total maximum price provided to the Authorized Agency by the Contractor, and accepted by the Authorized Agency, that includes all reimbursable costs of and fees for completion of the contract Work, as defined by the Public Improvement Contract, except for material changes in the Scope of Work. It may also include particularly identified contingency amounts.

(8) "Measurement and Verification" (M & V) means, as used in ESPC Procurement, the examination of installed ECMs using the International Performance Measurement and Verification Protocol (IPMVP), or any other comparable protocol or process, to monitor and verify the operation of energy-using systems pre-installation and post-installation.

(9) "Project Development Plan" means a secondary phase of Personal Services and Work performed by an ESCO in an ESPC Procurement when the ESCO performs more extensive design of the agreed-upon ECMs for the project, provides the detailed provisions of the ESCO's Energy Savings Guarantee that the fully installed and commissioned ECMs will achieve a particular energy savings level for the building or structure, and prepares an overall report or plan summarizing the ESCO's Work during this secondary phase of the Work and otherwise explaining how the agreed-upon ECMs will be implemented during the design and construction phase of the Work; The term "Project Development Plan" can also refer to the report or plan provided by the ESCO at the conclusion of this phase of the Work.

(10) "Qualified Energy Service Company" (ESCO) means, as used in ESPC Procurement, a company, firm or other legal Person with the following characteristics: demonstrated technical, operational, financial and managerial capabilities to design, install, construct, commission, manage, measure and verify, and otherwise implement Energy Conservation Measures and other Work on building systems or building components that are directly related to the ECMs in existing buildings and structures; a prior record of successfully performing ESPCs on projects involving existing buildings and structures that are comparable to the project under consideration by the Authorized Agency; and the financial strength to effectively guarantee energy savings and performance under the ESPC for the project in question, or the ability to secure necessary financial measures to effectively guarantee energy savings under an ESPC for that project.

(11) "Technical Energy Audit," as used in ESPC Procurement, means the initial phase of Personal Services to be performed by an ESCO that includes a detailed evaluation of an existing building or structure, an evaluation of the potential ECMs that could be effectively utilized at the facility, and preparation of a report to the Authorized Agency of the ESCO's Findings during this initial phase of the Work; the term "Technical Energy Audit" can also refer to the report provided by the ESCO at the conclusion of this phase of the Work.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065 & 279C.335
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0620
Use of Alternative Contracting Methods

(1) Competitive Bidding Exemptions. ORS Chapter 279C requires a competitive bidding process for Public Improvement Contracts unless a statutory exception applies, a class of Contracts has been exempted, or an individual Contract has been exempted in accordance with ORS 279C.335 and any applicable Authorized Agency rules. Use of Alternative Contracting Methods may be directed by the State Procurement Office as an exception to the prescribed Public Contracting practices in Oregon, and their use must be justified in accordance with the Public Contract law and these OAR 125-249-0600 to 125-249-0690 Rules. See OAR 125-249-0630 regarding required Findings and restrictions on class exemptions.

(2) Energy Savings Performance Contracts. Unlike other Alternative Contracting Methods covered by these OAR 125-249-0600 to 125-249-0690 Rules, ESPCs are exempt from the competitive bidding requirement process for Public Improvement Contracts pursuant to ORS 279C.335(1)(e), if the Authorized Agency complies with the procedures set forth in these OAR 125-249-0600 to 125-249-0690 Rules related to the Solicitation, Negotiation and contracting for ESPC Services. If those procedures are not followed, an ESPC procurement may still be exempted from competitive bidding requirements by following the general exemption procedures within ORS 279C.335.

(3) Post-Project Evaluation. ORS 279C.355 requires that the Authorized Agency prepare a formal post-project evaluation of Public Improvement projects in excess of $100,000 for which the competitive bidding process was not used. The purpose of this evaluation is to determine whether it was actually in the Authorized Agency's best interest to use an Alternative Contracting Method. The evaluation must be delivered to the Director of the Department as applicable within thirty (30) Days of the date the Authorized Agency "accepts" the Public Improvement project, which event is typically defined in the Contract. In the absence of such definition, acceptance of the Project occurs on the later of the date of final payment or the date of final completion of the Work. ORS 279C.355 describes the timing and content of this evaluation, with three (3) required elements:

(a) Financial information, consisting of cost estimates, any Guaranteed Maximum Price, changes and actual costs;

(b) A narrative description of successes and failures during design, engineering and construction; and

(c) An objective assessment of the use of the Alternative Contracting Method as compared to the exemption Findings.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065, 279C.335 & 351.086
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0630
Findings, Notice and Hearing

(1) General. This Rule provides guidance to the Agencies for making a request for an Exemption to the Chief Procurement Officer in accordance with ORS 279C.335 and OAR 125-246-0170(3)(c).

(2) Findings: Required Information. The statutory definition of "Findings" at ORS 279.330 means the justification for an Agency's conclusion that includes, "but is not limited to," information regarding eight identified areas.

(3) Findings Addressing Cost Savings. When Findings are required under ORS 279C.335 to exempt a Contract or class of Contracts from competitive bidding requirements, the "substantial cost savings" criterion at ORS 279C.335(2)(b) allows consideration of the type, cost, amount of the Contract, number of Entities available to Bid, and "such other factors as may be deemed appropriate." Accordingly, when the Contract or class of Contracts under consideration for an exemption contemplates the use of Alternative Contracting Methods, the "substantial cost savings" requirement may be addressed by a combination of:

(a) Specified Findings that address the factors and other information specifically identified by statute, including an analysis or reasonable forecast of future cost savings as well as present cost savings; and

(b) Additional Findings that address industry practices, surveys, trends, past experiences, evaluations of completed projects required by ORS 279C.355 and related information regarding the expected benefits and drawbacks of particular Alternative Contracting Methods. To the extent practicable, such Findings must relate back to the specific characteristics of the project or projects at issue in the exemption request.

(4) Findings Regarding Favoritism and Competition. The criteria at ORS 279C.335(2)(a) that it is "unlikely" that the exemption will "encourage favoritism" or "substantially diminish competition" may be addressed in contemplating the use of Alternative Contracting Methods by specifying the manner in which an RFP process will be utilized, that the Procurement will be formally advertised with public notice and disclosure of the planned Alternative Contracting Method, competition will be encouraged, Award made based upon identified selection criteria and an opportunity to protest that Award.

(5) Specificity of Findings.

(a) Method. Findings supporting a competitive bidding exemption must describe with specificity the Alternative Contracting Method to be used in lieu of competitive bidding, including, but not limited to, whether a one step (Request for Proposals) or two step (beginning with Requests for Qualifications) solicitation process will be utilized.

(b) Project(s). The Findings must clearly and generally identify the Project with respect to its defining characteristics. Those characteristics must include at least: Project descriptions, locations, anticipated time periods, anticipated contract values or the range of values, and other significant factors that distinguish the Project(s) from an Authorized Agency's overall construction program.

(c) Contract. The Findings may also describe anticipated characteristics or features of the resulting Public Improvement Contract. The parameters of the Public Improvement Contract are those characteristics or specifics that are announced in the Solicitation Document.

(d) Basis for an Order. The Chief Procurement Officer relies upon the representations and accuracy of the Authorized Agency's Findings in subsections (a) and (b), which form the basis for and are incorporated by reference in any subsequent Exemption Order.

(6) Prior Review of Draft Findings. Agencies must submit draft Findings to the State Procurement Office for review and concurrence prior to advertising the public hearing required by ORS 279C.335(5). Agencies must also submit draft Findings to the Department of Justice for review and comment prior to advertising the public hearing.

(7) Class Exemptions. In making the findings supporting a class exemption the Authorized Agency must clearly identify the class with respect to its defining characteristics. Those characteristics must include some combination of Project descriptions or locations, time periods, contract values or method of Procurement or other factors that distinguish the limited and related class of Projects from an Authorized Agency's overall construction program. Classes must not be defined solely by funding sources, such as a particular bond fund, or by method of Procurement, but must be defined by characteristics that reasonably relate to the exemption criteria set forth in ORS 279C.335(2).

(8) Public Hearing. Before final adoption of Findings exempting a Public Improvement Contract or class of Contracts from the requirement of competitive bidding, an Authorized Agency must give notice and hold a public hearing as required by ORS 279C.335(5). The hearing must be for the purpose of receiving public comment on the Authorized Agency's draft Findings.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065 & 279C.335
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0640
Competitive Proposals; Procedure

Authorized Agencies may utilize the following RFP process for Public Improvement Contracts, allowing flexibility in both Proposal evaluation and contract Negotiation, only in accordance with ORS 279C.400 to 279C.410 and OAR 125-249-0600 to 125-249-690, unless other applicable statutes control an Authorized Agency's use of competitive Proposals for Public Improvement Contracts. Also see the Subdivision of Rules in this Division entitled Formal Procurement Rules, OAR 125-249-0200 to 125-249-0490, and RFP related Rules under the Alternative Contracting Methods Subdivision at OAR 125-249-0640 to 125-249-0660. For ESPCs, the following RFP process must be utilized if an Authorized Agency desires the Procurement Process to be exempt from the competitive bidding requirements of ORS 279C.335. The RFP process for the Alternative Contracting Methods identified in OAR 125-249-0600 to 125-249-0690 includes the following steps:

(1) Proposal Evaluation. Factors in addition to price may be considered in the selection process, but only as set forth in the RFP. For ESPC Proposal evaluations, the Authorized Agency may provide in the RFP that qualifications-based evaluation factors will outweigh the Authorized Agency's consideration of price-related factors, due to the fact that prices for the major components of the Work to be performed during the ESPC process contemplated by the RFP will likely not be determinable at the time of Proposal evaluation. Proposal evaluation must be as objective as possible. Evaluation factors need not be precise predictors of future costs and performance, but to the extent possible such evaluation factors must:

(a) Be reasonable estimates based on information available to the Authorized Agency;

(b) Treat all Proposals equitably; and

(c) Recognize that public policy requires that Public Improvements be constructed at the least overall cost to the Authorized Agency. See ORS 279C.305.

(2) Evaluation Factors:

(a) In basic negotiated construction contracting, where the only reason for an RFP is to consider factors other than price, those factors may consist of firm and personnel experience on similar projects, adequacy of equipment and physical plant, sources of supply, availability of key personnel, financial capacity, past performance, safety records, project understanding, proposed methods of construction, proposed milestone dates, references, service, and related matters that affect cost or quality.

(b) In CM/GC contracting, in addition to (a) above, those factors may also include the ability to respond to the technical complexity or unique character of the project, analyze and propose solutions or approaches to complex project problems, coordination of multiple disciplines, the time required to commence and complete the improvement, and related matters that affect cost or quality.

(c) In Design-Build contracting, in addition to (a) and (b) above, those factors may also include design professional qualifications, specialized experience, preliminary design submittals, technical merit, design-builder team experience and related matters that affect cost or quality.

(d) In ESPC contracting, in addition to the factors set forth in Subsections (a), (b) and (c) above, those factors may also include sample Technical Energy Audits from similar projects, sample M & V reports, financial statements and related information of the ESCO for a time period established in the RFP, financial statements and related information of joint venturers comprising the ESCO, the ESCO's capabilities and experience in performing energy baseline studies for facilities (independently or in cooperation with an independent third-party energy baseline Consultant), past performance of the ESCO in meeting energy guarantee contract levels, the specific Person that will provide the Energy Savings Guarantee to be offered by the ESCO, the ESCO's management plan for the project, information on the specific methods, techniques and equipment that the ESCO will use in the performance of the Work under the ESPC, the ESCO's team members and Consultants to be assigned to the project, the ESCO's experience in the Energy Savings Performance contracting field, the ESCO's experience acting as the prime Contractor on previous ESPC projects (as opposed to a subcontractor or Consultant to a prime ESCO), the ESCO's vendor and product neutrality related to the development of ECMs, the ESCO's project history related to removal from an ESPC project or the inability or unwillingness of the ESCO to complete an ESPC project, the ESCO's M & V capabilities and experience (independently or in cooperation with an independent third-party M & V Consultant), the ESCO's ability to explain the unique risks associated with ESPC projects and the assignment of risk in the particular project between the Authorized Agency and the ESCO, the ESCO's equipment performance guarantee policies and procedures, the ESCO's energy savings and cost savings guarantee policies and procedures, the ESCO's project cost guarantee policies and procedures, the ESCO's pricing methodologies, the price that the ESCO will charge for the Technical Energy Audit phase of the Work and the ESCO's fee structure for all phases of the ESPC.

(3) Contract Negotiations. Contract terms may be negotiated to the extent allowed by the RFP and OAR 125-249-0600 to 125-249-0690, provided that the general Work Scope remains the same and that the field of competition does not change as a result of material changes to the requirements stated in the Solicitation Document. See OAR 125-249-0650. Terms that may be negotiated consist of details of contract performance, methods of construction, timing, assignment of risk in specified areas, fee, and other matters that affect cost or quality. In ESPC contracting, terms that may be negotiated also include the Scope of preliminary design of ECMs to be evaluated by the parties during the Technical Energy Audit phase of the Work, the Scope of services to be performed by the ESCO during the Project Development Plan phase of the Work, the detailed provisions of the Energy Savings Guarantee to be provided by the ESCO and Scope of Personal Services and Work, methodologies and compensation terms and conditions during the design and construction phase and M & V phase of the Work, consistent with the requirements of OAR 125-249-0680 below.

Stat. Auth.: ORS 279C.335 & 279A.065
Stats. Implemented: ORS 279A.065, 279C.335 & 351.086
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0645
Requests for Qualifications (RFQ)

As provided by ORS 279C.410(9), Authorized Agencies may utilize Requests for Qualifications (RFQs) to obtain information useful in the preparation or distribution of a Request for Proposals (RFPs). When using RFQs as the first step in a two (2) step solicitation process, in which distribution of the RFPs will be limited to the highest ranked firms submitting statements of qualification, Authorized Agencies must first advertise and provide notice of the RFQ in the same manner in which RFPs are advertised, include the RFP, specifically state that RFPs will be distributed only to the highest ranked firms in the RFQ process and also provide within the RFQ a protest provision substantially in form of OAR 125-249-0450(5) regarding protests of the competitive range. Thereafter, Authorizing Agencies may distribute RFPs to those highest ranked firms without further advertisement of the Solicitation.

Stat. Auth.: ORS 279C.410; 279A.065
Stats. Implemented: ORS 279C.410
Hist.: DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0650
Requests for Proposals (RFP)

(1) Generally. The use of competitive proposals must be specially authorized for a Public Improvement Contract under the competitive bidding requirement of ORS 279C.335(1), OAR 125-249-0130 and 125-249-0600 to 125-249-0690. Also see ORS 279C.400 to 279C.410 for statutory requirements regarding competitive Proposals, and OAR 125-249-0640 regarding competitive Proposal procedures.

(2) Solicitation Documents. In addition to the Solicitation Document requirements of OAR 125-249-0200, this Rule applies to the requirements for Requests for Proposals. RFP Solicitation Documents must conform to the following standards:

(a) The Authorized Agency must set forth selection criteria in the Solicitation Document. Examples of evaluation criteria include price or cost, quality of a product or service, past performance, management, capability, personnel qualification, prior experience, compatibility, reliability, operating efficiency, expansion potential, experience of key personnel, adequacy of equipment or physical plant, financial wherewithal, sources of supply, references and warranty provisions. See OAR 125-249-0640. Evaluation factors need not be precise predictors of actual future costs and performance, but to the extent possible, such factors must be reasonable estimates based on information available to the Authorized Agency;

(b) When the Authorized Agency is willing to negotiate terms and conditions of the Contract or allow submission of revised Proposals following Discussions, the Authorized Agency must identify the specific terms and conditions in or provisions of the Solicitation Document that are subject to Negotiation or Discussion and authorize Offerors to propose certain alternative terms and conditions in lieu of the terms and conditions the Authorized Agency has identified as authorized for Negotiation. The Authorized Agency must describe the evaluation and Discussion or Negotiation process, including how the Authorized Agency will establish the Competitive Range;

(c) The anticipated size of the Competitive Range must be stated in the Solicitation Document, but may be decreased if the number of the Proposers that submit responsive Proposals is less that the specified number, or may be increased as provided in OAR 125-249-0650(4)(a)(B);

(d) When the Authorized Agency intends to award Contracts to more than one Proposer, the Authorized Agency must identify in the Solicitation Document the manner in which it will determine the number of Contracts it will Award. The Authorized Agency must also include the criteria it will use to determine how the Authorized Agency will endeavor to achieve optimal value, utility and substantial fairness when selecting a particular Contractor to provide Supplies and Services from those Contractors Awarded Contracts.

(3) Evaluation of Proposals.

(a) Evaluation. The Authorized Agency must evaluate Proposals only in accordance with criteria set forth in the RFP and applicable law. The Authorized Agency must evaluate Proposals to determine the Responsible Proposer or Proposers submitting the best Responsive Proposal or Proposals.

(A) Clarifications. In evaluating Proposals, an Authorized Agency may seek information from a Proposer to clarify the Proposer's Proposal. A Proposer must submit Written and Signed clarifications and such clarifications must become part of the Proposer's Proposal.

(B) Limited Negotiation. If the Authorized Agency did not permit Negotiation in its Request for Proposals, the Authorized Agency may, nonetheless, negotiate with the highest-ranked Proposer, but may then only negotiate the:

(i) Statement of Work; and

(ii) Contract Price as it is affected by negotiating the statement of Work.

(iii) The process for Discussions or Negotiations that is outlined and explained in Subsections (5)(b) and (6) of this Rule does not apply to this limited Negotiation.

(b) Discussions; Negotiations. If the Authorized Agency permitted Discussions or Negotiations in the Request for Proposals, the Authorized Agency must evaluate Proposals and establish the Competitive Range, and may then conduct Discussions and Negotiations in accordance with this Rule.

(A) If the Solicitation Document provided that Discussions or Negotiations may occur at the Authorized Agency's discretion, the Authorized Agency may forego Discussions and Negotiations and evaluate all Proposals in accordance with this Rule.

(B) If the Authorized Agency proceeds with Discussions or Negotiations, the Authorized Agency must establish a Negotiation team tailored for the acquisition. The Authorized Agency's team may include legal, technical and negotiating personnel.

(c) Cancellation. Nothing in this Rule must restrict or prohibit the Authorized Agency from canceling the Solicitation at any time.

(4) Competitive Range, Protest, Award:

(a) Determining Competitive Range:

(A) If the Authorized Agency does not cancel the Solicitation, after the Opening the Authorized Agency will evaluate all Proposals in accordance with the evaluation criteria set forth in the Request for Proposals. After evaluation of all Proposals in accordance with the criteria set forth in the Request for Proposals, the Authorized Agency will determine and rank the Proposers in the Competitive Range.

(B) The Authorized Agency may increase the number of Proposers in the Competitive Range if the Authorized Agency's evaluation of Proposals establishes a natural break in the scores of Proposers indicating a number of Proposers greater than the initial Competitive Range are closely competitive, or have a reasonable chance of being determined the best Proposer after the Authorized Agency's evaluation of revised Proposals submitted in accordance with the process described in this Rule.

(b) Protesting Competitive Range. The Authorized Agency must provide Written notice to all Proposers identifying Proposers in the Competitive Range. A Proposer that is not within the Competitive Range may protest the Authorized Agency's evaluation and determination of the Competitive Range in accordance with OAR 125-249-0450.

(c) Intent to Award; Discuss or Negotiate. After the protest period provided in accordance with these Rules expires, or after the Authorized Agency has provided a final response to any protest, whichever date is later, the Authorized Agency may either:

(A) Provide Written notice to all Proposers in the Competitive Range of its intent to award the Contract to the highest-ranked Proposer in the Competitive Range.

(i) An unsuccessful Proposer may protest the Authorized Agency's intent to award in accordance with OAR 125-249-0450.

(ii) After the protest period provided in accordance with OAR 125-249-0450 expires, or after the Authorized Agency has provided a final response to any protest, whichever date is later, the Authorized Agency must commence final contract Negotiations with the highest-ranked Proposer in the Competitive Range; or

(B) Engage in Discussions with Proposers in the Competitive Range and accept revised Proposals from them, and, following such Discussions and receipt and evaluation of revised Proposals, conduct Negotiations with the Proposers in the Competitive Range.

(5) Discussions; Revised Proposals. If the Authorized Agency chooses to enter into Discussions with and receive revised Proposals from the Proposers in the Competitive Range, the Authorized Agency must proceed as follows:

(a) Initiating Discussions. The Authorized Agency must initiate oral or Written Discussions with all of the Proposers in the Competitive Range regarding their Proposals with respect to the provisions of the RFP that the Authorized Agency identified in the RFP as the subject of Discussions. The Authorized Agency may conduct Discussions for the following purposes:

(A) Informing Proposers of deficiencies in their initial Proposals;

(B) Notifying Proposers of parts of their Proposals for which the Authorized Agency would like additional information; and

(C) Otherwise allowing Proposers to develop revised Proposals that will allow the Authorized Agency to obtain the best Proposal based on the requirements and evaluation criteria set forth in the Request for Proposals.

(b) Conducting Discussions. The Authorized Agency may conduct Discussions with each Proposer in the Competitive Range necessary to fulfill the purposes of this Section, but need not conduct the same amount of Discussions with each Proposer. The Authorized Agency may terminate Discussions with any Proposer in the Competitive Range at any time. However, the Authorized Agency must offer all Proposers in the Competitive Range the opportunity to discuss their Proposals with the Authorized Agency before the Authorized Agency notifies Proposers of the date and time pursuant to this Section that revised Proposals will be due.

(A) In conducting Discussions, the Authorized Agency:

(i) Must treat all Proposers fairly and must not favor any Proposer over another;

(ii) Must not discuss other Proposers' Proposals;

(iii) Must not suggest specific revisions that a Proposer should make to its Proposal, and must not otherwise direct the Proposer to make any specific revisions to its Proposal.

(B) At any time during the time allowed for Discussions, the Authorized Agency may:

(i) Continue Discussions with a particular Proposer;

(ii) Terminate Discussions with a particular Proposer and continue Discussions with other Proposers in the Competitive Range; or

(iii) Conclude Discussions with all remaining Proposers in the Competitive Range and provide notice to the Proposers in the Competitive Range to submit revised Proposals.

(c) Revised Proposals. If the Authorized Agency does not cancel the Solicitation at the conclusion of the Authorized Agency's Discussions with all remaining Proposers in the Competitive Range, the Authorized Agency must give all remaining Proposers in the Competitive Range notice of the date and time by which they must submit revised Proposals. This notice constitutes the Authorized Agency's termination of Discussions, and Proposers must submit revised Proposals by the date and time set forth in the Authorized Agency's notice.

(A) Upon receipt of the revised Proposals, the Authorized Agency must score the revised Proposals based upon the evaluation criteria set forth in the Request for Proposals, and rank the revised Proposals based on the Authorized Agency's scoring.

(B) The Authorized Agency may conduct Discussions with and accept only one revised Proposal from each Proposer in the Competitive Range unless otherwise set forth in the Request for Proposals.

(d) Intent to Award; Protest. The Authorized Agency must provide Written notice to all Proposers in the Competitive Range of the Authorized Agency's intent to award the Contract. An unsuccessful Proposer may protest the Authorized Agency's intent to award in accordance with OAR 125-249-0450. After the protest period provided in accordance with that Rule expires, or after the Authorized Agency has provided a final response to any protest, whichever date is later, the Authorized Agency must commence final contract Negotiations.

(6) Negotiations:

(a) Initiating Negotiations. The Authorized Agency may determine to commence Negotiations with the highest-ranked Proposer in the Competitive Range following the:

(A) Initial determination of the Competitive Range; or

(B) Conclusion of Discussions with all Proposers in the Competitive Range and evaluation of revised Proposals.

(b) Conducting Negotiations and Scope. The Authorized Agency may negotiate:

(A) The statement of Work;

(B) The Contract Price as it is affected by negotiating the statement of Work; and

(C) Any other terms and conditions reasonably related to those expressly authorized for Negotiation in the Request for Proposals. Accordingly, Proposers must not submit, and the Authorized Agency must not accept, for Negotiation any alternative terms and conditions that are not reasonably related to those expressly authorized for Negotiation in the Request for Proposals.

(c) Terminating Negotiations. At any time during Discussions or Negotiations that the Authorized Agency conducts in accordance with this Rule, the Authorized Agency may terminate Discussions or Negotiations with the highest-ranked Proposer, or the Proposer with whom it is currently discussing or negotiating, if the Authorized Agency reasonably believes that:

(A) The Proposer is not discussing or negotiating in good faith; or

(B) Further Discussions or Negotiations with the Proposer will not result in the parties agreeing to the terms and conditions of a final Contract in a timely manner.

(d) Continuing Negotiations. If the Authorized Agency terminates Discussions or Negotiations with a Proposer, the Authorized Agency may then commence Negotiations with the next highest scoring Proposer in the Competitive Range, and continue the process described in this Rule until the Authorized Agency has either:

(A) Determined to award the Contract to the Proposer with whom it is currently discussing or negotiating; or

(B) Completed one round of Discussions or Negotiations with all Proposers in the Competitive Range, unless the Authorized Agency provided for more than one round of Discussions or Negotiations in the Request for Proposals.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.400 - 279C.410
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0660
RFP Pricing Mechanisms

(1) A Request for Proposals may result in a lump sum Contract Price, as in the case of competitive bidding. Alternatively, a cost reimbursement Contract may be negotiated.

(2) Economic incentives or disincentives may be included to reflect stated Authorized Agency purposes related to time of completion, safety or other Public Contracting objectives, including total least cost mechanisms such as Life Cycle Costing pursuant to OAR 125-247-0170.

(3) A Guaranteed Maximum Price (GMP) is used as the pricing mechanism for CM/GC where a total Contract Price is provided in the design phase in order to assist the Authorized Agency in determining whether the project Scope is within the Authorized Agency's budget, and allowing for design changes during preliminary design rather than after final design Work has been completed.

(a) If this collaborative process is successful, the Contractor must propose a final GMP, which may be accepted by the Authorized Agency and included within the Contract.

(b) If this collaborative process is not successful, and no mutually agreeable resolution on GMP can be achieved with the Contractor, then the Authorized Agency must terminate the Contract. The public Authorized Agency may then proceed to negotiate a new Contract (and GMP) with the firm that was next ranked in the original selection process, or employ other means for continuing the project under ORS Chapter 279C.

(4) When cost reimbursement Contracts are utilized, regardless of whether a GMP is included, the Authorized Agency must provide for audit controls that will effectively verify rates and ensure that costs are reasonable, allowable and properly allocated.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.335
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0670
Design-Build Contracts

(1) General. The Design-Build form of contracting, as defined at OAR 125-249-0610(3), has technical complexities that are not readily apparent. Authorized Agencies must use this contracting method only with the assistance of knowledgeable staff or Consultants who are experienced in its use. In order to use the Design-Build process, the Authorized Agency must be able to reasonably anticipate the following types of benefits:

(a) Obtaining, through a Design-Build team, engineering design, plan preparation, value engineering, construction engineering, construction, quality control and required documentation as a fully integrated function with a single point of responsibility;

(b) Integrating value engineering suggestions into the design phase, as the construction Contractor joins the project team early with design responsibilities under a team approach, with the potential of reducing contract changes;

(c) Reducing the risk of design flaws, misunderstandings and conflicts inherent in construction Contractors building from designs in which they have had no opportunity for input, with the potential of reducing contract claims;

(d) Shortening project time as construction activity (early submittals, mobilization, subcontracting and advance Work) commences prior to completion of a "Biddable" design, or where a design solution is still required (as in complex or phased projects); or

(e) Obtaining innovative design solutions through the collaboration of the Contractor and design team, which would not otherwise be possible if the Contractor had not yet been selected.

(2) Authority. Authorized Agencies must utilize the Design-Build form of contracting only in accordance with the requirements of these OARs 125-249-0600 to 125-249-0690 Rules. See particularly 125-249-0620 on "Use of Alternative Contracting Methods" and 125-249-0680 pertaining to ESPCs.

(3) Selection. Design-Build selection criteria may include those factors set forth above in OAR 125-249-0640(2)(a), (b), (c) and (d).

(4) QBS Inapplicable. Because the value of construction services predominates the Design-Build form of contracting, the qualifications based selection (QBS) process mandated by ORS 279C.110 for Authorized Agencies in obtaining certain Consultant services is not applicable.

(5) Licensing. If a Design-Build Contractor is not an Oregon licensed design professional, the Authorized Agency must require that the Design-Build Contractor disclose in its Written Offer that it is not an Oregon licensed design professional, and identify the Oregon licensed design professional(s) who will provide design services. See ORS 671.030(2)(g) regarding the offer of architectural services, and ORS 672.060(11) regarding the offer of engineering services that are appurtenant to construction services.

(6) Performance Security. ORS 279C.380(1)(a) provides that for Design-Build Contracts the surety's obligation on performance bonds, or the Bidder's obligation on cashier's or certified checks accepted in lieu thereof, includes the preparation and completion of design and related professional services specified in the Contract. This additional obligation, beyond performance of construction services, extends only to the provision of professional services and related design revisions, corrective Work and associated costs prior to final completion of the Contract (or for such longer time as may be defined in the Contract). The obligation is not intended to

be a substitute for professional liability insurance, and does not include errors and omissions or latent defects coverage.

(7) Contract Requirements. Authorized Agencies must conform their Design-Build contracting practices to the following requirements:

(a) Design Services. The level or type of design services required must be clearly defined within the Procurement Documents and Contract, along with a description of the level or type of design services previously performed for the project. The services to be performed must be clearly delineated as either design Specifications or performance standards, and performance measurements must be identified.

(b) Professional Liability. The Contract must clearly identify the liability of design professionals with respect to the Design-Build Contractor and the Authorized Agency, as well as requirements for professional liability insurance.

(c) Risk Allocation. The Contract must clearly identify the extent to which the Authorized Agency requires an express indemnification from the Design-Build Contractor for any failure to perform, including professional errors and omissions, design warranties, construction operations and faulty Work claims.

(d) Warranties. The Contract must clearly identify any express warranties made to the Authorized Agency regarding characteristics or capabilities of the completed project (regardless of whether errors occur as the result of improper design, construction, or both), including any warranty that a design will be produced that meets the stated project performance and budget guidelines.

(e) Incentives. The Contract must clearly identify any economic incentives and disincentives, the specific criteria that apply and their relationship to other financial elements of the Contract.

(f) Honoraria. If allowed by the RFP, honoraria or stipends may be provided for early design submittals from qualified finalists during the Solicitation process on the basis that the Authorized Agency is benefited from such deliverables.

Stat. Auth.: ORS 279C.335 & 279A.065
Stats. Implemented: ORS 279A.065, 279C.110, 279C.335 & 351.086
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0680
Energy Savings Performance Contracts (ESPC)

(1) Generally. These OAR 125-249-0600 to 125-249-0690 Rules include a limited, efficient method for Authorized Agencies to enter into ESPCs outside the competitive bidding requirements of ORS 279C.335 for existing buildings or structures, but not for new construction. If an Authorized Agency chooses not to utilize the ESPC Procurement method provided for by these OAR 125-249-0600 to 125-249-0690, the Authorized Agency may still enter into an ESPC by complying with the competitive bidding exemption process set forth in ORS 279C.335, or by otherwise complying with the procurement requirements applicable to any Authorized Agency not subject to all the requirements of ORS 279C.335.

(2) ESPC Contracting Method. The ESPC form of contracting, as defined at OAR 125-249-0610(6), has unique technical complexities associated with the determination of what ECMs are feasible for the Authorized Agency, as well as the additional technical complexities associated with a Design-Build Contract. Authorized Agencies must only utilize the ESPC contracting method with the assistance of knowledgeable staff or Consultants who are experienced in its use. In order to utilize the ESPC contracting process, the Authorized Agency must be able to reasonably anticipate one or more of the following types of benefits:

(a) Obtaining, through an ESCO, the following types of integrated services: facility profiling, energy baseline studies, ECMs, Technical Energy Audits, project development planning, engineering design, plan preparation, cost estimating, life cycle costing, construction administration, project management, construction, quality control, operations and maintenance staff training, commissioning services, M & V services and required documentation as a fully integrated function with a single point of responsibility;

(b) Obtaining, through an ESCO, an Energy Savings Guarantee;

(c) Integrating the Technical Energy Audit phase and the Project Development Plan phase into the design and construction phase of Work on the project;

(d) Reducing the risk of design flaws, misunderstandings and conflicts inherent in the construction process, through the integration of ESPC services;

(e) Obtaining innovative design solutions through the collaboration of the members of the ESCO integrated ESPC services team;

(f) Integrating cost-effective ECMs into an existing building or structure, so that the ECMs pay for themselves through savings realized over the useful life of the ECMs;

(g) Preliminary design, development, implementation and an Energy Savings Guarantee of ECMs into an existing building or structure through an ESPC, as a distinct part of a major remodel of that building or structure that is being performed under a separate remodeling Contract; and

(h) Satisfying local energy efficiency design criteria or requirements.

(3) Authority. Authorized Agencies desiring to pursue an exemption from the competitive bidding requirements of ORS 279C.335 (and, if applicable, ORS 351.086), must utilize the ESPC form of contracting only in accordance with the requirements of these OAR 125-249-0600 to 125-249-0690 Rules.

(4) No Findings Required. An Authorized Agency is only required to comply with the ESPC contracting procedures set forth in these OAR 125-249-0600 to 125-249-0690 Rules in order for the ESPC to be exempt from the competitive bidding processes of ORS 279C.335. No Findings are required for an ESPC to be exempt from the competitive bidding process for Public Improvement Contracts pursuant to ORS 279C.335, unless the Authorized Agency is subject to the requirements of ORS 279C.335 and chooses not to comply with the ESPC contracting procedures set forth in these OAR 125-249-0600 to 125-249-0690 Rules.

(5) Selection. ESPC selection criteria may include those factors set forth above in OAR 125-249-0640(2)(a), (b), (c) and (d). Since the Energy Savings Guarantee is such a fundamental component in the ESPC contracting process, Proposers must disclose in their Proposals the identity of any Person providing (directly or indirectly) any Energy Savings Guarantee that may be offered by the successful ESCO during the course of the performance of the ESPC, along with any financial statements and related information pertaining to any such Person.

(6) QBS Inapplicable. Because the value of construction services predominates in the ESPC method of contracting, the qualifications based selection (QBS) process mandated by ORS 279C.110 for Authorized Agencies in obtaining certain Consultant services is not applicable.

(7) Licensing. If the ESCO is not an Oregon licensed design professional, the Authorized Agency must require that the ESCO disclose in the ESPC that it is not an Oregon licensed design professional, and identify the Oregon licensed design professional(s) who will provide design services. See ORS 671.030(5) regarding the offer of architectural services, and ORS 672.060(11) regarding the offer of engineering services that are appurtenant to construction services.

(8) Performance Security. At the point in the ESPC when the parties enter into a binding Contract that constitutes a Design-Build Contract, the ESCO must provide a performance bond and a payment bond, each for 100% of the full Contract Price, including the construction and design and related professional services specified in the ESPC Design-Build Contract, pursuant to ORS 279C.380(1)(a). For ESPC Design-Build Contracts, these "design and related professional services" include conventional design services, commissioning services, training services for the Authorized Agency's operations and maintenance staff, and any similar professional services provided by the ESCO under the ESPC Design-Build Contract prior to final completion of construction. M & V services, and any services associated with the ESCO's Energy Savings Guarantee are not included in these ORS 279C.380(1)(a) "design and related professional services." Nevertheless, an Authorized Agency may require that the ESCO provide performance security for M & V services and any services associated with the ESCO's Energy Savings Guarantee, if the Authorized Agency so provides in the RFP.

(9) Contracting Requirements. Authorized Agencies must conform their ESPC contracting practices to the following requirements:

(a) General ESPC Contracting Practices. An ESPC involves a multi-phase project, which includes the following contractual elements:

(A) A contractual structure which includes general contract terms describing the relationship of the parties, the various phases of the Work, the contractual terms governing the Technical Energy Audit for the project, the contractual terms governing the Project Development Plan for the project, the contractual terms governing the final design and construction of the project, the contractual terms governing the performance of the M & V services for the project, and the detailed provisions of the ESCO's Energy Savings Guarantee for the project.

(B) The various phases of the ESCO's Work will include the following:

(i) The Technical Energy Audit phase of the Work;

(ii) The Project Development Plan phase of the Work;

(iii) A third phase of the Work that constitutes a Design-Build Contract, during which the ESCO completes any plans and Specifications required to implement the ECMs that have been agreed to by the parties to the ESPC, and the ESCO performs all construction, commissioning, construction administration and related services to actually construct the project; and

(iv) A final phase of the Work, whereby the ESCO, independently or in cooperation with an independent Consultant hired by the Authorized Agency, performs M & V services to ensure that the Energy Savings

Guarantee identified by the ESCO in the earlier phases of the Work and agreed to by the parties has actually been achieved.

(b) Design-Build Contracting Requirements in ESPCs. At the point in the ESPC when the parties enter into a binding Contract that constitutes a Design-Build Contract, the Authorized Agency must conform its Design-Build contracting practices to the Design-Build contracting requirements set forth in OAR 125-249-0670.

(c) Pricing Alternatives. The Authorized Agency may utilize one of the following pricing alternatives in an ESPC:

(A) A fixed price for each phase of the services to be provided by the ESCO;

(B) A cost reimbursement pricing mechanism, with a maximum not-to-exceed price or a GMP; or

(C) A combination of a fixed fee for certain components of the services to be performed, a cost reimbursement pricing mechanism for the construction services to be performed with a GMP, a single or annual fixed fee for M & V services to be performed for an identified time period after final completion of the construction Work, and a single or annual Energy Savings Guarantee fixed fee payable for an identified time period after final completion of the construction Work that is conditioned on certain energy savings being achieved at the facility by the ECMs that have been implemented by the ESCO during the project (in the event an annual M & V services fee and annual Energy Savings Guarantee fee is utilized by the parties, the parties may provide in the Design-Build Contract that, at the sole option of the Authorized Agency, the ESCO's M & V services may be terminated prior to the completion of the M & V/Energy Savings Guarantee period and the Authorized Agency's future obligation to pay the M & V services fee and Energy Savings Guarantee fee will likewise be terminated, under terms agreed to by the parties).

(d) Permitted ESPC Scope of Work. The Scope of Work under the ESPC is restricted to implementation and installation of ECMs, as well as other Work on building systems or building components that are directly related to the ECMs, and that, as an integrated unit, will pay for themselves over the useful life of the ECMs installed. The permitted Scope of Work for ESPCs resulting from a Solicitation under these OAR 125-249-0600 to 125-249-0690 Rules does not include maintenance services for the project facility.

Stat. Auth.: ORS 279C.335 & 279A.065
Stats. Implemented: ORS 279A.065, 279C.110, 279C.335 & 351.086
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0815
BOLI Public Works Bond

Pursuant to ORS 279C.830(3), the specifications for every Public Works Contract must contain a provision stating that the Contractor and every subcontractor must have a Public Works bond filed with the Construction Contractors Board before starting Work on the project, unless otherwise exempt. This bond is in addition to performance bond and payment bond requirements.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279C.830
Hist.: DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0820
Retainage

(1) Withholding of Retainage. Except to the extent an Authorized Agency's enabling laws require otherwise, an Authorized Agency must not retain an amount in excess of five percent (5%) of the Contract Price for Work completed. If the Contractor has performed at least fifty percent (50%) of the contract Work and is progressing satisfactorily, upon the Contractor's submission of Written application containing the surety's Written approval, the Authorized Agency may, in its discretion, reduce or eliminate retainage on any remaining progress payments. The Authorized Agency must respond in Writing to all such applications within a reasonable time. When the contract Work is ninety seven and one half percent (97-1/2%) completed, the Authorized Agency may, at its discretion and without application by the Contractor, reduce the retained amount to one hundred percent (100%) of the value of the remaining unperformed contract Work. An Authorized Agency may at any time reinstate retainage. Retainage must be included in the final payment of the Contract Price.

(2) Deposit in interest-bearing accounts. Upon request of the Contractor, an Authorized Agency must deposit cash retainage in an interest-bearing account in a bank, savings bank, trust company, or savings association, for the benefit of the Authorized Agency. Earnings on such account must accrue to the Contractor. State Authorized Agencies must establish the account through the State Treasurer.

(3) Alternatives to cash retainage. In lieu of cash retainage to be held by an Authorized Agency, the Contractor may substitute one of the following:

(a) Deposit of Securities:

(A) The Contractor may deposit bonds or securities with the Authorized Agency or in any bank or trust company to be held for the benefit of the Authorized Agency. In such event, the Authorized Agency must reduce the retainage by an amount equal to the value of the bonds and securities, and reimburse the excess to the Contractor.

(B) Bonds and securities deposited or acquired in lieu of retainage must be of a character approved by the Department, including but not limited to:

(i) Bills, certificates, notes or bonds of the United States.

(ii) Other obligations of the United States or its Authorized Agencies.

(iii) Obligations of any corporation wholly owned by the Federal Government.

(iv) Indebtedness of the Federal National Mortgage Association.

(v) Upon the Authorized Agency's determination that all requirements for the protection of the Authorized Agency's interests have been fulfilled, it must release to the Contractor all bonds and securities deposited in lieu of retainage.

(C) Deposit of Surety Bond. An Authorized Agency, at its discretion, may allow the Contractor to deposit a surety bond in a form acceptable to the Authorized Agency in lieu of all or a portion of funds retained or to be retained. A Contractor depositing such a bond must accept surety bonds from its subcontractors and suppliers in lieu of retainage. In such cases, retainage must be reduced by an amount equal to the value of the bond, and the excess must be reimbursed.

(4) Recovery of Costs. An Authorized Agency may recover from the Contractor all costs incurred in the proper handling of cash retainage and securities, by reduction of the final payment.

(5) Additional Retainage When Certified Payroll Statements Not Filed. Pursuant to ORS 279C.845(7), if a Contractor is required to file certified payroll statements and fails to do so, the Authorized Agency must retain 25 percent of any amount earned by the Contractor on a Public Works Contract until the Contractor has filed such statements with the Authorized Agency. The Authorized Agency must pay the Contractor the amount retained under this provision within 14 days after the Contractor files the certified statements, regardless of whether a subcontractor has filed such statements (but see ORS 279C.845(1) regarding the requirement for both contractors and subcontracts to file certified statements with the Authorized Agency).

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.560, 279C.570 & 701.420
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0860
Public Works Contracts

(1) Generally. ORS 279C.800 to 279C.870 regulates Public Works Contracts, as defined in ORS 279C.800(5), and requirements for payment of prevailing wage rates. Also see administrative rules of the Bureau of Labor and Industries (BOLI) at OAR chapter 839.

(2) Required Contract Conditions. As detailed in the above statutes and Rules, every Public Works Contract must contain the following provisions:

(a) Authorized Agency authority to pay certain unpaid claims and charge such amounts to Contractors, as set forth in ORS 279C.515(1).

(b) Maximum hours of labor and overtime, as set forth in ORS 279C.520(1).

(c) Employer notice to employees of hours and days that employees may be required to Work, as set forth in ORS 279C.520(2).

(d) Contractor required payments for certain services related to sickness or injury, as set forth in ORS 279C.530.

(e) Requirement for payment of prevailing rate of wage, as set forth in ORS 279C.830(1).

(f) Requirement for payment of fee to BOLI, as set forth in ORS 279C.830(2) and administrative rule of the BOLI commissioner.

(3) Requirements for Specifications. The Specifications for every Public Works Contract, consisting of the procurement package (such as the project manual, Bid or Proposal booklets, request for quotes or similar procurement Specifications), must contain the following provisions:

(a) The prevailing rate of wage, as required by ORS 279C.830(1), physically contained within or attached to hard copies of procurement Specifications, and by a downloadable direct link to the specific wage rates that apply to the project (either on the Authorized Agency web site or the BOLI web site) when procurement Specifications are also made available in electronic format.

(b) Reference to payment of fee to BOLI, as required by ORS 279C.830(2).

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.800 - 279C.870
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0870
Specifications; Brand Name Products

(1) Generally. The Authorized Agency's Solicitation Document must not expressly or implicitly require any product by brand name or mark, nor must it require the product of any particular manufacturer or seller, except pursuant to an exemption granted under ORS 279C.345(2).

(2) Equivalents. An Authorized Agency may identify products by brand names as long as the following language: "approved equal"; "or equal"; "approved equivalent" or "equivalent," or similar language is included in the Solicitation Document. The Authorized Agency must determine, in its sole discretion, whether an Offeror's alternate product is "equal" or "equivalent."

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.345
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0900
Contract Suspension; Termination Procedures

(1) Suspension of Work. In the event an Authorized Agency suspends performance of Work for any reason considered by the Authorized Agency to be in the public interest other than a labor dispute, the Contractor must be entitled to a reasonable extension of contract time, and to reasonable compensation for all costs, including a reasonable allowance for related overhead, incurred by the Contractor as a result of the suspension.

(2) Termination of Contract by Mutual Agreement for Reasons Other Than Default.

(a) Reasons for termination. The parties may agree to terminate the Contract or a divisible portion thereof if:

(A) The Authorized Agency suspends Work under the Contract for any reason considered to be in the public interest (other than a labor dispute, or any judicial proceeding relating to the Work filed to resolve a labor dispute); and

(B) Circumstances or conditions are such that it is impracticable within a reasonable time to proceed with a substantial portion of the Work.

(b) Payment. When a Contract, or any divisible portion thereof, is terminated pursuant to this Section (2), the Authorized Agency must pay the Contractor a reasonable amount of compensation for preparatory Work completed, and for costs and expenses arising out of termination. The Authorized Agency must also pay for all Work completed, based on the Contract Price. Unless the Work completed is subject to unit or itemized pricing under the Contract, payment must be calculated based on percent of Contract completed. No claim for loss of anticipated profits will be allowed.

(3) Public Interest Termination by the Authorized Agency. An Authorized Agency may include in its Contracts terms detailing the circumstances under which the Contractor must be entitled to compensation as a matter of right in the event the Authorized Agency unilaterally terminates the Contract for any reason considered by the Authorized Agency to be in the public interest.

(4) Responsibility for Completed Work. Termination of the Contract or a divisible portion thereof pursuant to this Rule must not relieve either the Contractor or its surety of liability for claims arising out of the Work performed.

(5) Remedies Cumulative. The Authorized Agency may, at its discretion, avail itself of any or all rights or remedies set forth in these Rules, in the Contract, or available at law or in equity.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.326, 279C.650, 279C.655, 279C.660, 279C.665 & 279C.670
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 5-2006, f. & cert. ef. 5-31-06

125-249-0910
Changes to the Work and Contract Amendments

(1) Definitions. As used in this Rule:

(a) "Amendment" means a Written modification to the terms and conditions of a Public Improvement Contract, other than by Changes to the Work, within the general Scope of the original Procurement that requires mutual agreement between the Agency and the Contractor.

(b) "Changes to the Work" means a mutually agreed upon change order, or a construction change directive or other Written order issued by the Agency or its authorized representatives to the Contractor requiring a change in the Work within the general Scope of a Public Improvement Contract and issued under its changes provisions in administering the Contract and, if applicable, adjusting the Contract Price or contract time for the changed Work.

(2) Changes Provisions. Changes to the Work are anticipated in construction and, accordingly, Agencies must include changes provisions in all Public Improvement Contracts that detail the Scope of the changes clause, provide pricing mechanisms, authorize the Agency or its authorized representatives to issue Changes to the Work and provide a procedure for addressing Contractor claims for additional time or compensation. When Changes to the Work are agreed to or issued consistent with the Contract's changes provisions they are not considered to be new Procurements and an exemption from competitive bidding is not required for their issuance by Agencies.

(3) Change Order Authority. Agencies may establish internal limitations and delegations for authorizing Changes to the Work, including dollar limitations. Dollar limitations on Changes to the Work are not set by these Rules, but such changes are limited by the above definition of that term.

(4) Contract Amendments. Contract Amendments within the general Scope of the original Procurement are not considered to be new Procurements and an exemption from competitive bidding is not required in order to add components or phases of Work specified in or reasonably implied from the Solicitation Document. Amendments to a Public Improvement Contract may be made only when:

(a) They are within the general Scope of the original Procurement;

(b) The field of competition and Contractor selection would not likely have been affected by the contract modification. Factors to be considered in making that determination include similarities in Work, project site, relative dollar values, differences in risk allocation and whether the original Procurement was accomplished through competitive bidding, competitive proposals, Competitive Quotes, sole source or emergency contract;

(c) In the case of a Contract obtained under an Alternative Contracting Method, any additional Work was specified or reasonably implied within the findings supporting the competitive bidding exemption; and

(d) The Amendment is made consistent with this Rule and other applicable legal requirements.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065 & 279C.400(1)
Hist.: DAS 4-2004, f. 11-23-04, cert. ef. 3-1-05; DAS 9-2005, f. & cert. ef. 8-3-05; DAS 5-2006, f. & cert. ef. 5-31-06

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Department of Agriculture
Chapter 603

Rule Caption: Proposed amendment establishes a time and travel fee in the brands program.
Adm. Order No.: DOA 12-2006
Filed with Sec. of State: 6-7-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 603-014-0055
Subject: The proposed amendment establishes a time and travel fee. The time and travel fee will be applied as authorized by ORS 604.046(2) in conjunction with a $10.00 service fee for brand inspection at locations other than an auction market or registered feedlot.
Rules Coordinator: Sue Gooch—(503) 986-4583

603-014-0055
Service Fee

(1) The service fee provided for in ORS 604.046(2) shall apply anytime a livestock inspector travels specifically with the intent to conduct a brand inspection except for auction markets and registered feedlots.

(2) An additional time and mileage fee provided for in ORS 604.046(2), a charge of $15.00, shall apply anytime a livestock inspector travels specifically with the intent to conduct a brand inspection and collects a service fee except for auction markets and registered feedlots.

Stat. Auth.: ORS 561.190
Stats. Implemented: ORS 604.046(2)
Hist.: DOA 14-1999, f. & cert. ef. 6-30-99; DOA 12-2006, f. 6-7-06 cert. ef. 7-1-06

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Department of Community Colleges and Workforce Development
Chapter 589

Rule Caption: Distribution of Community College Support Fund.
Adm. Order No.: DCCWD 2-2006(Temp)
Filed with Sec. of State: 6-15-2006
Certified to be Effective: 6-15-06 thru 11-30-06
Notice Publication Date:
Rules Amended: 589-002-0100

Subject: ORS 589-002-0100 currently allows for the creation of the College Support Fund by the State Board of Education; however, it does not outline any distribution mechanism.

The proposed amendment of ORS 589-002-0100 identifies a mechanism to allow for distribution of the Strategic Fund.

Rules Coordinator: Linda Hutchins—(503) 378-8649, ext. 474

589-002-0100
Distribution of Community College Support Fund

(1) Purpose Statement:

(a) It is in the state's interest to support a strong local community college system that meets local, regional and state economic and workforce development needs. Short- and long-term interests include the consideration of such things as comparable District funding capability, maintaining small districts as a means of educational access and stable, predictable funding. Oregon's Community College distribution formula is designed to provide a financial foundation to support undergraduate and lower-division education, professional technical education, remedial education, local response to workforce training and other educational services necessary at the local and state level.

(b) The State Board, through the authority vested in it by ORS 341.626, uses this rule to state clearly and concisely what the statewide interests are for Oregon community colleges and students through the adoption of a policy-driven distribution formula. The overarching policy levers, chosen by the State Board, have been structured to support access and quality and to do so with equity for Oregon students.

(c) The State Board, the Department, and the seventeen Oregon Community Colleges plan to pursue equalization of resources regardless of funding levels. This goal is reflected in the following principles:

(A) An expectation that equalization will be achieved in six years.

(B) Significant additional funds in a biennium compared to the previous biennium will benefit every college. The State Board will determine what level is significant on a biennial basis.

(C) Historic share of total public resources will be based on the immediate previous year for every year, with the exception of 2005-06. For 2005-06, historic share of public resources will be based on the average of 2003-04 and 2004-05.

(D) Buffered FTE will be used in the formula. The buffering is accomplished by using a three-year weighted average as defined in Section (8)(b).

(E) If significant additional resources are available compared to the previous biennium, equalization can go faster. The State Board will determine what level is significant on a biennial basis.

(F) The resource level available compared to the previous biennium may impact the pace of progress toward equalization.

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

(a) "Total Public Resources." The Community College Support Fund formula considers 100% of the next year's imposed property tax revenue and the General Fund appropriation from the legislature.

(b) "Property tax revenues" is defined as the amount determined by the Department of Revenue to be imposed on local property following the application of limits imposed by sections 11(b)(1) through 11(b)(3), Article XI, of the Oregon Constitution, and those limits imposed by legislation implementing Ballot Measure 50. This amount becomes the basis for operation of the funding formula without regard to uncollectible taxes, or taxes collected from previous years. Taxes levied or imposed by a community college district to provide a public library system established prior to January 1, 1995 shall be excluded from the definition of property taxes in this rule. Property tax revenues raised through voter approval of any local option or capital construction levy are not to be included as a resource to be distributed through the funding formula.

(c) "Community College Support Fund" is defined as those funds received through the State's General Fund appropriation and distributed to the community colleges for the purpose of funding educational programs.

(d) "Full-Time Equivalent (FTE) Enrollment" is defined as 510 clock hours for all coursework and for all terms including a fall 12-week term. For an 11 week fall term, the following calculation will be used; 11/12 of 510 hours or 467.5 hours.

(e) "Total Reimbursable FTE" is defined as the sum of 40% of second year prior to current FTE, 30% of third year prior to current FTE, and 30% of fourth year prior to current FTE.

(f) "Historic Share of Public Resources" is defined as the percent of statewide non-base total public resources allocated to each Oregon community college in the prior period. With the exception of 2005-06, historic share of public resources is calculated by dividing each college's total public resources from the prior year, exclusive of the base, by total weighted reimbursable FTE from the prior year. For 2005-06, historic share of public resources is calculated by dividing each college's average total public resources from the 2003-04 and 2004-05 fiscal years, exclusive of the base, by the amount of frozen reimbursable FTE used in both the 2003-04 and 2004-05 fiscal years.

(g) "Equalization" is defined as equal public resource support per FTE, regardless of institution, and exclusive of the base. Equalization is measured by dividing Total Public Resources, exclusive of the base, by weighted reimbursable FTE.

(3) The Community College Support Fund shall be distributed in equal payments as follows:

(a) For the first year of the biennium, August 15, October 15, January 15, and April 15;

(b) For the second year of the biennium, August 15, October 15, and January 15;

(c) The final payment of each biennium is deferred until July 15 of the following biennium as directed by Senate Bill 1022 of the Third Special Session of the 71st Oregon Legislative Assembly.

(d) Should any of the dates set forth above occur on a weekend, payment shall be made on the next business day.

(e) All payments made before actual property taxes imposed by each district are certified by the Oregon Department of Revenue shall be based on the Department's best estimate of quarterly entitlement using enrollment and property tax revenue projections. Payments shall be recalculated each year as actual property tax revenues become available from the Oregon Department of Revenue and any adjustments will be made in the final payment(s) of the fiscal year.

(4) Districts shall be required to submit enrollment reports in the format specified by the Commissioner, including numbers of clock hours realized for all coursework, in a term-end enrollment report by the Friday of the sixth week following the close of each term. If reports are outstanding at the time of the quarterly payments, payment to the district(s) not reporting may be delayed at the discretion of the Commissioner.

(5) Reimbursement from the Community College Support Fund shall be made for professional technical, lower division collegiate, developmental education and other courses approved by the State Board in accordance with OAR 589-006-0100 through 589-006-0400. State reimbursement is not available for hobby and recreation courses as defined in OAR 589-006-0400.

(6) Residents of the state of Oregon and the states of Idaho, Washington, Nevada, and California shall be counted as part of each Community College's Total Reimbursable FTE base but only for those students who take part in coursework offered within Oregon's boundaries.

(7) State funding for community college district operations is appropriated by the legislature on a biennial basis to the Community College Support Fund. For each biennium the amount of state funds available for distribution through the funding formula shall be calculated based on the following:

(a) Funds to support contracted out-of-district (COD) programs and corrections programs shall be subtracted from the amount allocated to the Community College Support Fund before the formula is calculated. The amount available for these programs shall be equal to the funding amount in the preceding biennium, except as adjusted to reflect the same percentage increase or decrease realized in the overall Community College Support Fund appropriation. Each Community College having a COD contract shall receive a biennial appropriation equal to the same percentage share of funding it received in the preceding biennium, except as adjusted to reflect the same percentage increase or decrease realized in the overall Community College Support Fund appropriation; funding for individual corrections programs will be determined in consultation with the Department of Corrections.

(b) The State Board may establish a Strategic Fund.

(c) For 2005-07, $1,187,565 shall be subtracted from the amount appropriated to the Community College Support Fund before the formula is calculated. These funds shall be used to support targeted investments including distributed learning activities, by deposit into the Strategic Fund.

(A) There are two basic categories for these funds. Incentivized statewide initiatives and activities and requests from individual Districts for assistance in meeting new requirements and expectations stemming from legislative change.

(B) The Commissioner will use a committee of stakeholders and Department staff to determine overall priorities for funding that consider the State Board work plan and initiatives.

(C) The Commissioner will review, rank, and approve proposals to incentivize statewide activities. After each proposal is approved, the Commissioner will provide the State Board with a report detailing the purpose of the activity, the amount of Strategic Fund monies approved, and the proposal's merit as assessed under the following parameters:

(i) Purpose of the proposal.

(ii) How does the activity support the initiatives and work plans of the Department and the State Board.

(iii) Does the activity relate to the Department's Key Performance Measures or other program-specific measures?

(iv) Is the funding one time (for this biennium) or will additional funding be needed in the future?

(v) If future funding is needed, how will those resources be obtained? Is the activity sustainable?

(vi) What is the activity's impact on the State three years from now? Five years from now?

(vii) What change is anticipated?

(viii) How will progress be measured?

(D) The Department will bring all requests for assistance in meeting new requirements or expectations stemming from legislative change to the State Board for discussion and consideration.

(E) The Department will assess the requests for assistance n meeting new requirements or expectations of the Legislature based on the following parameters:

(i) Purpose of the proposal.

(ii) How will the funds be used? To sustain or increase enrollment (not supplanting existing funds)?

(iii) Is the funding one time (for this biennium) or will additional funding be needed in the future?

(iv) If future funding is needed, how will those resources be obtained? Is the activity sustainable?

(v) What is the proposal's impact on the Community College three years from now? Five years from now?

(vi) How will progress be measured?

(F) The Department will provide a recommendation and reasoning to the State Board on whether the request merits funding.

(G) Funds remaining in the Community College Support Fund shall be divided equally between the two years of the biennium, and will be distributed in equal payments as described in Section 3 and through a distribution formula as described in Section 8.

(8) Distribution of funds to Community College Districts from the Community College Support Fund shall be accomplished through a formula, based on the following factors:

(a) Base Payment. Each community college district shall receive a base payment of $600 for each FTE up to 1,100 and $300 per FTE for unrealized enrollments between actual enrollment numbers and 1,100 FTE. The base payment may be adjusted by the State Board each biennium. The base payment for each District will be adjusted according to the size of the District. District size for purposes of this adjustment will be determined each year by the FTE set forth in section (8)(b) of this rule. The base payment adjustments shall be:

(A) 0-750 FTE 1.3513;

(B) 751-1,250 FTE 1.2784;

(C) 1,251-1,750 FTE 1.2062;

(D) 1,751-2,250 FTE 1.1347;

(E) 2,251-2,750 FTE 1.0641;

(F) 2,751-3,250 FTE 1.0108;

(G) 3,251-3,750 FTE 1.0081;

(H) 3,751-4,250 FTE 1.0054;

(I) 4,251-4,999 FTE 1.0027;

(J) 5,000 or more FTE 1.000.

(b) Student-Centered Funding: The formula is designed to progress toward a distribution of funds based on FTE students. The equalized amount per FTE is determined by dividing total public resources — excluding base payments, contracted out-of-district payments, and any other payments directed by the State Board or the Legislature — by Total Reimbursable FTE. The Department shall make the calculation based on submission of FTE reports by the districts and in accordance with established FTE principles.

(A) A three-year weighted average of Total Reported Reimbursable FTE by the Community Colleges will be used.

(B) For 2005-06 through 2007-08: FTE will be "thawed" from its current level one year at a time, beginning in 2005-06 when actual 2003-04 FTE is included in the formula. Beginning in 2007-08, the weighted average of FTE will consider only actual FTE. The "frozen" 96,027 total reimbursable FTE statewide was set by the State Board in 2002-03.

(i) The calculation for 2005-2006 Total Reimbursable FTE is 2003-04 actual enrollments (weighted at 40%); 2002-03 enrollments set at 96,027 (weighted at 30%); 2001-02 enrollments set at 96,027 (weighted at 30%).

(ii) The calculation for 2006-07 Total Reimbursable FTE is 2004-05 actual enrollments (weighted at 40%); 2003-04 actual enrollments (weighted at 30%); 2002-03 enrollments set at 96,027 (weighted at 30%).

(iii) The calculation for 2007-08 Total Reimbursable FTE is 2005-06 actual enrollments (weighted at 40%); 2004-05 actual enrollments (weighted at 30%); 2003-04 actual enrollments (weighted at 30%).

(C) All future calculations will use a three-year weighted average with second year prior to current actual enrollment weighted at 40%, third year prior to current actual enrollment weighted at 30% and fourth year prior to current actual enrollment weighted at 30%.

(c) Equalization. The State Board of Education expects to achieve Equalization in funding for all community college students in six years.

(A) Progress to Equalization is defined as: On an individual Community College level, progress toward Equalization will close the gap between non-base total public resource support per FTE and fully equalized non-base total public resource support per FTE by some fraction per year.

(B) The proposed model calculates how far each Community College's non-base allocation is from full equity every year, then moves incrementally toward Equalization each year. Each Community College makes the same percentage movement to Equalization each year unless the harm limit (described in Section (8)(d)) is invoked. Community Colleges at or near equity do not move much in real dollars under the equity adjustment. Community Colleges further from equity move more in real dollars under the equity adjustment.

(C) In early years, the focus is on stability as Community Colleges adjust to Equalization. A smaller proportion of funds is distributed through Equalization and a larger proportion is distributed based on historic share of public resources. As the timeframe progresses, this proportion reverses, and in later years more funds are distributed through Equalization.

(d) Harm Limit. The harm limit is designed to prevent individual Community Colleges from losing more than a certain percent of non-base total public resources from one year to the next due to Equalization. The harm limit does not limit losses in total public resources due to changes in FTE enrollment, changes in the General Fund appropriation, or changes in public resources. The harm limit is determined by combining the percent change in state appropriation funds from one year to the next with an adjustment percent determined by the State Board each year. In determining the adjustment, and therefore the total harm limit that results from combining the adjustment with the percent change in resources, the Board should consider the following issues:

(A) The total harm limit must not unnecessarily impede progress toward Equalization in the expected six-year period.

(B) The total harm limit should be adequate to ameliorate unreasonable negative effects of Equalization.

(e) Distribution of Significant Additional State Resources. In a biennium when significant additional state resources are available compared to the state appropriation in the previous biennium, in each year of the biennium:

(A) Fifty percent of additional state resources will be allocated through the Equalization methodology.

(B) The remaining fifty percent of additional state resources will be allocated based on the Community College's historic share of public resources.

(C) The State Board will determine on a biennial basis what level of additional resources is considered significant.

(D) The State Board retains the authority to alter the percent of significant additional state resources allocated according to equity and historic share of public resources for each biennium, beginning in 2007-09.

(9) State general fund and local property taxes for territories annexed or formed effective June 1, 1996, or later shall not be included in the funding formula for the first three years of service. Additionally, the FTE generated in newly annexed territories shall not impact the funding formula during the first three years of service. Beginning in the fourth year, funding will be distributed through the formula as outlined in this rule.

Stat. Auth.: ORS 326.051 & 341.626

Stats. Implemented: ORS 341.015, 341.022, 341.317, 341.440, 341.525, 341.528, 341.626 & 341.665

Hist.: 1EB 9-1979, f. & ef. 6-11-79; EB 12-1991, f. & cert. ef. 7-19-91; Renumbered from 581-043-0260; ODE 27-2000, f. & cert. ef. 10-30-00; DCCWD 1-2001, f. & cert. ef. 3-21-01, Renumbered from 581-041-0200; DCCWD 2-2001, f. & cert. ef. 5-7-01; DCCWD 3-2002, f. & cert. ef. 6-5-02; DCCWD 7-2002(Temp), f. & cert. ef. 12-16-02 thru 6-5-03; DCCWD 3-2003, f. & cert. ef. 5-14-03; DCCWD 1-2004, f. & cert. ef. 7-1-04; DCCWD 1-2005, f. & cert. ef. 7-13-05; DCCWD 2-2006(Temp), f. & cert. ef. 6-15-06 thru 11-30-06

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Rule Caption: Distribution of WIA Title IB State Incentive Grants for Local Performance Measures.

Adm. Order No.: DCCWD 3-2006(Temp)

Filed with Sec. of State: 6-15-2006

Certified to be Effective: 6-15-06 thru 11-30-06

Notice Publication Date:

Rules Amended: 589-020-0210

Rules Suspended: 589-020-0260

Subject: Amending OAR 589-020-0210 is necessary because new policy language refers to updated OAR regarding WIA regulations that transfers procedures to agency policy for the distribution of WIA Title 1B Incentive Grant Awards.

Repealing OAR 589-020-0260 is necessary because it is outdated and will be addressed in the amended OAR 589-020-0210.

Rules Coordinator: Linda Hutchins—(503) 378-8649, ext. 474

589-020-0210

Distribution of WIA Title IB State Incentive Grants for Local Performance Measures

(1) Purpose: This rule establishes the requirements and methodology that the Department of Community Colleges and Workforce Development will utilize for distribution of state incentive grants and performance improvement plans pursuant to the federal Workforce Investment Act (WIA), PL 105-220, its amendments and regulations thereto.

(2) Definitions:

(a) Continuous Performance Improvement Plan: Funds made available to LWIAs that achieve a cumulative program area score less than 100% and at least 80% of the negotiated performance level on each performance indicator within a program area. *See agency Policy 589-20.2 for application process.*

(b) Cumulative Program Area Score: The aggregate amount by which a Local Workforce Investment Area (LWIA) exceeds or falls below the negotiated performance levels in a particular program area.

(c) Exemplary Performance: Having achieved a cumulative program area score greater than 100% and at least 80% of the negotiated performance level on each performance indicator within a program area.

(d) Failure to Meet: Actual performance for any of the performance indicators that falls below the negotiated level of performance. Technical assistance is required to be provided under WIA Section 134(a)(2)(B)(iv) to Local Workforce Investment Areas (LWIAs) that fail to meet local performance measures.

(e) Grantee: Recipient of grant funds from the Department of Labor. Refers to the Department of Community Colleges and Workforce Development (CCWD).

(f) Incentive Awards: Funds awarded to LWIAs that meet Exemplary Performance.

(g) Incentive Grants: A portion of the Statewide Employment and Training Activities funds under WIA Title IB section 134(a)(2)(B)(iii) and (iv) that is required to be used to award exemplary performance by local areas on the local performance measures and to provide technical assistance for LWIAs that fail to meet local performance measures.

(h) Local Performance Measure: A performance measure established under section136(c) of WIA. Local performance measures consist of the core performance indicators established under section 136(b)(2)(A) of WIA and fall into four program areas – adult, dislocated worker, youth, and customer satisfaction.

(i) Local Workforce Investment Area(s): The area(s) in the state designated by the Governor under section 116 of WIA to which WIA Title IB funds are allocated to carry out WIA Title IB programs.

(j) Mandatory Performance Improvement Plan: LWIAs that achieve a cumulative program area score of less than 100% and less than 80% of the negotiated performance level on a performance indicator within a program area must prepare and seek funding for a plan to address failure to meet performance. *See agency Policy 589-20.2 for application process.*

(k) Negotiated Performance Level: The numeric performance target agreed to by the State and the LWIA for each of the core performance indicators.

(l) Performance Measures: The performance indicators required by the Workforce Investment Act of 1998.

(m) Program Area: Four program areas used in the evaluation of performance for incentive purposes: adults, dislocated workers, youth, and customer satisfaction.

(n) Program Year (PY): The period July 1 through June 30 of each year.

(3) Available WIA funds shall be reserved for incentive awards and awarded in accordance with the following criteria:

(a) To be eligible for an incentive award for a program area, the LWIA must achieve a cumulative average score greater than 100% for the performance measures in a given program area (adult, dislocated worker, youth, or customer satisfaction); and

(b) The LWIA must achieve at least 80% of the negotiated performance level on each performance measure within a given program area.

(c) Incentive funds shall be awarded annually after the end of each Program Year (PY), when data to compute actual performance becomes available.

(4) Funds available to each LWIA, which may be earned in accordance with (3)(a) and (b) shall be determined:

(a) By calculating the percent each of the adult, youth and dislocated worker program's PY allocation is of the total PY allocation;

(b) By multiplying the total funds available for incentive awards by the percentages identified in (5)(a) of this OAR to arrive at the available funds for each program (adult, dislocated worker, and youth); and finally

(c) By multiplying the amounts identified in (5)(b) of this OAR for each program by the PY allocation percentages of each LWIA for the respective program; these products are then added to arrive at the total funds that each LWIA might earn.

(5) Funds available to be earned for each program area (adult, dislocated worker, youth and customer satisfaction) shall be calculated in the following manner:

(a) Each program area bears equal weight (25% for each of the four program areas).

(b) The total funds that each LWIA might earn ((5)(c) of this OAR) are multiplied by 25% to arrive at the amount that might be earned for each program area (adult, dislocated worker, youth, and customer satisfaction).

(6) Incentive awards will be made from funds available for that purpose out of current year funding, e.g., PY '04 incentive funds are used to reward PY '03 performance.

(7) Awarded incentive funds may be used for any activities allowed under WIA Title 1B.

(8) Definitions used for performance measures shall conform to those provided by the Department of Labor in Training and Employment Guidance Letter (TEGL) 7-99.

(9) Incentive awards shall only be applied to performance in Title IB programs.

(10) Funds for Continuous Performance Improvement Plans and Mandatory Performance Improvement Plans will be made available for LWIAs whose cumulative program area scores fall below 100% of the negotiated level.

(a) LWIAs whose cumulative program area score falls below 100% of the negotiated performance level may seek funding for Continuous Performance Improvement Plans.

(b) LWIAs whose cumulative program area score falls below 80% of the negotiated performance level must develop and seek funding for Mandatory Performance Improvement Plans.

(c) Funds may be used for any allowable WIA Title IB activities in support of a Continuous Performance Improvement Plan or Mandatory Performance Improvement Plan to correct identified deficiencies that led to failure to meet agreed upon levels of performance.

(d) Continuous Performance Improvement Plan and Mandatory Performance Improvement Plan awards will not exceed the amount the LWIA would have earned had performance been met.

(e) LWIAs seeking funds to support Continuous Performance Improvement Plan or Mandatory Performance Improvement Plan must submit the plan in writing to the Department of Community Colleges and Workforce Development. The plan shall be submitted timely, identify the problem/issue to be remedied, and provide a budget supporting the work to be accomplished.

(11) Funds remaining after distribution of all incentive awards, and Continuous Improvement Plan and Mandatory Performance Improvement Plan awards will revert to CCWD's 15% Statewide Activities Fund for allowable uses at the discretion of the Commissioner.

Stat. Auth.: ORS 326.370
Stats. Implemented:
Hist.: DCCWD 4-2002, f. & cert. ef. 9-23-02; DCCWD 6-2003, f. & cert. ef. 10-20-03; DCCWD 3-2006(Temp), f. & cert. ef. 6-15-06 thru 11-30-06

589-020-0260

Distribution of WIA Title IB Unawarded Incentive Grant Funds

(1) Purpose: The purpose of this rule is to establish the requirements and procedures for distribution and use of WIA Title IB Unawarded Incentive Grant Funds.

(2) Definitions:

(a) Failure to Meet: Actual performance for any of the 17 core performance indicators that fall below 80% of the negotiated level of performance. Technical assistance is required to be provided under WIA Section 134(a)(2)(B)(iv) to Local Workforce Investment Areas (LWIAs) that fail to meet local performance measures.

(b) Incentive Grant Funds: A portion of the fifteen percent Statewide Employment and Training Activities funds under WIA Title IB section 134(a)(2)(B)(iii) that is required to be used to award exemplary performance by local areas on the local performance measures.

(c) Local Performance Measure: A performance measure established under section136(c) of WIA. Local performance measures consist of the 17 core performance indicators established under section 136(b)(2)(A) of WIA and fall into four program areas — adult, dislocated worker, youth, and customer satisfaction.

(d) Local Workforce Investment Area(s): The area(s) in the state designated by the Governor under section 116 of WIA to which WIA Title IB funds are allocated to carry out WIA Title IB programs.

(e) Negotiated Levels of Performance: Numeric performance targets agreed to by the LWIA and State WIA Title IB administering agency on behalf of the Governor.

(f) Unawarded Incentive Grant Funds: Those funds remaining after all incentive awards have been made.

(3) Unawarded Incentive Grant Fund Use:

(a) Funds shall be made available for technical assistance/program improvement to those LWIAs whose performance for any of the 17 core performance indicators falls below 80% of the negotiated performance level.

(b) Funds may be used for any allowable WIA Title IB activities in support of a program improvement plan to correct identified deficiencies that led to failure to meet agreed upon levels of performance.

(c) Funds not used for "failure to meet" technical assistance/program improvement for any of the 17 core performance indicators that fall below 80% of the negotiated level of performance will revert to the State administering agency's budget for 15% Statewide Employment and Training Activities funds under WIA Title IB.

(4) Unawarded Incentive Grant Funds Distribution:

(a) LWIAs seeking funds to support technical assistance/program improvement for "failure to meet" negotiated performance levels as defined under (2)(a) of this OAR, may submit a technical assistance/program improvement plan (TA/PIP) in writing to the State WIA Title IB administering agency. The TA/PIP shall be submitted timely, identify the problem/issue to be remedied, and provide a budget supporting the work to be accomplished.

(b) The State Title IB WIA administering agency may initiate a T/A-PIP plan for a LWIA failing to meet the negotiated performance levels for a performance measure or measures.

(c) Funds remaining after all technical assistance has been provided as required under (2)(a) and (3)(a) of this OAR will revert to the State administering agency's budget for 15% Statewide Employment Training and Activities funds under WIA Title IB. These funds may be redesignated for allowable uses under WIA Title IB.

Stat. Auth.: ORS 326.370
Stats. Implemented:
Hist.: DCCWD 4-2002, f. & cert. ef. 9-23-02; DCCWD 6-2003, f. & cert. ef. 10-20-03; Suspended by DCCWD 3-2006(Temp), f. & cert. ef. 6-15-06 thru 11-30-06

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Rule Caption: Employer Workforce Training Fund.
Adm. Order No.: DCCWD 4-2006(Temp)
Filed with Sec. of State: 6-15-2006
Certified to be Effective: 6-15-06 thru 11-30-06
Notice Publication Date:
Rules Amended: 589-020-0225
Subject: Executive Order #03-16 established the Employer Workforce Training Account and directed the Department of Community Colleges and Workforce Development to Develop and adopt rules to implement the administration of the Account. This rule established the role of the Workforce Response Teams; establishes the amount of funds and manner of distribution of funds; the criteria for the use of the funds earmarked for Regional disbursement and the 100% non-federal match requirement for such funds; the use of funds earmarked for Statewide Opportunity areas; responsibilities of the designated organization or entity serving as the fiscal agent; and performance and reporting requirements. This amendment is necessary because over 80 % of the rule is being transferred to agency policy and procedures.
Rules Coordinator: Linda Hutchins—(503) 378-8649, ext. 474

589-020-0225
Employer Workforce Training Fund

(1) Purpose: The Employer Workforce Training Account (EWTA) was established by Executive Order # 03 -16 to support the retention and growth of living wage jobs, a skilled workforce, and competitive businesses in Oregon. To administer the EWTA, the Department of Community Colleges and Workforce Development (CCWD) established the Employer Workforce Training Fund (EWTF). This workforce development strategy must ensure that public and private sector investments are leveraged for the greatest impact and that training programs are responsive to the needs of business, industry, and the workers.

(2) Definitions:

(a) Employer Workforce Training Account (EWTA) established by Executive Order to support the Governor's economic recovery plan to ensure that a skilled workforce available to keep Oregon's industries productive and competitive.

(b) Employer Workforce Training Fund (EWTF): Includes regional WRT funds (WRT), Statewide Opportunity funds (SO) and the Governor's Strategic Training Fund (GSTF). The EWTF has three outcome goals:

(A) Create and retain living wage jobs in Oregon;

(B) Build a highly skilled workforce, especially in knowledge-based industries;

(C) Enhance the global competitiveness of Oregon businesses based on the skill of their workforce.

(c) Oregon Workforce Investment Board (OWIB): A business sector majority oversight board mandated by the WIA, Section 111. The board oversees the workforce system in Oregon.

(d) Workforce Response Teams (WRT): Formed by and with the collective partners in their represented regional areas. These teams:

(A) provide a single point of contact and a quick turnaround for existing businesses and their workforce needs;

(B) select a fiscal agent to administer the regional funds;

(C) develop regional funding priorities for contracts; and

(D) prioritize projects and award funds to eligible businesses and associations.

(3) General Provisions: Employer Workforce Training Fund (EWTF).

(a) The Oregon Workforce Investment Board shall identify all workforce development funds from federal, state, local and private sources and maximize coordination of resources used.

(b) The EWTF includes by EO, the Oregon Workforce Investment Act (WIA) allocation, identified as reserve funds, under section 128(a) and 133(a) of the WIA. Includes regional WRT funds prioritized and awarded by the local Regional Workforce Response team, Statewide Opportunity funds (SO) and the Governor's Strategic Training Fund (GSTF) funded through the CCWD.

(c) The OWIB has developed guidelines for funding criteria to be utilized by the EWTF which are the most advantageous economically to the region and the state. These criteria may be updated yearly or at the direction of the OWIB and Governor, and published through CCWD EWTF Policy 589-20.4.

(d) EWTF funds shall be distributed in accordance with the allocation formula as determined by the OWIB through an annual review of EWTF outcomes, state and regional needs and economic conditions. Based on the recommendations of the OWIB and/or Governor the CCWD will update CCWD Policy 589-20.4 regarding the EWTF and the fund distribution as needed.

(e) Ineligible expenditures are those expenditures that have been identified as strictly prohibited by the individual funding sources, such as: Workforce Investment Act Title IB funding and relevant OMB Circulars establishing cost principles and as identified in CCWD EWTF policy 589-20.4.

(f) Contract Size — There is no minimum or maximum contract size for regional and/or state projects. Regional WRTs will have discretion in the award of contracts and will make appropriate investments to leverage resources and maximize program outcomes and performance measures. The Governor will determine the appropriate size for statewide contracts.

(g) Employer Match — Entities that receive contracts from the EWTF for projects must provide non-governmental matching funds or third-party in-kind contributions to the project that equal or exceed the amount of the contract. An entity's non-Federal contribution may be provided in cash or third-party in-kind, fairly evaluated, and shall only be used in a manner that is consistent with the purpose of this rule and in accordance with federal definitions found in 29 CFR Part 95.23 and 29 CFR Part 97.24.

(h) All projects are required to report performance outcomes as identified in their funding contract with CCWD and CCWD EWTF Policy 589-20.4.

(i) CCWD shall prepare an annual report to the OWIB expenditures and outcomes of the Employer Workforce Training Fund.

(j) All Employers and partner agencies participating in the Employer Workforce Training Fund must meet the requirements of the Methods of Administration (MOA) per CCWD EWTF Policy 589-20.4.

(3) Regional Workforce Response Teams:

(a) The Regional WRT Funds shall be used to support the training of incumbent/current private sector workers, for growing businesses, training

initiatives for industry associations and strategic economic clusters, and initiatives designed by business-labor consortia.

(b) Recapture Clause: Any WRT that does not make a satisfactory commitment to using the funds for their desired outcomes will be subject to the recapture policy as delineated in CCWD EWTF Policy 589-20.4.

(c) Regional Workforce Response Teams (WRT) will be required to provide responses to the Recognition Process every year as identified in CCWD EWTF Policy 589-20.4. The responses of the Workforce Response Team will be reviewed by CCWD before funds will be distributed to the region.

(d) CCWD shall contract with the WRT- selected fiscal agent in each workforce region to distribute, on a cost reimbursement basis, the regional funds. The fiscal agent is responsible for carrying out the functions of a fiscal agent as described in the CCWD EWTF Policy 589-20.4.

(4) Statewide Opportunity Funds (SO)

(a) Statewide Opportunity funds are awarded for the purpose of solving challenges or engaging in opportunities within the state with regard to its workforce development needs. Statewide Opportunity funds will only be used if the challenge or opportunity cannot be addressed with other system resources (e.g., Title 1B, Wagner-Peyser, Title II).

(b) Statewide Opportunity funds will be focused in opportunity areas as identified by the Oregon Workforce Investment Board and the Governor.

(c) CCWD will administer contracts for Statewide Opportunity funded projects per CCWD EWTF Policy 589-20.4.

(d) The Oregon Workforce Investment Board will approve Statewide Opportunity Projects.

(5) Governor's Strategic Training Fund (GSTF):

(a) The Governor's Strategic Training Fund may be used to finance economic and workforce development projects in existing Oregon businesses, industry or worker associations for incumbent /current workers.

(b) The GSTF in coordination with regional WRTs will be used for multiregional or statewide projects that are beyond the scope and/or resources of the regional funds. CCWD will administer GSTF contracts through the WRTs per CCWD EWTF Policy 589-20.4.

(c) The Governor will approve GSTF Projects.

Stat. Auth.: ORS 660.318
Stats. Implemented:
Hist.: DCCWD 2-2004, f. & cert. ef. 11-30-04; DCCWD 4-2006(Temp), f. & cert. ef. 6-15-06 thru 11-30-06

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

Rule Caption: Electrical and Plumbing Plan Review requirements and definitions for complex structures.
Adm. Order No.: BCD 7-2006
Filed with Sec. of State: 6-7-2006
Certified to be Effective: 10-1-06
Notice Publication Date: 6-1-04, 3-1-06
Rules Amended: 918-311-0030, 918-311-0040, 918-780-0040
Subject: The purpose of these amended rules is to implement ORS 455.483 by clarifying plumbing and electrical code plan review requirements. These rules make plan review mandatory only for complex structures located in jurisdictions that offer plan review services. This rulemaking clarifies that jurisdictions are not mandated to offer plumbing or electrical code plan review services; however, jurisdictions offering these services may require them only for complex structures, as defined in these rules. In addition, customers will be able to submit one set of plans for two or more structures under construction or reconstruction at the same job site, as long as the plumbing or electrical systems are materially alike, and permits are obtained within a reasonable time.
Rules Coordinator: Dodie Wagner—(503) 373-7438

918-311-0030
Qualifications for Persons Performing Electrical Reviews

Electrical plan reviews shall be conducted only by persons certified by the division to enforce the **Electrical Specialty Code** as an **Electrical Specialty Code** inspector, or its equivalent, and who have one of the following:

(1) Two years of experience as an Oregon supervising electri-cian;

(2) A degree in electrical engineering and three years experience in design, inspection or supervision of installations covered by the **National Electrical Code** or **Oregon Electrical Specialty Code**; or

(3) Equivalent experience and training approved by the board.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 479.870
Stats. Implemented: ORS 479.870
Hist.: BCA 33-1991(Temp), f. & cert. ef. 9-30-91; BCA 44-1991, f. & cert. ef. 12-26-91; BCD 19-1996, f. 9-17-96, cert. ef. 10-1-96, Renumbered from 918-320-0320; BCD 7-2006, f. 6-7-06, cert. ef. 10-1-06

918-311-0040
Electrical Plan Review for Complex Structures

(1) A jurisdiction providing electrical code plan review services may only require electrical plan review for a complex structure. For the purpose of this rule, "complex structures" have an electrical system designed, constructed or reconstructed with any of the following:

(a) Ampacity:

(A) A service or feeder beginning at 400 Amps where the available fault current exceeds 10,000 Amps at 150 Volts or less to ground or exceeds 14,000 Amps for all other installations; or

(B) Installation of a 150 KVA or larger separately derived system as defined in Article 100 of the **National Electrical Code** (NEC); or

(C) Addition of a new motor load of 100 HP or more; or

(D) Fire pump installations as defined in Article 695 of the NEC; or

(E) Emergency systems installations as defined in Article 700 of the NEC; or

(F) A service or feeder rated at 600 Amps or over.

(b) Voltage. More than 600 supply volts nominal;

(c) Height. More than three stories;

(d) Occupancy.

(A) Six or more residential units in one structure; or

(B) An "A" (Assembly) occupancy, "E" (Educational) occupancy, or "I-2" or "I-3" (Institutional) occupancy as defined in the adopted Oregon Structural Specialty Code; or

(C) Any of the following special occupancies as described in Chapter 5 of the NEC adopted by the board in OAR 918-305-0100:

(i) Hazardous (Classified) locations as defined in Articles 500 to 516; or

(ii) Installations in patient care areas of health care facilities as defined in Article 517; or

(iii) Agricultural buildings used for commercial purposes, as defined in Article 547; or

(iv) Floating buildings as defined in Article 553; or

(v) Marinas and boat yards as defined in Article 555; or

(e) Recreational Vehicle Park. A new recreational vehicle park, or any addition or alteration to an existing park.

(2) Plan review is not required for work permitted through minor installation labels under OAR 918-309-0210 to 918-309-0260.

(3) A jurisdiction requiring electrical plan review may not require plan review on more than one building or structure under construction or reconstruction at the same job site, as long as:

(a) The electrical systems of the buildings or structures are materially alike, and;

(b) A person obtains electrical permits for the buildings or structures within a reasonable time.

(4) Standardized Format for Plan Review. When electrical plan review is required the electrical plan shall meet the following requirements:

(a) Copies. Submit two sets of electrical plans;

(b) Readability. The plans shall be drawn to scale, contain definitions for legends used, be of sufficient clarity to indicate the location, nature and extent of the work proposed and show in detail that it will conform to the applicable electrical code requirements, laws, ordinances, rules and regulations;

(c) Contents. The plans shall contain the following minimum requirements:

(A) Feeder riser diagram showing panel location and circuit schedules;

(B) One line riser diagram showing bonding and grounding and conductor sizes;

(C) Available fault current on the line side of service disconnect;

(D) Complete load calculations, or provide applicable load records, for all new installations and for additions to existing installations;

(E) Fixture schedule, showing type, location and layout of the fixtures;

(F) Address of the installation and name of owner and address;

(G) Identification of the employer, identification and signature of person who prepared the plan, license number if the person is an electrical supervisor and professional registration number if the person is an architect or registered professional electrical engineer; and

(H) Location of emergency systems, identifying the power source and the system on plan.

(5) Nothing in these rules shall prohibit a jurisdiction from requiring a lighting energy budget.

(6) Nothing in these rules shall prohibit the owner or the owner's agent from requesting and receiving plan review for non-complex structures.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 479.870
Stats. Implemented: ORS 479.870
Hist.: BCA 33-1991(Temp), f. & cert. ef. 9-30-91; BCA 44-1991, f. & cert. ef. 12-26-91; BCD 19-1996, f. 9-17-96, cert. ef. 10-1-96, Renumbered from 918-320-0330; BCD 23-2000, f. 9-29-00, cert. ef. 10-1-00; BCD 7-2006, f. 6-7-06, cert. ef. 10-1-06

918-780-0040
Plumbing Plan Reviews

(1) A jurisdiction providing plumbing code plan review services may only require plumbing plan review for a complex structure. For purposes of this rule, a "complex structure" is a plumbing system designed, constructed or reconstructed to accommodate any of the following:

(a) The installation or alteration of a medical gas and vacuum system for health care facilities;

(b) The installation or alteration of chemical drainage waste and vent systems containing chemical agents potentially detrimental to the integrity of a plumbing system;

(c) The installation or alteration of wastewater pretreatment systems for building sewers;

(d) The installation of vacuum drainage waste and vent systems;

(e) The installation or alteration of reclaimed wastewater systems;

(f) The installation of a commercial booster pump system needed to maintain a minimum residual water pressure in a structure supplied by a municipal source;

(g) The installation of a plumbing system requiring a building water service line with an interior diameter or nominal pipe size of two inches or greater except those two inch systems which have been designed and stamped by a licensed engineer;

(h) The installation of any multi-purpose sprinkler system under standards adopted by the department.

(2) If a jurisdiction providing plumbing code plan review services requires a plumbing code plan review as authorized by section (1) of this rule, the jurisdiction may require the submission of complete speci-fications, piping layout and fixture location drawings of the pro-posed system or alteration before issuing a permit. Plans and speci-fications must indicate the nature and extent of the work pro-posed and show in detail that the work will conform to provisions of the Plumbing Specialty Code.

(3) A jurisdiction requiring plumbing code plan review may not require plan review on more than one building or structure under construction or reconstruction at the same jobsite, as long as:

(a) The plumbing systems of the buildings or structures are materially alike; and

(b) A person obtains plumbing permits for the buildings or structures within a reasonable time.

(4) Any required plumbing code plan review service may be waived by a jurisdiction if the nature of the work applied for is such that reviewing of plans is not necessary to determine compliance with the Plumbing Specialty Code.

(5) When the plumbing plan review is completed by a quali-fied plumbing plan reviewer and a plumbing permit issued, the plans must be endorsed in writing and stamped "Approved." The approved plans cannot be changed without authorization from the jurisdiction providing plumbing code plan review services.

(6) Issuance of a permit or approval of plans will not prevent the jurisdiction providing plumbing code plan review services from

(a) requiring the correction of errors in plans and specifications; or

(b) Preventing construction oper-a-tions when in violation of the Plumbing Specialty Code or of any other ordinance; or

(c) Revoking any certificate of approval when issued in error.

(7) Nothing in this rule prevents a jurisdiction from providing plan review services for utility systems situated outside the building exterior of a particular jobsite.

(8) Nothing in this rule prevents a jurisdiction from requiring information on grease processing equipment systems.

(9) Where applicable, the Department of Consumer and Business Services' fees for plan review on complex structures will be based on the time required to review the plans, but must not exceed 30 percent of the total plumbing permit fee for the building or structure under review. When plans are incomplete or substantially changed to require additional plan review services, the department may charge an additional fee based on the time required for the additional review.

(10) Nothing in these rules shall prohibit the owner or owner's agent from requesting and receiving a plan review for non-complex structures.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 447.020 & 455.020
Stats. Implemented: ORS 447.020
Hist.: DC 39, f. 1-6-75, ef. 2-1-75; DC 13-1981, f. 10-30-81, ef. 11-1-81; Renumbered from 814-021-0115; BCD 6-1998, f. 3-2-98, cert. ef. 4-1-98, Renumbered from 918-760-0020; BCD 21-1998, f. 9-30-98, cert. ef. 10-1-98; BCD 7-2006, f. 6-7-06, cert. ef. 10-1-06

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

Rule Caption: Technical change to adopt the current version of the Attorney General's model rules of procedure.
Adm. Order No.: FCS 4-2006
Filed with Sec. of State: 5-17-2006
Certified to be Effective: 5-17-06
Notice Publication Date:
Rules Amended: 441-001-0005
Subject: This amendment adopts the current version of the Attorney General's model rules of procedure dated January 1, 2006.
Rules Coordinator: Berri Leslie—(503) 947-7478

441-001-0005
Model Rules of Procedure

The Director adopts by reference, for all programs administered by the Division of Finance and Corporate Securities, the Attorney General's Model Rules of Procedure as published in the Oregon Attorney General's Administrative Law Manual dated January 1, 2006.

Stat. Auth.: ORS 59.285, 59.900, 192.845, 645.205, 646.396, 650.050, 697.085, 697.632, 705.730, 706.790, 717.310, 723.102, 725.505, 725.625 & 726.260
Stats. Implemented: ORS 183.341
Hist.: FCS 3-2003, f. 12-30-03 cert. ef. 1-1-04; FCS 2-2004, f. & cert. ef. 8-5-04; FCS 4-2006, f. & cert. ef. 5-17-06

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Department of Consumer and Business Services, Insurance Division Chapter 836

Rule Caption: Workers' Compensation Insurance Rates and Ratemaking; Loss Cost Reporting and Unit Statistical Plan.
Adm. Order No.: ID 10-2006
Filed with Sec. of State: 6-9-2006
Certified to be Effective: 6-9-06
Notice Publication Date: 5-1-06
Rules Amended: 836-042-0015, 836-042-0045
Subject: This rulemaking amends rules relating to workers' compensation insurance rates and rulemaking. The first rule, relating to insurer reporting of workers' compensation insurance loss cost information to the Insurance Division, is amended to allow insurers to use the Oregon or NAIC reporting form. The second rule, which adopts by reference the Unit Statistical Plan, the governing compilation of worker's compensation insurance statistics, is amended to recognize and apply the National Council on Compensation Insurance's change to the statistical plan for the Oregon Employer Paid Medical Program Limits, effective January 1, 2006. The NCCI made the latter change in response to the Oregon Legislative Assembly's enactment of legislation in 2005 that increased the amount of compensation a subject employer may pay for medical services for non-disabling claims.
Rules Coordinator: Sue Munson—(503) 947-7272

836-042-0015
Workers' Compensation Filings — Procedural Rules for Insurers and Rating Organizations

(1) Every workers' compensation insurer shall file with the Director copies of the workers' compensation insurance premium rates to be used by it. An insurer may satisfy this requirement by authorizing the Director to accept on its behalf the provisions for claims payment filed by a rating organization in accordance with section (4) of this rule, to the extent the insurer uses the classification system of the rating organization, and by specifying the factors by which every such provision shall be multiplied to make allowances for expenses, taxes or profit and a rule for rounding each such provision after multiplication.

(2) Workers' compensation insurance premium rates based on loss costs of a licensed rating organization filed by an insurer must each be accompanied by transmittal letters of the forms prescribed in Exhibits 1 and

2 or must be accompanied by the NAIC Loss Cost Data Entry Document and the NAIC Loss Cost Filing Document for Workers' Compensation.

(3) Every filing of workers' compensation insurance premium rates, rating plans or rating systems by an insurer and every filing of workers' compensation insurance rating plans, rating systems or provisions for claim payment by a rating organization must be submitted to the Director for review prior to becoming effective.

(4) The effective date of a workers' compensation insurance filing required by section (3) of this rule to be submitted to the Director for review shall be the date specified therein but not earlier than the 30th day after the date the filing is received by the Director, or the 30th day after the date of receipt of supporting information, whichever is later. If the Director has reviewed the filing prior to expiration of the waiting period, the Director may authorize an effective date prior to the expiration of the waiting period but not earlier than the date such written application and any required supporting information is received. The 30 day period may be extended to 60 days if the Director gives written notice within such waiting period to the insurer or rating organization which made the filing that the extended period is needed for consideration of such filing. A filing subject to this section shall be deemed to meet the requirements of ORS Chapter 737 unless disapproved by the Director within the waiting period or extension thereof.

(5) An insurer may authorize the Director to accept on its behalf the workers' compensation insurance rating plans or rating systems filed by a licensed rating organization of which it is a member when such filings have been approved by the Director and to the extent such plans or systems are complete and usable without addition of allowances for expenses, taxes or profit. When such plans and systems are not complete and usable, an insurer may file for review by the Director supplementary systems or values providing allowances for expenses, taxes or profit to be used in conjunction with such workers' compensation insurance rating plans and rating systems. An insurer may so adopt the rating plans and rating systems of a rating organization on part of the classifications of risks insured by it and may make its own filings as to other classifications.

(6)(a) Nothing in this rule should be construed to require any insurer to adopt any rating plan or rating system filed by a rating organization and approved by the Director nor to prohibit any insurer from filing any workers' compensation insurance rating plan or rating system which supplements or differs from any rating plans or rating systems filed by a rating organization; and

(b) Notwithstanding subsection (a) of this section, workers' compensation insurers shall adopt the experience rating plan established by the rating organization, or an alternative plan designed to promote worker safety approved by the Director, to be applied on a uniform basis.

(7) A licensed rating organization may assist any member with filing workers' compensation insurance premium rates, rating plans or rating systems following instructions from such member as to the provisions for expenses, taxes and profit appropriate for its use.

(8) Every workers' compensation insurance filing submission to the Director by an insurer shall also be simultaneously submitted to the rating organization of which the insurer is a member.

(9) Workers' compensation insurance policies shall be reviewed by the rating organization of which the insurer is a member to determine compliance with the insurer's filings. The rating organization shall review workers' compensation insurance policies issued by their members for compliance with ORS chapter 737 and OAR 836-042-0035.

(10) Section (6) of this rule, as amended effective July 28, 1998, applies to actions taken by insurers under that section on and after June 24, 1998.

[ED. NOTE: Exhibits referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 737.205(1)& (2), 737.225(1), 737.265(2) & 737.320(2) & (3)
Hist.: IC 4-1982, f. 1-27-82, ef. 7-1-82; ID 15-1992, f. & cert. ef. 11-16-92; ID 19-1997(Temp), f. 12-23-97, cert. ef. 1-1-98 thru 6-22-98; ID 9-1998, f. & cert. ef. 7-28-98; ID 10-2006, f. & cert. ef. 6-9-06

836-042-0045
Uniform Workers' Compensation Statistical Plan

(1) The Unit Report Expanded (URE) Workers Compensation Statistical Plan, Edition of July 1, 2001 filed by the National Council on Compensation Insurance and approved by the Director to become effective January 1, 2002 is prescribed as the statistical plan for workers' compensation insurance. The January 1, 2004 edition of Part 8, Pension Tables, of the NCCI URE Workers Compensation Statistical Plan is prescribed as the pension tables effective in this state January 1, 2004. The January 1, 2006 edition of Part 4, Paragraph 6, Gross Losses, and Paragraph 35, Deductible Reimbursement, and Part 5, Paragraph 4, Correction Reports, is prescribed as the statistical plan for the Oregon Employer Paid Medical Program Limits effective January 1, 2006.

(2) The State Accident Insurance Fund Corporation and each insurer transacting workers' compensation insurance in this state shall report statistics for such business to the workers' compensation rating organization of which it is a member according to the statistical plan prescribed by section (1) of this rule.

(3) The amendments in section (1) of this rule, which were filed in ID 7-2003 with the Secretary of State on December 3, 2003 to become effective on January 1, 2004, are re-adopted with the operative date of January 1, 2004.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 731.244 & 737.225
Stats. Implemented: ORS 737.225
Hist.: IC 3-1982, f. 1-27-82, ef. 7-1-82; IC 10-1982, f. 6-23-82, ef. 7-1-82; IC 2-1983, f. 3-16-83, ef. 4-1-83; IC 5-1983, f. 6-30-83, ef. 7-1-83; IC 4-1984, f. 9-28-84, ef. 10-1-84; ID 2-1998, f. & cert. ef. 2-6-98; ID 15-2001, f, 12-19-01, cert. ef. 1-1-02; ID 7-2003, f. 12-3-03 cert. ef. 1-1-04; ID 5-2005, f. & cert. ef. 4-7-05; ID 10-2006, f. & cert. ef. 6-9-06

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Department of Consumer and Business Services, Minority, Women and Emerging Small Business Chapter 445

Rule Caption: The Emerging Small Business eligibility requirements are modified to create a two-tier designation system.
Adm. Order No.: MWESB 1-2006
Filed with Sec. of State: 6-15-2006
Certified to be Effective: 6-15-06
Notice Publication Date: 11-1-05
Rules Amended: 445-050-0115, 445-050-0125, 445-050-0135
Subject: These rule changes implement the following changes made by 2005 Oregon Laws Chapter 683: Creates a two-tier system for certification of emerging small businesses and modifies the qualifications by increasing the employee and gross-receipts thresholds. "Tier one firm" means a business that employs fewer than 20 full-time equivalent employees and has average annual gross receipts for the last three years that do not exceed $1.5 million for a business performing construction, as defined in ORS 446.310, or $600,000 for a business not performing construction. "Tier two firm" means a business that employs fewer than 30 full-time equivalent employees and has average annual gross receipts for the last three years that do not exceed $3 million for a business performing construction, as defined in ORS 446.310, or $1 million for a business not performing construction.

Increases the limit on certification from seven to twelve years, six years at each tier. Allows reinstatement of a formerly certified business if the business still qualifies as an emerging small business and has eligibility remaining.

Transfers the Emerging Small Business Account from the Consumer and Business Services Fund to the State Highway Fund.
Rules Coordinator: Sheila Haywood—(503) 947-7950

445-050-0115
Eligibility Standards

To be eligible for certification as an ESB, a business must meet all the following criteria:

(1) A firm must be in existence, operational and in business for a profit;

(2) Have average, annual gross receipts over the last three years not exceeding $1.5 million for tier one construction firms and $600,000 for tier one non-construction firms; and $3 million for tier two construction firms and $1 million for tier two non-construction firms.

(3) The department will adjust annually the amount of the average annual gross receipts required to qualify as a tier one firm or a tier two firm using the most recent three-year average of the Portland-Salem Consumer Price Index (CPI) for All Urban Consumers for All Items, as reported by the United States Bureau of Labor Statistics.

(4) If a tier one firm provides compelling information showing, in the judgment of the Department of Consumer and Business services, that the firm has not been afforded an opportunity to bid on emerging small business projects during a year of eligibility, the department will extend the tier one designation of the firm for an additional year. A tier one firm may receive the extension only once.

(5) Have its principal place of business located in the State of Oregon, as determined by tax filing status;

(6) Be independent. An ESB is not eligible if it is a subsidiary or parent company belonging to a group of firms that are owned or controlled by

the same individuals if, in the aggregate, the group of firms does not qualify as a tier one firm or a tier two firm.

(7) Be properly licensed and if required, legally registered in this state: (e.g., registered as a domestic corporation or partnership, assumed business name filed, Construction Contractors Board registration, etc.);

(8) Have fewer than 20 full-time equivalent employees in tier one and have fewer than 30 full-time equivalent employees in tier two. A full-time equivalent employee is calculated as follows:

(a) Hours worked by part-time and seasonal employees shall be converted into full-time equivalent employee hours by dividing the total hours worked by all part-time and seasonal employees by 2080.

(b) The owners of the firm shall not be considered full-time equivalent employees.

(c) The year period during which full-time equivalent employees shall be calculated shall be the same period as the ESB's tax year.

Stat. Auth.: ORS 200.055
Stats. Implemented: ORS 200.055
Hist.: BAD 1997, f. & cert. ef. 5-20-97; MWESB 2-1998, f. & cert. ef. 12-11-98, Renumbered from 121-050-0115; MWESB 1-2000, f. 11-7-00, cert. ef. 12-1-00; MWESB 1-2005(Temp), f. & cert. ef. 12-29-05 thru 6-27-06; MWESB 1-2006, f. & cert. ef. 6-15-06

445-050-0125
Application Form and Procedure

(1) OMWESB will utilize ORS 200.005 to review for eligibility for certification as an ESB tier one or tier two.

(2) Application Form. Firms wishing to be certified as ESBs shall complete the application form provided by OMWESB.

(3) Submittal of application. The completed application form, together with all required supporting documentation, shall be submitted to the Office of Minority, Women and Emerging Small Business, 350 Winter St NE, Salem, PO Box 14480, OR 97309-0405

(4) Processing applications. The OMWESB will conduct a review and take action on completed applications as promptly as its resources permit. The order of priority for processing applications shall be the date received by OMWESB.

(5) Determination. The OMWESB shall make a determination based on the eligibility standards included in this chapter and the applicable laws of the State of Oregon. As part of its investigation, OMWESB may require owners to provide information in addition to that requested on the application forms. The applicant has the burden of proving that it is eligible for certification and re-certification at all levels of review. Applicants shall be notified by mail promptly after a decision has been made. Where the OMWESB has denied an application, the letter shall set forth the specific reasons for the denial. Certification may be revoked at any time if the OMWESB determines that the ESB no longer meets the eligibility standards. The ESB shall notify OMWESB within 30 days of any changes in its ownership which may affect its continued eligibility as an ESB. Failure to notify OMWESB may result in denial/decertification.

(6) The applicable emerging small business size standard for each applicant set out in OAR 445-050-0115(1)(b) shall be determined by the firm's primary area of work. Registration of the firm with Construction Contractors and/or Landscape Contractors Board will establish a firm as a construction firm. A construction-related trucking firm will also be considered a construction firm for the purposes of this program.

Stat. Auth.: ORS 200.055
Stats. Implemented: ORS 200.055
Hist.: BAD 1997, f. & cert. ef. 5-20-97; MWESB 2-1998, f. & cert. ef. 12-11-98, Renumbered from 121-050-0125; MWESB 1-2000, f. 11-7-00, cert. ef. 12-1-00; MWESB 1-2005(Temp), f. & cert. ef. 12-29-05 thru 6-27-06; MWESB 1-2006, f. & cert. ef. 6-15-06

445-050-0135
Recertification

(1) Certification as an ESB is valid for three years from the date of certification.

(2) A recertification notice shall be sent to certified ESBs 60 days prior to expiration of current certification. The ESB shall promptly return the recertification application along with any requested documentation (e.g., evidence of change in ownership; federal tax returns for the last year, etc.). Recertification is not automatic. The applicant must demonstrate that their business still meets the criteria set out in OAR 445-050-0105 through 445-050-0165.

(3) The signed and notarized recertification application shall be reviewed by the OMWESB staff to determine the ESB's continued eligibility. A request to verify information submitted to OMWESB may be required.

(4) Failure to return the completed recertification application by the expiration date shall result in administrative closure of the file.

(5) Firms may only be certified as an ESB for a maximum of twelve consecutive years from original certification date or 13 years for tier 1 firms that meet the criteria for eligibility standards under OAR 445-050-0115(d).

(6) An annual affidavit of "no change" will be sent to the firm approximately 30 days prior to the one-year and two-year anniversaries of the certification date. The completed affidavit, along with federal tax information for the previous year, and documentation of any changes, must be submitted prior to the anniversary date, or the firm will be decertified.

Stat. Auth.: ORS 200.055
Stats. Implemented: ORS 200.055
Hist.: BAD 1997, f. & cert. ef. 5-20-97; MWESB 2-1998, f. & cert. ef. 12-11-98, Renumbered from 121-050-0135; MWESB 1-2000, f. 11-7-00, cert. ef. 12-1-00; MWESB 1-2005(Temp), f. & cert. ef. 12-29-05 thru 6-27-06; MWESB 1-2006, f. & cert. ef. 6-15-06

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

Rule Caption: Adoption of new Respiratory Protection standard in Agriculture.
Adm. Order No.: OSHA 3-2006
Filed with Sec. of State: 6-7-2006
Certified to be Effective: 3-1-07
Notice Publication Date: 4-1-06
Rules Adopted: 437-004-1041
Rules Repealed: 437-004-1040
Subject: The Respiratory Protection Standard was reworded for clarity and plain language, and to bring the rules up to Division 2/I standards having one rule for all respirator users. **Summary of changes:**

• There are new requirements for voluntary use of respirators. You must provide respirator users with the information contained in Appendix D, and have a medical evaluation required for respirators with the exception of filtering face-pieces and have cleaning, storing and maintenance procedures in the program.

• There is a requirement for annual fit-testing of required use of respirators.

• There is a change from annual medical evaluations to a medical evaluations before the first fit-test.

• New appendices **A, B1, B2** and **D** were added for procedures on fit-testing (A), user seal check (B1) and proper cleaning (B2) the medical questionnaire was moved to (C) and voluntary use information (D). The mandatory appendices **C** and **D** are also in Spanish.

• There is a section on interior structural firefighting requiring the two in two out rules.

• Training is required annually.

• A change out schedule for canisters and cartridges is required.

Rules Coordinator: Sue C. Joye—(503) 947-7449

437-004-1041
Respiratory Protection.

(1) Permissible practice.

(a) To control occupational diseases caused by contaminated air, the best method is to prevent contamination with engineering controls. When this approach is not feasible, employers must comply with this standard.

(b) You must provide respirators to all employees when it is necessary to protect their health. Respirators must be appropriate for the hazard. You must also have an effective respirator program that includes at least the requirements of this standard. (See paragraph (3)).

(2) Definitions. The following definitions apply to this standard.

(a) Air-purifying respirator is a respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through the air-purifying element.

(b) Atmosphere-supplying respirator is a respirator that supplies the user with breathing air from a source independent of the ambient atmosphere, and includes supplied-air respirators (SARs) and self-contained breathing apparatus (SCBA) units.

(c) Canister or cartridge is a container with a filter, sorbent, or catalyst, or combination of these items, that removes specific contaminants from the air passed through the container.

(d) Demand respirator is an atmosphere-supplying respirator that admits breathing air to the face piece only when inhalation creates a negative pressure inside the face piece.

(e) Elastomer (elastomeric) is an elastic substance like rubber or neoprene.

(f) Emergency situation is any event such as, but not limited to, equipment failure, rupture of containers, or failure of control equipment that may or does result in an uncontrolled significant release of an airborne contaminant.

(g) Employee exposure is exposure to a concentration of an airborne contaminant that would occur if the employee were not using respiratory protection.

(h) End-of-service-life indicator (ESLI) is a device, on the cartridge, that warns respirator users when their respirator is near the end of its ability to protect them. For example, an indicator on the cartridge will change to warn the user that the cartridge sorbent material is nearing saturation and is no longer effective.

(i) Engineering control measures are methods to eliminate or control employee exposure to the hazard; e.g., substitution of a less toxic material, general or local ventilation and enclosing the operation.

(j) Escape-only respirator is a respirator only for use during emergency exit.

(k) Filter or air purifying element is a respirator component (e.g., canister or cartridge) that removes solid or liquid aerosols from the inspired air.

(l) Filtering face piece (dust mask) is a tight fitting negative pressure particulate respirator with a filter as an integral part of the face piece or with the entire face piece made of the filtering medium.

(m) Fit factor is a quantitative estimate of the fit of a particular respirator to a specific person, and typically estimates the ratio of the concentration of a substance in ambient air to its concentration inside the respirator when worn. Instrumentation is used with ambient air as the "test agent" to quantify the respirator fit. See appendix A.

(n) Fit test is the use of procedures in Appendix A to qualitatively or quantitatively evaluate the fit of a respirator on a person. (See also Qualitative fit test QLFT and Quantitative fit test QNFT.)

(o) Helmet is a rigid respirator covering that also provides head protection against impact and penetration.

(p) High efficiency particulate air (HEPA) filter is a filter that is at least 99.97 percent efficient in removing monodisperse particles of 0.3 micrometers in diameter. The equivalent NIOSH 42 CFR 84 particulate filters are the N100, R100, and P100 filters.

(q) Hood is a respirator covering that completely covers the head and neck and may also cover portions of the shoulders and torso.

(r) Immediately dangerous to life or health (IDLH) is an atmosphere that poses an immediate threat to life, would cause irreversible adverse health effects, or would impair an individual's ability to escape from a dangerous atmosphere.

(s) Interior structural firefighting is the physical activity of fire suppression, rescue or both, inside of buildings or enclosed structures which are involved in a fire situation beyond the incipient stage.

(t) Loose-fitting face piece is a respiratory covering that forms a partial seal with the face, e.g., hood.

(u) Negative pressure respirator (tight fitting) is a respirator in which the air pressure inside the face piece is negative during inhalation with respect to the ambient air pressure outside the respirator.

(v) Oxygen deficient atmosphere is an atmosphere with an oxygen content less than 19.5 percent by volume.

(w) Physician or other licensed health care professional (PLHCP) is a person whose legally permitted scope of practice (i.e., license, registration, or certification) allows them to independently provide, or be delegated to provide, some or all of the health care services required by this standard.

(x) Positive pressure respirator is a respirator in which the pressure inside the respiratory covering is higher than the air pressure outside the respirator.

(y) Powered air-purifying respirator (PAPR) is an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering.

(z) Pressure demand respirator is a positive pressure atmosphere-supplying respirator that admits breathing air to the face piece when inhalation reduces the positive pressure inside the face piece.

(aa) Qualitative fit test (QLFT) is a pass/fail fit test to assess the adequacy of respirator fit that relies on the individual's response to the test agent. See Appendix A.

(bb) Quantitative fit test (QNFT) is an assessment of the adequacy of respirator fit by numerically measuring the amount of leakage into the respirator. See Appendix A.

(cc) Respirator covering is that part of a respirator that forms the protective barrier between the user's respiratory tract and an air-purifying device or breathing air source, or both. It may be a face piece, helmet, hood, suit, or a mouthpiece respirator with nose clamp.

(dd) Self-contained breathing apparatus (SCBA) is an atmosphere-supplying respirator for which user carries the breathing air source.

(ee) Service life is the period of time that a respirator, filter or sorbent, or other respiratory equipment adequately protects the wearer.

(ff) Supplied-air respirator (SAR) or airline respirator is an atmosphere-supplying respirator for which the source of breathing air is not carried by the user.

(gg) Tight-fitting face piece is a respirator covering that forms a complete seal with the face, e.g., half mask or full-face piece.

(hh) User seal check is an action by the respirator user to determine if the respirator is properly seated to the face. See appendix B-1.

(3) Respiratory protection program.

(a) When respirators are necessary to protect the health of workers or when you require workers to wear them, you must have an effective, written respiratory protection program, managed by a knowledgeable person, with procedures specific to your work site. Keep the program updated to reflect changes in conditions that require the use of respirators. You must include at least these points:

(A) Procedures for selecting respirators for use in the workplace;

(B) Medical evaluations of employees require to use respirators;

(C) Fit testing procedures for tight-fitting respirators;

(D) Procedures for proper use of respirators in routine and reasonably foreseeable emergency situations;

(E) Procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding, and otherwise maintaining respirators;

(F) Procedures to ensure adequate air quality, quantity, and flow of breathing air for atmosphere-supplying respirators;

(G) Training of employees in the respiratory hazards to which they are potentially exposed during routine and emergency situations;

(H) Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance; and

(I) Procedures for regularly evaluating the effectiveness of the program.

(b) The employer must provide respirators, training, and medical evaluations at no cost to the employee.

(c) Where respirator use is voluntary:

(A) You may provide respirators to employees who request them or they may use their own respirators. If you allow this voluntary use, you must determine that it will not create a hazard to the user. You must provide the voluntary user with the information in Appendix D, and;

(B) You must have a limited written respiratory program for voluntary users. It must include those parts of the standard necessary to ensure that:

(i) The user is medically able to use it without creating a hazard to themselves. Use of respirators other than dust masks require medical evaluations.

(ii) The program includes proper cleaning, storing and maintenance.

EXCEPTION: No program is necessary for voluntary users who only use dust masks (filtering face pieces).

(4) Selection of respirators. Identify and evaluate the respiratory hazard(s) including a reasonable estimate of employee exposures and an identification of the contaminant's chemical state and physical form. You must treat atmospheres with the potential for IDLH conditions as an IDLH hazard and provide appropriate respiratory protection.

(a) General requirements.

(A) You must evaluate respiratory hazards, conditions in the workplace and user factors, then select and provide the appropriate respirators.

(B) All respirators must have NIOSH certification and all use must conform to that certification.

(C) Respirators must correctly fit and be acceptable to the user.

(b) Respirators for IDLH atmospheres.

(A) Provide the following respirators for employee use in IDLH atmospheres:

(i) A full face piece pressure demand SCBA certified by NIOSH for a minimum service life of 30 minutes, or

(ii) A combination full-face piece pressure demand supplied-air respirator (SAR) with auxiliary self-contained air supply.

(B) Respirators only for escape from IDLH atmospheres must have NIOSH certification for escape from the atmosphere of use.

(C) Treat all oxygen-deficient atmospheres as IDLH. EXCEPTION: If you can demonstrate that, under all foreseeable conditions, the oxygen concentration will stay within the ranges in **Table II** (i.e., for the altitudes set out in the table), then use any atmosphere-supplying respirator.

(c) Respirators for atmospheres that are not IDLH.

(A) Provide respirators adequate to protect the health of workers and ensure compliance with all other OR-OSHA requirements, under routine and reasonably foreseeable emergency situations.

(i) Assigned Protection Factors (APFs) (Reserved)

(ii) Maximum Use Concentration (MUC) (Reserved)

(B) The respirator must be appropriate for the chemical state and physical form of the contaminant.

(C) For protection against gases and vapors, provide:

(i) An atmosphere-supplying respirator, or

(ii) An air-purifying respirator, if:

(I) It has and end-of-service-life indicator (ESLI) certified by NIOSH for the contaminant; or

(II) If there is no ESLI appropriate for your conditions, implement a change schedule for canisters and cartridges that is based on objective information or data that will ensure that canisters and cartridges are changed before the end of their service life. Describe in the respirator program the information and data relied on and the basis for the canister and cartridge change schedule and the basis for reliance on the data.

(**NOTE:** The Worker Protection Standard contains criteria for specific change out schedules for respirator canisters and cartridges. See OAR 437-002-170.240.)

(D) For protection against particulates, provide:

(i) An atmosphere-supplying respirator; or

(ii) An air-purifying respirator with a filter certified by NIOSH under 30 CFR part 11 as a high efficiency particulate air (HEPA) filter, or an air-purifying respirator with a filter certified for particulates by NIOSH under 42 CFR part 84; or

(iii) For contaminants consisting primarily of particles with mass median aerodynamic diameters (MMAD) of at least 2 micrometers, an air-purifying respirator with any filter certified for particulates by NIOSH. [Table not included. See ED. NOTE.]

(5) Medical evaluation.

(a) General. You must provide medical evaluations to determine workers' ability to use a respirator safely. Do this before the worker's fit test and before any work requiring respirator use. The employer may discontinue an employee's medical evaluations when the employee no longer uses a respirator.

(b) Medical evaluation procedures.

(A) Use a physician or other licensed health care professional (PLHCP) to do the evaluations using either a medical questionnaire or an initial examination that produces the same information as in Appendix C.

(c) Follow-up medical examination.

(A) If the PLHCP reports that the employee needs a follow-up examination because of a positive response to any of questions 1 through 8 of the questionnaire in Appendix C or if their initial exam caused the need for a follow-up, you must ensure that they get the opportunity for the examination. NOTE: If the employee refuses the examination, they may not work in jobs that require a respirator.

(d) Administration of the medical questionnaire and examinations.

(A) You must allow the employee to complete the questionnaire in a way that protects the confidentiality of the information. Employers are not to see the answers or review the completed form. You must allow employees to complete the form during normal working hours or at a time and place convenient to them. If employees need help, allow them to ask your PLHCP or anybody other than their employer or representatives of their employer.

(B) The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP.

(e) Supplemental information for the PLHCP.

(A) You must give the PLHCP the following information before they make any recommendation about a worker's ability to use a respirator.

(i) The type and weight of the respirator the employee will use;

(ii) How long and how often the employee will use the respirator (including use for rescue and escape);

(iii) The expected physical work effort;

(iv) Additional protective clothing and equipment to be worn; and

(v) Temperature and humidity extremes that may exist during use.

(B) You need not provide information more than once if it is unchanged.

(C) You must provide a copy of your written respiratory program and this standard to the PLHCP. Note to Paragraph (5)(e)(C): When the employer replaces a PLHCP, the employer must ensure that the new PLHCP has this information, either by providing the documents directly to the PLHCP or having the documents transferred from the former PLHCP to the new PLHCP. However, OR-OSHA does not expect employers to have employees medically reevaluated solely because there is a new PLHCP.

(f) Medical determination. In determining the employee's ability to use a respirator, the employer must:

(A) Obtain a written recommendation about the employee's ability to use the respirator from the PLHCP. The recommendation must provide only the following information:

(i) Any limitations on respirator use relating to the medical condition of the employee, or relating to the workplace conditions, including whether or not the employee is medically able to use the respirator;

(ii) The need, if any, for follow-up medical evaluations; and

(iii) A statement that the PLHCP gave a copy of the recommendation to the worker.

(B) If the respirator is a negative pressure respirator and the PLHCP finds that using it would increase the employee's health risk, the employer must provide a PAPR until a subsequent evaluation clears the employee for another type.

(g) Additional medical evaluations. At a minimum, the employer must provide additional medical evaluations that comply with this standard if:

(A) An employee reports medical signs or symptoms related to ability to use a respirator;

(B) A PLHCP, supervisor, or the knowledgeable person informs the employer that an employee needs a reevaluation; or

(C) Information from the respiratory protection program, including observations made during fit testing and program evaluation, indicates a need for employee reevaluation; or

(D) A change occurs in work conditions (e.g., physical work effort, protective clothing, temperature) that may result in a substantial increase in the physiological burden to the employee.

(6) Fit testing.

(a) You must be certain that employees using a tight-fitting face piece respirator pass a qualitative fit test (QLFT) or quantitative fit test (QNFT), using the same make, model, style and size respirator, The fit test must comply with this standard.

(b) Workers using a tight-fitting face piece respirator must renew their fit test annually, before initial use and when they change to another type, style, model or make.

(c) You must do a new fit test on any worker when they or a PLCHP report or you observe any change in the worker's physical condition that could affect the respirator fit.

(d) If after passing a QLFT or QNFT, the employee notifies the employer, supervisor, or PLHCP that the fit of the respirator is unacceptable, you must give them a reasonable opportunity to select a different respirator face piece and redo the fit test.

(e) All fit tests must comply with the Appendix A to this standard.

(f) Do not use qualitative fit tests (QLFT) for negative pressure air purifying respirators for use in atmospheres where the contaminant could be more than 10 times the permissible exposure limit (PEL).

(g) A QNFT fit factor of 100 or more for tight fitting half face piece or a fit factor of 500 for tight fitting full face piece respirators is necessary to pass a quantitative fit test.

(h) For both negative and positive pressure respirators that are tight-fitting, atmosphere-supplying types or powered air-purifying, use only negative pressure quantitative or qualitative fit tests, testing only in the negative pressure mode.

(A) Do qualitative fit testing of these respirators by temporarily converting the respirator user's actual face piece into a negative pressure respirator with appropriate filters, or by using an identical negative pressure air-purifying respirator face piece with the same sealing surfaces as a surrogate for the atmosphere-supplying or powered air-purifying respirator face piece.

(B) Do quantitative fit testing of these respirators by modifying the face piece to allow sampling inside the face piece in the breathing zone of the user, midway between the nose and mouth. Do this by installing a permanent sampling probe onto a surrogate face piece, or by using a sampling adapter designed to temporarily provide a way to sample air from inside the face piece.

(C) Before returning a face piece to normal use, completely remove any modifications done for fit testing, and restore the face piece to NIOSH-approved.

(7) Use of respirators.

(a) Face piece seal protection.

(A) Workers who must wear tight-fitting face pieces may not have either of the following:

(i) Facial hair between the sealing surface and face or anything that interferes with the valve function; or

(ii) Any other condition that interferes with the face-to-face piece seal or valve function.

(B) If an employee wears glasses or goggles or other personal protective equipment, the employer must ensure that it does not interfere with the seal of the face piece to the face of the user.

(C) Employers must train workers who wear respirators on the need for and technique of doing a user seal check before every use. This training must include the procedures in Appendix B-1 or the recommendations of the respirator manufacturer.

(b) Continuing respirator effectiveness.

(A) You must evaluate the effectiveness of a respirator when there is a change in work area conditions or degree of employee exposure or stress that may affect respirator effectiveness.

(B) You must ensure that employees leave the respirator use area:

(i) To wash their faces and respirator face pieces as necessary to prevent eye or skin irritation associated with respirator use; or

(ii) If they detect vapor or gas breakthrough, changes in breathing resistance, or leakage of the face piece; or

(iii) To replace the respirator or the filter, cartridge, or canister elements.

(C) If the employee detects vapor or gas breakthrough, changes in breathing resistance, or leakage of the face piece, the employer must replace or repair the respirator before allowing the employee to return to the work area.

(c) Procedures for IDLH atmospheres. For all IDLH atmospheres, the employer must ensure that:

(A) One employee or, when needed, more than one employee is outside the IDLH atmosphere;

(B) Visual, voice, or line communication is continuous between the employee(s) in the IDLH atmosphere and the employee(s) outside the IDLH atmosphere;

(C) The employee(s) outside the IDLH atmosphere have the training and equipment to provide effective emergency rescue;

(D) The employer or designee is notified before the employee(s) outside the IDLH atmosphere enter the IDLH atmosphere to provide emergency rescue;

(E) The employer or designee authorized to do so by the employer, once notified, provides necessary assistance appropriate to the situation;

(F) Employee(s) outside the IDLH atmospheres have:

(i) Pressure demand or other positive pressure SCBAs, or a pressure demand or other positive pressure supplied-air respirator with auxiliary SCBA; and either

(ii) Appropriate retrieval equipment for removing the employee(s) who enter(s) these hazardous atmospheres where retrieval equipment would contribute to the rescue of the employee(s) and would not increase the overall risk resulting from entry; or

(iii) Equivalent means for rescue when there is no requirement for retrieval equipment under paragraph (g)(3)(vi)(B).

(d) Procedures for interior structural firefighting. If you require your workers to fight interior structural fires, paragraph (7)(c) applies. You must do the following:

(A) At least two employees enter the IDLH atmosphere and remain in visual or voice contact with one another at all times; and

(B) At least two employees are located outside the IDLH atmosphere; and

(C) All employees engaged in interior structural firefighting use SCBA's. Note 1 to paragraph (7): One of the two individuals located outside the IDLH atmosphere may be assigned to an additional role, such as incident commander in charge of the emergency or safety officer, so long as this individual is able to perform assistance or rescue activities without jeopardizing the safety of health of any firefighter working at the incident. Note 2 to paragraph (7): Nothing in this section is meant to preclude firefighters from performing emergency rescue activities before an entire team has assembled.

(8) Maintenance and care of respirators.

(a) Cleaning and disinfecting. You must provide each respirator user with a respirator that is clean, sanitary, and in good working order. You also must ensure that respirators are clean and disinfected using the procedures in Appendix B-2, or procedures recommended by the respirator manufacturer, if they are of equivalent effectiveness. Clean and disinfect the respirators at the following intervals:

(A) Clean and disinfect respirators for exclusive use of one worker as often as necessary to keep them sanitary;

(B) Clean and disinfect respirators for use by more than one worker after each use;

(C) Clean and disinfect emergency use respirators after each use; and

(D) Clean and disinfect fit test and training respirators after each use.

(b) Storage. Store all respirators as follows:

(A) Store all respirators to protect them from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, damaging chemicals, and to prevent deformation of the face piece and exhalation valve.

(B) In addition to the requirements of paragraph (h)(2)(i), keep emergency respirators:

(i) Accessible to the work area;

(ii) In compartments or in covers clearly marked as containing emergency respirators; and

(iii) In accordance with any applicable manufacturer instructions.

(c) Inspection.

(A) The employer must require respirator inspections as follows:

(i) Inspect all routine use respirators before each use and during cleaning;

(ii) Inspect emergency use respirators at least monthly and according to the manufacturer's recommendations. Check for proper function before and after each use; and

(iii) Inspect escape respirators before taking them into the area for possible use.

(B) The employer must ensure that respirator inspections include the following:

(i) A check of respirator function, tightness of connections, and the condition of the various parts including, but not limited to, the face piece, head straps, valves, connecting tube, and cartridges, canisters or filters; and

(ii) A check of elastomeric parts for pliability and signs of deterioration.

(C) In addition to the requirements of paragraphs (h)(3)(i) and (ii), inspect self-contained breathing apparatus monthly. Keep air and oxygen fully charged and recharge them when the pressure falls to 90 percent of the manufacturer's recommended pressure level. Be certain the regulator and warning devices work properly.

(D) For emergency use respirators, the employer must:

(i) Certify the respirator by documenting the date of inspection, the name (or signature) of the inspector, the findings, required remedial action, and a serial number or other means of identifying the respirator; and

(ii) Provide this information on a tag or label attached to the respirator storage compartment, or keep it with the respirator, or include it in paper or electronic inspection reports. Keep this information until the next report replaces it.

(d) Repairs. Do not use respirators that fail an inspection or are otherwise defective. Discard or repair them according to these procedures:

(A) Only people with appropriate training may repair or adjust respirators. They must use only the manufacturer's NIOSH-approved parts for the particular respirator;

(B) Repairs must conform to the manufacturer's recommendations;

(C) Only the manufacturer or a technician trained by the manufacturer may repair or adjust the reducing and admission valves, regulators and alarms.

(9) Breathing air quality and use.

(a) The employer must ensure or have their supplier certify that compressed air, compressed oxygen, liquid air, and liquid oxygen used for respiration meets the following specifications:

(A) Compressed and liquid oxygen must meet the United States Pharmacopoeia requirements for medical or breathing oxygen; and

(B) Compressed breathing air must meet at least the requirements for Grade D breathing air described in ANSI/Compressed Gas Association Commodity Specification for Air, G-7.1-1989, to include:

(i) Oxygen content (v/v) of 19.5 – 23.5 percent;

(ii) Hydrocarbon (condensed) content of 5 milligrams per cubic meter of air or less;

(iii) Carbon monoxide (CO) content of 10 ppm or less;

(iv) Carbon dioxide content of 1,000 ppm or less; and

(v) Lack of noticeable odor.

NOTE: Do not fill your own air vessels unless they and the contents meet all the requirements of this standard

(b) Do not use compressed oxygen in respirators that previously held compressed air.

(c) The employer must ensure that the oxygen concentrations more than 23.5 percent are used only in equipment designed for oxygen service or distribution.

(d) The employer must ensure that cylinders to supply breathing air to respirators meet the following requirements:

(A) Cylinders must comply with the Shipping Container Specification Regulations of the Department of Transportation (49 CFR part 173 and part 178);

(B) Cylinders of purchased breathing air have a certificate of analysis from the supplier that the breathing air meets the requirements for Grade D breathing air; and

(C) The moisture content in the cylinder does not exceed a dew point of -50 degrees F. (-45.6 degrees C.) at 1 atmosphere pressure.

(e) The employer must ensure that compressors supplying breathing air to respirators:

(A) Prevent entry of contaminated air into the air-supply system;

(B) Minimize moisture content so that the dew point at 1 atmosphere pressure is 10 degrees F. (5.56 degrees C.) below the ambient temperature;

(C) Have suitable in-line air-purifying sorbent beds and filters to further ensure breathing air quality. Maintain and replace sorbent beds and filters according to the manufacturer's instructions.

(D) Have a tag at the compressor showing the most recent change date and the signature of the authorized person who did the change.

(f) For compressors that are not oil-lubricated, ensure that carbon monoxide levels in the breathing air do not exceed 10 ppm.

(g) For oil-lubricated compressors, use only a high-temperature or carbon monoxide alarm, or both, to monitor carbon monoxide levels. If you use only high-temperature alarms, monitor the air supply often enough to prevent carbon monoxide in the breathing air from exceeding 10 ppm.

(h) The employer must ensure that breathing air couplings are incompatible with outlets for nonrespirable worksite air or other gas systems. Do not allow any asphyxiating substance to get into breathing airlines.

(i) Use only breathing gas containers with marking that comply with the NIOSH respirator certification standard, 42 CFR part 84.

(10) Identification of filters, cartridges, and canisters. The employer must ensure that all filters, cartridges and canisters have labels and color codes that comply with the NIOSH standards and that the label remains in place and legible.

(11) Training and information.

(a) The employer must ensure that each employee can demonstrate knowledge of at least the following:

(A) Why the respirator is necessary and how improper fit, use, or maintenance can compromise the protective effect of the respirator;

(B) What the limitations and capabilities of the respirator are;

(C) How to use the respirator effectively in emergency situations, including situations in which the respirator malfunctions;

(D) How to inspect, put on and remove, use, and check the seals of the respirator;

(E) What the procedures are for maintenance and storage of the respirator;

(F) How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators; and

(G) The general requirements of this rule.

(b) Training must be in a language or form that workers understand.

(c) Training must be complete before workers use respirators.

(d) Retrain respirator users annually and when these situations happen:

(A) Changes in the work or the type of respirator make previous training obsolete;

(B) Inadequacies in the employee's knowledge or use of the respirator indicate that they no longer have the basic understanding or skill; or

(C) Any other situation arises in which retraining appears necessary to ensure safe respirator use.

(e) An employer who can demonstrate that a new employee has training within the last 12 months that addresses the elements in paragraph (k)(1)(i) through (vii) does not have to repeat that training if, the employee can demonstrate knowledge of those element(s). Previous training not repeated initially by the employer must be provided no later than 12 months from the date of the previous training.

(f) Provide every voluntary respirator user with the basic advisory information in Appendix D. Any written or oral format is acceptable.

(12) Program evaluation.

(a) Evaluate the workplace as necessary to ensure effective use of the current written program.

(b) Regularly consult your users to get their views on your program's effectiveness and to identify problems. Correct the problem. Things to assess include at least:

(A) Respirator fit (including the ability to use the respirator without interfering with effective workplace performance);

(B) Users have and use the correct respirator for their exposure hazards;

(C) Proper respirator use; and

(D) Proper respirator maintenance.

(13) Recordkeeping.

(a) Medical evaluation. Retain and make available, according to 437-002-1910.1020, all medical evaluations required by this standard.

(b) Fit testing.

(A) You must keep a record of qualitative and quantitative fit tests for each user including:

(i) The name or identification of the employee;

(ii) Type of fit test;

(iii) Specific make, model, style, and size of respirator tested;

(iv) Date of test; and

(v) The pass/fail results for QLFTs or the fit factor and strip chart recording or other recording of the test results for QNFTs.

(B) Keep fit test records until records of a new test replace them.

(c) You must keep a written copy of your current respirator program.

(d) On request, you must make written records required by this standard, available to the OR-OSHA Administrator or their designee for examination or copying.

(14) Appendices.

(a) Compliance with Appendix A, Appendix B-1, Appendix B-2, and Appendix C of this rule is mandatory.

(b) Appendix D of this rule is mandatory and does not create any additional obligations or detract from any existing obligations.

(15) Effective Date. OAR 437-004-1041, Respiratory Protection, is effective March 1, 2007.

[ED. NOTE: Tables referenced are available from the agency.]
[ED. NOTE: Appendix referenced are available from the agency.]
Stat. Auth.: ORS 654.025(2), 656.726(4).
Stats. Implemented: ORS 654.001 - 654.295.
Hist.: OSHA 3-2006, f. 6-7-06, cert. ef. 3-1-07

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

Rule Caption: Amendment of workers' compensation rules affecting unjured workers, employers, medical providers, insurers, and others.
Adm. Order No.: WCD 5-2006
Filed with Sec. of State: 6-15-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 436-010-0005, 436-010-0210, 436-010-0220, 436-010-0230, 436-010-0240, 436-010-0265, 436-010-0275, 436-010-0280, 436-055-0008, 436-055-0070, 436-055-0085, 436-055-0110, 436-060-0035, 436-060-0095, 436-070-0020
Rules Repealed: 436-055-0120, 436-070-0020(T)
Subject: These rules have been amended to:

• (OAR 436-010-0220) Clarify that referrals to a specialist physician by an attending physician or authorized nurse practitioner must be written. Clarify that the referral includes authority for the specialist physician to provide services and treatment unless the referral includes limitations;

• (OAR 436-010-0230) Clarify that any consent form for attendance by an employer representative at a worker's medical exam must be written in a way that allows the worker to understand it and to overcome language or cultural differences;

• (OAR 436-010-0265):

-State the criteria for a person to be added to the list of qualified independent medical examination (IME) providers;

-Describe training requirements for IME providers;

-State the criteria for removal of an IME provider from the list;

-Establish the curriculum to be used to train IME providers;

- Disallow use of IME reports from providers who are not on the director's IME provider list;

- Eliminate the seven-day time frame for an IME provider to send the examination report to the insurer;

• (OAR 436-010-0265 & 436-060-0095) Require that insurers and IME providers give workers survey forms to report their IME experiences to the Workers' Compensation Division;

• (436-010-0275) Require that the insurer forward information to the appropriate managed care organization if the information was sent to the insurer in error;

• (OAR 436-055-0008) Reflect the requirement, effective January 1, 2006, that hearings on workers' compensation matters previously processed by the Office of Administrative Hearings have been transferred to the Workers' Compensation Board;

• (OAR 436-055-0085) Clarify that specific training for renewal of claims examiner certification can be approved if it covers some, but not necessarily all, of the components listed in OAR 436-055-0085(2);

• (OAR 436-055-0120) Repeal specific requirements affecting service of orders by the director; and

• (OAR 436-070-0020) Clarify the criteria for issuance of a Failure to File Notice or Notice of Audit Findings.

Direct questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; or e-mail fred.h.bruyns@state.or.us. Rules are available on the internet: http://www.wcd.oregon.gov/policy/rules/rules.html

For a copy of the rules, contact Publications at 503-947-7627, Fax 503-947-7630.

Rules Coordinator: Fred Bruyns—(503) 947-7717

436-010-0005
Definitions

For the purpose of these rules, OAR 436-009 and 436-015, unless the context otherwise requires:

(1) "Administrative Review" means any decision making process of the director requested by a party aggrieved with an action taken under these rules except the hearing process described in OAR 436-001.

(2) "Attending Physician" means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury or illness and who is:

(a) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral surgeon licensed by the Oregon Board of Dentistry;

(b) A medical doctor, doctor of osteopathy, or oral surgeon practicing in and licensed under the laws of another state;

(c) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits, during that 30 day period, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon;

(d) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits during that 30 day period, whichever first occurs, a doctor or physician of chiropractic practicing and licensed under the laws of another state; or

(e) Any medical service provider authorized to be an attending physician in accordance with a managed care organization contract.

(3) "Authorized nurse practitioner" means a nurse practitioner licensed under ORS 678.375 to 678.390 who has certified to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director and has been assigned an authorized nurse practitioner number by the director.

(4) "Board" means the Workers' Compensation Board and includes its Hearings Division.

(5) "Chart note" means a notation made in chronological order in a medical record in which the medical service provider records such things as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return to work goals and status.

(6) "Coordinated Health Care Program" means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the worker with health care benefits even if a worker's compensation claim is denied.

(7) "Current Procedural Terminology" or "CPT"® means the Current Procedural Terminology codes and terminology most recently published by the American Medical Association unless otherwise specified in these rules.

(8) "Customary Fee" means a fee that falls within the range of fees normally charged for a given service.

(9) "Days" means calendar days.

(10) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend, or take over the medical service at any time.

(11) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(12) "Eligible" means an injured worker who has filed a claim and is employed by an employer who is located in an MCO's authorized geographical service area, covered by an insurer who has a contract with that MCO. "Eligible" also includes a worker with an accepted claim having a date of injury prior to contract when that worker's employer later becomes covered by an MCO contract.

(13) "Enrolled" means an eligible injured worker has received notification from the insurer that the worker is being required to treat under the auspices of the MCO. However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical service area.

(14) "First Chiropractic Visit" means a worker's first visit to a chiropractic physician on the initial claim.

(15) "Health Care Practitioner" has the same meaning as a "medical service provider."

(16) "HCFA form 2552" (Hospital Care Complex Cost Report) means the annual report a hospital makes to Medicare.

(17) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(18) "Home Health Care" means medically necessary medical and medically related services provided in the injured worker's home environment. These services might include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.

(19) "Hospital" means an institution licensed by the State of Oregon as a hospital.

(20) "Initial Claim" means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the "initial claim" means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(21) "Inpatient" means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(22) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; or, an employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.

(23) "Interim Medical Benefits" means those services provided under ORS 656.247 on initial claims with dates of injury on or after January 1, 2002 that are not denied within 14 days of the employer's notice of the claim.

(24) "Mailed or Mailing Date," for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped or punched in by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(25) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(26) "Medical Evidence" includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, x-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material utilized, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

(27) "Medical Service" means any medical treatment or any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(28) "Medical Service Provider" means a person duly licensed to practice one or more of the healing arts.

(29) "Medical Provider" means a medical service provider, a hospital, medical clinic, or vendor of medical services.

(30) "Medical Treatment" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

(31) "Non-attending Physician" means a medical service provider who is not qualified to be an attending physician, or a chiropractor who no longer qualifies as an attending physician under ORS 656.005 and subsections (2)(c) and (2)(d) of this rule.

(32) "Outpatient" means a worker not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments which do not result in admission are also considered outpatient services.

(33) "Parties" mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(34) "Physical Capacity Evaluation" or "PCE" means an objective, directly observed, measurement of a worker's ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, and Functional Capacity Assessment will be considered to have the same meaning as Physical Capacity Evaluation.

(35) "Physical Restorative Services" means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia, a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the injured worker to the highest functional ability consistent with the worker's condition. Physical restorative services are not services

to replace medical services usually prescribed during the course of recovery.

(36) "Report" means medical information transmitted in written form containing relevant subjective or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(37) "Residual Functional Capacity" means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the worker can perform each activity.

(38) "Specialist Physician" means a licensed physician who qualifies as an attending physician and who examines a worker at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, and/or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice and/or an opinion regarding the treatment being rendered, or considered, for a workers' compensable injury.

(39) "Usual Fee" means the medical provider's fee charged the general public for a given service.

(40) "Work Capacity Evaluation" or "WCE" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening will be considered to have the same meaning as Work Capacity Evaluation.

(41) "Work Hardening" means an individualized, medically prescribed and monitored, work oriented treatment process. The process involves the worker participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the worker to a specific job.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.000 et seq. & 656.005

Hist.: WCB 4-1976, f. 10-20-76, ef. 11-1-76; WCD 7-1978(Admin), f. & ef. 6-5-78; WCD 2-1980(Admin), f. 1-28-80, ef. 2-1-80; WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0005, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 4-1986(Admin), f. 6-26-86, ef. 7-1-86; WCD 2-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 14-1990(Temp), f. & cert. ef. 7-20-91; WCD 16-1990(Temp), f. & cert. ef. 8-17-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-010-0210
Who May Provide Medical Services and Authorize Timeloss

(1) Attending physicians and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of these rules. However, an MCO may designate any medical service provider as an attending physician who may provide medical services to an enrolled worker in accordance with ORS 656.260.

(2) Authorized primary care physicians and authorized nurse practitioners may provide medical services to injured workers subject to the terms and conditions of the governing MCO.

(3) Attending physicians and authorized nurse practitioners may prescribe treatment or services to be carried out by persons licensed to provide a medical service. Attending physicians may prescribe treatment or services to be carried out by persons not licensed to provide a medical service or treat independently only when such services or treatment is rendered under the physician's direct control and supervision. Reimbursement to a worker for home health care provided by a worker's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(4) Physician assistants may provide compensable medical services for a period of 30 days from the date of injury or 12 visits on the initial claim, whichever occurs first. Thereafter, medical services provided are not compensable without authorization of an attending physician. Additionally, those physician assistants practicing in Type A, Type B, and Type C rural hospital areas as specified in ORS 656.245, may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of first visit on the initial claim. Definitions of Type A, Type B, and Type C rural hospitals are contained in ORS 442.470. A list of rural hospitals is provided in Appendix A.

(5) Authorized nurse practitioners, out-of-state nurse practitioners, and physician assistants working within the scope of their license and as directed by the attending physician, need not be working under a written treatment plan as prescribed in OAR 436-010-0230(4)(a), nor under the direct control and supervision of the attending physician.

(6) A physician assistant, licensed under ORS 677.515, may provide services when the Board of Medical Examiners approves the physician assistant for practice.

(7) Effective October 1, 2004, in order to provide any compensable medical service under ORS chapter 656, a nurse practitioner licensed under ORS 678.375 to 678.390 must certify in a form provided by the director that the nurse practitioner has reviewed a packet of materials which the director will provide upon request and must have been assigned an authorized nurse practitioner number by the director. An authorized nurse practitioner may:

(a) Provide compensable medical services to an injured worker for a period of 90 days from the date of the first nurse practitioner visit on the initial claim. Thereafter, medical services provided by an authorized nurse practitioner are not compensable without authorization of an attending physician; and

(b) Authorize temporary disability benefits for a period of up to 60 days from the date of the first nurse practitioner visit on the initial claim.

(8) In accordance with ORS 656.245(2)(a), with the approval of the insurer, the worker may choose an attending physician outside the state of Oregon. Upon receipt of the worker's request, or the insurer's knowledge of the worker's request to treat with an out-of-state physician, the insurer must give the worker written notice of approval or denial of the worker's choice of attending physician within 14 days.

(a) If the insurer does not approve the worker's out-of-state physician, notice to the worker must clearly state the reason(s) for the denial, which may include, but are not limited to, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010, and identify at least two other physicians of the same healing art and specialty whom it would approve. The notice must also inform the worker that if the worker disagrees with the denial, the worker may refer the matter to the director for review under the provisions of OAR 436-010-0220.

(b) If the insurer approves the worker's choice of out-of-state attending physician, the insurer must immediately notify the worker and the medical service provider in writing of the following:

(A) The Oregon fee schedule requirements;

(B) The manner in which the out-of-state physician may provide compensable medical treatment or services to Oregon injured workers; and

(C) Billings for compensable services in excess of the maximum allowed under the fee schedule may not be paid by the insurer.

(9) After giving prior approval, if the out-of-state physician does not comply with these rules, the insurer may object to the worker's choice of physician and must notify the worker and the physician in writing of the reason for the objection, that payment for services rendered by that physician after notification will not be reimbursable, and that the worker may be liable for payment of services rendered after the date of notification.

(10) If the worker is aggrieved by an insurer decision to object to an out-of-state attending physician, the worker or the worker's representative may refer the matter to the director for review under the provisions of OAR 436-010-0220.

Stat. Auth.:ORS 656.726(4)

Stats. Implemented: ORS 656.005(12), 656.245 & 656.260

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 5-1984(Admin), f. & ef. 8-20-84; Renumbered from 436-069-0301, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 6-1988, f. 9-6-88, cert. ef. 9-15-88; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0050; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-000; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-010-0220
Choosing and Changing Medical Providers

(1) A newly selected attending physician, authorized nurse practitioner, or a specialist physician who becomes primarily responsible for the worker's care, must notify the insurer not later than five days after the date of change or first treatment, using Form 827. An attending physician or authorized nurse practitioner:

(a) Is primarily responsible for the worker's care,

(b) Authorizes time loss,

(c) Monitors ancillary care and specialized care, and

(d) Is determined by the facts of the case and the actions of the physician, not whether a Form 827 is filed.

(2) The worker may have only one attending physician or authorized nurse practitioner at a time. Simultaneous or concurrent treatment by other medical service providers must be based upon a written request of the attending physician or authorized nurse practitioner, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be authorized by the injured worker's attending physician or authorized nurse practitioner to be reimbursable. When the attending physician or authorized nurse practitioner refers the worker to a specialist physician, the referral must be written. An attending physician must specify any limitations regarding the referral within such document. Unless the documented referral limits the referral to consultation only, the referral is deemed to include attending physician authorization for the specialist physician to provide or order all compensable medical services and treatment he or she determines appropriate. Nothing in this rule diminishes the attending physician's responsibility to fulfill all their duties under ORS chapter 656, including authorizing temporary disability. Fees for services by more than one physician at the same time are payable only when the service is sufficiently different that separate medical skills are needed for proper care.

(3) The worker is allowed to change his or her attending physician or authorized nurse practitioner by choice two times after the initial choice. Referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, initiated by the worker, will count in this calculation. The limitations of the worker's right to choose physicians or authorized nurse practitioners under this section begin with the date of injury and extend through the life of the claim. For purposes of this rule, the following are not considered changes by choice of the worker:

(a) Emergency services by a physician;

(b) Examinations at the request of the insurer;

(c) Consultations or referrals for specialized treatment or services initiated by the attending physician or authorized nurse practitioner;

(d) Referrals to radiologists and pathologists for diagnostic studies;

(e) When workers are required to change medical service providers to receive compensable medical services, palliative care, or time loss authorization because their medical service provider is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(f) Changes of attending physician or authorized nurse practitioner required due to conditions beyond the worker's control. This could include, but not be limited to:

(A) When the physician terminates practice or leaves the area;

(B) When a physician is no longer willing to treat an injured worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the physician;

(D) When the 90 day period for treatment or services by an authorized nurse practitioner has expired;

(E) When the nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure; and

(F) When a worker is subject to managed care and compelled to be treated inside an MCO;

(g) A Worker Requested Medical Examination;

(h) Whether a worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines; or

(i) When a worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence.

(4) When a worker has made an initial choice of attending physician or authorized nurse practitioner and subsequently changed two times by choice or reaches the maximum number of changes established by the MCO, the insurer must inform the worker by certified mail that any subsequent changes by choice must have the approval of the insurer or the director. If the insurer fails to provide such notice and the worker subsequently chooses another attending physician or authorized nurse practitioner, the insurer must pay for compensable services rendered prior to notice to the worker. If an attending physician or authorized nurse practitioner begins treatment without being informed that the worker has been given the required notification, the insurer must pay for appropriate services rendered prior to the time the insurer notifies the medical service provider that further payment will not be made and informs the worker of the right to seek approval of the director.

(5)(a) If a worker not enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the limit established in section (3) of this rule, the worker must request approval from the insurer. Within 14 days of receipt of a request for a change of medical service provider or a Form 827 indicating the worker is choosing to change his or her attending physician or authorized nurse practitioner, the insurer must notify the worker in writing whether the change is approved. If the insurer objects to the change, the insurer must advise the worker of the reasons, advise that the worker may request director approval, and provide the worker with Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner) to complete and submit to the director if the worker wishes to make the requested change.

(b) If a worker enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the changes allowed in the MCO contract or certified plan, the worker must request approval from the insurer. Within 14 days of receiving the request, the insurer must notify the worker in writing whether the change is approved. If the insurer denies the change, the insurer must provide the reasons and give notification that the worker may request dispute resolution through the MCO. If the MCO does not have a dispute resolution process for change of attending physician or authorized nurse practitioner issues, the insurer shall give notification that the worker may request director approval and provide the worker with a copy of Form 2332.

(6) Upon receipt of a worker's request for an additional change of attending physician or authorized nurse practitioner, the director may notify the parties and request additional information. Upon receipt of a written request from the director for additional information, the parties will have 14 days to respond in writing.

(7) After receipt and review, the director will issue an order advising whether the change is approved. The change of attending physician or authorized nurse practitioner will be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule. On a case by case basis consideration may be given, but is not limited to, the following:

(a) Whether there is medical justification for a change, including whether the attending physician or authorized nurse practitioner can provide the type of treatment or service that is appropriate for the worker's condition.

(b) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

(c) Whether such a change will cause unnecessary travel costs or lost time from work.

(8) Any party that disagrees with the director's order may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order. OAR 436-001 applies to the hearing.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.276(4)

Stats. Implemented: ORS 656.245, 656.252 & 656.260

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0401, 5-1-85; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0060; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-010-0230
Medical Services and Treatment Guidelines

(1) Medical services provided to the injured worker must not be more than the nature of the compensable injury or the process of recovery requires. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

(2) An employer or insurer representative may not attend a worker's medical appointment without written consent of the worker. The worker has the right to refuse such attendance.

(a) The consent form must state that the worker's benefits cannot be suspended if the worker refuses to have a representative present.

(b) The consent form must be written in a way that allows the worker to understand it and to overcome language or cultural differences.

(c) The insurer must retain a copy of a signed consent form in the claim file.

(3) Insurers have the right to require evidence of the frequency, extent, and efficacy of treatment and services. Unless otherwise provided for by statute, or within utilization and treatment standards under an MCO contract, treatment typically does not exceed 15 office visits by any and all attending physicians or authorized nurse practitioners in the first 60 days from first date of treatment, and two visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment.

(4)(a) Except as otherwise provided by an MCO, ancillary services including but not limited to physical therapy or occupational therapy, by a medical service provider other than the attending physician, authorized nurse practitioner, or specialist physician will not be reimbursed unless prescribed by the attending physician, authorized nurse practitioner, or specialist physician and carried out under a treatment plan prepared prior to the commencement of treatment and sent by the ancillary medical service provider to the attending physician, authorized nurse practitioner, or specialist physician, and the insurer within seven days of beginning treatment. The treatment plan shall include objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes. Treatment plans required under this subsection do not apply to services provided under ORS 656.245(2)(b)(A).

(b) The attending physician, authorized nurse practitioner, or specialist physician must sign a copy of the treatment plan within 30 days of the commencement of treatment and send it to the insurer. Failure of the physician or nurse practitioner to sign or mail the treatment plan may subject the attending physician or authorized nurse practitioner to sanctions under OAR 436-010-0340, but shall not affect payment to the ancillary medical service provider.

(c) Medical services prescribed by an attending physician, specialist physician, or authorized nurse practitioner and provided by a chiropractor, naturopath, acupuncturist, or podiatrist will be subject to the treatment plan requirements set forth in subsection (4)(a) and (b) of this rule.

(d) Unless otherwise provided for within utilization and treatment standards under an MCO contract, the usual range for therapy visits does not exceed 20 visits in the first 60 days, and 4 visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment or services. The attending physician or authorized nurse practitioner must document the need for medical services in excess of these guidelines when submitting a written treatment plan. The process outlined in OAR 436-010-0008 should be followed when an insurer believes the treatment plan is inappropriate.

(5) The attending physician or authorized nurse practitioner, when requested by the insurer or the director through the insurer to complete a physical capacity or work capacity evaluation, must complete the evaluation within 20 days, or refer the worker for such evaluation within seven days. The attending physician or authorized nurse practitioner must notify the insurer and the worker in writing if the worker is incapable of participating in such evaluation.

(6) Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), (1)(b), and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-010-0290. A pharmacist, dispensing physician, or authorized nurse practitioner must dispense generic drugs to injured workers in accordance with and under ORS 689.515. For the purposes of this rule, the worker will be deemed the "purchaser" and may object to the substitution of a generic drug. However, payment for brand name drugs are subject to the limitations provided in OAR 436-009-0090. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the the requirements of the provider's licensing board, this rule and OAR 436-009-0090. Compensation for certain drugs is limited as provided in OAR 436-009-0090.

(7) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker or they are provided in accordance with a utilization and treatment standard adopted by the director. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(8) X-ray films must be of diagnostic quality and accompanied by a report. 14" x 36" lateral views are not reimbursable.

(9) Upon request of either the director or the insurer, original diagnostic studies, including but not limited to actual films, must be forwarded to the director, the insurer, or the insurer's designee, within 14 days of receipt of a written request.

(a) Diagnostic studies, including films must be returned to the medical provider within a reasonable time.

(b) The insurer must pay for a reasonable charge made by the provider for the costs of delivery of diagnostic studies, including films.

(c) If a medical provider does not forward the films to the director or the insurer within 14 days of receipt of a written request, civil penalties may be imposed.

(10) Articles including but not limited to beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury or the process of recovery requires" the item be furnished. The report must specifically set forth why the worker requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(11) Physical restorative services may include but are not limited to a regular exercise program or swim therapy. Such services are not compensable unless the nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social and/or functional activity. The attending physician or authorized nurse practitioner must justify by report why the worker requires services not usually considered necessary for the majority of injured workers.

(12) The cost of repair or replacement of prosthetic appliances damaged when in use at the time of and in the course of a compensable injury is a compensable medical expense, including when the worker received no physical injury. For purposes of this rule, a prosthetic appliance is an artificial substitute for a missing body part or any device by which performance of a natural function is aided, including but not limited to hearing aids and eyeglasses.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248 & 656.252

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 5-1984(Admin), f. & ef. 8-20-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0201, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 2-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 6-1988, f. 9-6-88, cert. ef. 9-15-88; WCD 2-1989, f. 8-21-89, cert. ef. 9-1-89; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0040; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-1999(Temp), f. & cert. ef. 2-11-99 thru 8-10-99; WCD 7-1999, f. & cert. ef. 4-28-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-010-0240
Reporting Requirements for Medical Providers

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any medical provider and other custodians of claims records to release relevant medical records under ORS 656.252 and diagnostic records required under ORS 656.325. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. The authorization is valid for the duration of the work related injury or illness and is not subject to revocation by the worker or the worker's representative. However, this authorization does not authorize the release of information regarding:

(a) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, or

(b) The release of HIV related information otherwise protected by ORS 433.045(3). HIV related information should only be released when a claim is made for HIV or AIDS or when such information is directly relevant to the claimed condition(s).

(2) Any physician, hospital, clinic, or other medical service provider, must provide all relevant information to the director, the insurer or their representative upon presentation of a signed Form 801, 827, or 2476 (Release of Information). "Signature on file," printed on the worker's signature line of any authorized Release of Information prescribed by the director, is a valid medical release, provided the insurer maintains the signed original in accordance with OAR 436-010-0270. However, nothing in this rule will prevent a medical provider from requiring a signed authorized Release of Information.

(3) When the worker has initiated a claim or wishes to initiate a claim, the worker and the first medical service provider on the initial claim must complete the first medical report (Form 827) in every detail, to include the worker's name, address, and social security number (SSN), and information required by ORS 656.252 and 656.254. The medical service provider must mail it to the proper insurer no later than 72 hours after the worker's first visit (Saturdays, Sundays, and holidays will not be counted in the 72-hour period).

(a) Diagnoses stated on Form 827 and all subsequent reports must conform to terminology found in the International Classification of Disease-9-Clinical Manifestations (ICD-9-CM) or taught in accredited institutions of the licentiate's profession.

(b) The worker's SSN will be used by the director to carry out its duties under ORS chapter 656. The worker may voluntarily authorize addi-

tional use of the worker's SSN by various government agencies to carry out their statutory duties.

(4) All medical service providers must notify the worker at the time of the first visit of the manner in which they can provide compensable medical services and authorize time loss. The worker must also be notified that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the worker's chart notes.

(5) Attending physicians or authorized nurse practitioners must, upon request from the insurer, submit verification of the worker's medical limitations related to the worker's ability to work, resulting from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return to work form, the insurer must use Form 3245.

(6) Medical providers must maintain records necessary to document the extent of medical services provided to injured workers.

(7) Progress reports are essential. When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days through the use of the physician's report, Form 827. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report. Fees for such narrative reports must be in accordance with OAR 436-009-0015(11), 436-009-0070(2) or (3), whichever applies

(8) Reports may be handwritten and include all relevant or requested information.

(9) All records must be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(10) The medical provider must respond within 14 days to the request for relevant medical records as specified in section (1) of this rule, progress reports, narrative reports, original diagnostic studies, including, but not limited to, actual films, and any or all necessary records needed to review the efficacy of medical treatment or medical services, frequency, and necessity of care. The medical provider must be reimbursed for copying documents in accordance with OAR 436-009-0070 (1). If the medical provider fails to provide such information within fourteen (14) days of receiving a request sent by certified mail, penalties under OAR 436-010-0340 or 436-015-0120 may be imposed.

(11) The attending physician or authorized nurse practitioner must inform the insurer and the worker of the anticipated date of release to work, the anticipated date the worker will become medically stationary, the next appointment date, and the worker's medical limitations. To the extent any medical provider can determine these matters they must be included in each progress report. The insurer must not consider the anticipated date of becoming medically stationary as a release to return to work.

(12) At the time the attending physician or authorized nurse practitioner declares the worker medically stationary, the attending physician or authorized nurse practitioner must notify the worker, the insurer, and all other medical providers who are providing services to the worker. For disabling claims, if the worker has been under the care of an authorized nurse practitioner, the authorized nurse practitioner must follow the requirements of OAR 436-010-0280 regarding the determination and reporting of permanent impairment and closing examinations. The attending physician must send a closing report to the insurer within 14 days of the examination in which the worker is declared medically stationary, except where a consulting physician examines the worker. The procedures and time frames for a consulting physician to perform the closing exam are provided in OAR 436-010-0280.

(13) The attending physician or authorized nurse practitioner must advise the worker, and within five days provide the insurer with written notice, of the date the injured worker is released to return to regular or modified work. The physician or nurse must not notify the insurer or employer of the worker's release to return to regular or modified work without first advising the worker.

(14) When an injured worker files a claim for aggravation, the claim must be filed on Form 827 and must be signed by the worker or the worker's representative and the attending physician. The attending physician, on the worker's behalf, must submit the aggravation form to the insurer within five days of the examination where aggravation is identified. When an insurer or self-insured employer receives a completed aggravation form, it must process the claim. Within 14 days of the examination the attending physician must also send a written report to the insurer that includes objective findings that document:

(a) Whether the worker is unable to work as a result of the compensable worsening; and

(b) Whether the worker has suffered a worsened condition attributable to the compensable injury under the criteria contained in ORS 656.273.

(15) The attending physician, authorized nurse practitioner, or the MCO may request consultation regarding conditions related to an accepted claim. The attending physician, authorized nurse practitioner, or the MCO must promptly notify the insurer of the request for consultation. This requirement does not apply to diagnostic studies performed by radiologists and pathologists. The attending physician, authorized nurse practitioner, or MCO must provide the consultant with all relevant clinical information. The consultant must submit a copy of the consultation report to the attending physician, authorized nurse practitioner, the MCO, and the insurer within 10 days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report. MCO requested consultations that are initiated by the insurer, which include examination of the worker, must be considered independent medical examinations subject to the provisions of OAR 436-010-0265.

(16) A medical service provider must not unreasonably interfere with the right of the insurer, under OAR 436-010-0265(1), to obtain a medical examination of the worker by a physician of the insurer's choice.

(17) Any time an injured worker changes his or her attending physician or authorized nurse practitioner:

(a) The new provider is responsible for:

(A) Submitting Form 827 to the insurer not later than five days after the change or the date of first treatment; and

(B) Requesting all available medical information, including information concerning previous temporary disability periods, from the previous attending physician, authorized nurse practitioner, or from the insurer.

(b) The requirements of paragraphs (A) and (B) also apply anytime a worker is referred to a new physician qualified to be an attending physician or to a new authorized nurse practitioner primarily responsible for the worker's care.

(c) Anyone failing to forward requested information within 14 days to the new physician or nurse will be subject to penalties under OAR 436-010-0340.

(18) Injured workers, or their representatives, are entitled to copies of all protected health information in the medical records. These records should ordinarily be available from the insurers, but may also be obtained from medical providers under the following conditions:

(a) A medical provider may charge the worker for copies in accordance with OAR 436-009-0070(1), but a patient may not be denied summaries or copies of his/her medical records because of inability to pay.

(b) For the purpose of this rule, "protected health information in the medical record" means any oral or written information in any form or medium that is created or received and relates to:

(A) The past, present, or future physical or mental health of the patient;

(B) The provision of health care to the patient; and

(C) The past, present, or future payment for the provision of health care to the patient.

(c) A worker or the worker's representative may request all or part of the record. A summary may substitute for the actual record only if the patient agrees to the substitution. Upon request, the entire health information record in the possession of the medical provider will be provided to the worker or the worker's representative. This includes records from other healthcare providers, except that the following may be withheld:

(A) Information which was obtained from someone other than a healthcare provider under a promise of confidentiality and access to the information would likely reveal the source of the information;

(B) Psychotherapy notes;

(C) Information compiled for use in a civil, criminal, or administrative action or proceeding; and

(D) Other reasons specified by federal regulation.

[ED. NOTE: Forms referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.276(4)

Stats. Implemented: ORS 656.245, 656.252, 656.254 & 656.273

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0101, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 14-1990(Temp), f. & cert. ef. 7-20-91; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0030; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-010-0265

Insurer Medical Examinations (IME)

(1) The insurer may obtain three medical examinations of the worker by medical service providers of its choice for each opening of the claim. These examinations may be obtained prior to or after claim closure. Effective July 1, 2006, the insurer must choose a provider to perform the independent medical examination from the director's list described in section (13) of this rule. A claim for aggravation, Board's Own Motion, or

reopening of a claim where the worker becomes enrolled or actively engaged in training according to rules adopted under ORS 656.340 and 656.726 permits a new series of three medical examinations. For purposes of this rule, "independent medical examination" (IME) means any medical examination including a physical capacity or work capacity evaluation or consultation that includes an examination, except as provided in section (5) of this rule, that is requested by the insurer and completed by any medical service provider, other than the worker's attending physician or authorized nurse practitioner. The examination may be conducted by one or more providers with different specialty qualifications, generally done at one location and completed within a 72-hour period. If the providers are not at one location, the examination is to be completed within a 72-hour period and at locations reasonably convenient to the worker.

(2) When the insurer has obtained the three medical examinations allowed under this rule and wishes to require the worker to attend an additional examination, the insurer must first notify and request authorization from the director. Insurers that fail to first notify and request authorization from the director, may be assessed a civil penalty. The process for requesting such authorization will be as follows:

(a) The insurer must submit a request for such authorization to the director in a form and format as prescribed by the director in Bulletin 252 including, but not limited to, the reasons for an additional IME, the conditions to be evaluated, dates, times, places, and purposes of previous examinations, copies of previous IME notification letters to the worker, and any other information requested by the director. A copy of the request must be provided to the worker and the worker's attorney; and

(b) The director will review the request and determine if additional information is necessary prior to issuing an order approving or disapproving the request. Upon receipt of a written request for additional information from the director, the parties have 14 days to respond. If the parties do not provide the requested information, the director will issue an order approving or disapproving the request based on available information.

(3) In determining whether to approve or deny the request for an additional IME, the director may give consideration, but is not limited, to the following:

(a) Whether an IME involving the same discipline(s) or review of the same condition has been completed within the past six months.

(b) Whether there has been a significant change in the worker's condition.

(c) Whether there is a new condition or compensable aspect introduced to the claim.

(d) Whether there is a conflict of medical opinion about a worker's medical treatment or medical services, impairment, stationary status, or other issue critical to claim processing/benefits.

(e) Whether the IME is requested to establish a preponderance for medically stationary status.

(f) Whether the IME is medically harmful to the worker.

(g) Whether the IME requested is for a condition for which the worker has sought treatment or services, or the condition has been included in the compensable claim.

(4) Any party aggrieved by the director's order approving or disapproving a request for an additional IME may request a hearing by the Hearings Division of the board under ORS 656.283 and OAR chapter 438.

(5) For purposes of determining the number of IMEs, any examinations scheduled but not completed are not counted as a statutory IME. The following examinations are not considered IMEs and do not require approval as outlined in section (2) of this rule:

(a) An examination conducted by or at the request or direction of the worker's attending physician or authorized nurse practitioner;

(b) An examination obtained at the request of the director;

(c) An elective surgery consultation obtained in accordance with OAR 436-010-0250(3);

(d) An examination of a permanently totally disabled worker required under ORS 656.206(5);

(e) A closing examination by a consulting physician that has been arranged by the insurer, the worker's attending physician or authorized nurse practitioner in accordance with OAR 436-010-0280;

(f) A consultation requested by the Managed Care Organization (MCO) for the purpose of clarifying or refining a plan for continuing medical services as provided under its contract.

(6) Examinations must be at times and intervals reasonably convenient to the worker and must not delay or interrupt proper treatment of the worker.

(7) When the insurer requires a worker to attend an IME, the insurer must comply with the notification and reimbursement requirements found in OAR 436-009-0025 and 436-060-0095.

(8) A medical provider who unreasonably fails to timely provide diagnostic records required for an IME in accordance with OAR 436-010-0230(9) and 436-010-0240(10) may be assessed a penalty under ORS 656.325.

(9) When a worker objects to the location of an IME, the worker may request review by the director within six business days of the mailing date of the appointment notice.

(a) The request may be made in-person, by telephone, facsimile, or mail.

(b) The director may facilitate an agreement between the parties regarding location.

(c) If necessary, the director will conduct an expedited review and issue an order regarding the reasonableness of the location.

(d) The director will determine if there is substantial evidence to support a finding that the travel is medically contraindicated, or unreasonable based on a showing of good cause.

(A) For the purposes of this rule, "medically contraindicated" means that the travel required to attend the IME exceeds the travel or other limitations imposed by the attending physician, authorized nurse practitioner or other persuasive medical evidence, and alternative methods of travel will not overcome the limitations.

(B) For the purposes of this rule, "good cause" means the travel would impose a hardship for the worker that outweighs the right of the insurer or self-insured employer to select an IME location of its choice.

(10) If a worker fails to attend an IME without notifying the insurer or self-insured employer before the date of the examination or without sufficient reason for not attending, the director may impose a monetary penalty against the worker for such failure under OAR 436-010-0340.

(11) When scheduling an IME, the insurer must ensure the medical service provider has:

(a) An Invasive Medical Procedure Authorization (Form 440-3227), if applicable; and

(b) A Worker IME Survey (Form 440-0858), with instructions to give the form(s) to the worker at the time of the IME.

(12) If a medical service provider intends to perform an invasive procedure as part of an IME, the provider must explain the risks involved in the procedure to the worker and the worker's right to refuse the procedure. The worker then must check the applicable box on Form 440-3227 either agreeing to the procedure or declining the procedure, and sign the form. For the purposes of this rule, an invasive procedure is a procedure in which the body is entered by a needle, tube, scope, or scalpel.

(13) Any medical service provider wishing to perform an IME or a Worker Requested Medical Exam (WRME) under ORS 656.325(1)(e) and OAR 436-060-0147 for a workers' compensation claim must meet the director's criteria and be included on the list of authorized providers maintained by the Director of the Department of Consumer and Business Services under ORS 656.325.

(a) To be on the director's list to perform IMEs or WRMEs, a medical service provider must:

(A) Hold a current license and be in good standing with the professional regulatory board that issued the license, for example the Oregon Board of Medical Examiners.

(B) Complete a director-approved three-hour initial training course regarding IMEs. The training curriculum must include, at a minimum, all topics listed in Appendix B.

(i) Any party may request the director to place a provider on the director's list with less than the three-hour training. At the director's discretion, providers may be placed on the director's list to perform IMEs with less than the three-hour required training when extraordinary circumstances exist in a given case or if the worker and the insurer agree that a certain provider may perform the examination. Providers placed on the director's list in this circumstance are limited to being on the director's list only for the time required for the examination at issue.

(ii) When determining if extraordinary circumstances exist in a given case, the director may consider, but is not limited to, such factors as: medical specialty needed; number of IMEs the provider has performed in a calendar year; where the worker lives; and factors that would make the three-hour training unreasonable in a given case.

(C) Submit the Application for Independent Medical Exam Medical Service Provider Authorization (Form 440-3930) to the director. On the application, the provider must supply his or her license number, the name of the training vendor, and the date the provider completed a director-approved initial training course regarding IMEs. By signing and submitting the application form, the provider agrees to abide by:

(i) The standards of professional conduct for performing IMEs adopted by the provider's regulatory board or the guidelines of professional conduct for IMEs published by the American Board of Independent Medical Examiners in effect as of January 1, 2006, if the provider's regulatory board does not adopt standards of conduct for IMEs; and

(ii) All relevant workers' compensation laws and rules.

(b) Any party may make a written request to the director to add a provider to the director's list according to subsection (a).

(c) A provider may be sanctioned or excluded from the director's list of providers authorized to perform IMEs after a finding by the director that the provider:

(A) Violated the applicable standards or guidelines of professional conduct for performing IMEs under sub-paragraph (a)(C)(i) of this section;

(B) Failed to comply with the requirements of this rule, as determined by the director;

(C) Has a current restriction on their license or is under a current disciplinary action from their professional regulatory board;

(D) Has entered into a voluntary agreement with his or her regulatory board which the director determines is detrimental to performing IMEs;

(E) Violated workers' compensation laws or rules; or

(F) Has failed to attend training required by the director.

(d) Within 60 days of the director's decision to exclude a provider from the director's list, the provider may appeal the decision under ORS 656.704(2) and OAR 436-001-0019.

(14) The medical service provider conducting the examination will determine the conditions under which the examination will be conducted. Subject to the provider's approval, the worker may use a video camera or tape recorder to record the examination.

(15) If there is a finding by the director, an administrative law judge, the Workers' Compensation Board, or the court, that the IME was performed by a provider who was not on the director's list of authorized IME providers at the time of the examination, the insurer shall not use the IME report nor shall the report be used in any subsequent proceeding.

(16) Except as provided in subsection (a) of this section, a worker may elect to have an observer present during the IME.

(a) An observer is not allowed in a psychological examination unless the examining provider approves the presence of the observer.

(b) The worker must submit a signed observer form (440-3923A) to the examining provider acknowledging that the worker understands the worker may be asked sensitive questions during the examination in the presence of the observer. If the worker does not sign form 440-3923A, the provider may exclude the observer.

(c) An observer cannot participate in or obstruct the examination.

(d) The worker's attorney or any representative of the worker's attorney shall not be an observer. Only a person who does not receive compensation in any way for attending the examination can be an injured worker's observer.

(e) The IME provider must verify that the injured worker and any observer have been notified of the requirement in sub-section (b).

(17) Upon completion of the examination, the examining medical service provider must:

(a) Give the worker a copy of the IME Survey (Form 440-0858) on the day of the examination; and

(b) Send the insurer a copy of the report and, if applicable, the observer form (440-3923A) or the invasive procedure form (440-3227), or both.

(c) Sign a statement at the end of the report verifying who performed the examination and dictated the report, the accuracy of the content of the report, and acknowledging that any false statements may result in sanction by the director.

(18) The insurer must forward a copy of the signed report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report.

(19) A complaint about an IME may be sent to the director for investigation. The director will determine the appropriate action to take in a given case, which may include consultation with or referral to the appropriate regulatory board.

(20) Training must be approved by the director before it is given. Any party may submit medical service provider IME training curriculum to the director for approval. The curriculum must include training outline, goals, objectives, specify the method of training and the number of training hours, and must include all topics addressed in Appendix B.

(21) Within 21 days of the IME training, the training supplier must send the director the date of the training and a list of all medical providers who completed the training, including names, license numbers, and addresses.

(22) Insurer claims examiners must be trained and certified in accordance with OAR 436-055 regarding appropriate interactions with IME medical service providers.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264

Hist.: WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-1999(Temp), f. & cert. ef. 2-11-99 thru 8-10-99; WCD 7-1999, f. & cert. ef. 4-28-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-010-0275

Insurer's Duties Under MCO Contracts

(1) Insurers who enter into an MCO contract in accordance with OAR 436-015, must notify the affected insured employers of the following:

(a) The names and addresses of the complete panel of MCO medical providers within the employer's geographical service area(s);

(b) The manner in which injured workers can receive compensable medical services within the MCO;

(c) The manner in which injured workers can receive compensable medical services by medical providers outside the MCO; and

(d) The geographical service area governed by the MCO.

(2) Insurers under contract with an MCO must notify all newly insured employers in accordance with section (1) of this rule, prior to or on the effective date of coverage.

(3) At least 30 days prior to any significant changes to an MCO contract affecting injured worker benefits, the insurer must notify in accordance with OAR 436-015-0035 all affected insured employers and injured workers of the manner in which injured workers will receive medical services.

(4) When the insurer is enrolling a worker in an MCO, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO of enrollment. The notice must:

(a) Notify the worker of the eligible attending physicians within the relevant MCO geographic service area and describe how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(b) Advise the worker of the manner in which the worker may receive medical services for compensable injuries within the MCO;

(c) Describe how the worker can receive compensable medical treatment from a primary care physician or authorized nurse practitioner qualified to provide services as described in OAR 436-015-0070, who is not a member of the MCO, including how to request qualification of their primary care physician or authorized nurse practitioner;

(d) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer except when the employer provides a coordinated health care program as defined in OAR 436-010-0005(6);

(e) Provide the worker with the title, address and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes;

(f) Advise the worker of the time lines for appealing disputes beginning with the MCO's internal dispute resolution process through administrative review before the director, that disputes to the MCO must be in writing and filed within 30 days of the disputed action and with whom the dispute is to be filed, and that failure to request review to the MCO precludes further appeal; and

(g) Notify the MCO of any request by the worker for qualification of a primary care physician or authorized nurse practitioner.

(5) Insurers under contract with MCOs who enroll workers prior to claim acceptance must inform the worker in writing that the insurer will pay as provided in ORS 656.248 for all reasonable and necessary medical services received by the worker that are not otherwise covered by health insurance, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever occurs first.

(6) Insurers enrolling a worker who is not yet medically stationary and is required to change medical providers, must notify the worker of the right to request review by the MCO if the worker believes the change would be medically detrimental.

(7) If, at the time of MCO enrollment, the worker's medical service provider is not a member of the MCO and does not qualify as a primary care physician or authorized nurse practitioner, the insurer must notify the worker and medical service provider regarding provision of care under the MCO contract, including the provisions for continuity of care.

(8) When an insurer under contract with an MCO receives a dispute regarding a matter that is to be resolved through the MCO dispute resolution process and that dispute has not been simultaneously provided to the MCO, the insurer must within 14 days:

(a) Send a copy of the dispute to the MCO; or

(b) If the MCO does not have a dispute resolution process for that issue, the insurer must notify the parties in writing to seek administrative review before the director.

(9) The insurer must also notify the MCO of:

(a) The name, address, and telephone number of the worker and, if represented, the name of the worker's attorney, any changes in this information; and

(b) Any requests for medical services received from the worker or the worker's medical provider.

(10) Insurers under contract with MCOs must maintain records as requested including, but not limited to, a listing of all employer's covered by MCO contracts, their WCD employer numbers, the estimated number of employees governed by each MCO contract, a list of all injured workers enrolled in the MCO, and the effective dates of such enrollments.

(11) When the insurer is dis-enrolling a worker from an MCO, the insurer must simultaneously provide written notice of the dis-enrollment to the worker, the worker's representative, all medical service providers, and the MCO. The notice must be mailed no later than seven days prior to the date the worker is no longer subject to the contract. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer enrolled.

(12) When a managed care contract expires or terminates without renewal, the insurer must simultaneously provide written notice to the worker, the worker's representative, all medical service providers, and the MCO, that the worker is no longer subject to the MCO contract. The notice must be mailed no later than three days prior to the date of the contract's expiration or termination. The notice must advise the worker of the manner in which the worker may receive compensable medical services after the worker is no longer subject.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260, 656.264
Hist.: WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-010-0280
Determination of Impairment

(1) The attending physician or authorized nurse practitioner must notify the insurer of the date on which the worker became medically stationary from the compensable injury or illness and whether or not the worker is released to any form of work. The medically stationary date should not be a projected date and should relate to an examination. On disabling claims, when finding or notification that the worker is medically stationary, a determination of permanent impairment for claim closure must be done under OAR 436-030-0020(2). An authorized nurse practitioner must refer the worker to a licensed physician who qualifies as an attending physician to complete a closing examination if there is a reasonable expectation of permanent impairment under ORS 656.214(1)(a) and OAR 436-030-0020(2)(b).

(2) A report must be submitted to the insurer by the attending physician or authorized nurse practitioner within 14 days of the examination in which the worker was determined medically stationary unless:

(a) The attending physician does not wish to perform the closing examination, in which case, he or she must arrange or request the insurer arrange, within eight days of the examination in which the worker is declared medically stationary, for the worker to be examined by a consulting physician for all or any part of the closing examination; or

(b) The authorized nurse practitioner refers the worker for a closing examination, in which case he or she must arrange or request the insurer arrange, within eight days of the examination in which the worker is declared medically stationary, for the worker to have a closing examination under section (1) of this rule.

(3) An examination must be performed when the attending physician or authorized nurse practitioner is notified by the insurer that the worker's accepted injury is no longer the major contributing cause of the worker's condition and a denial has been issued.

(a) The attending physician must submit a closing report within 14 days of the examination. If the attending physician refers the worker to a consulting physician for all or any part of the closing examination, the examination must be scheduled within five days of the denial notification.

(b) The authorized nurse practitioner must either refer the worker for a closing examination or provide a written statement, in accordance with sections (1) and (2) of this rule.

(4) Closing reports for examinations performed by a physician other than the attending physician under this rule must be submitted to the attending physician within seven days of the examination asking whether or not the physician concurs with the report and requesting a description of any finding or conclusion with which the attending physician disagrees. The attending physician must review the report and, within seven days of receipt of the report, concur in writing or provide a report to the insurer describing any finding/conclusion with which the attending physician disagrees.

(5) The physician conducting the examination must provide all objective findings of impairment pursuant to these rules and in accordance with OAR 436-035-0007.

(6) The closing examination report does not include any rating of impairment or disability, but describes impairment findings to be rated by either the insurer or the director. Physicians must provide comments regarding the validity of the examination findings as they pertain to the accepted compensable conditions.

(7) The director may prescribe by bulletin what comprises a complete closing report, including, but not limited to, those specific clinical findings related to the specific body part or system affected. The bulletin may also include the impairment reporting format or form to be used as a supplement to the narrative report.

(8) The attending physician must specify the worker's residual functional capacity or refer the worker for completion of a second level PCE or WCE (as described in OAR 436-009-0070(4) pursuant to the following:

(a) A PCE when the worker has not been released to return to regular work, has not returned to regular work, has returned to modified work, or has refused an offer of modified work.

(b) A WCE when there is question of the worker's ability to return to suitable and gainful employment. It may also be required to specify the worker's ability to perform specific job tasks.

(9) When the worker's condition is not medically stationary and a denial has been issued because the worker's accepted injury is no longer the major contributing cause of the worker's condition, the physician must estimate the worker's future impairment and residual functional capacity according to OAR 436-035-0014.

(10) A closing examination scheduled and performed under section (2) of this rule is not an IME or a change of attending physician.

Stat. Auth.: ORS 656.726(4) & 656.245(2)(b)(B)
Stats. Implemented: ORS 656.245 & 656.252
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0601, 5-1-85; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0080; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-055-0008
Administrative Review

(1) Any party that disagrees with a proposed order or proposed assessment of civil penalty of the director issued under ORS 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740. The request for hearing must be mailed or delivered to the Administrator of the Workers' Compensation Division by the aggrieved person within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(2) Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules, other than as described in section (1), may request a hearing by filing a hearing request as provided in OAR 436-001-0019 within 60 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(3) Any person that disagrees with an action taken under these rules by another person, except as described in sections (1) and (2), may request administrative review by the director as follows:

(a) The request for administrative review must be mailed or delivered to the Administrator of the Workers' Compensation Division within 90 days of the action. The request must specify the grounds upon which the action is contested.

(b) The review will be conducted by the director.

(c) The director will review the relevant information submitted by all parties.

(d) The director will issue an administrative order that specifies whether the determination constitutes a final order or whether an aggrieved party may request a hearing under section (2).

Stat. Auth.: ORS 656.735(5)-(7), 656.745(4) & 656.726(3)
Stats. Implemented: ORS 656
Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-055-0070
Certification of Claims Examiners

(1) Claims examiners shall be certified by the insurer upon satisfactory completion of an examination which demonstrates the individual's:

(a) Familiarity with the workers' compensation statutes;

(b) Ability to navigate the administrative rules found in this chapter;

(c) Capability to perform claim processing activities; and

(d) Understanding of activities related to interactions with independent medical examination providers that includes all the components in OAR 436-055-0085(2).

(2) Any person taking an examination may use a copy of ORS Chapter 656 and the Oregon Administrative Rules during the examination.

(3) A passing score on an examination shall be 80 percent or greater.

(4) Any examination completed through dishonest or fraudulent means shall be considered invalid.

(5) Certification will be for a three-year period. The certification date shall be the date of the examination.

(6) Certification shall be renewed at any time during the certification period by providing verification of completion of 24 hours of training during the current certification period, to include at least:

(a) Four hours of training on the workers' compensation statutes, administrative rules, and case law since the last certification; and

(b) For renewals on or after January 1, 2007, three hours of training related to interactions with independent medical examination providers that covers all the components in OAR 436-055-0085(2). The three hours of training may be completed in increments.

(7) Training may be provided in the form of a seminar, workshop, association meeting, forum, correspondence, video or similar course. It may include any of the following subjects:

(a) Medical case management including, but not be limited to, medical terminology, basic human anatomy and interpreting medical reports.

(b) Communication skills including, but not be limited to, courses in ethics, mediation, negotiation and dealing with angry people.

(c) Instruction dealing specifically with the processing of Oregon workers' compensation claims.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656
Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 5-1994, f. 7-14-94, cert. ef. 9-1-94; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-055-0085
Training for Interactions with Independent Medical Examination Providers

(1) Any training provided under OAR 436-055-0070 or 436-055-0100(4) relating to independent medical examination provider interaction must first be approved by the director.

(2) To be approved, a training curriculum for initial certification must incorporate the following components:

(a) Appropriate and ethical communication with independent medical examination providers;

(b) Insurers' rights and responsibilities;

(c) Injured workers' rights and responsibilities;

(d) Independent medical examination providers' standards of conduct requirement;

(e) IME complaint process and investigations by WCD; and

(f) Training specific to the requirements of ORS 656.325 and OAR 436-010.

(3) To be approved, a training curriculum for renewal of certification must incorporate some or all of the components in (2).

(4) Any person may develop training and receive approval by the director by submitting an application in a format prescribed by the director. The application must describe the training content that meets the criteria in section (2) of this rule, and specify the number of training hours for that topic.

(5) The director's approval will remain in effect until the content or number of hours of training change. At that time, the person will be required to resubmit an application that meets the requirements of sections (2) and (4) or (3) and (4) of this rule.

(6) The division will review an application and notify the applicant of the results within 30 days of receipt of the application. The division will reject incomplete applications.

(7) If an application is rejected or disapproved, the applicant will be notified of the reasons. The application may be resubmitted when the reasons for the rejection or disapproval have been corrected.

(8) The director will maintain a registry of approved training curricula.

Stat. Auth.: ORS 656.726
Statutes Implemented:ORS 656.780(1), OL Ch. 675, Sec. 3
Hist.: WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-055-0110
Assessment of Civil Penalties

(1) Under ORS 656.745 the director may assess a civil penalty against an insurer which fails to comply with these rules.

(2) Under ORS 656.780 the director may assess a civil penalty against an insurer that fails to maintain or produce certification and training records or that employs anyone other than certified workers' compensation claims examiner to process workers' compensation claims. The insurer shall be subject to a penalty of not more than $2000 per violation. Each violation, or each day a violation continues, shall be considered a separate violation.

Stat. Auth.: ORS 656.447(1)(a), 656.745(2)(b) & 656.780(3)
Stats. Implemented: ORS 656
Hist.: WCD 28-1990, f. 11-30-90, cert. ef. 1-1-91; WCD 5-1994, f. 7-14-94, cert. ef. 9-1-94; WCD 15-1999, f. 12-21-99, cert. ef. 1-1-00; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-060-0035
Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) For the purpose of this rule:

(a) "Assigned processing administrator" is the company or business whom the director has selected and authorized to process and pay supplemental disability benefits on behalf of the director, when the insurer has elected not to process and pay these benefits.

(b) "Primary job" means the job at which the injury occurred.

(c) "Secondary job" means any other job(s) held by the worker in Oregon subject employment at the time of injury.

(d) "Temporary disability" means wage loss replacement for the primary job.

(e) "Supplemental disability" means wage loss replacement for the secondary job(s) that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210.

(f) "Verifiable documentation" means information which provides:

(A) Identification of the Oregon subject employer(s) and the time period that establishes the worker held the secondary job, in addition to the primary job, at the time of injury; and

(B) Adequate information to calculate the average weekly wage in accordance with OAR 436-060-0025.

(g) "Insurer" includes third party administrator.

(2) The insurer shall establish the temporary disability rate by multiplying the weekly wage, determined under OAR 436-060-0025, from the primary employer by 66 2/3% (.6667). If the result meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits.

(3) Within five business days of receiving notice or knowledge of employment in addition to the primary job on a claim on which the temporary disability rate for the primary job does not meet or exceed the maximum rate, the insurer must send a worker an initial notice informing the worker what type of information the insurer or the assigned processing administrator must receive to determine the worker's eligibility for supplemental disability. If the insurer has elected not to process and pay these benefits, the insurer must copy the assigned processing administrator with the notice to the worker. The notice must contain the name, address, and telephone number of the assigned processing administrator, and must also clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator.

(4) The initial notice in section (3) must also inform the worker that if the verifiable documentation is not received, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred. If the insurer later receives the documentation, the insurer must determine the worker's eligibility for supplemental disability benefits and, if the worker is found eligible, re-calculate the temporary disability rate. Additional benefits due, but not yet paid because of the worker's prior failure to provide documentation, must be paid retroactively. Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this paragraph will not result in a penalty under ORS 656.262(11).

(5) Within 14 days of receiving the worker's verifiable documentation, the insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the decision to the worker and the worker's representative, if any, in writing. The letter must also advise the worker why he/she is not eligible when that is the decision and how to appeal the decision, if the worker disagrees with the decision.

(6) A worker is eligible if:

(a) The worker was employed at the secondary job by an Oregon subject employer at the time of the injury,

(b) The worker provides notification of a secondary job to the insurer within 30 days of the insurer's receipt of the initial claim, and

(c) The worker's temporary disability rate from wages at the primary job does not meet or exceed the maximum rate under section (2) of this rule.

(7) The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding all earnings the worker received from all subject employment, under ORS 656.210(2)(a)(B). In no case shall an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer.

(8) If the temporary disability rate from the primary employer does not meet or exceed the maximum rate, the insurer or the assigned processing administrator must combine the weekly wages, determined under OAR 436-060-0025, for each employer and multiply by 66 2/3% (.6667) to establish the combined disability rate up to the maximum rate. This is the base amount on which the worker's combined benefits will be calculated.

(9) No three-day waiting period applies to supplemental disability benefits.

(10) The worker's scheduled days off for the job at which the injury occurred shall be used to calculate and pay supplemental disability.

(11) To establish the combined partial disability benefits when the worker has post injury wages from either job, the insurer or the assigned processing administrator must use all post injury wages from both primary and all secondary employers. The insurer or the assigned processing administrator must calculate the amount due the worker based on the combined wages at injury and combined post injury wages using the temporary partial disability calculation in OAR 436-060-0030. The insurer or the assigned processing administrator must then calculate the amount due from the primary job based only on the primary wages at injury and the primary post injury wages. That amount shall be subtracted from the amount due the worker; the remainder is the supplemental disability amount.

(12) If the worker receives post injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due.

(13) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.

(14) Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job. The nondisabling claim will not change to disabling status due to payment of supplemental disability. When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to appeal that action to the Workers' Compensation Board within 60 days of the notice, if the worker disagrees.

(15) If the insurer has elected to process and pay supplemental disability under ORS 656.210(5)(a), the insurer must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability simultaneously with any temporary disability due. Reimbursement for supplemental disability paid will be made under OAR 436-060-0500.

(16) If the insurer has elected not to process and pay supplemental disability, the assigned processing administrator must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability due once each 14 days.

(17) A worker who is eligible for supplemental disability under section (5) of this rule has an on-going responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.

(18) If the insurer has elected not to process and pay supplemental disability, the insurer must cooperate and communicate with the assigned processing administrator and both must retain documentation of shared information, as necessary, to coordinate benefits due.

(19) Supplemental disability applies to occupational disease claims the same as injury claims. Supplemental disability benefits for an occupational disease shall be based on the worker's combined primary and secondary wages at the time there is medical verification the worker is unable to work because of the disability.

(20) When an insurer elects to pay supplemental disability under ORS 656.210(5)(a) and OAR 436-060-0010(20) and receive reimbursement under OAR 436-060-0500, the insurer must maintain a record of supplemental disability paid to the worker, separate from temporary disability paid as a result of the job at injury.

(21) If a worker disagrees with the insurer's or the assigned processing administrator's decision about the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker may request a hearing before the Hearings Division of the Workers' Compensation Board. If the worker chooses to request a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability, the worker must submit an appeal of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule. Disputes that arise about the rate of supplemental disability may be resolved under OAR 436-060-0025(5) and may be submitted at any time. However, the insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation. By requesting resolution of the dispute under OAR 436-060-0025(5), the worker authorizes the Workers' Compensation Division to contact the secondary job employer to verify information provided by the worker to resolve the dispute.

(22) An insurer who elects not to process and pay supplemental disability benefits may be sanctioned upon a worker's complaint if the insurer delays sending necessary information to the assigned processing administrator and that delay causes a delay in the worker receiving supplemental disability benefits.

(23) In the event of a third party recovery, previously reimbursed supplemental disability benefits are a portion of the paying agency's lien.

(24) Remittance on recovered benefits shall be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and ORS 656.593.

Stat. Auth.: ORS 656.210, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.210, 656.325(5), 656.704, 656.726(4) & Sec. 3(2)(a), Ch. 865, OL 2001
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 6-2002(Temp), f. 4-22-02, cert. ef. 5-10-02 thru 11-5-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-060-0095
Medical Examinations; Suspension of Compensation; and Insurer Medical Examination Notice

(1) The division will suspend compensation by order under conditions set forth in this rule. The worker must have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension when the worker refuses or fails to submit to, or otherwise obstructs, an independent medical examination reasonably requested by the insurer or the director under ORS 656.325(1). Compensation will be suspended until the examination has been completed. The conditions of the examination shall be consistent with conditions described in OAR 436-010-0265. Any action of a friend or family member which obstructs the examination shall be considered an obstruction of the examination by the worker for the purpose of this rule. The division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(2) The division will consider requests to authorize suspension of benefits on accepted claims, deferred claims and on denied claims in which the worker has appealed the insurer's denial.

(3) A worker must submit to independent medical examinations reasonably requested by the insurer or the director. The insurer may request no more than three separate independent medical examinations for each open period of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(7).

(4) The insurer may contract with a third party to schedule independent medical examinations. If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice is required to be sent on the insurer's stationery and must conform with the requirements of OAR 436-060-0095(5).

(5) If an examination is scheduled by the insurer or by another party at the request of the insurer, the worker and the worker's attorney shall be simultaneously notified in writing of the scheduled medical examination under ORS 656.331. The notice shall be sent at least 10 days prior to the examination. The notice sent for each appointment, including those which have been rescheduled, must contain the following:

(a) The name of the examiner or facility;

(b) A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;

(c) The date, time and place of the examination;

(d) The first and last name of the attending physician or authorized nurse practitioner and verification that the attending physician or authorized nurse practitioner was informed of the examination by, at least, a copy of the appointment notice, or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(e) If applicable, confirmation that the director has approved the examination;

(f) That the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed. A request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance;

(g) That an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the

medical examination if benefits are not received under ORS 656.210(4) during the absence;

(h) That the worker has the right to have an observer present at the examination, but the observer may not be compensated in any way for attending the exam; however, for a psychological examination, the notice must explain that an observer is allowed to be present only if the examination provider approves the presence of an observer; and

(i) The following notice in prominent or bold face type:

"You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend and do not have a good reason for not attending, or you fail to cooperate with the examination, your workers' compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.325 and OAR 436-060. You may be charged a $100 penalty if you fail to attend without a good reason or if you fail to notify the insurer before the examination. The penalty is taken out of future benefits.If you object to the location of this appointment you must contact the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 within six business days of the mailing date of this notice. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or 503-947-7585 or the Ombudsman for Injured Workers at 1-800-927-1271."

(6) The insurer must include with each appointment notice it sends to the worker:

(a) A form for requesting reimbursement;

(b) The director's brochure, Form 440-3923, "Important Information about Independent Medical Exams"; and

(c) Form 440-0858, "Worker Independent Medical Exam (IME) Survey."

(7) Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(8) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service as for a summons. The request must include the following information:

(a) That the insurer requests suspension of benefits under ORS 656.325 and OAR 436-060-0095;

(b) The claim status and any accepted or newly claimed conditions;

(c) What specific actions of the worker prompted the request;

(d) The dates of any prior independent medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;

(e) A copy of any approvals given by the director for more than three independent medical examinations, or a statement that no approval was necessary, whichever is appropriate;

(f) Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(g) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's representative will be sufficient documentation with which to request suspension;

(h) A copy of the letter required in section (5) and a copy of any written verification received under subsection (8)(g);

(i) Any other information which supports the request; and

(j) The following notice in prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date of this request. If the division grants this request, you may lose all or part of your benefits. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized."

(9) If the division consents to suspend compensation, the suspension shall be effective from the date the worker fails to attend an examination or such other date the division deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.

(10) The insurer must assist the worker in meeting requirements necessary for the resumption of compensation payments. When the worker has undergone the independent medical examination, the insurer must verify the worker's participation and reinstate compensation effective the date of the worker's compliance.

(11) If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the date of the consent to suspend order, the insurer must close the claim under OAR 436-030-0034(7).

(12) If the division denies the insurer's request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. Failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(13) The division may also take the following actions in regard to the suspension of compensation:

(a) Modify or set aside the order of consent before or after filing of a request for hearing.

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error.

(c) Reevaluate the necessity of continuing a suspension.

(14) An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

Stat. Auth.: ORS 656.325, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.325, 656.704 & 656.726(4)
Hist.: WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94, Renumbered from 436-060-0085(1),(2),(4); WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2000, f. 12-22-00, cert. ef. 1-1-01; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

436-070-0020
Assessments: Manner and Intervals for Filing and Payment

(1) Every employer must compute the total assessment amount due for each employee by multiplying the assessment rate determined in OAR 436-070-0010 by the number of hours or parts of an hour the employee worked in the pay period.

(a) If actual hours worked are not tracked, an employer may either calculate the assessments using a flat rate, use contract information stating the number of hours an employee works, or come up with a reasonable method for calculating hours worked. If the flat rate method is used, the calculation must be based on 40 hours per week for employees paid weekly or biweekly, or 173.33 hours per month for employees paid monthly or semimonthly.

(b) The employer will retain from the moneys earned by each employee one half (1/2) of the amount due. In addition, the employer will be assessed an amount equal to the amount retained from each employee.

(2) Every employer must file a report of employee hours worked and remit amounts due upon a combined tax and assessment report form prescribed by the Department of Revenue. The report must be filed with the Department of Revenue:

(a) At the times and in the manner prescribed in ORS 316.168 and 316.171; or

(b) Annually as required or allowed pursuant to ORS 316.197 or 657.571.

(3) For employers required to report quarterly, reports and payments are due on or before the last day of the first month after the close of each calendar quarter. For employers that report annually, reports and payments are due on or before the last day of January following the close of each calendar year.

(4) Employers who fail to timely and accurately file and remit assessments may be charged interest on all overdue balances at the rate established by ORS 82.010 and may be assessed civil penalties in accordance with OAR 436-070-0050.

(5)(a) If an employer fails to file a report or the director determines, based on the available data, that the report filed understates assessments, the director may send to the employer a written Failure to File Notice or Notice of Audit Findings. The notice will include a warning that failure to timely and accurately resolve all issues addressed in the written notice may result in the imposition of a civil penalty. The director may coordinate with the Department of Revenue and Employment Department to provide written notice of failure to file.

(b) Within 30 days of the Failure to File Notice or the Notice of Audit Findings, the employer must file an accurate report and remit the assessments due, or otherwise resolve to the satisfaction of the director all issues identified in the written notice. If an employer fails to comply with the notice, the director may estimate the assessments due, including penalties and interest, and send to the employer a Notice of Estimation.

(c) Within 30 days of the Notice of Estimation, the employer must pay the director's estimated assessment or file and remit accurate assessment due. If the employer fails to comply with the notice, the director may send to the employer an Order of Default assessing all amounts due as calculated by the director.

(d) Within 30 days of the Order of Default, the employer must remit the estimated assessment due, unless the order is timely appealed as provided in OAR 436-070-0008.

(6) Employers or the director may initiate activity to resolve reporting errors, omissions, or discrepancies for a period not to exceed the current

calendar year plus three prior calendar years. No calendar year limitation applies to cases involving fraud.

(7) When the director determines that the department has received moneys in excess of the amount legally due and payable or that it has received moneys to which it has no legal interest, the director will refund or credit the excess amount. For amounts less than $20, the director will refund to employers the excess amount only upon receipt of a written request from the employer or the employer's legal representative.

Stat. Auth.: ORS 656.506 & 82.010
Stats. Implemented: ORS 656.506 & 293.445
Hist.: WCD 3-1983(Admin), f. 6-30-83, ef. 7-1-83; Renumbered from 436-055-0125, 5-1-85; WCD 9-1994, f. 10-31-94, cert. ef. 1-1-95; WCD 2-1996, f. & cert. ef. 1-12-96; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 2-2006(Temp), f. & cert. ef. 1-27-06 thru 7-23-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06

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Department of Corrections
Chapter 291

Rule Caption: Confidentiality and Inadmissibility of Workplace Interpersonal Mediation Communications.
Adm. Order No.: DOC 3-2006(Temp)
Filed with Sec. of State: 5-31-2006
Certified to be Effective: 6-1-06 thru 11-27-06
Notice Publication Date:
Rules Adopted: 291-001-0100
Subject: Adoption of this rule is necessary to allow for the confidential mediation of workplace interpersonal disputes involving Department of Corrections' employees. Without such a rule the department employees would have limited ability to participate in candid, confidential mediation. Mediation has the potential for resolving disputes less expensively, achieving more satisfactory outcomes, and improving workplace productivity. OAR 291-001-0100 contains the text of the Attorney General's model "Simplified Workplace Interpersonal Dispute Rule — Confidential and Inadmissibility of Mediation Communications."
Rules Coordinator: Janet R. Worley—(503) 945-0933

291-001-0100
Confidentiality and Inadmissibility of Workplace Interpersonal Dispute Mediation Communications

(1) This rule applies to workplace interpersonal disputes, which are disputes involving the interpersonal relationships between Department of Corrections' (department) employees, officials or employees and officials. This rule does not apply to disputes involving the negotiation of labor contracts or matters about which a formal grievance under a labor contract, a tort claim notice or a lawsuit has been filed.

(2) The words and phrases used in this rule have the same meaning as given to them in ORS 36.110 and 36.234.

(3) Nothing in this rule affects any confidentiality created by other law.

(4) To the extent mediation communications would otherwise be compromise negotiations under ORS 40.190 (OEC Rule 408), those mediation communications are not admissible as provided in ORS 40.190 (OEC Rule 408), notwithstanding any provisions to the contrary in section (9) of this rule.

(5) **Disclosures by Mediator**: A mediator may not disclose or be compelled to disclose mediation communications in a mediation and, if disclosed, such communications may not be introduced into evidence in any subsequent administrative, judicial or arbitration proceeding unless:

(a) All the parties to the mediation and the mediator agree in writing to the disclosure; or

(b) The mediation communication may be disclosed or introduced into evidence in a subsequent proceeding as provided in subsections (c) or (h)-(j) of section (7) of this rule.

(6) **Confidentiality and Inadmissibility of Mediation Communications**: Except as provided in section (7) of this rule, mediation communications in mediations involving workplace interpersonal disputes are confidential and may not be disclosed to any other person, are not admissible in any subsequent administrative, judicial or arbitration proceeding and may not be disclosed during testimony in, or during any discovery conducted as part of a subsequent proceeding, or introduced into evidence by the parties or the mediator in any subsequent proceeding so long as:

(a) The parties to the mediation and the department have agreed in writing to the confidentiality of the mediation, and;

(b) The person agreeing to the confidentiality of the mediation on behalf of the department:

(A) Is neither a party to the dispute nor the mediator, and

(B) Is designated by the department to authorize confidentiality for the mediation, and

(C) Is at the same or higher level in the department than any of the parties to the mediation or who is a person with responsibility for human resources or personnel matters in the department, unless the Director or Deputy Director is one of the persons involved in the interpersonal dispute, in which case the Governor or the Governor's designee.

(7) **Exceptions to confidentiality and inadmissibility**:

(a) Any statements, memoranda, work products, documents and other materials, otherwise subject to discovery that were not prepared specifically for use in the mediation are not confidential and may be disclosed or introduced into evidence in a subsequent proceeding.

(b) Any mediation communications that are public records, as defined in ORS 192.410(4), and were not specifically prepared for use in the mediation are not confidential and may be disclosed or introduced into evidence in a subsequent proceeding unless the substance of the communication is confidential or privileged under state or federal law.

(c) A mediation communication is not confidential and may be disclosed by any person receiving the communication to the extent that person reasonably believes that disclosing the communication is necessary to prevent the commission of a crime that is likely to result in death or bodily injury to any person. A mediation communication is not confidential and may be disclosed in a subsequent proceeding to the extent its disclosure may further the investigation or prosecution of a felony crime involving physical violence to a person.

(d) The parties to the mediation may agree in writing that all or part of the mediation communications are not confidential or that all or part of the mediation communications may be disclosed and may be introduced into evidence in a subsequent proceeding unless the substance of the communication is confidential, privileged or otherwise prohibited from disclosure under state or federal law.

(e) A party to the mediation may disclose confidential mediation communications to a person if the party's communication with that person is privileged under ORS chapter 40 or other provision of law. A party to the mediation may disclose confidential mediation communications to a person for the purpose of obtaining advice concerning the subject matter of the mediation, if all the parties agree.

(f) A written mediation communication may be disclosed or introduced as evidence in a subsequent proceeding at the discretion of the party who prepared the communication so long as the communication is not otherwise confidential under state or federal law and does not contain confidential information from the mediator or another party who does not agree to the disclosure.

(g) In any proceeding to enforce, modify or set aside a mediation agreement, a party to the mediation may disclose mediation communications and such communications may be introduced as evidence to the extent necessary to prosecute or defend the matter. At the request of a party, the court may seal any part of the record of the proceeding to prevent further disclosure of mediation communications or agreements to persons other than the parties to the agreement.

(h) In an action for damages or other relief between a party to the mediation and a mediator or mediation program, mediation communications are not confidential and may be disclosed and may be introduced as evidence to the extent necessary to prosecute or defend the matter. At the request of a party, the court may seal any part of the record of the proceeding to prevent further disclosure of the mediation communications or agreements

(i) To the extent a mediation communication contains information the substance of which is required to be disclosed by Oregon statute, other than ORS 192.410 to 192.505, that portion of the communication may be disclosed as required by statute.

(j) The mediator may report the disposition of a mediation to the department at the conclusion of the mediation so long as the report does not disclose specific confidential mediation communications. The department or the mediator may use or disclose confidential mediation communications for research, training or educational purposes, subject to the provisions of ORS 36.232(4).

(8) The terms of any agreement arising out of the mediation of a workplace interpersonal dispute are confidential so long as the parties and the agency so agree in writing. Any term of an agreement that requires an expenditure of public funds, other than expenditures of $1,000 or less for employee training, employee counseling or purchases of equipment that remain the property of the agency, may not be made confidential.

(9) When a mediation is subject to section (6) of this rule, the department will provide to all parties to the mediation and to the mediator a copy of this rule or an explanation of where a copy of the rule may be obtained. Violation of this provision does not waive confidentiality or inadmissibility.

Stat. Auth: ORS 36.224
Stats. Implemented: ORS 36.224, 36.230(4)
Hist.: DOC 3-2006(Temp), f. 5-31-06, cert. ef. 1-1-06 thru 11-27-06

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Rule Caption: Change in Classifications System for Assigning Custody Level to Inmates.
Adm. Order No.: DOC 4-2006
Filed with Sec. of State: 5-31-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 2-1-06
Rules Adopted: 291-104-0111, 291-104-0116, 291-104-0125, 291-104-0130, 291-104-0135
Rules Amended: 291-104-0005, 291-104-0010
Subject: The department has developed a new custody classification tool that relies on objective data that associates inmate characteristics (factors) with inmate misconduct. The tool also incorporates a number of elements that address the risk an inmate may pose to the public. These changes will assist institutions in behavior-based management. These rule modifications are necessary to implement the new methodology for assigning inmates with the appropriate classification level.
Rules Coordinator: Janet R. Worley—(503) 945-0933

291-104-0005
Authority, Purpose, and Policy

(1) Authority: The authority for these rules is granted to the Director of the Department of Corrections in accordance with ORS 179.040, 423.020, 423.030, and 423.075.

(2) Purpose: The purpose of these rules (OAR 291-104-0005 to 291-104-0135) is to:

(a) Establish Department of Corrections policy and procedures for identifying and assigning an appropriate custody level to each inmate committed or transferred to the Department of Corrections and housed in a Department of Corrections operated or contracted facility;

(b) Provide information for population management and planning; and

(c) Provide information to support the appropriate distribution of correctional resources for both inmate and agency needs.

(3) Policy:

(a) Custody Level: It is the policy of the Department of Corrections to assign each inmate committed or transferred to the custody of the department the lowest custody level deemed appropriate by the department to:

(A) Provide the amount of supervision necessary to account for the inmate's whereabouts;

(B) Provide for the safe, secure, and orderly operation of Department of Corrections facilities;

(C) Provide reasonable protection to the general community, staff, and inmate population;

(D) Allow each inmate to exercise independent responsibility commensurate with his or her demonstrated ability and behavior; and

(E) Ensure the provision of appropriate inmate health, treatment and work programs.

(b) Housing Assignments: It is the policy of the Department of Corrections to assign an inmate housing consistent with his/her custody level, demonstrated behavior, and special needs. No Level 5 or maximum custody inmates shall be housed in a general population housing unit.

(c) Implementation: Inmates delivered to department custody on or after June 1, 2006 will be assigned a custody classification level in accordance with OAR 291-104-0116 to 291-104-0135 (five-level system). Inmates in the physical custody of the department prior to June 1, 2006 will retain their custody classification level as assigned in accordance with OAR 291-104-0010 through 291-104-0035 (four-level system) until their custody is reviewed at the regular six-month review cycle as required by rule, or until the inmate incurs:

(A) A major rule violation;

(B) A program failure;

(C) A return from parole, transitional leave or a lower custody facility;

(D) Any new conviction;

(E) Any action by the Board of Parole and Post-Prison Supervision that may affect the scoring for any element of the inmate's custody level; or

(F) Any new information or any change in circumstances that may affect the scoring for any element of the inmate's custody level, at which time the inmate may be reclassified in accordance with OAR 291-104-0111 to 291-104-0140.

(e) If an inmate classified under 291-104-0015 through 291-104-0035 appeals any element of his/her custody score, the Institution Classification Committee will conduct the review according to the scoring criteria listed in Attachment 3 (Classification Guide and Matrix), which reflects the process used to determine the four-level custody classification scores.

(f) Once all inmates have been reclassified according to the five-level custody classification system, use of the four-level classification system will be discontinued.

(g) During the six-month transition from the four-level custody classification system to the new five-level custody classification system, the following custody designations will be used interchangeably between the four-level and five-level custody classification systems:

(A) Maximum custody under the old four-level system corresponds to Level 5 under the new five-level classification system.

(B) Close custody under the old four-level system corresponds to Level 4 under the new five-level classification system.

(C) Medium custody under the old four-level system corresponds to Level 3 under the new five-level classification system.

(D) Minimum custody under the old four-level system corresponds to both Levels 1 and 2 under the new five-level classification system.

(f) This corresponding custody terminology will also apply interchangeably when interpreting the following administrative rule divisions:

(A) Use of Force (OAR 291-013): References to minimum security facilities will correspond to facilities housing inmates classified as custody Levels 1 and 2 under the new five-level custody classification system. References to medium or higher security facilities will correspond to facilities housing inmates classified as Level 3 or higher under the new five-level custody classification system.

(B) Capital Punishment (Death by Lethal Injection) (OAR 291-024): References to inmates classified as maximum custody will correspond to inmates classified as custody Level 5 under the new five-level custody classification system.

(C) Intensive Management Unit (OAR 291-055): References to inmates classified as maximum custody will correspond to inmates classified as custody Level 5 under the new five-level custody classification system.

(D) Alternative Incarceration Programs (OAR 291-062): References to minimum custody will correspond to inmates classified as custody Levels 1 and 2 under the new five-level custody classification system. References to minimum housing will correspond to housing designated for inmates classified as Levels 1 and 2 under the new five-level custody classification system.

(E) Short-Term Transitional Leave, Emergency Leaves and Supervised Trips (OAR 291-063): References minimum custody will correspond to inmates classified as custody Levels 1 and 2 under the new five-level custody classification system.

(F) Assessment, Assignment, and Supervision of Inmates for Work Assignments and Unfenced Minimum Housing (OAR 291-082) References to minimum custody will correspond to inmates classified as custody Levels 1 and 2 under the new five-level custody classification system. References to minimum housing will correspond to housing designated for inmates classified as Levels 1 and 2 under the new five-level custody classification system.

(G) Work Release Programs (OAR 291-149) References to minimum custody will correspond to inmates classified as custody Levels 1 and 2 under the new five-level custody classification system.

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 4-2006, f. 5-31-06, cert. ef. 6-1-06

291-104-0010
Definitions

(1) This rule includes definitions for OAR 291-104-0010 through 291-104-0035.

(2) Classification Review: The process used by the department to re-evaluate an inmate's assigned custody level. The assigned custody level may be changed as a result of the review.

(3) Classification Unit: Central Office staff responsible for the development, implementation, training, oversight, and management of the classification function within the department.

(4) 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.

(5) Custody Classification Guide and Matrix (Attachment 3): 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.

(6) 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.

(7) Department of Corrections Facility: Any institution, facility or staff office, including the grounds, operated by the Department of Corrections.

(8) 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.

(9) Disciplinary Severity Scale (Attachment 2): 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.

(10) 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.

(11) 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.

(12) Inmate: Any person under the supervision of the Department of Corrections who is not on parole, probation, or post-prison supervision status.

(13) 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.

(14) 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.

(15) 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, which justifies a higher or lower custody level than indicated by the classification instrument.

(16) Public Risk: Factors considered to assess the severity of criminal behavior that an inmate has presented to the community.

(17) 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.

(18) 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; DOC 15-2005, f. & cert. ef. 12-7-05; DOC 4-2006, f. 5-31-06, cert. ef. 6-1-06

291-104-0111

Definitions for OAR 291-104-0111 through 291-104-0135

(1)This rule includes definitions for OAR 291-104-0111 through 291-104-0135.

(2) Corrections Information System (CIS): A computer system dedicated to tracking information critical to the management of inmates and offenders under the custody, supervision or both of the Department of Corrections.

(3) Classification Review: The process used by the department to re-evaluate an inmate's assigned custody level. The assigned custody level may be changed as a result of the review.

(4) Classification Unit: Central Office staff responsible for the development, implementation, training, oversight and management of the classification function within the department.

(5) Conduct Factor: A formula which interrelates the elements of an inmate's age, percentage of sentence served, security threat group affiliation, time remaining to serve, Oregon Corrections Plan (OCP) program compliance and prior incarcerations to produce one of three composite scores that represent an inmate's anticipated conduct, which is then adjusted to reflect an inmate's actual recent conduct history.

(6) 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.

(7) Custody Classification Guide (**Attachment 1**): 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 to achieve a resulting proposed custody level. The highest score achieved on any of the elements will be used to calculate the inmate's final classification level. The classification criteria include the following elements:

(a) Offense Type;

(b) History of Violence;

(c) Escape/Abscond History;

(d) Sentence Remaining;

(e) Detainers;

(f) Prior Incarcerations;

(g) Major Misconduct Violations;

(h) Severity of Institutional Misconduct;

(i) OCP Program Compliance; and

(j) Security Threat Group Behavior.

(8) Custody Level: One of five levels of supervision assigned each inmate through initial and classification review procedures:

(a) Level Five: An inmate assigned this custody level presents extreme risk of escape, violence 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 level five.

(b) Level Four: An inmate assigned this custody level presents a serious risk of escape, violence or disruption to the safe, secure and orderly operation of a Department of Corrections facility.

(c) Level Three: An inmate assigned this custody level presents moderate risk of escape, violence or disruption to the safe, secure and orderly operation of a Department of Corrections facility.

(d) Level Two: An inmate assigned this custody level presents limited risk of escape, violence or disruption to the safe, secure and orderly operation of a Department of Corrections facility.

(e) Level One: An inmate assigned this custody level presents minimal risk of escape, violence or disruption to the safe, secure, and orderly operation of a Department of Corrections facility.

(9) Department of Corrections (DOC) Facility: Any institution, facility or staff office, including the grounds, operated by the Department of Corrections.

(10) 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.

(11) Disciplinary Severity Scale (**Attachment 2**): A classification tool used by the department, in conjunction with the Custody Classification Guide (**Attachment 1**), 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 misconduct element of the classification instrument.

(12) 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.

(13) Inmate: Any person under the supervision of the Department of Corrections who is not on parole, probation, or post-prison supervision status.

(14) Institution 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.

(15) Oregon Corrections Plan (OCP): An automated case management tool incorporated into the Corrections Information System, which serves as the primary tool for tracking an inmate's progress in working to mitigate the identified risk factors.

(16) 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.

(17) Policy Elements: Ten areas of potential risk listed in the Custody Classification Guide (Attachment 1) which must be evaluated when scoring the five-level custody classification system. Each of these classification criteria relates to sound correctional practices and good public policy for managing risks posed by inmates in order to maintain a high level of safety both within the DOC facilities and for the community as a whole.

(18) Program Failure: Removal from a program for failure to satisfactorily perform in a program assignment or refusal to participate in a recommended or required program.

(19) Security Threat Group (STG): Any group of two or more individuals who:

(a) Have a common name, identifying symbol, or characteristic which serves to distinguish themselves from others.

(b) Have members, affiliates, and/or associates who individually or collectively engage, or have engaged, in a pattern of illicit activity or acts of misconduct that violates Oregon Department of Corrections rules.

(c) Have the potential to act in concert to present a threat, or potential threat, to staff, public, visitors, inmates, offenders or the secure and orderly operation of the institution.

(20) 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.

(21) Special Case Factor (SCF): A descriptive list of specific circumstances, with corresponding codes, from which elements may be selected to indicate pertinent information related to an inmate's classification and placement, that may not have been captured by the classification elements.

(22) Special Population Management — Inmate Program Committee (SPM-IPC): A committee composed of three department administrative staff to include the Chief of Security, Counseling and Treatment Services Mental Health supervisor, and the Capacity and Resources Administrator who are responsible to review classification status for inmates who score level five in order to determine if assignment to the Intensive Management Unit (IMU) is appropriate.

[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.: DOC 4-2006, f. 5-31-06, cert. ef. 6-1-06

291-104-0116
Initial Classification

(1) The Department of Corrections shall assign inmates an initial custody level in accordance with the department's conduct factor calculation, Custody Classification Guide (**Attachment 1**), Disciplinary Severity Scale (**Attachment 2**) and these rules (OAR 291-104-0116 to 291-104-0135). 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) Determining an inmate's custody classification score is a multistage process. The first step is an automated calculation by CIS of each inmate's conduct factor. Once CIS determines the predictive conduct factor, assigning a numeric score of 1, 2, or 3, CIS will then compare this predictive score with the inmate's actual conduct history and adjust the conduct factor score to correspond to the inmate's actual conduct record.

(a) Inmates with a conduct factor of 1 or 2 who have been found guilty of a single major rule violation during the preceding twelve months will have their conduct factor adjusted upward by one point.

(b) Inmates with a conduct factor of 1 or 2 who have been found guilty of two or more major rule violations during the preceding twelve months will have their conduct factor adjusted upward to a score of 3.

(c) Inmates with a conduct factor of 2 or 3 who have no major rule violations during the preceding twelve months will have their conduct factor adjusted downward by one point.

(d) Inmates with a conduct factor of 3 who have no major rule violations during the preceding 24 months will have their conduct factor adjusted downward to a score of 1.

(3) The second stage in determining an inmate's custody classification score is for the inmate's assigned counselor to enter information into the department's Corrections Information System which is necessary to score each of the ten policy elements.

(4) The next stage in the classification scoring process is for CIS to adjust the assigned policy element scores based on the inmate's conduct factor. A low conduct factor will lower the score on most policy elements, and a high conduct factor will raise the score on most policy elements, as detailed in Attachment 4, Automated Scoring Adjustments.

(5) The final stage of the classification scoring process is for CIS to generate a classification summary report which reflects all scores for the conduct factor and the ten policy elements. An inmate's proposed custody level will be equal to the highest score on any single policy element after automated adjustments are made based on the conduct factor.

(6) After generating a classification summary, the assigned counselor will review it for accuracy. Having assured 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.

(7) No classification action is official until the functional unit manager or designee approves the classification summary. Level 5 classifications are not official until approved by the Special Population Management – Inmate Program Committee. 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.: DOC 4-2006, f. 5-31-06, cert. ef. 6-1-06

291-104-0125
Classification Review

(1) Each inmate's custody level will be reviewed at a minimum of every six months.

(2) Circumstances may arise when a classification review will be completed more frequently than every six months (e.g., major rule violations, return from parole, transitional leave or a minimum custody facility, new convictions, or Board of Parole and Post-Prison Supervision actions affecting the inmate's custody). It is the responsibility of the assigned counselor to determine if circumstances warrant a classification review prior to six months.

(3) A new classification summary will be completed as part of each classification review, even if no scoring changes have occurred.

(4) New information or a change in circumstance(s) affecting the conduct factor calculation or scoring of any element of the classification criteria contained in the Custody Classification Guide that would make the inmate's custody level no longer appropriate requires a classification review. A copy of all official classification summaries shall be offered to the affected inmate, unless safety or security reasons would dictate otherwise.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: DOC 4-2006, f. 5-31-06, cert. ef. 6-1-06

291-104-0130
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 for all overrides, except Level 5, will be made at the institutional level.

(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.: DOC 4-2006, f. 5-31-06, cert. ef. 6-1-06

291-104-0135
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 (CD1120aD). To obtain an administrative review, an inmate must complete the portions of a CD1120aD 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 or 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-level five classification scoring, the reason(s) for an override of a scored custody level, and an inmate's Level 5 custody classification.

(a) Accuracy of Scoring (Levels One, Two, Three and Four):

(A) To obtain an administrative review of a classification score, an inmate must complete the top portion of a CD1120aD 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 CD1120aD 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 CD1120aD 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) Level Five: An inmate's Level 5 custody classification may be administratively reviewed utilizing the bottom portion of the CD1120aD 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 Level 5 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.: DOC 4-2006, f. 5-31-06, cert. ef. 6-1-06

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Department of Fish and Wildlife
Chapter 635

Rule Caption: Open spring Chinook sport fishery and modifiations to Columbia River and Youngs Bay commercial fisheries.
Adm. Order No.: DFW 29-2006(Temp)
Filed with Sec. of State: 5-16-2006
Certified to be Effective: 5-16-06 thru 7-31-06
Notice Publication Date:
Rules Amended: 635-023-0125, 635-042-0022, 635-042-0145
Rules Suspended: 635-023-0125(T), 635-042-0022(T), 635-042-0145(T)
Subject: Amend rule to open Columbia River spring Chinook sport fishery in the mainstem from Rocky Point/Tongue Point line upstream to Bonneville Dam effective 12:01 a.m. May 17, 2006 through June 15, 2006; to extend the spring Chinook gillnet commercial fishery in the Columbia River mainstem; and provide consistency in harvest regulations for Youngs Bay. Implementation consistent with action taken May 15, 2006 by the Columbia River Compact.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-023-0125
Spring Sport Fishery

(1) The **2006 Oregon Sport Fishing Regulations** provide requirements for the Columbia River Zone and the Snake River Zone. However, additional regulations may be adopted in this rule division from time to time, and, to the extent of any inconsistency, they supersede the **2006 Oregon Sport Fishing Regulations**.

(2) The Columbia River is open to angling for salmon, steelhead and shad effective 12:01 a.m. May 17, 2006 through June 15, 2006 or until guideline is reached from Rocky Point/Tongue Point line upstream to the Bonneville Dam. The Columbia River opens effective 12:01 a.m. May 13, through 11:59 p.m. Thursday June 15, 2006 from the Tower Island power lines upstream to McNary Dam plus the Oregon bank between Bonneville Dam and the Tower Island power lines with the following restrictions:

(a) Adipose fin-clipped chinook salmon, adipose fin-clipped steelhead and shad may be retained.

(b) All non-adipose fin-clipped chinook salmon and non-adipose fin-clipped steelhead must be released immediately unharmed.

(c) Catch limits of two adult salmon or steelhead and five jacks per day are in effect as per permanent regulations.

(3) Effective May 17, 2006 through June 15, 2006, in the mainstem Columbia River upstream of the Rocky Point/Tongue Point line it is unlawful when fishing from vessels which are less than 30 feet in length, substantiated by Coast Guard documentation or Marine Board Registration, to totally remove from the water any salmon or steelhead required to be released.

(4) It is unlawful to continue to angle for jack salmon after retaining a limit of adult salmon or steelhead.

(5) All other specifications and restrictions as outlined in the current **2006 Oregon Sport Fishing Regulations** apply.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162 & 506.129
Hist.: DFW 11-2004, f. & cert. ef. 2-13-04; DFW 17-2004(Temp), f. & cert. ef. 3-10-04 thru 7-31-04; DFW 29-2004(Temp), f. 4-15-04, cert. ef. 4-22-04 thru 7-31-04; DFW 30-2004(Temp), f. 4-21-04, cert. ef. 4-22-04 thru 7-31-04; DFW 36-2004(Temp), f. 4-29-04, cert. ef. 5-1-04 thru 7-31-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 51-2004(Temp), f. 6-9-04, cert. ef. 6-16-04 thru 7-31-04; Administrative correction 8-19-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 35-2005(Temp), f. 5-4-05, cert. ef. 5-5-05 thru 10-16-05; DFW 38-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 44-2005(Temp), f. 5-17-05, cert. ef. 5-22-05 thru 10-16-05; DFW 51-2005(Temp), f. 6-3-05, cert. ef. 6-4-05 thru 7-31-05; Administrative correction 11-18-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 21-2006(Temp), f. 4-13-06, cert. ef. 4-14-06 thru 5-15-06; DFW 27-2006(Temp), f. 5-12-06, cert. ef. 5-13-06 thru 6-15-06; DFW 29-2006(Temp), f. & cert. ef. 5-16-06 thru 7-31-06

635-042-0022
Spring Chinook Gill Net and Tangle Net Fisheries

(1) Adipose fin-clipped chinook salmon, sturgeon and shad may be taken by gill net or tangle net for commercial purposes from the mouth of the Columbia River upstream to Kelley Point (Zones 1-3 and part of Zone 4).

(a) Individual fishing periods will not exceed sixteen hours in length during small mesh fisheries and twenty-four hours in length during large mesh fisheries. Fishing periods may occur on Tuesdays and Thursdays, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) White sturgeon possession and sales restrictions by each participating vessel will be determined inseason based on gear type and number of fish remaining on the guideline.

(2) An adipose fin clip salmon is defined as a hatchery salmon with a clipped adipose fin and having a healed scar at the location of the fin. The adipose fin is the small fatty fin on salmonids located between the dorsal fin and tail.

(3) During the spring chinook gill net fishery:

(a) It is unlawful to use a gill net having a mesh size less than 8 inches or more than 9-3/4 inches. Use of monofilament nets is allowed.

(b) Mesh size for the fishery is determined as described in OAR 635-042-0010(4).

(c) From the area as described in section (1) of this rule, adipose fin-clipped chinook salmon, sturgeon and shad may be taken for commercial purposes by gill net during the following open period:

(A) 12:00 noon, February 23 to 6:00 a.m., February 24, 2006.

(B) 12:00 noon, March 2, 2006 to 12:00 noon, March 3, 2006.

(C) 6:00 a.m., March 7, 2006 to 6:00 a.m., March 8, 2006.

(D) 12:00 noon, March 9, 2006 to 6:00 a.m., March 10, 2006.

(E) 12:00 noon, March 14, 2006 to 6:00 a.m., March 15, 2006.

(F) 2:00 p.m., May 16, 2006 to 12:00 midnight, May 16, 2006.

(4) A maximum of eight sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) the fishery is open. The eight sturgeon possession/sales limit includes both mainstem and Select Area fisheries.

(5) During the spring chinook tangle net fishery:

(a) It is unlawful to use other than a single-wall multi-filament net. Monofilament tangle nets are not allowed. Maximum mesh size is 4-1/4 inches stretched taut.

(b) Mesh size is determined by placing three consecutive meshes under hand tension and the measurement is taken from the inside of one vertical knot to the outside of the opposite vertical knot of the center mesh. Hand tension means sufficient linear tension to draw opposing knots of meshes into contact.

(6) Nets shall not exceed 900 feet (150 fathoms) in length. A red cork must be placed on the corkline every 25 fathoms as measured from the first mesh of the net. Red corks at 25-fathom intervals must be in color contrast to the corks used in the remainder of the net.

(7) On tangle nets, an optional use of a steelhead excluder panel of mesh may be hung between the corkline and the 4-1/4 inch maximum mesh size tangle net. The excluder panel web must be a minimum mesh size of 12 inches when stretched taut under hand tension. Monofilament mesh is allowed for the excluder panel. The excluder panel (including any associated hangings) must be a minimum of 5 linear feet in depth and not exceed 10 linear feet in depth, as measured from the corkline to the upper margin of the tangle net mesh as the net hangs naturally from a taut corkline. Weedlines or droppers (bobber-type) may be used in place of the steelhead excluder panel. A weedline-type excluder means the net is suspended below the corkline by lines of no less than five feet in length between the corkline and the upper margin of the tangle net. A dropper-type excluder means the entire net is suspended below the surface of the water by lines of no less than five feet in length extending from individual surface floats to a submersed corkline. The corkline cannot be capable of floating the net in its entirety (including the leadline) independent of the attached floats. Weedlines or droppers must extend a minimum of 5 feet above the 4-1/4 inch maximum mesh size tangle net.

(a) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, may extend to a maximum length of 1,050 feet (175 fathoms).

(b) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, along with a red cork every 25 fathoms as required in (5) above, must have two red corks at each end of the net.

(8) There are no restrictions on the hang ratio. The hang ratio is used to horizontally add slack to the net. The hang ratio is determined by the length of the web per length of the corkline.

(9) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(10) Nets shall be fished for no longer than 45 minutes per set. The time of fishing is measured from when the first mesh of the net is deployed into the water until the last mesh of the net is fully retrieved from the water.

(11) It is unlawful for a net in whole or in part to be anchored, tied, staked, fixed, or attached to the bottom, shore, or a beached boat; left unattended at any time it is fished; or attended by more than one boat while being fished.

(12) It is unlawful to fish more than one net from a licensed commercial fishing boat at any one time.

(13) Nets fished from sunset to sunrise shall have lighted buoys on both ends of the net unless the net is attached to the boat then one lighted buoy on the opposite end of the net from the boat is required.

(14) Non-legal sturgeon, nonadipose fin-clipped chinook salmon, and steelhead must be released immediately with care and the least possible injury to the fish to the river without violence or into an operating recovery box.

(a) One operating recovery box with two chambers or two operating recovery boxes with one chamber each to aid survival of released fish must be on board each fishing vessel participating in the fishery. Recovery boxes shall be operating during any time that a net is being retrieved or picked.

(b) All salmon and steelhead that are bleeding, in lethargic condition, or appearing dead must be placed in the recovery box for rehabilitation purposes prior to release to the river.

(c) Each chamber of the recovery box must meet the following dimensions as measured from within the box; the inside length measurement must be at or within 39-1/2 to 48 inches, the inside width measurement must be at or within 8 to 10 inches, and the inside height measurement must be at or within 14 to 16 inches.

(d) Each chamber of the recovery box must include an operating water pumping system capable of delivering a minimum flow of 16 gallons per minute not to exceed 20 gallons per minute of fresh river water into each chamber. The fisher must demonstrate to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers, upon request, that the pumping system is delivering the proper volume of fresh river water into each chamber.

(e) Each chamber of the recovery box must include a water inlet hole between 3/4 inch and 1 inch in diameter, centered horizontally across the door or wall of chamber and 1-3/4 inches from the floor of the chamber.

(f) Each chamber of the recovery box must include a water outlet that is at least 1-1/2 inches in diameter. The center of the outlet hole must be located a minimum of 12 inches above the floor of the box or chamber, on either the same or opposite end as the inlet.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(15) At least one fisher on each boat engaged in the fishery must have in possession a certificate issued by a representative of the Oregon Department of Fish and Wildlife (ODFW) or the Washington Department of Fish and Wildlife (WDFW) that indicates the fisher had attended a one-day workshop hosted by ODFW or WDFW to educate fishers on regulations and best methods for conduct of the selective fishery. No individual may obtain more than one certificate. The certificate must be displayed to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers upon request.

(16) Nothing in this section sets any precedent for any fishery after the 2006 spring chinook fishery. The fact that an individual may hold a selective fishery certificate in spring 2006 does not entitle the certificate holder to participate in any other fishery. If ODFW authorizes a selective fishery in spring 2007 or at any other time, ODFW may establish qualifications and requirements that are different from those established for 2006. In particular, ODFW may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future tangle net fisheries.

(17) As authorized by OAR 635-006-0140 owners or operators of commercial fishing vessels must cooperate with Department fishery observers, or observers collecting data for the Department, when asked by the Department to carry and accommodate an observer on fishing trips for observation and sampling during an open fishery.

(18) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, and Lewis-B sanctuary are in effect during the open fishing periods identified.

Stat. Auth.: ORS 496.138, 496.146 & 506.119

Stats. Implemented: ORS 496.162, 506.129 & 507.030

Hist.: DFW 11-2004, f. & cert. ef. 2-13-04; DFW 12-2004(Temp), f. & cert. ef. 3-1-04, thru 7-31-04; DFW 13-2004(Temp), f. & cert. ef. 3-3-04 thru 7-31-04; DFW 16-2004(Temp), f. & cert. ef. 3-8-04 thru 7-31-04; DFW 18-2004(Temp), f. & cert. ef. 3-10-04 thru 7-31-04; DFW 20-2004(Temp) f. & cert. ef. 3-15-04 thru 7-31-04; DFW 21-2004(Temp), f. & cert. ef. 3-18-04 thru 7-31-04; DFW 25-2004(Temp), f. 3-22-04, cert. ef. 3-23-04 thru 7-31-04; DFW 26-2004(Temp), f. & cert. ef. 3-25-04 thru 7-31-04; DFW 27-2004(Temp), f. & cert. ef. 3-29-04 thru 7-31-04; Administrative correction 8-19-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 9-2005(Temp), f. & cert. ef. 3-1-05 thru 7-31-05; DFW 11-2005(Temp), f. 3-2-05, cert. ef. 3-3-05 & 7-31-05; DFW 13-2005(Temp), f. & cert. ef. 3-7-05 thru 7-31-05; DFW 14-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; DFW 20-2005(Temp), f. & cert. ef. 3-29-05 thru 3-30-05; DFW 21-2005(Temp), f. & cert. ef. 3-31-05 thru 4-1-05; Administrative correction, 4-20-05; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 7-2006(Temp), f. & cert. ef. 2-23-06 thru 7-31-06; DFW 9-2006(Temp), f. 3-1-06, cert. ef. 3-2-06 thru 7-31-06; DFW 10-2006(Temp), f. 3-6-06, cert. ef. 3-7-06 thru 7-31-06; DFW 11-2006(Temp), f. & cert. ef. 3-9-06 thru 7-31-06; DFW 12-2006(Temp), f. 3-13-06, cert. ef. 3-14-06 thru 7-31-06; DFW 29-2006(Temp), f. & cert. ef. 5-16-06 thru 7-31-06

635-042-0145
Youngs Bay Salmon Season

(1) Salmon, sturgeon, and shad may be taken for commercial purposes in those waters of Youngs Bay.

(a) The open fishing periods are established in three segments categorized as the winter fishery, paragraph (A), the spring fishery, paragraph (B), and summer fishery, paragraph (C), as follows:

(A) Winter Season:

(i) 6:00 p.m. February 15, 2006 to 6:00 a.m. February 16, 2006; 6:00 p.m. February 19, 2006 to 12 Noon February 20, 2006; 6:00 p.m. February 22, 2006 to 6:00 a.m. February 23, 2006; 6:00 p.m. February 26, 2006 to

12 Noon February 27, 2006; 6:00 p.m. March 1, 2006 to 6:00 a.m. March 2, 2006; 6:00 p.m. March 5, 2006 to 12 Noon March 6, 2006; 6:00 p.m. March 8, 2006 to 12 Noon March 9, 2006 and 6:00 p.m. March 12, 2006 to 6:00 a.m. March 13, 2006.

(ii) March 16, 2006 from 6:00 a.m. to 10:00 a.m. and March 23, 2006 from 12 noon to 4:00 p.m.

(iii) March 27, 2006 from 6:00 a.m. to 6:00 p.m.; March 30, 2006 from 6:00 a.m. to 8:00 p.m.; April 3, 2006 from 6:00 a.m. to 8:00 p.m.; April 6, 2006 from 6:00 a.m. to 8:00 p.m.; April 10, 2006 from 6:00 a.m. to 8:00 p.m. and April 13, 2006 from 6:00 a.m. to 8:00 p.m.

(B) Spring Season:

(i) April 17, 2006 from 9:00 a.m. to 1:00 p.m.

(ii) 6:00 p.m. April 20, 2006 to 6:00 a.m. April 21, 2006; 6:00 p.m. April 24, 2006 to 6:00 a.m. April 25, 2006; 6:00 p.m. April 27, 2006 to 6:00 a.m. April 28, 2006; 6:00 p.m. May 1, 2006 to 12 Noon May 2, 2006; 6:00 p.m. May 4, 2006 to 12 Noon May 5, 2006; 12 Noon May 8, 2006 to 12 Noon May 12, 2006; 12 Noon May 15, 2006 to 12 Noon May 19, 2006; 12 Noon May 22, 2006 to 12 Noon May 26, 2006; 12 Noon May 29, 2006 to 12 Noon June 2, 2006; 12 Noon June 5, 2006 to 12 Noon June 9, 2006 and 12 Noon June 13, 2006 to 12 Noon June 16, 2006.

(C) Summer Season: 12 Noon June 21, 2006 to 12 Noon June 23, 2006; 12 Noon June 28, 2006 to 12 Noon June 30, 2006; 12 Noon July 5, 2006 to 6:00 p.m. July 6, 2006; 12 Noon July 12, 2006 to 6:00 p.m. July 13, 2006; 12 Noon July 19, 2006 - 6:00 p.m. July 20, 2006 and 12 Noon July 26, 2006 to 6:00 p.m. July 27, 2006.

(b) The fishing areas for the winter, spring and summer fisheries are:

(A) From February 15, 2006 through March 23, 2006 and from April 20, 2006 through July 27, 2006, the fishing area is identified as the waters of Youngs Bay from the Highway 101 Bridge upstream to the upper boundary markers at the confluence of the Klaskanine and Youngs rivers; except for those waters which are closed southerly of the alternate Highway 101 Bridge (Lewis and Clark River).

(B) On April 17, 2006, the fishing area extends from old Youngs Bay Bridge upstream to the confluence of the Youngs and Klaskanine rivers.

(C) From March 27, 2006 through April 13, 2006 the fishing area extends from markers directly under the first power lines downstream of the Walluski River to the confluence of the Youngs and Klaskanine rivers.

(2) Gill nets may not exceed 1,500 feet (250 fathoms) in length and weight may not exceed two pounds per any fathom. A red cork must be placed on the corkline every 25 fathoms as measured from the first mesh of the net. Red corks at 25-fathom intervals must be in color contrast to the corks used in the remainder of the net. Monofilament gillnets are allowed.

(a) It is unlawful to use a gill net having a mesh size that is less than 7-inches during the winter season from February 15, 2006 to April 13, 2006. It is unlawful to use a gill net having a mesh size that is more than 8-inches during the spring and summer seasons from April 17, 2006 to July 27, 2006.

(b) In the fishing area, as described in (1)(b)(iii), the use of additional weights or anchors attracted directly to the leadline is allowed upstream of the mouth of the Walluski River.

(c) Retention of non-adipose fin-clipped spring Chinook is prohibited from 2:00 p.m. Tuesday May 16, 2006 through Sunday May 21, 2006

(3) A maximum of three green or white sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fisheries are open. During the fishing periods identified in (1)(a)(A),(1)(a)(B) and (1)(a)(C), the weekly aggregate sturgeon limit applies to possessions and sales in the Youngs Bay fishery and other open Select Area fisheries.

Stat. Auth.: ORS 496.138, 496.146 & 506.119

Stats. Implemented: ORS 496.162, 506.129 & 507.030

Hist.: FWC 32-1979, f. & ef. 8-22-79; FWC 28-1980, f. & ef. 6-23-80; FWC 42-1980(Temp), f. & ef. 8-22-80; FWC 30-1981, f. & ef. 8-14-81; FWC 42-1981(Temp), f. & ef. 11-5-81; FWC 54-1982, f. & ef. 8-17-82; FWC 37-1983, f. & ef. 8-18-83; FWC 61-1983(Temp), f. & ef. 10-19-83; FWC 42-1984, f. & ef. 8-20-84; FWC 39-1985, f. & ef. 8-15-85; FWC 37-1986, f. & ef. 8-11-86; FWC 72-1986(Temp), f. & ef. 10-31-86; FWC 64-1987, f. & ef. 8-7-87; FWC 73-1988, f. & cert. ef. 8-19-88; FWC 55-1989(Temp), f. 8-7-89, cert. ef. 8-20-89; FWC 82-1990(Temp), f. 8-14-90, cert. ef. 8-19-90; FWC 86-1991, f. 8-7-91, cert. ef. 8-18-91; FWC 123-1991(Temp), f. & cert. ef. 10-21-91; FWC 30-1992(Temp), f. & cert. ef. 4-27-92; FWC 35-1992(Temp), f. 5-22-92, cert. ef. 5-25-92; FWC 74-1992 (Temp), f. 8-10-92, cert. ef. 8-16-92; FWC 28-1993(Temp), f. & cert. ef. 4-26-93; FWC 48-1993, f. 8-6-93, cert. ef. 8-9-93; FWC 21-1994(Temp), f. 4-22-94, cert. ef. 4-25-94; FWC 51-1994, f. 8-19-94, cert. ef. 8-22-94; FWC 64-1994(Temp), f. 9-14-94, cert. ef. 9-15-94; FWC 66-1994(Temp), f. & cert. ef. 9-20-94; FWC 27-1995, f. 3-29-95, cert. ef. 4-1-95; FWC 48-1995(Temp), f. & cert. ef. 6-5-95; FWC 66-1995, f. 8-22-95, cert. ef. 8-27-95; FWC 69-1995, f. 8-25-95, cert. ef. 8-27-95; FWC 8-1995, f. 2-28-96, cert. ef. 3-1-96; FWC 37-1996(Temp), f. 6-11-96, cert. ef. 6-12-96; FWC 41-1996, f. & cert. ef. 8-12-96; FWC 45-1996(Temp), f. 8-16-96, cert. ef. 8-19-96; FWC 54-1996(Temp), f. & cert. ef. 9-23-96; FWC 4-1997, f. & cert. ef. 1-30-97; FWC 47-1997, f. & cert. ef. 8-15-97; DFW 8-1998(Temp), f. & cert. ef. 2-5-98 thru 2-28-98; DFW 14-1998, f. & cert. ef. 3-3-98; DFW 18-1998(Temp), f. 3-9-98, cert. ef. 3-11-98 thru 3-31-98; DFW 60-1998(Temp), f. & cert. ef. 8-7-98 thru 8-21-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 52-1999(Temp), f. & cert. ef. 8-2-99 thru 8-6-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 66-2001(Temp), f. 8-2-01, cert. ef. 8-6-01 thru 8-14-01; DFW 76-2001(Temp), f. & cert. ef. 8-20-01 thru 10-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 82-2002(Temp), f. 8-5-02, cert. ef. 8-7-02 thru 9-1-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 17-2003(Temp), f. 2-27-03, cert. ef. 3-1-03 thru 8-1-03; DFW 32-2003(Temp), f. & cert. ef. 4-23-03 thru 8-1-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 37-2003(Temp), f. & cert. ef. 5-7-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04; DFW 22-2004(Temp), f. & cert. ef. 3-18-04 thru 3-31-04; DFW 28-2004(Temp), f. 4-8-04 cert. ef. 4-12-04 thru 4-15-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 15-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 46-2005(Temp), f. 5-17-05, cert. ef. 5-18-05 thru 10-16-05; DFW 73-2005(Temp), f. 7-8-05, cert. ef. 7-11-05 thru 7-31-05; DFW 77-2005(Temp), f. 7-14-05, cert. ef. 7-18-05 thru 7-31-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 14-2006(Temp), f. 3-15-06, cert. ef. 3-16-06 thru 7-27-06; DFW 15-2006(Temp), f. & cert. ef. 3-23-06 thru 7-27-06; DFW 17-2006(Temp), f. 3-29-06, cert. ef. 3-30-06 thru 7-27-06; DFW 29-2006(Temp), f. & cert. ef. 5-16-06 thru 7-31-06

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Rule Caption: Fishing period modifications to Columbia River mainstem spring Chinook commercial gill net fishery.
Adm. Order No.: DFW 30-2006(Temp)
Filed with Sec. of State: 5-18-2006
Certified to be Effective: 5-18-06 thru 7-31-06
Notice Publication Date:
Rules Amended: 635-042-0022
Rules Suspended: 635-042-0022(T)
Subject: Amend rule to extend the spring Chinook gillnet commercial fishing periods in the Columbia River mainstem. Revision is consistent with action taken May 18, 2006 by the Columbia River Compact.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-042-0022
Spring Chinook Gill Net and Tangle Net Fisheries

(1) Adipose fin-clipped chinook salmon, sturgeon and shad may be taken by gill net or tangle net for commercial purposes from the mouth of the Columbia River upstream to Kelley Point (Zones 1-3 and part of Zone 4).

(a) Individual fishing periods will not exceed sixteen hours in length during small mesh fisheries and twenty-four hours in length during large mesh fisheries. Fishing periods may occur on Tuesdays and Thursdays, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) White sturgeon possession and sales restrictions by each participating vessel will be determined inseason based on gear type and number of fish remaining on the guideline.

(2) An adipose fin clip salmon is defined as a hatchery salmon with a clipped adipose fin and having a healed scar at the location of the fin. The adipose fin is the small fatty fin on salmonids located between the dorsal fin and tail.

(3) During the spring chinook gill net fishery:

(a) It is *unlawful* to use a gill net having a mesh size less than 8 inches or more than 9-3/4 inches. Use of monofilament nets is allowed.

(b) Mesh size for the fishery is determined as described in OAR 635-042-0010(4).

(c) From the area as described in section (1) of this rule, adipose fin-clipped chinook salmon, sturgeon and shad may be taken for commercial purposes by gill net during the following open period:

(A) 12:00 noon, February 23 to 6:00 a.m., February 24, 2006.

(B) 12:00 noon, March 2, 2006 to 12:00 noon, March 3, 2006.

(C) 6:00 a.m., March 7, 2006 to 6:00 a.m., March 8, 2006.

(D) 12:00 noon, March 9, 2006 to 6:00 a.m., March 10, 2006.

(E) 12:00 noon, March 14, 2006 to 6:00 a.m., March 15, 2006.

(F) 2:00 p.m., May 16, 2006 to 12:00 midnight, May 16, 2006.

(G) 7:00 p.m., May 18, 2006 to 7:00 a.m., May 19, 2006

(4) A maximum of twelve sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) the fishery is open. The twelve sturgeon possession/sales limit includes both mainstem and Select Area fisheries.

(5) During the spring chinook tangle net fishery:

(a) It is *unlawful* to use other than a single-wall multi-filament net. Monofilament tangle nets are not allowed. Maximum mesh size is 4-1/4 inches stretched taut.

(b) Mesh size is determined by placing three consecutive meshes under hand tension and the measurement is taken from the inside of one vertical knot to the outside of the opposite vertical knot of the center mesh. Hand tension means sufficient linear tension to draw opposing knots of meshes into contact.

(6) Nets shall not exceed 900 feet (150 fathoms) in length. A red cork must be placed on the corkline every 25 fathoms as measured from the first mesh of the net. Red corks at 25-fathom intervals must be in color contrast to the corks used in the remainder of the net.

(7) On tangle nets, an optional use of a steelhead excluder panel of mesh may be hung between the corkline and the 4-1/4 inch maximum mesh size tangle net. The excluder panel web must be a minimum mesh size of 12 inches when stretched taut under hand tension. Monofilament mesh is allowed for the excluder panel. The excluder panel (including any associated hangings) must be a minimum of 5 linear feet in depth and not exceed 10 linear feet in depth, as measured from the corkline to the upper margin of the tangle net mesh as the net hangs naturally from a taut corkline. Weedlines or droppers (bobber-type) may be used in place of the steelhead excluder panel. A weedline-type excluder means the net is suspended below the corkline by lines of no less than five feet in length between the corkline and the upper margin of the tangle net. A dropper-type excluder means the entire net is suspended below the surface of the water by lines of no less than five feet in length extending from individual surface floats to a submersed corkline. The corkline cannot be capable of floating the net in its entirety (including the leadline) independent of the attached floats. Weedlines or droppers must extend a minimum of 5 feet above the 4-1/4 inch maximum mesh size tangle net.

(a) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, may extend to a maximum length of 1,050 feet (175 fathoms).

(b) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, along with a red cork every 25 fathoms as required in (5) above, must have two red corks at each end of the net.

(8) There are no restrictions on the hang ratio. The hang ratio is used to horizontally add slack to the net. The hang ratio is determined by the length of the web per length of the corkline.

(9) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(10) Nets shall be fished for no longer than 45 minutes per set. The time of fishing is measured from when the first mesh of the net is deployed into the water until the last mesh of the net is fully retrieved from the water.

(11) It is *unlawful* for a net in whole or in part to be anchored, tied, staked, fixed, or attached to the bottom, shore, or a beached boat; left unattended at any time it is fished; or attended by more than one boat while being fished.

(12) It is *unlawful* to fish more than one net from a licensed commercial fishing boat at any one time.

(13) Nets fished from sunset to sunrise shall have lighted buoys on both ends of the net unless the net is attached to the boat then one lighted buoy on the opposite end of the net from the boat is required.

(14) Non-legal sturgeon, nonadipose fin-clipped chinook salmon, and steelhead must be released immediately with care and the least possible injury to the fish to the river without violence or into an operating recovery box.

(a) One operating recovery box with two chambers or two operating recovery boxes with one chamber each to aid survival of released fish must be on board each fishing vessel participating in the fishery. Recovery boxes shall be operating during any time that a net is being retrieved or picked.

(b) All salmon and steelhead that are bleeding, in lethargic condition, or appearing dead must be placed in the recovery box for rehabilitation purposes prior to release to the river.

(c) Each chamber of the recovery box must meet the following dimensions as measured from within the box; the inside length measurement must be at or within 39-1/2 to 48 inches, the inside width measurement must be at or within 8 to 10 inches, and the inside height measurement must be at or within 14 to 16 inches.

(d) Each chamber of the recovery box must include an operating water pumping system capable of delivering a minimum flow of 16 gallons per minute not to exceed 20 gallons per minute of fresh river water into each chamber. The fisher must demonstrate to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers, upon request, that the pumping system is delivering the proper volume of fresh river water into each chamber.

(e) Each chamber of the recovery box must include a water inlet hole between 3/4 inch and 1 inch in diameter, centered horizontally across the door or wall of chamber and 1-3/4 inches from the floor of the chamber.

(f) Each chamber of the recovery box must include a water outlet that is at least 1-1/2 inches in diameter. The center of the outlet hole must be located a minimum of 12 inches above the floor of the box or chamber, on either the same or opposite end as the inlet.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(15) At least one fisher on each boat engaged in the fishery must have in possession a certificate issued by a representative of the Oregon Department of Fish and Wildlife (ODFW) or the Washington Department of Fish and Wildlife (WDFW) that indicates the fisher had attended a one-day workshop hosted by ODFW or WDFW to educate fishers on regulations and best methods for conduct of the selective fishery. No individual may obtain more than one certificate. The certificate must be displayed to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers upon request.

(16) Nothing in this section sets any precedent for any fishery after the 2006 spring chinook fishery. The fact that an individual may hold a selective fishery certificate in spring 2006 does not entitle the certificate holder to participate in any other fishery. If ODFW authorizes a selective fishery in spring 2007 or at any other time, ODFW may establish qualifications and requirements that are different from those established for 2006. In particular, ODFW may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future tangle net fisheries.

(17) As authorized by OAR 635-006-0140 owners or operators of commercial fishing vessels must cooperate with Department fishery observers, or observers collecting data for the Department, when asked by the Department to carry and accommodate an observer on fishing trips for observation and sampling during an open fishery.

(18) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, and Lewis-B sanctuary are in effect during the open fishing periods identified.

Stat. Auth.: ORS 496.138, 496.146 & 506.119

Stats. Implemented: ORS 496.162, 506.129 & 507.030

Hist.: DFW 11-2004, f. & cert. ef. 2-13-04; DFW 12-2004(Temp), f. & cert. ef. 3-1-04, thru 7-31-04; DFW 13-2004(Temp), f. & cert. ef. 3-3-04 thru 7-31-04; DFW 16-2004(Temp), f. & cert. ef. 3-8-04 thru 7-31-04; DFW 18-2004(Temp), f. & cert. ef. 3-10-04 thru 7-31-04; DFW 20-2004(Temp) f. & cert. ef. 3-15-04 thru 7-31-04; DFW 21-2004(Temp), f. & cert. ef. 3-18-04 thru 7-31-04; DFW 25-2004(Temp), f. 3-22-04, cert. ef. 3-23-04 thru 7-31-04; DFW 26-2004(Temp), f. & cert. ef. 3-25-04 thru 7-31-04; DFW 27-2004(Temp), f. & cert. ef. 3-29-04 thru 7-31-04; Administrative correction 8-19-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 9-2005(Temp), f. & cert. ef. 3-1-05 thru 7-31-05; DFW 11-2005(Temp), f. 3-2-05, cert. ef. 3-3-05 & 7-31-05; DFW 13-2005(Temp), f. & cert. ef. 3-7-05 thru 7-31-05; DFW 14-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; DFW 20-2005(Temp), f. & cert. ef. 3-29-05 thru 3-30-05; DFW 21-2005(Temp), f. & cert. ef. 3-31-05 thru 4-1-05; Administrative correction, 4-20-05; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 7-2006(Temp), f. & cert. ef. 2-23-06 thru 7-31-06; DFW 9-2006(Temp), f. 3-1-06, cert. ef. 3-2-06 thru 7-31-06; DFW 10-2006(Temp), f. 3-6-06, cert. ef. 3-7-06 thru 7-31-06; DFW 11-2006(Temp), f. & cert. ef. 3-9-06 thru 7-31-06; DFW 12-2006(Temp), f. 3-13-06, cert. ef. 3-14-06 thru 7-31-06; DFW 29-2006(Temp), f. & cert. ef. 5-16-06 thru 7-31-06; DFW 30-2006(Temp), f. & cert. ef. 5-18-06 thru 7-31-06

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Rule Caption: Open a spring Chinook sport fishery on the Snake River below Hells Canyon Dam.

Adm. Order No.: DFW 31-2006(Temp)

Filed with Sec. of State: 5-18-2006

Certified to be Effective: 5-20-06 thru 6-19-06

Notice Publication Date:

Rules Amended: 635-023-0134

Subject: Amend rule to open a spring Chinook fishery from Dug Bar Boat Ramp upstream to the deadline below Hells Canyon Dam on the Snake River.

Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-023-0134

Snake River Fishery

(1) Notwithstanding, all other specifications and restrictions as outlined in the current **2006 Oregon Sport Fishing Regulations**, the following conditions apply:

(2) The Snake River from Dug Bar boat ramp upstream to the deadline below Hell's Canyon Dam is open effective May 20, 2006 through June 19, 2006 during the following periods:

(a) Saturday through Monday May 20 to May 22;

(b) Friday through Monday May 26 to May 29;

(c) Friday through Monday June 2 to June 5;

(d) Friday through Monday June 9 to June 12; and

(e) Friday through Monday June 16 to June 19.

(3) Daily bag limit is one adipose fin-clipped spring Chinook adult or jack salmon per day.

(4) Barbless hooks are required.

[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 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 47-2005(Temp), f. 5-19-05, cert. ef. 5-21-05 thru 6-20-05; Administrative correction 7-20-05; DFW 31-2006(Temp), f. 5-18-06, cert. ef. 5-20-06 thru 6-19-06

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Rule Caption: Modifications to Columbia River mainstem and Select Areas spring Chinook an dshand commercial gill net fisheries.

Adm. Order No.: DFW 32-2006(Temp)

Filed with Sec. of State: 5-23-2006

Certified to be Effective: 5-23-06 thru 7-31-06

Notice Publication Date:

Rules Amended: 635-042-0022, 635-042-0110, 635-042-0145, 635-042-0160, 635-042-0180

Rules Suspended: 635-042-0022(T), 635-042-0145(T), 635-042-0160(T)

Subject: Amend rules to extend spring Chinook commercial fishing periods, fishing area, and sanctuaries in the Columbia River and Select Area fisheries. Revision is consistent with action taken May 22, 2006 by the Columbia River Compact.

Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-042-0022
Spring Chinook Gill Net and Tangle Net Fisheries

(1) Adipose fin-clipped chinook salmon, sturgeon and shad may be taken by gill net or tangle net for commercial purposes from the mouth of the Columbia River upstream to a line projected from deadline markers on the Oregon and Washington banks, both such deadline markers located approximately five miles downstream from Bonneville Dam (Zones 1-5).

(a) Individual fishing periods will not exceed sixteen hours in length during small mesh fisheries and twenty-four hours in length during large mesh fisheries. Fishing periods may occur on Tuesdays and Thursdays, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) White sturgeon possession and sales restrictions by each participating vessel will be determined inseason based on gear type and number of fish remaining on the guideline.

(2) An adipose fin clip salmon is defined as a hatchery salmon with a clipped adipose fin and having a healed scar at the location of the fin. The adipose fin is the small fatty fin on salmonids located between the dorsal fin and tail.

(3) During the spring chinook gill net fishery:

(a) It is *unlawful* to use a gill net having a mesh size less than 8 inches or more than 9-3/4 inches. Use of monofilament nets is allowed.

(b) Mesh size for the fishery is determined as described in OAR 635-042-0010(4).

(c) From the area as described in section (1) of this rule, adipose fin-clipped chinook salmon, sturgeon and shad may be taken for commercial purposes by gill net during the following open period:

(A) 12:00 noon, February 23 to 6:00 a.m., February 24, 2006.

(B) 12:00 noon, March 2, 2006 to 12:00 noon, March 3, 2006.

(C) 6:00 a.m., March 7, 2006 to 6:00 a.m., March 8, 2006.

(D) 12:00 noon, March 9, 2006 to 6:00 a.m., March 10, 2006.

(E) 12:00 noon, March 14, 2006 to 6:00 a.m., March 15, 2006.

(F) 2:00 p.m., May 16, 2006 to 12:00 midnight, May 16, 2006.

(G) 7:00 p.m., May 18, 2006 to 7:00 a.m., May 19, 2006.

(H) 7:00 p.m., May 23, 2006 to 7:00 a.m., May 24, 2006.

(I) 7:00 p.m., May 25, 2006 to 7:00 a.m., May 26, 2006.

(4) A maximum of fifteen sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) the fishery is open. The fifteen sturgeon possession/sales limit includes both mainstem and Select Area fisheries.

(5) During the spring chinook tangle net fishery:

(a) It is *unlawful* to use other than a single-wall multi-filament net. Monofilament tangle nets are not allowed. Maximum mesh size is 4-1/4 inches stretched taut.

(b) Mesh size is determined by placing three consecutive meshes under hand tension and the measurement is taken from the inside of one vertical knot to the outside of the opposite vertical knot of the center mesh. Hand tension means sufficient linear tension to draw opposing knots of meshes into contact.

(6) Nets shall not exceed 900 feet (150 fathoms) in length. A red cork must be placed on the corkline every 25 fathoms as measured from the first mesh of the net. Red corks at 25-fathom intervals must be in color contrast to the corks used in the remainder of the net.

(7) On tangle nets, an optional use of a steelhead excluder panel of mesh may be hung between the corkline and the 4-1/4 inch maximum mesh size tangle net. The excluder panel web must be a minimum mesh size of 12 inches when stretched taut under hand tension. Monofilament mesh is allowed for the excluder panel. The excluder panel (including any associated hangings) must be a minimum of 5 linear feet in depth and not exceed 10 linear feet in depth, as measured from the corkline to the upper margin of the tangle net mesh as the net hangs naturally from a taut corkline. Weedlines or droppers (bobber-type) may be used in place of the steelhead excluder panel. A weedline-type excluder means the net is suspended below the corkline by lines of no less than five feet in length between the corkline and the upper margin of the tangle net. A dropper-type excluder means the entire net is suspended below the surface of the water by lines of no less than five feet in length extending from individual surface floats to a submersed corkline. The corkline cannot be capable of floating the net in its entirety (including the leadline) independent of the attached floats. Weedlines or droppers must extend a minimum of 5 feet above the 4-1/4 inch maximum mesh size tangle net.

(a) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, may extend to a maximum length of 1,050 feet (175 fathoms).

(b) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, along with a red cork every 25 fathoms as required in (5) above, must have two red corks at each end of the net.

(8) There are no restrictions on the hang ratio. The hang ratio is used to horizontally add slack to the net. The hang ratio is determined by the length of the web per length of the corkline.

(9) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(10) Nets shall be fished for no longer than 45 minutes per set. The time of fishing is measured from when the first mesh of the net is deployed into the water until the last mesh of the net is fully retrieved from the water.

(11) It is *unlawful* for a net in whole or in part to be anchored, tied, staked, fixed, or attached to the bottom, shore, or a beached boat; left unattended at any time it is fished; or attended by more than one boat while being fished.

(12) It is *unlawful* to fish more than one net from a licensed commercial fishing boat at any one time.

(13) Nets fished from sunset to sunrise shall have lighted buoys on both ends of the net unless the net is attached to the boat then one lighted buoy on the opposite end of the net from the boat is required.

(14) Non-legal sturgeon, nonadipose fin-clipped chinook salmon, and steelhead must be released immediately with care and the least possible injury to the fish to the river without violence or into an operating recovery box.

(a) One operating recovery box with two chambers or two operating recovery boxes with one chamber each to aid survival of released fish must be on board each fishing vessel participating in the fishery. Recovery boxes shall be operating during any time that a net is being retrieved or picked.

(b) All salmon and steelhead that are bleeding, in lethargic condition, or appearing dead must be placed in the recovery box for rehabilitation purposes prior to release to the river.

(c) Each chamber of the recovery box must meet the following dimensions as measured from within the box; the inside length measurement must be at or within 39-1/2 to 48 inches, the inside width measurement must be at or within 8 to 10 inches, and the inside height measurement must be at or within 14 to 16 inches.

(d) Each chamber of the recovery box must include an operating water pumping system capable of delivering a minimum flow of 16 gallons per minute not to exceed 20 gallons per minute of fresh river water into each chamber. The fisher must demonstrate to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers, upon request, that the pumping system is delivering the proper volume of fresh river water into each chamber.

(e) Each chamber of the recovery box must include a water inlet hole between 3/4 inch and 1 inch in diameter, centered horizontally across the door or wall of chamber and 1-3/4 inches from the floor of the chamber.

(f) Each chamber of the recovery box must include a water outlet that is at least 1-1/2 inches in diameter. The center of the outlet hole must be located a minimum of 12 inches above the floor of the box or chamber, on either the same or opposite end as the inlet.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(15) At least one fisher on each boat engaged in the fishery must have in possession a certificate issued by a representative of the Oregon Department of Fish and Wildlife (ODFW) or the Washington Department of Fish and Wildlife (WDFW) that indicates the fisher had attended a one-day workshop hosted by ODFW or WDFW to educate fishers on regulations and best methods for conduct of the selective fishery. No individual may obtain more than one certificate. The certificate must be displayed to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers upon request.

(16) Nothing in this section sets any precedent for any fishery after the 2006 spring chinook fishery. The fact that an individual may hold a selective fishery certificate in spring 2006 does not entitle the certificate holder to participate in any other fishery. If ODFW authorizes a selective fishery in spring 2007 or at any other time, ODFW may establish qualifications and requirements that are different from those established for 2006. In particular, ODFW may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future tangle net fisheries.

(17) As authorized by OAR 635-006-0140 owners or operators of commercial fishing vessels must cooperate with Department fishery observers, or observers collecting data for the Department, when asked by the Department to carry and accommodate an observer on fishing trips for observation and sampling during an open fishery.

(18) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, Lewis-B sanctuary, and Sandy River sanctuary are in effect during the open fishing periods identified.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: DFW 11-2004, f. & cert. ef. 2-13-04; DFW 12-2004(Temp), f. & cert. ef. 3-1-04, thru 7-31-04; DFW 13-2004(Temp), f. & cert. ef. 3-3-04 thru 7-31-04; DFW 16-2004(Temp), f. & cert. ef. 3-8-04 thru 7-31-04; DFW 18-2004(Temp), f. & cert. ef. 3-10-04 thru 7-31-04; DFW 20-2004(Temp) f. & cert. ef. 3-15-04 thru 7-31-04; DFW 21-2004(Temp), f. & cert. ef. 3-18-04 thru 7-31-04; DFW 25-2004(Temp), f. 3-22-04, cert. ef. 3-23-04 thru 7-31-04; DFW 26-2004(Temp), f. & cert. ef. 3-25-04 thru 7-31-04; DFW 27-2004(Temp), f. & cert. ef. 3-29-04 thru 7-31-04; Administrative correction 8-19-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 9-2005(Temp), f. & cert. ef. 3-1-05 thru 7-31-05; DFW 11-2005(Temp), f. 3-2-05, cert. ef. 3-3-05 & 7-31-05; DFW 13-2005(Temp), f. & cert. ef. 3-7-05 thru 7-31-05; DFW 14-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; DFW 20-2005(Temp), f. & cert. ef. 3-29-05 thru 3-30-05; DFW 21-2005(Temp), f. & cert. ef. 3-31-05 thru 4-1-05; Administrative correction, 4-20-05; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 7-2006(Temp), f. & cert. ef. 2-23-06 thru 7-31-06; DFW 9-2006(Temp), f. 3-1-06, cert. ef. 3-2-06 thru 7-31-06; DFW 10-2006(Temp), f. 3-6-06, cert. ef. 3-7-06 thru 7-31-06; DFW 11-2006(Temp), f. & cert. ef. 3-9-06 thru 7-31-06; DFW 12-2006(Temp), f. 3-13-06, cert. ef. 3-14-06 thru 7-31-06; DFW 29-2006(Temp), f. & cert. ef. 5-16-06 thru 7-31-06; DFW 30-2006(Temp), f. & cert. ef. 5-18-06 thru 7-31-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06

635-042-0110
Gary Island to Bonneville Dam Shad Season

(1) Shad may be taken for commercial purposes from the area of the Columbia River described in section (2) daily from 3:00 p.m. to 10:00 p.m. during the following open fishing periods: May 15, 2006 through May 19, 2006; May 22, 2006; May 24, 2006; May 26, 2006 and May 30, 2006 through June 2, 2006; June 5, 2006 through June 9, 2006; June 12, 2006 through June 16, 2006 and June 19, 2006 through June 23, 2006.

(2) The area of the Columbia River open to fishing is from a downstream boundary of a true north/south line through the flashing red 4-second Light "50" near the Oregon bank to an upstream boundary of a straight line from a deadline marker on the Oregon bank to a deadline marker on the Washington bank, both such deadline markers located approximately five miles downstream from Bonneville Dam.

(3) It is *unlawful* to use a gill net having a mesh size less than 5-3/8 inches or more than 6-1/4 inches with a breaking strength greater than a 10-pound pull, or to use a gill net other than a single wall floater net, or to use a gill net having slackers, or to use a gill net of more than 150 fathoms in length or 40 meshes in depth. Rip lines are authorized spaced not closer than 20 corks apart.

(4) All salmon, steelhead, walleye and sturgeon taken in shad nets must be immediately returned unharmed to the water.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: FWC 85, f. & ef. 1-28-77; FWC 116(Temp), f. & ef. 6-1-77 thru 6-3-77; FWC 124(Temp), f. & ef. 6-17-77 thru 10-14-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 27-1978(Temp), f. & ef. 5-26-78 thru 9-22-78; FWC 2-1979, f. & ef. 1-25-79, Renumbered from 635-035-0275; FWC 6-1980, f. & ef. 1-28-80; FWC 25-1980(Temp), f. & ef. 6-13-80; FWC 1-1981, f. & ef. 1-19-81; FWC 18-1981(Temp), f. & ef. 6-10-81; FWC 6-1982, f. & ef. 1-28-82; FWC 36-1982 (Temp), f. & ef. 6-11-82; FWC 2-1983, f. 1-21-83, ef. 2-1-83; FWC 21-1983(Temp), f. & ef. 6-10-83; FWC 4-1984, f. & ef. 1-31-84; FWC 2-1985, f. & ef. 1-30-85; FWC 19-1985, f. & ef. 5-1-85; FWC 4-1986(Temp), f. & ef. 1-28-86; FWC 16-1986 (Temp), f. & ef. 5-23-86; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 23-1987(Temp), f. & ef. 5-20-87; FWC 10-1988, f. & cert. ef. 3-4-88; FWC 5-1989, f. 2-6-89, cert. ef. 2-7-89; FWC 15-1990(Temp), f. 2-8-90, cert. ef. 2-9-90; FWC 20-1990, f. 3-6-90, cert. ef. 3-15-90; FWC 10-1991, f. 2-7-91, cert. ef. 2-8-91; FWC 8-1992, f. & cert. ef. 2-11-92; FWC 34-1992(Temp), f. 5-19-92, cert. ef. 5-20-92; FWC 11-1993, f. 2-11-93, cert. ef. 2-16-93; FWC 9-1994, f. 2-14-94, cert. ef. 2-15-94; FWC 15-1995, f. & cert. ef. 2-15-95; FWC 6-1996, f. & cert. ef. 2-7-96; FWC 4-1997, f. & cert. ef. 1-30-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 36-2000(Temp), f. 6-28-00, cert. ef. 6-28-00 thru 7-1-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 39-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 45-2005(Temp), f. 5-17-05, cert. ef. 5-23-05 thru 10-16-05; DFW 63-2005(Temp), f. & cert. ef. 6-29-05 thru 7-31-05; Administrative correction 11-18-05; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06

635-042-0145
Youngs Bay Salmon Season

(1) Salmon, sturgeon, and shad may be taken for commercial purposes in those waters of Youngs Bay except for the period from 7:00 p.m. Tuesday May 23, 2006 through Saturday May 27, 2006 when only adipose fin-clipped spring Chinook salmon, sturgeon, and shad may be taken.

(a) The open fishing periods are established in three segments categorized as the winter fishery, paragraph (A), the spring fishery, paragraph (B), and summer fishery, paragraph (C), as follows:

(A) Winter Season:

(i) 6:00 p.m. February 15, 2006 to 6:00 a.m. February 16, 2006; 6:00 p.m. February 19, 2006 to 12 Noon February 20, 2006; 6:00 p.m. February 22, 2006 to 6:00 a.m. February 23, 2006; 6:00 p.m. February 26, 2006 to 12 Noon February 27, 2006; 6:00 p.m. March 1, 2006 to 6:00 a.m. March 2, 2006; 6:00 p.m. March 5, 2006 to 12 Noon March 6, 2006; 6:00 p.m. March 8, 2006 to 12 Noon March 9, 2006 and 6:00 p.m. March 12, 2006 to 6:00 a.m. March 13, 2006.

(ii) March 16, 2006 from 6:00 a.m. to 10:00 a.m. and March 23, 2006 from 12 noon to 4:00 p.m.

(iii) March 27, 2006 from 6:00 a.m. to 6:00 p.m.; March 30, 2006 from 6:00 a.m. to 8:00 p.m.; April 3, 2006 from 6:00 a.m. to 8:00 p.m.; April 6, 2006 from 6:00 a.m. to 8:00 p.m.; April 10, 2006 from 6:00 a.m. to 8:00 p.m. and April 13, 2006 from 6:00 a.m. to 8:00 p.m.

(B) Spring Season:

(i) April 17, 2006 from 9:00 a.m. to 1:00 p.m.

(ii) 6:00 p.m. April 20, 2006 to 6:00 a.m. April 21, 2006; 6:00 p.m. April 24, 2006 to 6:00 a.m. April 25, 2006; 6:00 p.m. April 27, 2006 to 6:00 a.m. April 28, 2006; 6:00 p.m. May 1, 2006 to 12 Noon May 2, 2006; 6:00 p.m. May 4, 2006 to 12 Noon May 5, 2006; 12 Noon May 8, 2006 to 12 Noon May 12, 2006; 12 Noon May 15, 2006 to 12 Noon May 19, 2006; 12 Noon May 22, 2006 to 12 Noon May 26, 2006; 12 Noon May 29, 2006 to 12 Noon June 2, 2006; 12 Noon June 5, 2006 to 12 Noon June 9, 2006 and 12 Noon June 13, 2006 to 12 Noon June 16, 2006.

(C) Summer Season: 12 Noon June 21, 2006 to 12 Noon June 23, 2006; 12 Noon June 28, 2006 to 12 Noon June 30, 2006; 12 Noon July 5, 2006 to 6:00 p.m. July 6, 2006; 12 Noon July 12, 2006 to 6:00 p.m. July 13, 2006; 12 Noon July 19, 2006 - 6:00 p.m. July 20, 2006 and 12 Noon July 26, 2006 to 6:00 p.m. July 27, 2006.

(b) The fishing areas for the winter, spring and summer fisheries are:

(A) From February 15, 2006 through March 23, 2006 and from April 20, 2006 through July 27, 2006, the fishing area is identified as the waters of Youngs Bay from the Highway 101 Bridge upstream to the upper boundary markers at the confluence of the Klaskanine and Youngs rivers; except for those waters which are closed southerly of the alternate Highway 101 Bridge (Lewis and Clark River).

(B) On April 17, 2006, the fishing area extends from old Youngs Bay Bridge upstream to the confluence of the Youngs and Klaskanine rivers.

(C) From March 27, 2006 through April 13, 2006 the fishing area extends from markers directly under the first power lines downstream of the Walluski River to the confluence of the Youngs and Klaskanine rivers.

(2) Gill nets may not exceed 1,500 feet (250 fathoms) in length and weight may not exceed two pounds per any fathom. A red cork must be placed on the corkline every 25 fathoms as measured from the first mesh of the net. Red corks at 25-fathom intervals must be in color contrast to the corks used in the remainder of the net. Monofilament gillnets are allowed.

(a) It is *unlawful* to use a gill net having a mesh size that is less than 7-inches during the winter season from February 15, 2006 to April 13, 2006. It is *unlawful* to use a gill net having a mesh size that is more than 8-inches during the spring and summer seasons from April 17, 2006 to July 27, 2006.

(b) In the fishing area, as described in (1)(b)(iii), the use of additional weights or anchors attracted directly to the leadline is allowed upstream of the mouth of the Walluski River.

(c) Retention of non-adipose fin-clipped spring Chinook is prohibited from 2:00 p.m. Tuesday May 16, 2006 through Sunday May 21, 2006

(3) A maximum of three green or white sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fisheries are open. During the fishing periods

identified in (1)(a)(A), (1)(a)(B) and (1)(a)(C), the weekly aggregate sturgeon limit applies to possessions and sales in the Youngs Bay fishery and other open Select Area fisheries.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: FWC 32-1979, f. & ef. 8-22-79; FWC 28-1980, f. & ef. 6-23-80; FWC 42-1980(Temp), f. & ef. 8-22-80; FWC 30-1981, f. & ef. 8-14-81; FWC 42-1981(Temp), f. & ef. 11-5-81; FWC 54-1982, f. & ef. 8-17-82; FWC 37-1983, f. & ef. 8-18-83; FWC 61-1983(Temp), f. & ef. 10-19-83; FWC 42-1984, f. & ef. 8-20-84; FWC 39-1985, f. & ef. 8-15-85; FWC 37-1986, f. & ef. 8-11-86; FWC 72-1986(Temp), f. & ef. 10-31-86; FWC 64-1987, f. & ef. 8-7-87; FWC 73-1988, f. & cert. ef. 8-19-88; FWC 55-1989(Temp), f. 8-7-89, cert. ef. 8-20-89; FWC 82-1990(Temp), f. 8-14-90, cert. ef. 8-19-90; FWC 86-1991, f. 8-7-91, cert. ef. 8-18-91; FWC 123-1991(Temp), f. & cert. ef. 10-21-91; FWC 30-1992(Temp), f. & cert. ef. 4-27-92; FWC 35-1992(Temp), f. 5-22-92, cert. ef. 5-25-92; FWC 74-1992 (Temp), f. 8-10-92, cert. ef. 8-16-92; FWC 28-1993(Temp), f. & cert. ef. 4-26-93; FWC 48-1993, f. 8-6-93, cert. ef. 8-9-93; FWC 21-1994(Temp), f. 4-22-94, cert. ef. 4-25-94; FWC 51-1994, f. 8-19-94, cert. ef. 8-22-94; FWC 64-1994(Temp), f. 9-14-94, cert. ef. 9-15-94; FWC 66-1994(Temp), f. & cert. ef. 9-20-94; FWC 27-1995, f. 3-29-95, cert. ef. 4-1-95; FWC 48-1995(Temp), f. & cert. ef. 6-5-95; FWC 66-1995, f. 8-22-95, cert. ef. 8-27-95; FWC 69-1995, f. 8-25-95, cert. ef. 8-27-95; FWC 8-1995, f. 2-28-96, cert. ef. 3-1-96; FWC 37-1996(Temp), f. 6-11-96, cert. ef. 6-12-96; FWC 41-1996, f. & cert. ef. 8-12-96; FWC 45-1996(Temp), f. 8-16-96, cert. ef. 8-19-96; FWC 54-1996(Temp), f. & cert. ef. 9-23-96; FWC 4-1997, f. & cert. ef. 1-30-97; FWC 47-1997, f. & cert. ef. 8-15-97; DFW 8-1998(Temp), f. & cert. ef. 2-5-98 thru 2-28-98; DFW 14-1998, f. & cert. ef. 3-3-98; DFW 18-1998(Temp), f. 3-9-98, cert. ef. 3-11-98 thru 3-31-98; DFW 60-1998(Temp), f. & cert. ef. 8-7-98 thru 8-21-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 52-1999(Temp), f. & cert. ef. 8-2-99 thru 8-6-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 66-2001(Temp), f. 8-2-01, cert. ef. 8-6-01 thru 8-14-01; DFW 76-2001(Temp), f. & cert. ef. 8-20-01 thru 10-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 82-2002(Temp), f. 8-5-02, cert. ef. 8-7-02 thru 9-1-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 17-2003(Temp), f. 2-27-03, cert. ef. 3-1-03 thru 8-1-03; DFW 32-2003(Temp), f. & cert. ef. 4-23-03 thru 8-1-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 37-2003(Temp), f. & cert. ef. 5-7-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04; DFW 22-2004(Temp), f. & cert. ef. 3-18-04 thru 3-31-04; DFW 28-2004(Temp), f. 4-8-04 cert. ef. 4-12-04 thru 4-15-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 15-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 46-2005(Temp), f. 5-17-05, cert. ef. 5-18-05 thru 10-16-05; DFW 73-2005(Temp), f. 7-8-05, cert. ef. 7-11-05 thru 7-31-05; DFW 77-2005(Temp), f. 7-14-05, cert. ef. 7-18-05 thru 7-31-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 14-2006(Temp), f. 3-15-06, cert. ef. 3-16-06 thru 7-27-06; DFW 15-2006(Temp), f. & cert. ef. 3-23-06 thru 7-27-06; DFW 17-2006(Temp), f. 3-29-06, cert. ef. 3-30-06 thru 7-27-06; DFW 29-2006(Temp), f. & cert. ef. 5-16-06 thru 7-31-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06

635-042-0160
Blind Slough and Knappa Slough Select Area Salmon Season

(1) Salmon, sturgeon, and shad may be taken for commercial purposes during open fishing periods described as the winter fishery and the spring fishery in paragraphs (1)(a)(A) or (1)(a)(B) of this rule in those waters of Blind Slough and Knappa Slough except for the period from 7:00 p.m. Tuesday May 23, 2006 through Saturday May 27, 2006 when only adipose fin-clipped spring Chinook salmon, sturgeon, and shad may be taken. The following restrictions apply:

(a) The open fishing periods are established in segments categorized as the winter fishery in Blind Slough only in paragraph (A), and the spring fishery in Blind Slough and Knappa Slough in paragraph (B). The seasons are open nightly from 7:00 p.m. to 7:00 a.m. the following morning (12 hours), as follows:

(A) Blind Slough Only: February 22–February 23, 2006; February 26 – February 27, 2006; March 1 – March 2, 2006; March 5 – March 6, 2006; March 8 – March 9, 2006; March 12 – March 13, 2006; March 19 – March 20, 2006; March 22 – March 23, 2006; March 26 – March 27, 2006; March 29 – March 30, 2006; April 2 – April 3, 2006; April 5 – April 6, 2006; April 9 – April 10, 2006; and April 12 – April 13, 2006.

(B) Blind and Knappa Sloughs:

(i) April 20 – April 21, 2006; April 24 – April 25, 2006 and April 27 – April 28, 2006;

(ii) May 1 – May 2, 2006; May 4 – May 5, 2006; May 8 – May 9, 2006; May 11 – May 12, 2006; May 15 –May 16, 2006; May 18 – May 19, 2006; May 22 – May 23, 2006; May 25 – May 26, 2006; May 29 – May 30, 2006; June 1 – June 2, 2006; June 5 – June 6, 2006; June 8 – June 9, 2006; June 12 – June 13, 2006 and June 15 –June 16, 2006.

(b) The fishing areas for the winter and springs seasons are:

(A) Blind Slough are those waters adjoining the Columbia River which extend from markers at the mouth of Blind Slough upstream to markers at the mouth of Gnat Creek which is located approximately 1/2 mile upstream of the county road bridge.

(B) Knappa Slough are all waters bounded by a line from the northerly most marker at the mouth of Blind Slough westerly to a marker on Karlson Island downstream to a north-south line defined by a marker on the eastern end of Minaker Island to markers on Karlson Island and the Oregon shore.

(C) During the periods identified in (1)(a)(B)(i), the Knappa Slough fishing area extends downstream to the boundary lines defined by markers on the west end of Minaker Island to markers on Karlson Island and the Oregon shore.

(c) Gear restrictions are as follows:

(A) During the winter fishery, outlined above (1)(a)(A), gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. The attachment of additional weight and anchors directly to the lead line is permitted. Monofilament gill nets are allowed. It is *unlawful* to use a gill net having a mesh size that is less than 7- inches;

(B) During the spring fishery, outlined above (1)(a)(B) and (1)(a)(C), gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. The attachment of additional weight and anchors directly to the lead line is permitted. Monofilament gill nets are allowed. It is unlawful to use a gill net having a mesh size that is more than 8-inches.

(2) A maximum of three 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 (1)(a)(A), (1)(a)(B) and (1)(a)(C), the weekly aggregate sturgeon limit applies to possessions and sales in the Youngs Bay fishery and other open Select Area fisheries.

(3) Oregon licenses are required in the open waters upstream from the railroad bridge.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998(Temp), f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 65-2000(Temp) f. 9-22-00, cert. ef. 9-25-00 thru 12-31-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 86-2001, f. & cert. ef. 9-4-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 14-2002(Temp), f. 2-13-02, cert. ef. 2-18-02 thru 8-17-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04; DFW 22-2004(Temp), f. & cert. ef. 3-18-04 thru 3-31-04; DFW 28-2004(Temp), f. 4-8-04 cert. ef. 4-12-04 thru 4-15-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 16-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 14-2006(Temp), f. 3-15-06, cert. ef. 3-16-06 thru 7-27-06; DFW 16-2006(Temp), f. 3-23-06 & cert. ef. 3-26-06 thru 7-27-06; DFW 18-2006(Temp), f. 3-29-06, cert. ef. 4-2-06 thru 7-27-06; DFW 20-2006(Temp), f. 4-7-06, cert. ef. 4-9-06 thru 7-27-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06

635-042-0180
Deep River Select Area Salmon Season

(1) Salmon, shad, and sturgeon may be taken for commercial purposes from the US Coast Guard navigation marker #16 upstream to the Highway 4 Bridge except for the period from 7:00 p.m. Tuesday May 23, 2006 through Saturday May 27, 2006 when only adipose fin-clipped spring Chinook salmon, sturgeon, and shad may be taken.

(2) The fishing seasons are open:

(a) Winter season: nightly from 6:00 p.m. to 8:00 a.m. the following morning (14 hours), February 20 – February 21, 2006; February 27 – February 28, 2006; March 6 – March 7, 2006 and March 13 – March 14, 2006.

(b) Spring season: nightly from 7:00 p.m. to 7:00 a.m. the following morning (12 hours), April 17 – April 18, 2006; April 20 – April 21, 2006; April 24 – April 25, 2006; April 27 – April 28, 2006; May 1 – May 2, 2006; May 4 – May 5, 2006; May 8 – May 9, 2006; May 11 – May 12, 2006; May 15 – May 16, 2006; May 18 – May 19, 2006; May 22 – May 23, 2006; May 25 – May 26, 2006; May 29 – May 30, 2006; June 1 – June 2, 2006; June

5 – June 6, 2006; June 8 – June 9, 2006; June 12 – June 13, 2006 and June 15 – June 16, 2006.

(3) Gill nets may not exceed 100 fathoms in length and there is no weight limit on the lead line. The attachment of additional weight and anchors directly to the lead line is permitted. Monofilament gill nets are allowed. Nets may not be tied off to stationary structures and may not fully cross navigation channel.

(a) During the winter season, outlined above (2)(a), it is *unlawful* to use a gill net having a mesh size that is less than 7- inches;

(b) During the spring season, outlined above (2)(b) it is *unlawful* to use a gill net having a mesh size that is more than 8-inches.

(4) A maximum of three 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 (2)(a) and (2)(b), the weekly aggregate sturgeon limit applies to possessions and sales in the Youngs Bay fishery and other open Select Area fisheries.

Stat. Auth.: ORS 183.325, 506.109 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 19-2003(Temp), f. 3-12-03, cert. ef. 4-17-03 thru 6-13-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06

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Rule Caption: Partial opening of the Umatilla River to angling for adipose fin-clipped spring Chinook salmon.
Adm. Order No.: DFW 33-2006(Temp)
Filed with Sec. of State: 5-24-2006
Certified to be Effective: 5-25-06 thru 6-30-06
Notice Publication Date:
Rules Amended: 635-019-0090
Rules Suspended: 635-019-0090(T)
Subject: Amends rule to implement partial opening of the Umatilla River to angling for adipose fin-clipped spring Chinook salmon effective 12:01 A.M. May 25, 2006 through June 30, 2006.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-019-0090
Inclusions and Modifications

(1) The **2006 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 2006 Oregon Sport Fishing Regulations.

(2) The Umatilla River from Three Mile Dam upstream to the reservation boundary located upstream from Highway 11 Bridge at Pendleton is open to angling for adipose fin-clipped spring Chinook salmon effective 12:01 a.m., May 25, 2006 through June 30, 2006.

(3) The bag limit is two adults and five jacks per day and 10 adults per year.

[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; Administrative correction 10-19-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 28-2006(Temp), f. & cert. ef. 5-15-06 thru 6-30-06; DFW 33-2006(Temp), f. 5-24-06, cert. ef. 5-25-06 thru 6-30-06

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Rule Caption: Ocean sport Pacific halibut closure from Leadbetter Point, Washington to Cape Falcon, Oregon.
Adm. Order No.: DFW 34-2006(Temp)
Filed with Sec. of State: 5-25-2006
Certified to be Effective: 5-27-06 thru 8-3-06
Notice Publication Date:
Rules Amended: 635-039-0085
Subject: Amends rule to close the sport fishery for Pacific halibut in the area between Leadbetter Point, Washington and Cape Falcon, Oregon, at 11:59 p.m. on May 27, 2006 when the quota of 14,819 pounds is projected to have been taken. This rule is consistent with regulations that have been implemented by the federal government and the International Pacific Halibut Commission for the 2006 Oregon recreational fishery for Pacific Halibut.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

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 71, Number 42, dated March 3, 2006.

(2) Effective 11:59 p.m., Saturday May 27, 2006 through Thursday August 3, 2006 the Columbia River sub-area (Cape Falcon, OR to Leadbetter Pt., WA) is closed 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; DFW 121-2005(Temp), f. 10-12-05, cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-19-06; DFW 34-2006(Temp), f. 5-25-06, cert. ef. 5-27-06 thru 8-3-06

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Rule Caption: Modifications to Columbia River mainstem and Select Areas spring Chinook and shad commercial gill net fisheries.
Adm. Order No.: DFW 35-2006(Temp)
Filed with Sec. of State: 5-30-2006
Certified to be Effective: 5-30-06 thru 7-31-06
Notice Publication Date:
Rules Amended: 635-042-0022, 635-042-0110, 635-042-0145, 635-042-0160, 635-042-0180
Rules Suspended: 635-042-0022(T), 635-042-0145(T), 635-042-0160(T), 635-042-0180(T)
Subject: Amend rules to extend spring Chinook commercial fishing periods in the Columbia River and Select Area fisheries. Revision is consistent with action taken May 30, 2006 by the Columbia River Compact.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-042-0022
Spring Chinook Gill Net and Tangle Net Fisheries

(1) Adipose fin-clipped chinook salmon, sturgeon and shad may be taken by gill net or tangle net for commercial purposes from the mouth of the Columbia River upstream to a line projected from deadline markers on

the Oregon and Washington banks, both such deadline markers located approximately five miles downstream from Bonneville Dam (Zones 1-5).

(a) Individual fishing periods will not exceed sixteen hours in length during small mesh fisheries and twenty-four hours in length during large mesh fisheries. Fishing periods may occur on Tuesdays and Thursdays, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) White sturgeon possession and sales restrictions by each participating vessel will be determined inseason based on gear type and number of fish remaining on the guideline.

(2) An adipose fin clip salmon is defined as a hatchery salmon with a clipped adipose fin and having a healed scar at the location of the fin. The adipose fin is the small fatty fin on salmonids located between the dorsal fin and tail.

(3) During the spring chinook gill net fishery:

(a) It is *unlawful* to use a gill net having a mesh size less than 8 inches or more than 9-3/4 inches. Use of monofilament nets is allowed.

(b) Mesh size for the fishery is determined as described in OAR 635-042-0010(4).

(c) From the area as described in section (1) of this rule, adipose fin-clipped chinook salmon, sturgeon and shad may be taken for commercial purposes by gill net during the following open period:

(A) 12:00 noon, February 23 to 6:00 a.m., February 24, 2006.

(B) 12:00 noon, March 2, 2006 to 12:00 noon, March 3, 2006.

(C) 6:00 a.m., March 7, 2006 to 6:00 a.m., March 8, 2006.

(D) 12:00 noon, March 9, 2006 to 6:00 a.m., March 10, 2006.

(E) 12:00 noon, March 14, 2006 to 6:00 a.m., March 15, 2006.

(F) 2:00 p.m., May 16, 2006 to 12:00 midnight, May 16, 2006.

(G) 7:00 p.m., May 18, 2006 to 7:00 a.m., May 19, 2006.

(H) 7:00 p.m., May 23, 2006 to 7:00 a.m., May 24, 2006.

(I) 7:00 p.m., May 25, 2006 to 7:00 a.m., May 26, 2006.

(J) 7:00 p.m., May 30, 2006 to 7:00 a.m., May 31, 2006.

(K) 7:00 p.m., June 1, 2006 to 7:00 a.m., June 2, 2006.

(4) A maximum of three sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) the fishery is open. The three sturgeon possession/sales limit includes both mainstem and Select Area fisheries.

(5) During the spring chinook tangle net fishery:

(a) It is *unlawful* to use other than a single-wall multi-filament net. Monofilament tangle nets are not allowed. Maximum mesh size is 4-1/4 inches stretched taut.

(b) Mesh size is determined by placing three consecutive meshes under hand tension and the measurement is taken from the inside of one vertical knot to the outside of the opposite vertical knot of the center mesh. Hand tension means sufficient linear tension to draw opposing knots of meshes into contact.

(6) Nets shall not exceed 900 feet (150 fathoms) in length. A red cork must be placed on the corkline every 25 fathoms as measured from the first mesh of the net. Red corks at 25-fathom intervals must be in color contrast to the corks used in the remainder of the net.

(7) On tangle nets, an optional use of a steelhead excluder panel of mesh may be hung between the corkline and the 4-1/4 inch maximum mesh size tangle net. The excluder panel web must be a minimum mesh size of 12 inches when stretched taut under hand tension. Monofilament mesh is allowed for the excluder panel. The excluder panel (including any associated hangings) must be a minimum of 5 linear feet in depth and not exceed 10 linear feet in depth, as measured from the corkline to the upper margin of the tangle net mesh as the net hangs naturally from a taut corkline. Weedlines or droppers (bobber-type) may be used in place of the steelhead excluder panel. A weedline-type excluder means the net is suspended below the corkline by lines of no less than five feet in length between the corkline and the upper margin of the tangle net. A dropper-type excluder means the entire net is suspended below the surface of the water by lines of no less than five feet in length extending from individual surface floats to a submersed corkline. The corkline cannot be capable of floating the net in its entirety (including the leadline) independent of the attached floats. Weedlines or droppers must extend a minimum of 5 feet above the 4-1/4 inch maximum mesh size tangle net.

(a) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, may extend to a maximum length of 1,050 feet (175 fathoms).

(b) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, along with a red cork every 25 fathoms as required in (5) above, must have two red corks at each end of the net.

(8) There are no restrictions on the hang ratio. The hang ratio is used to horizontally add slack to the net. The hang ratio is determined by the length of the web per length of the corkline.

(9) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(10) Nets shall be fished for no longer than 45 minutes per set. The time of fishing is measured from when the first mesh of the net is deployed into the water until the last mesh of the net is fully retrieved from the water.

(11) It is *unlawful* for a net in whole or in part to be anchored, tied, staked, fixed, or attached to the bottom, shore, or a beached boat; left unattended at any time it is fished; or attended by more than one boat while being fished.

(12) It is unlawful to fish more than one net from a licensed commercial fishing boat at any one time.

(13) Nets fished from sunset to sunrise shall have lighted buoys on both ends of the net unless the net is attached to the boat then one lighted buoy on the opposite end of the net from the boat is required.

(14) Non-legal sturgeon, nonadipose fin-clipped chinook salmon, and steelhead must be released immediately with care and the least possible injury to the fish to the river without violence or into an operating recovery box.

(a) One operating recovery box with two chambers or two operating recovery boxes with one chamber each to aid survival of released fish must be on board each fishing vessel participating in the fishery. Recovery boxes shall be operating during any time that a net is being retrieved or picked.

(b) All salmon and steelhead that are bleeding, in lethargic condition, or appearing dead must be placed in the recovery box for rehabilitation purposes prior to release to the river.

(c) Each chamber of the recovery box must meet the following dimensions as measured from within the box; the inside length measurement must be at or within 39-1/2 to 48 inches, the inside width measurement must be at or within 8 to 10 inches, and the inside height measurement must be at or within 14 to 16 inches.

(d) Each chamber of the recovery box must include an operating water pumping system capable of delivering a minimum flow of 16 gallons per minute not to exceed 20 gallons per minute of fresh river water into each chamber. The fisher must demonstrate to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers, upon request, that the pumping system is delivering the proper volume of fresh river water into each chamber.

(e) Each chamber of the recovery box must include a water inlet hole between 3/4 inch and 1 inch in diameter, centered horizontally across the door or wall of chamber and 1-3/4 inches from the floor of the chamber.

(f) Each chamber of the recovery box must include a water outlet that is at least 1-1/2 inches in diameter. The center of the outlet hole must be located a minimum of 12 inches above the floor of the box or chamber, on either the same or opposite end as the inlet.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(15) At least one fisher on each boat engaged in the fishery must have in possession a certificate issued by a representative of the Oregon Department of Fish and Wildlife (ODFW) or the Washington Department of Fish and Wildlife (WDFW) that indicates the fisher had attended a one-day workshop hosted by ODFW or WDFW to educate fishers on regulations and best methods for conduct of the selective fishery. No individual may obtain more than one certificate. The certificate must be displayed to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers upon request.

(16) Nothing in this section sets any precedent for any fishery after the 2006 spring chinook fishery. The fact that an individual may hold a selective fishery certificate in spring 2006 does not entitle the certificate holder to participate in any other fishery. If ODFW authorizes a selective fishery in spring 2007 or at any other time, ODFW may establish qualifications and requirements that are different from those established for 2006. In particular, ODFW may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future tangle net fisheries.

(17) As authorized by OAR 635-006-0140 owners or operators of commercial fishing vessels must cooperate with Department fishery observers, or observers collecting data for the Department, when asked by the Department to carry and accommodate an observer on fishing trips for observation and sampling during an open fishery.

(18) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, Lewis-B sanctuary, and Sandy River sanctuary are in effect during the open fishing periods identified.

Stat. Auth.: ORS 496.138, 496.146 & 506.119

Stats. Implemented: ORS 496.162, 506.129 & 507.030

Hist.: DFW 11-2004, f. & cert. ef. 2-13-04; DFW 12-2004(Temp), f. & cert. ef. 3-1-04, thru 7-31-04; DFW 13-2004(Temp), f. & cert. ef. 3-3-04 thru 7-31-04; DFW 16-2004(Temp), f. & cert. ef. 3-8-04 thru 7-31-04; DFW 18-2004(Temp), f. & cert. ef. 3-10-04 thru 7-31-04; DFW 20-2004(Temp) f. & cert. ef. 3-15-04 thru 7-31-04; DFW 21-2004(Temp), f. & cert. ef.

3-18-04 thru 7-31-04; DFW 25-2004(Temp), f. 3-22-04, cert. ef. 3-23-04 thru 7-31-04; DFW 26-2004(Temp), f. & cert. ef. 3-25-04 thru 7-31-04; DFW 27-2004(Temp), f. & cert. ef. 3-29-04 thru 7-31-04; Administrative correction 8-19-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 9-2005(Temp), f. & cert. ef. 3-1-05 thru 7-31-05; DFW 11-2005(Temp), f. 3-2-05, cert. ef. 3-3-05 & 7-31-05; DFW 13-2005(Temp), f. & cert. ef. 3-7-05 thru 7-31-05; DFW 14-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; DFW 20-2005(Temp), f. & cert. ef. 3-29-05 thru 3-30-05; DFW 21-2005(Temp), f. & cert. ef. 3-31-05 thru 4-1-05; Administrative correction, 4-20-05; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 7-2006(Temp), f. & cert. ef. 2-23-06 thru 7-31-06; DFW 9-2006(Temp), f. 3-1-06, cert. ef. 3-2-06 thru 7-31-06; DFW 10-2006(Temp), f. 3-6-06, cert. ef. 3-7-06 thru 7-31-06; DFW 11-2006(Temp), f. & cert. ef. 3-9-06 thru 7-31-06; DFW 12-2006(Temp), f. 3-13-06, cert. ef. 3-14-06 thru 7-31-06; DFW 29-2006(Temp), f. & cert. ef. 5-16-06 thru 7-31-06; DFW 30-2006(Temp), f. & cert. ef. 5-18-06 thru 7-31-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06

635-042-0110
Gary Island to Bonneville Dam Shad Season

(1) Shad may be taken for commercial purposes from the area of the Columbia River described in section (2) daily from 3:00 p.m. to 10:00 p.m. during the following open fishing periods: May 15, 2006 through May 19, 2006; May 22, 2006; May 24, 2006; May 26, 2006 and May 30, 2006 through June 2, 2006; June 5, 2006 through June 9, 2006; June 12, 2006 through June 16, 2006 and June 19, 2006 through June 23, 2006.

(2) The area of the Columbia River open to fishing is from a downstream boundary of a true north/south line through the flashing red 4-second Light "50" near the Oregon bank to an upstream boundary of a straight line from a deadline marker on the Oregon bank to a deadline marker on the Washington bank, both such deadline markers located approximately five miles downstream from Bonneville Dam.

(3) It is *unlawful* to use a gill net having a mesh size less than 5-3/8 inches or more than 6-1/4 inches with a breaking strength greater than a 10-pound pull, or to use a gill net other than a single wall floater net, or to use a gill net having slackers, or to use a gill net of more than 150 fathoms in length or 40 meshes in depth. Rip lines are authorized spaced not closer than 20 corks apart.

(4) Salmon nets are not permitted on board a vessel participating in the above fishery.

(5) All salmon, steelhead, walleye and sturgeon taken in shad nets must be immediately returned unharmed to the water.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: FWC 85, f. & ef. 1-28-77; FWC 116(Temp), f. & ef. 6-1-77 thru 6-3-77; FWC 124(Temp), f. & ef. 6-17-77 thru 10-14-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 27-1978(Temp), f. & ef. 5-26-78 thru 9-22-78; FWC 2-1979, f. & ef. 1-25-79, Renumbered from 635-035-0275; FWC 6-1980, f. & ef. 1-28-80; FWC 25-1980(Temp), f. & ef. 6-13-80; FWC 1-1981, f. & ef. 1-19-81; FWC 18-1981(Temp), f. & ef. 6-10-81; FWC 6-1982, f. & ef. 1-28-82; FWC 36-1982 (Temp), f. & ef. 6-11-82; FWC 2-1983, f. 1-21-83, ef. 2-1-83; FWC 21-1983(Temp), f. & ef. 6-10-83; FWC 4-1984, f. & ef. 1-31-84; FWC 2-1985, f. & ef. 1-30-85; FWC 19-1985, f. & ef. 5-1-85; FWC 4-1986(Temp), f. & ef. 1-28-86; FWC 16-1986 (Temp), f. & ef. 5-23-86; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 23-1987(Temp), f. & ef. 5-20-87; FWC 10-1988, f. & cert. ef. 3-4-88; FWC 5-1989, f. 2-6-89, cert. ef. 2-7-89; FWC 15-1990(Temp), f. 2-8-90, cert. ef. 2-9-90; FWC 20-1990, f. 3-6-90, cert. ef. 3-15-90; FWC 10-1991, f. 2-7-91, cert. ef. 2-8-91; FWC 8-1992, f. & cert. ef. 2-11-92; FWC 34-1992(Temp), f. 5-19-92, cert. ef. 5-20-92; FWC 11-1993, f. 2-11-93, cert. ef. 2-16-93; FWC 9-1994, f. 2-14-94, cert. ef. 2-15-94; FWC 15-1995, f. & cert. ef. 2-15-95; FWC 6-1996, f. & cert. ef. 2-7-96; FWC 4-1997, f. & cert. ef. 1-30-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 36-2000(Temp), f. 6-28-00, cert. ef. 6-28-00 thru 7-1-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 39-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 45-2005(Temp), f. 5-17-05, cert. ef. 5-23-05 thru 10-16-05; DFW 63-2005(Temp), f. & cert. ef. 6-29-05 thru 7-31-05; Administrative correction 11-18-05; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06

635-042-0145
Youngs Bay Salmon Season

(1) Salmon, sturgeon, and shad may be taken for commercial purposes in those waters of Youngs Bay except for the period from 7:00 p.m. Tuesday May 30, 2006 through midnight Saturday June 3, 2006 when only adipose fin-clipped spring Chinook salmon, sturgeon, and shad may be taken.

(a) The open fishing periods are established in three segments categorized as the winter fishery, paragraph (A), the spring fishery, paragraph (B), and summer fishery, paragraph (C), as follows:

(A) Winter Season:

(i) 6:00 p.m. February 15, 2006 to 6:00 a.m. February 16, 2006; 6:00 p.m. February 19, 2006 to 12 Noon February 20, 2006; 6:00 p.m. February 22, 2006 to 6:00 a.m. February 23, 2006; 6:00 p.m. February 26, 2006 to 12 Noon February 27, 2006; 6:00 p.m. March 1, 2006 to 6:00 a.m. March 2, 2006; 6:00 p.m. March 5, 2006 to 12 Noon March 6, 2006; 6:00 p.m. March 8, 2006 to 12 Noon March 9, 2006 and 6:00 p.m. March 12, 2006 to 6:00 a.m. March 13, 2006.

(ii) March 16, 2006 from 6:00 a.m. to 10:00 a.m. and March 23, 2006 from 12 noon to 4:00 p.m.

(iii) March 27, 2006 from 6:00 a.m. to 6:00 p.m.; March 30, 2006 from 6:00 a.m. to 8:00 p.m.; April 3, 2006 from 6:00 a.m. to 8:00 p.m.; April 6, 2006 from 6:00 a.m. to 8:00 p.m.; April 10, 2006 from 6:00 a.m. to 8:00 p.m. and April 13, 2006 from 6:00 a.m. to 8:00 p.m.

(B) Spring Season:

(i) April 17, 2006 from 9:00 a.m. to 1:00 p.m.

(ii) 6:00 p.m. April 20, 2006 to 6:00 a.m. April 21, 2006; 6:00 p.m. April 24, 2006 to 6:00 a.m. April 25, 2006; 6:00 p.m. April 27, 2006 to 6:00 a.m. April 28, 2006; 6:00 p.m. May 1, 2006 to 12 Noon May 2, 2006; 6:00 p.m. May 4, 2006 to 12 Noon May 5, 2006; 12 Noon May 8, 2006 to 12 Noon May 12, 2006; 12 Noon May 15, 2006 to 12 Noon May 19, 2006; 12 Noon May 22, 2006 to 12 Noon May 26, 2006; 12 Noon May 29, 2006 to 12 Noon June 2, 2006; 12 Noon June 5, 2006 to 12 Noon June 9, 2006 and 12 Noon June 13, 2006 to 12 Noon June 16, 2006.

(C) Summer Season: 12 Noon June 21, 2006 to 12 Noon June 23, 2006; 12 Noon June 28, 2006 to 12 Noon June 30, 2006; 12 Noon July 5, 2006 to 6:00 p.m. July 6, 2006; 12 Noon July 12, 2006 to 6:00 p.m. July 13, 2006; 12 Noon July 19, 2006 - 6:00 p.m. July 20, 2006 and 12 Noon July 26, 2006 to 6:00 p.m. July 27, 2006.

(b) The fishing areas for the winter, spring and summer fisheries are:

(i) From February 15, 2006 through March 23, 2006 and from April 20, 2006 through July 27, 2006, the fishing area is identified as the waters of Youngs Bay from the Highway 101 Bridge upstream to the upper boundary markers at the confluence of the Klaskanine and Youngs rivers; except for those waters which are closed southerly of the alternate Highway 101 Bridge (Lewis and Clark River).

(ii) On April 17, 2006, the fishing area extends from old Youngs Bay Bridge upstream to the confluence of the Youngs and Klaskanine rivers.

(iii) From March 27, 2006 through April 13, 2006 the fishing area extends from markers directly under the first power lines downstream of the Walluski River to the confluence of the Youngs and Klaskanine rivers.

(2) Gill nets may not exceed 1,500 feet (250 fathoms) in length and weight may not exceed two pounds per any fathom. A red cork must be placed on the corkline every 25 fathoms as measured from the first mesh of the net. Red corks at 25-fathom intervals must be in color contrast to the corks used in the remainder of the net. Monofilament gillnets are allowed.

(a) It is *unlawful* to use a gill net having a mesh size that is less than 7-inches during the winter season from February 15, 2006 to April 13, 2006. It is unlawful to use a gill net having a mesh size that is more than 8-inches during the spring and summer seasons from April 17, 2006 to July 27, 2006.

(b) In the fishing area, as described in (1)(b)(iii), the use of additional weights or anchors attracted directly to the leadline is allowed upstream of the mouth of the Walluski River.

(c) Retention of non-adipose fin-clipped spring Chinook is prohibited from 2:00 p.m. Tuesday May 16, 2006 through Sunday May 21, 2006

(3) A maximum of three green or white sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fisheries are open. During the fishing periods identified in (1)(a)(A),(1)(a)(B) and (1)(a)(C), the weekly aggregate sturgeon limit applies to possessions and sales in the Youngs Bay fishery and other open Select Area fisheries.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: FWC 32-1979, f. & ef. 8-22-79; FWC 28-1980, f. & ef. 6-23-80; FWC 42-1980(Temp), f. & ef. 8-22-80; FWC 30-1981, f. & ef. 8-14-81; FWC 42-1981(Temp), f. & ef. 11-5-81; FWC 54-1982, f. & ef. 8-17-82; FWC 37-1983, f. & ef. 8-18-83; FWC 61-1983(Temp), f. & ef. 10-19-83; FWC 42-1984, f. & ef. 8-20-84; FWC 39-1985, f. & ef. 8-15-85; FWC 37-1986, f. & ef. 8-11-86; FWC 72-1986(Temp), f. & ef. 10-31-86; FWC 64-1987, f. & ef. 8-7-87; FWC 73-1988, f. & cert. ef. 8-19-88; FWC 55-1989(Temp), f. 8-7-89, cert. ef. 8-20-89; FWC 82-1990(Temp), f. 8-14-90, cert. ef. 8-19-90; FWC 86-1991, f. 8-7-91, cert. ef. 8-18-91; FWC 123-1991(Temp), f. & cert. ef. 10-21-91; FWC 30-1992(Temp), f. & cert. ef. 4-27-92; FWC 35-1992(Temp), f. 5-22-92, cert. ef. 5-25-92; FWC 74-1992 (Temp), f. 8-10-92, cert. ef. 8-16-92; FWC 28-1993(Temp), f. & cert. ef. 4-26-93; FWC 48-1993, f. 8-6-93, cert. ef. 8-9-93; FWC 21-1994(Temp), f. 4-22-94, cert. ef. 4-25-94; FWC 51-1994, f. 8-19-94, cert. ef. 8-22-94; FWC 64-1994(Temp), f. 9-14-94, cert. ef. 9-15-94; FWC 66-1994(Temp), f. & cert. ef. 9-20-94; FWC 27-1995, f. 3-29-95, cert. ef. 4-1-95; FWC 48-1995(Temp), f. & cert. ef. 6-5-95; FWC 66-1995, f. 8-22-95, cert. ef. 8-27-95; FWC 69-1995, f. 8-25-95, cert. ef. 8-27-95; FWC 8-1995, f. 2-28-96, cert. ef. 3-1-96; FWC 37-1996(Temp), f. 6-11-96, cert. ef. 6-12-96; FWC 41-1996, f. & cert. ef. 8-12-96; FWC 45-1996(Temp), f. 8-16-96, cert. ef. 8-19-96; FWC 54-1996(Temp), f. & cert. ef. 9-23-96; FWC 4-1997, f. & cert. ef. 1-30-97; FWC 47-1997, f. & cert. ef. 8-15-97; DFW 8-1998(Temp), f. & cert. ef. 2-5-98 thru 2-28-98; DFW 14-1998, f. & cert. ef. 3-3-98; DFW 18-1998(Temp), f. 3-9-98, cert. ef. 3-11-98 thru 3-31-98; DFW 60-1998(Temp), f. & cert. ef. 8-7-98 thru 8-21-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 52-1999(Temp), f. & cert. ef. 8-2-99 thru 8-6-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 66-2001(Temp), f. 8-2-01, cert. ef. 8-6-01 thru 8-14-01; DFW 76-2001(Temp), f. & cert. ef. 8-20-01 thru 10-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 82-2002(Temp), f. 8-5-02, cert. ef. 8-7-02 thru 9-1-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 17-2003(Temp), f. 2-27-03, cert. ef. 3-1-03 thru 8-1-03; DFW 32-2003(Temp),

f. & cert. ef. 4-23-03 thru 8-1-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 37-2003(Temp), f. & cert. ef. 5-7-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04; DFW 22-2004(Temp), f. & cert. ef. 3-18-04 thru 3-31-04; DFW 28-2004(Temp), f. 4-8-04 cert. ef. 4-12-04 thru 4-15-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 15-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 46-2005(Temp), f. 5-17-05, cert. ef. 5-18-05 thru 10-16-05; DFW 73-2005(Temp), f. 7-8-05, cert. ef. 7-11-05 thru 7-31-05; DFW 77-2005(Temp), f. 7-14-05, cert. ef. 7-18-05 thru 7-31-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 14-2006(Temp), f. 3-15-06, cert. ef. 3-16-06 thru 7-27-06; DFW 15-2006(Temp), f. & cert. ef. 3-23-06 thru 7-27-06; DFW 17-2006(Temp), f. 3-29-06, cert. ef. 3-30-06 thru 7-27-06; DFW 29-2006(Temp), f. & cert. ef. 5-16-06 thru 7-31-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06

635-042-0160
Blind Slough and Knappa Slough Select Area Salmon Season

(1) Salmon, sturgeon, and shad may be taken for commercial purposes during open fishing periods described as the winter fishery and the spring fishery in paragraphs (1)(a)(A) or (1)(a)(B) of this rule in those waters of Blind Slough and Knappa Slough except for the period from 7:00 p.m. Tuesday May 30, 2006 through midnight Saturday June 3, 2006 when only adipose fin-clipped spring Chinook salmon, sturgeon, and shad may be taken. The following restrictions apply:

(a) The open fishing periods are established in segments categorized as the winter fishery in Blind Slough only in paragraph (A), and the spring fishery in Blind Slough and Knappa Slough in paragraph (B). The seasons are open nightly from 7:00 p.m. to 7:00 a.m. the following morning (12 hours), as follows:

(A) Blind Slough Only: February 22–February 23, 2006; February 26 – February 27, 2006; March 1 – March 2, 2006; March 5 – March 6, 2006; March 8 – March 9, 2006; March 12 – March 13, 2006; March 19 – March 20, 2006; March 22 – March 23, 2006; March 26 – March 27, 2006; March 29 – March 30, 2006; April 2 – April 3, 2006; April 5 – April 6, 2006; April 9 – April 10, 2006; and April 12 – April 13, 2006.

(B) Blind and Knappa Sloughs:

(i) April 20 – April 21, 2006; April 24 – April 25, 2006 and April 27 – April 28, 2006;

(ii) May 1 – May 2, 2006; May 4 – May 5, 2006; May 8 – May 9, 2006; May 11 – May 12, 2006;

May 15 –May 16, 2006; May 18 – May 19, 2006; May 22 – May 23, 2006; May 25 – May 26, 2006;

May 29 – May 30, 2006; June 1 – June 2, 2006; June 5 – June 6, 2006; June 8 – June 9, 2006; June 12 – June 13, 2006 and June 15 –June 16, 2006.

(b) The fishing areas for the winter and springs seasons are:

(i) Blind Slough are those waters adjoining the Columbia River which extend from markers at the mouth of Blind Slough upstream to markers at the mouth of Gnat Creek which is located approximately 1/2 mile upstream of the county road bridge.

(ii) Knappa Slough are all waters bounded by a line from the northerly most marker at the mouth of Blind Slough westerly to a marker on Karlson Island downstream to a north-south line defined by a marker on the eastern end of Minaker Island to markers on Karlson Island and the Oregon shore.

(iii) During the periods identified in (1)(a)(B)(i), the Knappa Slough fishing area extends downstream to the boundary lines defined by markers on the west end of Minaker Island to markers on Karlson Island and the Oregon shore.

(c) Gear restrictions are as follows:

(A) During the winter fishery, outlined above (1)(a)(A), gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. The attachment of additional weight and anchors directly to the lead line is permitted. Monofilament gill nets are allowed. It is unlawful to use a gill net having a mesh size that is less than 7- inches;

(B) During the spring fishery, outlined above (1)(a)(B) and (1)(a)(C), gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. The attachment of additional weight and anchors directly to the lead line is permitted. Monofilament gill nets are allowed. It is unlawful to use a gill net having a mesh size that is more than 8-inches.

(2) A maximum of three 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 (1)(a)(A), (1)(a)(B) and (1)(a)(C), the weekly aggregate sturgeon limit applies to possessions and sales in the Youngs Bay fishery and other open Select Area fisheries.

(3) Oregon licenses are required in the open waters upstream from the railroad bridge.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998(Temp), f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 65-2000(Temp) f. 9-22-00, cert. ef. 9-25-00 thru 12-31-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 86-2001, f. & cert. ef. 9-4-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 14-2002(Temp), f. 2-13-02, cert. ef. 2-18-02 thru 8-17-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04; DFW 22-2004(Temp), f. & cert. ef. 3-18-04 thru 3-31-04; DFW 28-2004(Temp), f. 4-8-04 cert. ef. 4-12-04 thru 4-15-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp), f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 16-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 14-2006(Temp), f. 3-15-06, cert. ef. 3-16-06 thru 7-27-06; DFW 16-2006(Temp), f. 3-23-06 & cert. ef. 3-26-06 thru 7-27-06; DFW 18-2006(Temp), f. 3-29-06, cert. ef. 4-2-06 thru 7-27-06; DFW 20-2006(Temp), f. 4-7-06, cert. ef. 4-9-06 thru 7-27-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06

635-042-0180
Deep River Select Area Salmon Season

(1) Salmon, shad, and sturgeon may be taken for commercial purposes from the US Coast Guard navigation marker #16 upstream to the Highway 4 Bridge except for the period from 7:00 p.m. Tuesday May 30, 2006 through midnight Saturday June 3, 2006 when only adipose fin-clipped spring Chinook salmon, sturgeon, and shad may be taken.

(2) The fishing seasons are open:

(a) Winter season: nightly from 6:00 p.m. to 8:00 a.m. the following morning (14 hours), February 20 – February 21, 2006; February 27 – February 28, 2006; March 6 – March 7, 2006 and March 13 – March 14, 2006.

(b) Spring season: nightly from 7:00 p.m. to 7:00 a.m. the following morning (12 hours), April 17 – April 18, 2006; April 20 – April 21, 2006; April 24 – April 25, 2006; April 27 – April 28, 2006; May 1 – May 2, 2006; May 4 – May 5, 2006; May 8 – May 9, 2006; May 11 – May 12, 2006; May 15 – May 16, 2006; May 18 – May 19, 2006; May 22 – May 23, 2006; May 25 – May 26, 2006; May 29 – May 30, 2006; June 1 – June 2, 2006; June 5 – June 6, 2006; June 8 – June 9, 2006; June 12 – June 13, 2006 and June 15 – June 16, 2006.

(3) Gill nets may not exceed 100 fathoms in length and there is no weight limit on the lead line. The attachment of additional weight and anchors directly to the lead line is permitted. Monofilament gill nets are allowed. Nets may not be tied off to stationary structures and may not fully cross navigation channel.

(a) During the winter season, outlined above (2)(a), it is unlawful to use a gill net having a mesh size that is less than 7- inches;

(b) During the spring season, outlined above (2)(b) it is unlawful to use a gill net having a mesh size that is more than 8-inches.

(4) A maximum of three 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 (2)(a) and (2)(b), the weekly aggregate sturgeon limit applies to possessions and sales in the Youngs Bay fishery and other open Select Area fisheries.

Stat. Auth.: ORS 183.325, 506.109 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thru 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 19-2003(Temp), f. 3-12-03, cert. ef. 4-17-03 thru 6-13-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 39-2004(Temp), f. 5-5-04, cert.ef. 5-6-04 thru 7-31-04; DFW 44-2004(Temp),

f. 5-17-04, cert. ef. 5-20-04 thru 7-31-04; DFW 79-2004(Temp), f. 8-2-04, cert. ef. 8-3-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 109-2004(Temp), f. & cert. ef. 10-19-04 thru 12-31-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 27-2005(Temp), f. & cert. ef. 4-20-05 thru 6-15-05; DFW 28-2005(Temp), f. & cert. ef. 4-28-05 thru 6-16-05; DFW 37-2005(Temp), f. & cert. ef. 5-5-05 thru 10-16-05; DFW 40-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 109-2005(Temp), f. & cert. ef. 9-19-05 thru 12-31-05; DFW 110-2005(Temp), f. & cert. ef. 9-26-05 thru 12-31-05; DFW 116-2005(Temp), f. 10-4-05, cert. ef. 10-5-05 thru 12-31-05; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; DFW 124-2005(Temp), f. & cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-20-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06

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Rule Caption: Modifications to the Pacific Lamprey Harvest season in the Willamette River.
Adm. Order No.: DFW 36-2006(Temp)
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 6-1-06 thru 9-30-06
Notice Publication Date:
Rules Amended: 635-017-0090
Subject: This rule implements modifications to the Pacific Lamprey Harvest season in the Willamette River.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-017-0090
Inclusions and Modifications

(1) The **2006 Oregon Sport Fishing Regulations** provide requirements for the Willamette 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 2006 Oregon Sport Fishing Regulations.

(2) Pacific Lamprey Harvest:

(a) Pursuant to OAR 635-044-0130(1)(b), authorization from the Oregon Fish and Wildlife Commission must be in possession by individuals collecting or possessing Pacific lamprey for personal use. Permits are available from ODFW, 17330 SE Evelyn Street, Clackamas, OR 97015;

(b) Open fishing period is June 1 through August 31 from 7:00 A.M. to 6:00 P.M.; personal use harvest is permitted Friday through Monday each week. All harvest is prohibited Tuesday through Thursday;

(c) Open fishing area is the Willamette River at Willamette Falls on the east side of the falls only, excluding Horseshoe Area at the peak of the falls;

(d) Gear is restricted to hand or hand-powered tools only;

(e) No permit holder shall harvest more than one hundred (100) lamprey during each lamprey season;

(f) Catch must be recorded daily on a harvest record card prior to leaving the open fishing area. Harvest record cards will be provided by ODFW. All harvest record cards must be returned to the ODFW Clackamas office by September 30 to report catch. Permit holders who do not return the harvest record cards by September 30 will be ineligible to receive a permit in the following year.

(g) Harvesters must allow sampling or enumeration of catches by ODFW personnel.

[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 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 3-1994, f. 1-25-94, cert. ef. 1-26-94; FWC 65-1994(Temp), f. 9-15-94, cert. ef. 9-17-94; FWC 86-1994(Temp), f. 10-31-94, cert. ef. 11-1-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 32-1995, f. & cert. ef. 4-24-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 14-1996, f. 3-29-96, cert. ef. 4-1-96; FWC 20-1996, f. & cert. ef. 4-29-96; FWC 22-1996(Temp), f. 5-9-96 & cert. ef. 5-10-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 5-1997, f. & cert. ef. 2-4-97; FWC 13-1997, f. 3-5-97, cert. ef. 3-11-97; FWC 17-1997(Temp), f. 3-19-97, cert. ef. 4-1-97; FWC 24-1997(Temp), f. & cert. ef. 4-10-97; FWC 31-1997(Temp), f. 5-14-97, cert. ef. 5-15-97; FWC 39-1997(Temp), f. 6-17-97, cert. ef. 6-18-97; FWC 69-1997, f. & cert. ef. 11-6-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 19-1998, f. & cert. ef. 3-12-98; DFW 28-1998(Temp), f. & cert. ef. 4-9-98 thru 4-24-98; DFW 31-1998(Temp), f. & cert. ef. 4-24-98 thru 7-31-98; DFW 33-1998(Temp), f. & cert. ef. 4-30-98 thru 5-15-98; DFW 34-1998, f. & cert. ef. 5-4-98; DFW 35-1998(Temp), f. & cert. ef. 5-10-98 thru 5-15-98; DFW 37-1998(Temp), f. & cert. ef. 5-15-98 thru 7-31-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 15-1999, f. & cert. ef. 3-9-99; DFW 16-1999(Temp), f. & cert. ef. 3-10-99 thru 3-19-99; DFW 19-1999(Temp), f. & ef. 3-19-99 thru 4-15-99; DFW 27-1999(Temp), f. & cert. ef. 4-23-99 thru 10-20-99; DFW 30-1999(Temp), f. & cert. ef. 4-27-99 thru 5-12-99; DFW 35-1999(Temp), f. & cert. ef. 5-13-99 thru 7-31-99; DFW 39-1999(Temp), f. 5-26-99, cert. ef. 5-27-99 thru 7-31-99; DFW 78-1999, f. & cert. ef. 10-4-99; DFW 88-1999(Temp), f. 11-5-99, cert. ef. 11-6-99 thru 11-30-99; administrative correction 11-17-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 13-2000, f. & cert. ef. 3-20-00; DFW 22-2000, f. 4-14-00, cert. ef. 4-16-00 thru 7-31-00; DFW 23-2000(Temp), f. 4-19-00, cert. ef. 4-22-00 thru 7-31-00; DFW 58-2000(Temp), f. & cert. ef. 9-1-00 thru 12-31-00; 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 6-2001, f. & cert. ef. 3-1-01; DFW 23-2001(Temp), f. & cert. ef. 4-23-01 thru 10-19-01; DFW 28-2001, f. & cert. ef. 5-1-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 46-2001(Temp) f. 6-8-01, cert. ef. 6-16-01 thru 12-13-01; DFW 70-2001, f. & cert. ef. 8-10-01; DFW 72-2001(Temp), f. 8-10-01, cert. ef. 8-16-01 thru 12-31-01; DFW 90-2001(Temp), f. 9-14-01, cert. ef. 9-15-01 thru 12-31-01; DFW 95-2001(Temp), f. 9-27-01, cert. ef. 10-20-01 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 42-2002, f. & cert. ef. 5-3-02; DFW 44-2002(Temp), f. 5-7-02, cert. ef. 5-8-02 thru 11-3-02; DFW 70-2002(Temp), f. 7-10-02 cert ef. 7-12-02 thru 12-31-02; 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 16-2003(Temp), f. 2-27-03, cert. ef. 3-1-03 thru 7-1-03; DFW 42-2003, f. & cert. ef. 5-16-03; DFW 53-2003(Temp), f. 6-17-03, cert. ef. 6-18-03 thru 12-14-03; DFW 57-2003(Temp), f. & cert. ef. 7-8-03 thru 12-31-03; DFW 59-2003(Temp), f. & cert. ef. 7-11-03 thru 12-31-03; DFW 70-2003(Temp), f. & cert. ef. 7-23-03 thru 12-31-03; DFW 71-2003(Temp), f. 7-24-03, cert. ef. 7-25-03 thru 12-31-03; DFW 90-2003(Temp), f. 9-12-03 cert. ef. 9-13-03 thru 12-31-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 33-2004, f. 4-22-04, cert ef. 5-1-04; DFW 48-2004(Temp), f. 5-26-04, cert. ef. 5-28-04 thru 11-23-04; DFW 69-2004(Temp), f. & cert. ef. 7-12-04 thru 11-23-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 24-2005, f. 4-15-05, cert. ef. 5-1-05; DFW 78-2005(Temp), f. 7-19-05, cert. ef. 7-21-05 thru 7-22-05; Administrative correction 8-17-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 36-2006(Temp), f. & cert. ef. 6-1-06 thru 9-30-06

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Rule Caption: Modifications to the Southwest Zone Chinook salmon regulations for the Rogue River.
Adm. Order No.: DFW 37-2006(Temp)
Filed with Sec. of State: 6-2-2006
Certified to be Effective: 6-5-06 thru 12-1-06
Notice Publication Date:
Rules Amended: 635-016-0090
Subject: The Rogue River spring chinook run count at Gold Ray Dam is currently at 22% of the recent 10-year average. The total return of wild fish in 2006 will likely fall below the draft conservation status level of 3,500 wild spring chinook. Evaluation of factors affecting Rogue River spring chinook run timing by District staff shows no indication that this year's run is delayed. And, a lack of fish in the lower river fishery indicates a low number of spring chinook returning to the Rogue River this year. This rule reduces angling impacts for wild spring chinook salmon while maximizing spawning escapement, allows for opportunities to harvest hatchery spring chinook, and provides opportunities for harvest of the more abundant fall chinook.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-016-0090
Inclusions and Modifications

(1) The **2006 Oregon Sport Fishing Regulations** provide requirements for the Southwest 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 **2006 Oregon Sport Fishing Regulations**.

(2) Diamond Lake is open April 22 – May 12, 5 trout per day, 2 daily limits in possession, 8-inch minimum length, only 1 trout over 20-inches in length may be taken per day, per zone regulations.

(3) Diamond Lake is open May 13 – Sept. 4, 20 trout per day, 2 daily limits in possession. No harvest restrictions on trout length.

(4) Diamond Lake is closed after Sept. 4.

(5) Rogue River, tidewater upstream to Hog Creek boat landing:

(a) Mouth upstream to Whiskey Creek:

(A) From 12:01 a.m. June 5 thru July 14, 2006 only adipose fin-clipped Chinook salmon may be retained.

(B) From July 15 thru December 31, 2006 Oregon Sport Fishing Regulations for Southwest Zone apply.

(b) Whiskey Creek upstream to Hog Creek boat landing:

(A) From 12:01 a.m. June 5 thru July 31, 2006 only adipose fin-clipped Chinook salmon may be retained.

(B) From August 1 thru December 31, 2006 Oregon Sport Fishing Regulations for Southwest Zone apply.

(6) Rogue River, Hog Creek boat landing to Gold Ray Dam:

(a) From 12:01 a.m. June 5 thru August 14, 2006 only adipose fin-clipped Chinook salmon may be retained.

(b) From August 15 thru September 30, 2006 Oregon Sport Fishing Regulations for Southwest Zone apply.

(7) Rogue River, from Gold Ray Dam to Cole Rivers Hatchery Diversion Dam:

(a) Gold Ray Dam to the Rogue Elk boat ramp:

(A) From 12:01 a.m. June 5 thru June 30, 2006 only adipose fin-clipped Chinook salmon may be retained.

(B) Closed to retention of Chinook salmon from July 1 thru October 31, 2006.

(b) Rogue Elk boat ramp to Cole Rivers Hatchery diversion dam:

(A) From 12:01 a.m. June 5 thru July 31 only adipose fin-clipped Chinook salmon may be retained.

(B) Closed to retention of Chinook salmon August 1 thru October 31, 2006.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138 & 496.146
Stats. Implemented: ORS 496.162
Hist.: FWC 80-1993(Temp), f. 12-21-93, cert. ef. 1-1-94; FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 31-1994, f. 5-26-94, cert. ef. 6-20-94; FWC 79-1994(Temp), f. 10-21-94, cert. ef. 7-22-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 34-1995, f. & cert. ef. 5-1-95; FWC 57-1995(Temp), f. 7-3-95, cert. ef. 7-4-95; FWC 59-1995(Temp), f. 7-24-95, cert. ef. 8-1-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 82-1995(Temp), f. 9-29-95, cert. ef. 10-1-95; FWC 90-1995(Temp), f. 11-29-95, cert. ef. 1-1-96; FWC 20-1996, f. & cert. ef. 4-29-96; FWC 52-1996, f. & cert. ef. 9-11-96; FWC 61-1996, f. & cert. ef. 10-9-96; 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 17-1997(Temp), f. 3-19-97, cert. ef. 4-1-97; FWC 32-1997(Temp), f. & cert. ef. 5-23-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 24-1998(Temp), f. & cert. ef. 3-25-98 thru 9-15-98; DFW 34-1998, f. & cert. ef. 5-4-98; DFW 52-1998(Temp), f. 7-10-98, cert. ef. 7-11-98 thru 7-24-98; DFW 55-1998(Temp), f. & cert. ef. 7-24-98 thru 12-31-98; DFW 70-1998, f. & cert. ef. 8-28-98; 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 48-2000(Temp), f. 8-14-00, cert. ef. 8-15-00 thru 12-31-00; 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 8-2001, f. & cert. ef. 3-5-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 42-2001(Temp), f. 5-25-01, cert. ef. 5-29-01 thru 7-31-01; DFW 70-2001, f. & cert. ef. 8-10-01; DFW 72-2001(Temp), f. 8-10-01, cert. ef. 8-16-01 thru 12-31-01; DFW 90-2001(Temp), f. 9-14-01, cert. ef. 9-15-01 thru 12-31-01; DFW 97-2001(Temp), f. 10-4-01, cert. ef. 11-1-01 thru 12-31-01; DFW 105-2001(Temp), f. 10-26-01, cert. ef. 11-1-01 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 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 55-2002(Temp), f. 5-28-02, cert. ef. 7-1-02 thru 11-31-02; 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 124-2002(Temp), f. & cert. ef. 10-30-02 thru 12-31-02 (Suspended by DFW 125-2002(Temp), f. 11-8-02, certe. ef. 11-9-2002); DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 90-2003(Temp), f. 9-12-03 cert. ef. 9-13-03 thru 12-31-03; 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 127-2004, f. 12-22-04, cert. ef. 1-1-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 24-2006(Temp), f. 4-25-06, cert. ef. 5-13-06 thru 10-31-06; DFW 37-2006(Temp), f. 6-2-06, cert. ef. 6-5-06 thru 12-1-06

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Rule Caption: Amended Cougar Management Plan and associated administrative rules.
Adm. Order No.: DFW 38-2006
Filed with Sec. of State: 6-6-2006
Certified to be Effective: 6-6-06
Notice Publication Date: 1-1-06
Rules Amended: 635-180-0001, 635-180-0015
Rules Repealed: 635-180-0005, 635-180-0010
Subject: Rules were amended in regards to the Cougar Management Plan. Revisions were made to both the Plan and the associated administrative rules.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-180-0001
Cougar Management Plan Content and Purpose

The **2006 Oregon Cougar Management Plan** establishes state policy and direction for Oregon's cougar management program. The 2006 Plan replaces previous plans. Chapters V (Cougar Management Objectives) and VI (Adaptive Management Process) of that 2006 Plan, as well as its **Appendix I** (Glossary), are incorporated here by reference as administrative rule. Copies may be obtained at the Salem headquarters office of the Oregon Department of Fish and Wildlife, 3406 Cherry Avenue NE, Salem, OR 97303. The 2006 Plan also serves as an informational and historical document for the Department.

[Publications: Publications referenced are available from the agency.]
[Appendix 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 108-1987, f. & ef. 12-28-87; FWC 26-1993, f. & cert. ef. 3-31-93; DFW 38-2006, f. & cert. ef. 6-6-06

635-180-0015
Five Year Review

The Cougar Management Plan will be updated and reviewed by the Oregon Fish and Wildlife Commission by April, 2011.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 108-1987, f. & ef. 12-28-87; FWC 118-1992, f. & cert. ef. 10-28-927; FWC 26-1993, f. & cert. ef. 3-31-93; DFW 38-2006, f. & cert. ef. 6-6-06

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Rule Caption: Allowable sale of fish caught during Tribal Treaty platform fishery in the Columbia River.
Adm. Order No.: DFW 39-2006(Temp)
Filed with Sec. of State: 6-8-2006
Certified to be Effective: 6-8-06 thru 7-31-06
Notice Publication Date:
Rules Amended: 635-041-0076
Subject: This rule allows sales of fish caught in a Tribal Treaty platform fishery in the Columbia River. Implementation is consistent with actions taken June 7, 2006 by the Columbia River Compact.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-041-0076
Summer Salmon Season

(1) Commercial sale of platform and hook-and-line caught fish from Zone 6 of the mainstem Columbia River is allowed beginning 6:00 a.m., Thursday, June 8, 2006 until further notice.

(a) Gear is restricted to subsistence fishing gear: hoopnets, dipnets, and rod and reel with hook-and-line.

(b) Allowable sales include chinook, coho, steelhead, walleye, carp, and shad. Sockeye may be retained but not sold.

(c) Sturgeon may not be sold. However, sturgeon between 4 feet and 5 feet in length from The Dalles and John Day pools may be kept for subsistence use. Sturgeon from the Bonneville Pool between 45 inches and 60 inches in length may be kept for subsistence use.

(d) Closed areas as set forth in OAR 635-041-0020.

(2) Sale of fish caught in the Klickitat River, Wind River, Drano Lake and Big White Salmon River is allowed beginning 6:00 a.m., Thursday, June 8, 2006, during those days and hours when the tributaries are open under lawfully enacted tribal fishing periods.

Stat. Auth.: ORS 496.118, 506.119
Stats. Implemented: ORS 506.109, 506.129, 507.030
Hist.: DFW 5-2006, f. & cert. ef. 2-15-06; DFW 39-2006(Temp), f. & cert. ef. 6-8-06 thru 7-31-06

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Rule Caption: Procedures to Suspend or Revoke Licenses.
Adm. Order No.: DFW 40-2006
Filed with Sec. of State: 6-9-2006
Certified to be Effective: 6-9-09
Notice Publication Date: 5-1-06
Rules Amended: 635-001-0210, 635-001-0215
Subject: Amended rules relating to the procedures for suspending or revoking licenses under the Wildlife Violator Compact.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-001-0210
Standard for License Suspension or Revocation

(1)(a) Upon receipt of the following information from a party state to the Compact, the Director shall initiate license suspension proceedings in accordance with OAR 635-01-215:

(b) That a person has failed to comply with the terms of a citation from the licensing authority of a party state. Such suspension shall remain in effect until the Director receives adequate evidence of compliance with the citation.

(2) Upon receipt of the following information from a party state to the Compact, the Director or Commission may initiate license suspension or revocation proceedings as appropriate in accordance with OAR 635-01-215.

(a) That a person has had his or her license privileges suspended or revoked in a party state for an offense which could have been the basis for suspension or revocation of license privileges in Oregon. Where the Commission chooses to suspend, such suspension shall remain in effect until the Commission receives adequate evidence of reinstatement of license privileges in the party state;

(b) That a person has been convicted in a party state of a misdemeanor or felony or forfeited bail, for an offense that could have been the basis for revocation of license privileges had it occurred in Oregon and when bail in Oregon for the offense would have been $50 or more;

(c) That an individual has been convicted in a party state of a crime which would be classed as a violation in Oregon; and that person has been convicted of previous violations in Oregon or of previous crimes in a party state that would be classed as a violation in Oregon.

Stat. Auth.: ORS 496.750
Stats. Implemented:
Hist.: FWC 43-1991, f. 5-1-91, cert. ef. 5-6-91; DFW 40-2006, f. & cert. ef. 6-9-06

635-001-0215
Procedures to Suspend or Revoke

(1) When the Director is notified of a failure to comply with the terms of a citation from the licensing authority of a party state, the Director shall initiate license suspension proceedings in accordance with this section.

(2) When the Commission has been notified of any of the conditions under 635-001-0210(2), the Director or Commission may initiate license suspension or revocation proceedings in accordance with this section.

(3) The person shall be notified in writing of the Director's or Commission's intention to suspend, revoke, or refuse to issue, licenses and tags, and shall be provided with an opportunity to request a hearing within 14 days of the date of mailing.

(4) If at the end of 14 days no response has been received, a final order shall be issued suspending, revoking or refusing to issue license privileges and mailed by certified mail to the person.

(5) If prior to 14 days from the date of mailing the person submits a request for a hearing, a hearing will occur. At the discretion of the Department, the case may be reviewed in writing upon stipulation by the licensee or a hearing may be scheduled before the administrative law judge.

(6) Following the administrative law judge's review, a proposed order, including findings of fact and conclusions of law, shall be prepared by the administrative law judge, served on all parties, and shall be forwarded to the Director or Commission.

(7) In accordance with ORS Chapter 183, the Director or Commission shall provide an opportunity to all parties to respond in writing within 14 days to the proposed order of the administrative law judge.

(8) A final order shall be reviewed and signed by the Director or Commission chair and all parties shall be provided a copy by certified mail.

Stat. Auth.: ORS 496 & 497
Stats. Implemented: ORS 496 & 497
Hist.: FWC 43-1991, f. 5-1-91, cert. ef. 5-6-91; DFW 40-2006, f. & cert. ef. 6-9-06

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Rule Caption: 2006 tag numbers and/or baglimits for Controlled Antelope, Sheep, Mountain Goat, Dear, Elk, Squirrel.
Adm. Order No.: DFW 41-2006
Filed with Sec. of State: 6-14-2006
Certified to be Effective: 6-14-06
Notice Publication Date: 5-1-06
Rules Amended: 635-002-0008, 635-065-0090, 635-067-0000, 635-067-0004, 635-067-0015, 635-068-0000, 635-069-0000, 635-070-0000, 635-071-0000, 635-071-0010, 635-073-0000, 635-073-0050, 635-073-0065, 635-073-0070
Subject: Rules were amended to set the 2006 controlled hunt tag numbers for the hunting of pronghorn antelope, bighorn sheep, Rocky Mountain goat, deer and elk. Bag limit changes were made in certain units relating to the general archery season and the Oregon Disabilities Hunting and Fishing Permit Program.

Rules were amended regarding the disposition of cougar carcasses.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-002-0008
Disposition of Wildlife Taken on Damage

In accordance with ORS 498.012, any wildlife taken on damage shall be disposed of in the following manner:

(1) Any deer, elk, antelope, bighorn sheep or gamebird shall be salvaged and delivered to a location determined by the Department. Carcasses shall be disposed of as directed by OAR 635-002-0005.

(2) Black bear taken on damage shall be disposed of in the following manner:

(a) The carcass and hide, including gall bladder and female reproductive tract, shall be delivered to a location determined by the Department;

(b) The department may permit the landowner to retain the carcass including hide, skull, paws, claws, and meat (but not the gall bladder) for personal use. The hide, head, paws, claws, and meat may not be sold or bartered.

(A) If the landowner chooses to retain the carcass he/she must sign a written release provided by the department acknowledging the proper methods of preparation for human consumption, accepting the carcass as is, and that the meat will not be offered for sale;

(B) If the carcass, including hide, skull, paws and claws or meat, is transferred to another person, written documentation must be provided as outlined in OAR 635-065-0765(5).

(c) If the landowner chooses not to retain the carcass, including the hide, skull, paws, claws, and meat, the carcass shall be disposed of as directed in OAR 635-002-0007.

(d) The hide, skull, paws, claws, and gall bladder shall be salvaged and disposed of in a manner determined by the department. Options for disposition include but are not limited to scientific, enforcement, or educational purposes.

(3) Any cougar taken when damaging livestock shall be disposed of in the following manner:

(a) The carcass and hide, including viscera, shall be delivered to a location determined by the Department;

(b) The Department may permit the landowner to retain the legally marked hide and carcass, including the skull of such cougar for personal use. Such skull, hide, and carcass, including feet and claws, may not be sold or bartered;

(c) Such hide shall be marked with a possession tag which shall remain with the hide.

(4) Any red fox or bobcat shall be disposed of in a manner determined by the Department. Priority for disposition shall be for scientific, enforcement, or educational purposes.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 32-1991, f. & cert. ef. 3-25-91; DFW 96-1998, f. & cert. ef. 11-25-98; DFW 41-2006, f. & cert. ef. 6-14-06

635-065-0090
Disabled Hunter Seasons and Bag Limits

(1) ORS 496.018 provides that in order to be considered a person with a disability under the wildlife laws, a person shall provide to the Fish and Wildlife Commission either written certification from a physician of certain specified disabilities or written proof that the U.S. Department of Veterans Affairs or the Armed Forces shows the person to be at least 65 percent disabled. To implement that statute, this rule provides for the issuance of an "Oregon Disabilities Hunting and Fishing Permit" by the Department.

(2) To obtain an "Oregon Disabilities Hunting and Fishing Permit," a person shall submit to the Department a completed form specified by the Department. If the completed form accurately provides all required information, the Department shall issue an "Oregon Disabilities Hunting and Fishing Permit". Permits are valid for two calendar years. To renew a permit, the holder must submit a new, updated application form.

(3) The Department may revoke, suspend or decline to issue or renew an "Oregon Disabilities Hunting and Fishing Permit" for failure to submit accurate information. The holder or applicant may request a contested case hearing to appeal such an action.

(4) A person who possesses an Oregon Disabilities Hunting and Fishing Permit issued by the department is qualified for expanded bag limits as follows: [Table not included. See ED. NOTE.]

(5) The Oregon Disabilities Hunting and Fishing Permit is valid only with a general season or controlled bull elk, buck deer, or pronghorn antelope tag for the area and time period being hunted. The permit must be carried on the person while hunting.

(6) An able-bodied companion may accompany a person with an Oregon Disabilities Hunting and Fishing Permit and kill any animal wounded by the permit holder. The wounded animal must be killed using a legal weapon for the season and species designated on the tag. The companion must immediately attach the permit holder's tag to the carcass of the animal. The companion is not required to possess a hunting license or tag.

[ED. NOTE: Tables 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 29-1987, f. & ef. 6-19-87; FWC 63-1989, f. & cert. ef. 8-15-89; FWC 20-1991, f. & cert. ef. 3-12-91; FWC 36-1993, f. & cert. ef. 6-14-93; FWC 18-1994, f. 3-30-94, cert. ef. 5-1-94; FWC 4-1995, f. 1-23-95, cert. ef. 7-1-95; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 122-2004, f. 12-21-04, cert. ef. 1-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 142-2005, f. & cert. ef. 12-16-05; DFW 41-2006, f. & cert. ef. 6-14-06

635-067-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods, and other restrictions for hunting pronghorn antelope, cougar, bighorn sheep, and Rocky Mountain goat pursuant to ORS Chapter 496.

(2) OAR chapter 635, division 067 incorporates, by reference, the requirements for hunting pronghorn antelope, cougar, bighorn sheep, and Rocky Mountain goat set out in the document entitled "**2006 Oregon Big Game Regulations**," into Oregon Administrative Rules. Therefore, persons must consult the "**2006 Oregon Big Game Regulations**" in addition to OAR Chapter 635, to determine all applicable requirements for hunting pronghorn antelope, cougar, bighorn sheep, and Rocky Mountain goat. The annual Oregon Big Game Regulations are available at authorized license agents and regional, district and headquarters offices of the Oregon Department of Fish and Wildlife.

(3) Controlled hunt tags shall be issued by a controlled hunt drawing following the procedures established in OAR chapter 635, division 060. Permitted arms and ammunition are established in OAR chapter 635, division 065. Controlled hunt tag numbers for 2006 are listed in Tables 1, 2, and 3 and are adopted and incorporated into OAR chapter 635, division 067 by reference.

[ED. NOTE: Tables referenced are available from the agency.]
[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 65-1989, f. & cert. ef. 8-15-89; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 122-2004, f. 12-21-04, cert. ef. 1-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 128-2005, f. 12-1-05, cert. ef. 1-1-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-067-0004
Cougar Hunting Regulations

(1) Tag Requirement: Any person hunting cougar shall have on his/her person a general season cougar tag or a Blue Mountain additional cougar tag. General season cougar tags may be purchased through any authorized license agent;

(2) Hunt Area: Hunt zones, and harvest quotas for each hunt zone, are established in OAR 635-067-0015;

(a) Hunters may hunt within all hunt zones;

(b) Hunt zones will be closed to hunting when individual zone harvest quotas are reached.

(3) All hunters are required to check in the hide with skull and proof of sex attached of any cougar killed within ten days of harvest at a Department of Fish and Wildlife office;

(a) Hunters are also required to submit the reproductive tract of any female cougar taken.

(4) No person shall hunt or assist another to hunt a cougar during an authorized cougar season unless in possession of an unused cougar tag or accompanied by the holder of an cougar tag which is valid for that area and time period.

(5) No person shall use dogs to hunt or pursue cougar.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 128-2005, f. 12-1-05, cert. ef. 1-1-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-067-0015
General Cougar Season Zone Harvest Quotas

(1) Hunt Zone: A — Hunt Name: Coast/North Cascades;

(a) Harvest Quota: 120;

(b) Hunt Area: All of Wildlife Units: 10, 11, 12, 14, 15, 16, 17, 18, 20, 24, 25, 26, 27, 39, 41, and 42;

(2) Hunt Zone: B — Hunt Name: Southwest Cascades;

(a) Harvest Quota: 165;

(b) Hunt Area: All of Wildlife Units: 19, 21, 22, 23, 28, 29, 30, and 31;

(3) Hunt Zone: C — Hunt Name: Southeast Cascades;

(a) Harvest Quota: 65;

(b) Hunt Area: All of Wildlife Units: 32, 33, 34, 35, 75, 76, and 77;

(4) Hunt Zone: D — Hunt Name: Columbia Basin;

(a) Harvest Quota: 62;

(b) Hunt Area: All of Wildlife Units: 38, 40, 43, 44, and 45;

(5) Hunt Zone: E — Hunt Name: Blue Mountains;

(a) Harvest Quota: 245;

(b) Hunt Area: All of Wildlife Units: 37, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, and 64;

(6) Hunt Zone: F — Hunt Name: Southeast Oregon;

(a) Harvest Quota: 120;

(b) Hunt Area: All of Wildlife Units: 36, 65, 66, 67, 68, 69, 70, 71, 72, 73, and 74.

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 32-1978, f. & ef. 6-30-78; FWC 12-1979, f. & ef. 3-28-79; FWC 29-1979, f. & ef. 8-2-79; FWC 14-1980, f. & ef. 4-8-80; FWC 19-1980, f. & ef. 4-18-80; FWC 10-1981, f. & ef. 3-31-81; FWC 22-1981, f. & ef. 6-29-81; FWC 21-1982, f. & ef. 3-31-82, Renumbered from 635-060-0700; FWC 15-1983, f. & ef. 4-19-83; FWC 16-1984, f. 4-6-84, ef. 4-15-84; FWC 21-1985, f. & ef. 5-7-85; FWC 29-1986, f. & ef. 7-23-86; FWC 11-1987, f. & ef. 3-6-87; FWC 14-1988, f. & cert. ef. 3-10-88; FWC 65-1989, f. & cert. ef. 8-15-89; FWC 57-1990, f. & cert. ef. 6-21-90; FWC 60-1991, f. & cert. ef. 6-24-91; FWC 45-1992, f. & cert. ef. 7-15-92; FWC 36-1993, f. & cert. ef. 6-14-93; FWC 46-1993, f. & cert. ef. 8-4-93; FWC 18-1994, f. 3-30-94, cert. ef. 5-1-94; FWC 40-1994, f. & cert. ef. 6-28-94; FWC 90-1994(Temp), f. & cert. ef. 12-8-94; FWC 6-1995, f. 1-23-95, cert. ef. 4-1-95; FWC 10-1995, f. & cert. ef. 2-3-95; FWC 54-1995, f. & cert. ef. 6-20-95; FWC 38-1997, f. & cert. ef. 6-17-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 122-2004, f. 12-21-04, cert. ef. 1-1-05; DFW 128-2005, f. 12-1-05, cert. ef. 1-1-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-068-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods and other restrictions for hunting western Oregon deer pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2006 are listed in Tables 1 and 2 and are adopted and incorporated into OAR chapter 635, division 068 by reference.

(3) OAR chapter 635, division 068 incorporates, by reference, the requirements for hunting western Oregon deer set out in the document entitled "**2006 Oregon Big Game Regulations,**" into Oregon Administrative Rules. Therefore, persons must consult the "**2006 Oregon Big Game Regulations**" in addition to OAR Chapter 635, to determine all applicable requirements for hunting western Oregon deer. The annual Oregon Big Game Regulations are available at authorized license agents and regional, district, and headquarters offices of the Oregon Department of Fish and Wildlife.

[ED. NOTE: Tables referenced are available from the agency.]
[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 39-1988, f. & cert. ef. 6-13-88; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001. f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 3-2003, f. 1-17-03, cert. ef. 1-20-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 121-2003, f. 12-4-03, cert. ef. 1-19-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 124-2004, f. 12-21-04, cert. ef. 3-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 131-2005, f. 12-1-05, cert. ef. 3-1-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-069-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods and other restrictions for hunting eastern Oregon deer pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2006 are listed in Tables 1 and 2 and are adopted and incorporated into OAR chapter 635, division 069 by reference.

(3) OAR chapter 635, division 069 incorporates, by reference, the requirements for hunting eastern Oregon deer set out in the document entitled "**2006 Oregon Big Game Regulations**," into Oregon Administrative Rules. Therefore, persons must consult the "**2006 Oregon Big Game Regulations**" in addition to OAR Chapter 635, to determine all applicable requirements for hunting eastern Oregon deer. The annual Oregon Big Game Regulations are available at hunting license agents and regional, district and headquarters offices of the Oregon Department of Fish and Wildlife.

[ED. NOTE: Tables referenced are available from the agency.]
[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 40-1988, f. & cert. ef. 6-13-88; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 32-1999(Temp), f. & cert. ef. 5-4-99 thru 10-31-99; DFW 34-1999(Temp), f. & cert. ef. 5-12-99 thru 10-31-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 20-2000(Temp), f. 4-12-00, cert. ef. 4-12-00 thru 6-30-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 7-2003, f. 1-17-03, cert. ef. 2-1-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 122-2003, f. 12-4-03, cert. ef. 2-2-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 123-2004, f. 12-21-04, cert. ef. 2-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 130-2005, f. 12-1-05, cert. ef. 2-1-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-070-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods and other restrictions for hunting Cascade and Coast elk pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2006 are listed in Tables 1 and 2 and are adopted and incorporated into OAR chapter 635, division 070 by reference.

(3) OAR chapter 635, division 070 incorporates, by reference, the requirements for hunting western Oregon elk set out in the document entitled "**2006 Oregon Big Game Regulations**," into Oregon Administrative Rules. Therefore, persons must consult the "**2006 Oregon Big Game Regulations**" in addition to OAR Chapter 635, to determine all applicable requirements for hunting western Oregon elk. The annual Oregon Big Game Regulations are available at hunting license agents and regional,

district and headquarters offices of the Oregon Department of Fish and Wildlife.

[ED. NOTE: Tables referenced are available from the agency.]
[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 41-1988, f. & cert. ef. 6-13-88; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 9-2003(Temp), f. & cert. ef. 1-28-03 thru 6-16-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 119-2003, f. 12-4-03, cert. ef. 4-1-04; DFW 130-2003(Temp), f. & cert. ef. 12-24-03 thru 3-1-04; DFW 8-2004(Temp), f. & cert. ef. 2-2-04 thru 7-31-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 107-2004(Temp), f. & cert. ef 10-18-04 thru 11-27-04; DFW 131-2004, f. 12-21-04, cert. ef. 4-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 132-2005, f. 12-1-05, cert. ef. 4-1-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-071-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas, methods and other restrictions for hunting Rocky Mountain elk pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2006 are listed in Tables 1 and 2 and are adopted and incorporated in OAR chapter 635, division 071 by reference.

(3) OAR Chapter 635, Division 071 incorporates, by reference, the requirements for hunting Rocky Mountain elk set out in the document entitled "**2006 Oregon Big Game Regulations**," into Oregon Administrative Rules. Therefore, persons must consult the "**2006 Oregon Big Game Regulations**" in addition to OAR Chapter 635, to determine all applicable requirements for hunting Rocky Mountain elk. The annual **Oregon Big Game Regulations** are available at hunting license agents and regional, district and headquarters offices of the Oregon Department of Fish and Wildlife. Notwithstanding this, the **2006 Oregon Big Game Regulations** are amended to change the boundary description for Hunt 249B-McKay Creek on page 88 and open season dates for Hunt 258A-Zumwalt on page 80. The corrected boundary description and open season dates can be found under 635-071-0010.

[ED. NOTE: Tables referenced are available from the agency.]
[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 42-1988, f. & cert. ef. 6-13-88; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 9-2003(Temp), f. & cert. ef. 1-28-03 thru 6-16-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 1-2004(Temp), f. & cert. ef. 1-13-04 thru 7-9-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 105-2004(Temp), f. & cert. ef. 10-13-04 thru 11-15-04, Administrative correction 11-22-04; DFW 131-2004, f. 12-21-04, cert. ef. 4-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 132-2005, f. 12-1-05, cert. ef. 4-1-06; DFW 22-2006(Temp), f. & cert. ef. 4-7-06 thru 10-4-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-071-0010
Controlled Rocky Mountain Antlerless Elk Rifle Hunts

(1) Hunt 249B-McKay Creek

(a) Bag Limit: one antlerless elk

(b) Open Season: December 2 through December 10, 2006

(c) Hunt Area: 5% public lands. That part of Unit 49 north of East Birch Ck Co Rd (including Indian Lk Rd) and that part of Unit 44 north of Interstate 84.

(2) Hunt 258A-Zumwalt

(a) Bag Limit: one antlerless elk

(b)Open Season: October 25 through October 29 and November 18 through November 26, 2006

(c) Hunt Area: 5% public lands. That part of Unit 58 south of the following line: Beginning where Crow Cr RD crosses Chesnimnus Cr; east on Chesnimnus Cr to pine Cr; southeast on Pine Cr to FR 990; east on 990 to FR #46; south on 46 to Indian Village-Fence Cr Rd; east on Village-Fence Cr Rd to Imnaha Rvr.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 37-1982, f. & ef. 6-25-82; FWC 28-1983, f. & ef. 7-8-83; FWC 34-1984, f. & ef. 7-24-84; FWC 43-1985, f. & ef. 8-22-85; FWC 76-1985(Temp), f. & ef. 12-6-85; FWC 71-1985, f. & ef. 11-8-85; FWC 35-1986, f. & ef. 8-7-86; FWC 45-1987, f. & ef. 7-6-87; FWC 42-1988, f. & cert. ef. 6-13-88; FWC 69-1989, f. & cert. ef. 8-15-89; FWC 115-1989(Temp), f. & cert. ef. 11-16-89; FWC 61-1990, f. & cert. ef. 6-21-90; FWC 116-1990(Temp), f. & cert. ef. 10-11-90; FWC 64-1991, f. & cert. ef. 6-24-91; FWC 115-1991, f. & cert. ef. 9-30-91; FWC 49-1992, f. & cert. ef. 7-15-92; FWC 36-1993, f. & cert. ef. 6-14-93; FWC 46-1993, f. & cert. ef. 8-4-93; FWC 18-1994, f. 3-30-94, cert. ef. 5-1-94; FWC 40-1994, f. & cert. ef. 6-28-94; FWC 63-1994(Temp), f. & cert. ef. 9-13-94; FWC 6-1995, f. 1-23-95, cert. ef. 4-1-95; FWC 54-1995, f. & cert. ef. 6-20-95; FWC 17-1996, f. 4-10-96, cert. ef. 4-15-96; FWC 17-1996, f. 4-10-96, cert. ef. 4-15-96; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 22-2006(Temp), f. & cert. ef. 4-7-06 thru 10-4-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-073-0000
Purpose and General Information

(1) The purpose of these rules is to establish season dates, bag limits, areas and other restrictions for bow and muzzleloader hunting and controlled deer and elk youth hunts; pursuant to ORS Chapter 496.

(2) Controlled hunt tag numbers for 2006 for deer and elk bow and muzzleloader hunting and deer and elk youth hunts are listed in Tables 1 and 2 and are adopted and incorporated into OAR chapter 635, division 073 by reference.

(3) OAR Chapter 073 incorporates, by reference, the requirements for bow and muzzleloader hunting and controlled deer and elk youth hunts set out in the document entitled "**2006 Oregon Big Game Regulations**," into Oregon Administrative Rules. Therefore, persons must consult the "**2006 Oregon Big Game Regulations**," in addition to OAR Chapter 635, to determine all applicable requirements for bow and muzzleloader hunting and controlled deer and elk youth hunts. The annual Oregon Big Game Regulations are available at hunting license agents and regional, district and headquarters offices of the Oregon Department of Fish and Wildlife. Notwithstanding this, the **2006 Oregon Big Game Regulations** are amended to change the open season dates for Hunt 644T2-Umatilla County Private on page 70. The corrected open season dates can be found under 635-073-0050.

[ED. NOTE: Tables referenced are available from the agency.]
[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 44-1988, f. & cert. ef. 6-13-88; FWC 18-1994, f. 3-30-94, cert. ef. 5-1-94; FWC 17-1996, f. 4-10-96, cert. ef. 4-15-96; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 49-1998, f. & cert. ef. 6-22-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 21-2000(Temp), f. 4-12-00, cert. ef. 4-12-00 thru 6-30-00; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 47-2001, f. & cert. ef. 6-13-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 3-2003, f. 1-17-03, cert. ef. 1-20-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 122-2003, f. 12-4-03, cert. ef. 2-2-04; DFW 130-2003(Temp), f. & cert. ef. 12-24-03 thru 3-1-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 123-2004, f. 12-21-04, cert. ef. 2-1-05; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 130-2005, f. 12-1-05, cert. ef. 2-1-06; DFW 22-2006(Temp), f. & cert. ef. 4-7-06 thru 10-4-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-073-0050
Controlled Antlerless Deer Youth Hunts

Hunt 644T2-Umatilla County Private

(1) Bag Limit: one antlerless deer

(2) Open Season: November 25 through December 10, 2006

(3) Hunt Area: 0% public lands. All of Umatilla County outside exterior boundaries of the Umatilla and Wallowa Whitman National Forest.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 66-1991, f. & cert. ef. 6-24-91; FWC 51-1992, f. & cert. ef. 7-15-92; FWC 36-1993, f. & cert. ef. 6-14-93; FWC 46-1993, f. & cert. ef. 8-4-93; FWC 72-1993(Temp), f. 11-19-93, cert. ef. 11-20-93; FWC 18-1994, f. 3-30-94, cert. ef. 5-1-94; FWC 40-1994, f. & cert. ef. 6-28-94; FWC 6-1995, f. 1-23-95, cert. ef. 4-1-95; FWC 54-1995, f. & cert. ef. 6-20-95; FWC 17-1996, f. 4-10-96, cert. ef. 4-15-96; FWC 35-1996, f. & cert. ef. 6-7-96; FWC 9-1997, f. & cert. ef. 2-27-97; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 30-2000, f. & cert. ef. 6-14-00; DFW 113 2001(Temp), f. & cert. ef. 12-13-01 thru 1-31-02; Administrative correction 1-13-05; DFW 22-2006(Temp), f. & cert. ef. 4-7-06 thru 10-4-06; DFW 41-2006, f. & cert. ef. 6-14-06

635-073-0065
Early Western Oregon Bowhunting Seasons

(1) General Bowhunting Seasons — Western Oregon.

(a) Open Season: August 26 — September 24, 2006;

(b) Bag Limit and Hunt Area: The bag limit is one buck deer having not less than a forked antler in the Tioga, Dixon, Sixes, Powers, Evans Creek, Rogue, Chetco, and Applegate units; the bag limit is one deer in the Alsea, Indigo, McKenzie, Melrose, Saddle Mountain, Santiam, Scappoose, Siuslaw, Stott Mountain, Trask, Willamette, and Wilson units,

(2) General Bowhunting Seasons — Western Oregon.

(a) Open Season: August 26 — September 24, 2006;

(b) Bag Limit and Hunt Area: The bag limit is one legal bull elk in the Sixes, Powers, and Chetco units; the bag limit is one legal bull or antlerless elk in the Alsea, Applegate, Dixon, Evans Creek, Indigo, McKenzie, Melrose, Rogue, Saddle Mountain, Santiam (within the exterior boundary of Mt. Hood National Forest, antlerless elk cannot be harvested), Scappoose, Siuslaw, Stott Mountain, Tioga, Trask, Willamette, and Wilson units.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162

Hist.: DFW 53-2004, f. & cert. ef. 6-16-04; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 41-2006, f. & cert. ef. 6-14-06

635-073-0070
Early Eastern Oregon Bowhunting Seasons

(1) General Bowhunting Seasons — Eastern Oregon.

(a)Open Season: August 26 — September 24, 2006;

(b) Bag Limit and Hunt Area: The bag limit is one buck deer having a visible antler in the Grizzly, Metolius, Upper Deschutes, Paulina, Sprague, Fort Rock, Heppner, Keno, Klamath Falls, Interstate, Warner, Wagontire, Juniper, Beatys Butte, Steens Mountain, Owyhee, Malheur River, Silvies, Maury, Ochoco, Murderers Creek, Beulah, Fossil, Northside, Desolation, Ukiah, Starkey, Mt. Emily, Walla Walla, Wenaha, Sled Springs, Chesnimnus, Minam, Catherine Creek, Sumpter, Lookout Mountain, Keating, Pine Creek, Imnaha, Snake River, Silver Lake, and Whitehorse units and that part of the White River Unit within the Mt. Hood National Forest except that: That part of the Whitehorse Unit south of Whitehorse Ranch Rd. and west of US Hwy 95 (Trout Creek Mts.), is closed to deer bowhunting during the general bowhunting season unless the hunter has a Trout Creek Mts. controlled bow deer tag. Approximately 40 square miles of the Starkey Experimental Forest within the Starkey Unit shall be closed to all bowhunting. The Chesnimnus Unit shall be closed to deer bowhunting during the general bowhunting season unless the hunter also has a Chesnimnus controlled bow elk tag (used or unused). The Sled Springs Unit shall be closed to deer bowhunting during the general bowhunting season unless the hunter also has a Sled Springs controlled bow elk tag (used or unused).The Ochoco Unit shall be closed to deer bowhunting during the general bowhunting season unless the hunter also has a Ochoco controlled bow elk tag (used or unused). The bag limit is one deer in the Biggs, Columbia Basin (except: That portion of the Columbia Basin Unit described as follows shall be closed to all bowhunting: Beginning at Heppner; north and west State Highway 74 to Lexington; north and east on State Highway 207 to Butter Creek Junction; south on Butter Creek Road to Highway 74 at Vinson; west on Highway 74 to Heppner; point of beginning.), Hood, Maupin and White River (outside the National Forest) units.

(2) General Bowhunting Seasons — Eastern Oregon.

(a) Open Season: August 26 — September 24, 2006;

(b) Bag Limit and Hunt Area: The bag limit is one legal bull elk in the Metolius, Upper Deschutes, Heppner, Keno, Klamath Falls, Interstate, Warner, Maury, Ukiah, Silver Lake, Sprague, Starkey, Mt. Emily, Walla Walla, Wenaha, Catherine Creek, Chesnimnus, Minam, Keating, Snake River, Approximately 40 square miles of the Starkey Experimental Forest within the Starkey Unit shall be closed to all bowhunting. The Chesnimnus Unit shall be closed to all elk bowhunting unless the hunter has a valid, controlled Chesnimnus elk bow tag. The Sled Springs Unit shall be closed to all elk bowhunting unless the hunter has a valid, controlled Sled Springs elk bow tag. The Ochoco Unit shall be closed to all elk bowhunting unless the hunter has a valid, controlled Ochoco elk bow tag. The bag limit is one legal bull or antlerless elk in the Beatys Butte, Beulah, Biggs, Columbia Basin (except: That portion of the Columbia Basin Unit described as follows shall be closed to all bowhunting: Beginning at Heppner; north and west State Highway 74 to Lexington; north and east on State Highway 207 to Butter Creek Junction; south on Butter Creek Road to Highway 74 at Vinson; west on Highway 74 to Heppner; point of beginning.), Desolation, Fort Rock, Fossil, Grizzly, Hood, Imnaha, Juniper, Lookout Mountain, Malheur River, Maupin, Murderers Creek, Northside, Ochoco, Owyhee, Paulina, Pine Creek, Silvies, Sled Springs, Steens Mountain, Sumpter, Wagontire, White River, and Whitehorse units.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 9-1997, f. & cert. ef. 2-27-97; FWC 38-1997, f. & cert. ef. 6-17-97; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 47-1999, f. & cert. ef. 6-16-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 57-2001, f. & cert. ef. 7-6-01; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 50-2003, f. & cert. ef. 6-13-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 53-2004, f. & cert. ef. 6-16-04; DFW 53-2005, f. & cert. ef. 6-14-05; DFW 41-2006, f. & cert. ef. 6-14-06

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Rule Caption: Wildlife Habitat Conservation and Management Program -- Allow Director to designate eligibility for wildlife habitat assessment.
Adm. Order No.: DFW 42-2006
Filed with Sec. of State: 6-14-2006
Certified to be Effective: 6-14-06
Notice Publication Date:
Rules Amended: 635-430-0025
Subject: The Administrative rules for the Wildlife Habitat Conservation and Management Program have been amended to allow the Director to designate land as eligible for wildlife habitat special assessment.
Rules Coordinator: Casaria Tuttle—(503) 947-6033

635-430-0025
State Fish and Wildlife Commission Designation of Eligible Land

(1) At the request of the governing body of a county, the Director of the State Fish and Wildlife Department may designate any or all of the following land in unincorporated areas within the county as eligible for wildlife habitat special assessment:

(a) Any land that is zoned for exclusive farm use, mixed farm and forest use or forest use under a land use planning goal protecting agricultural land or forestland; or

(b) Land that is clearly identifiable as containing significant wildlife habitat.

(2) At the request of the governing body of a city, the Director may designate any or all of the following land within the incorporated city as eligible for wildlife habitat special assessment:

(a) Any land that is zoned for exclusive farm use, mixed farm and forest use or forest use under a land use planning goal protecting agricultural land or forestland; or

(b) Land that is clearly identifiable as containing significant wildlife habitat.

(3) With the prior consent of the governing body of a city, the county in which all or a part of the city is located may apply to the Director on behalf of the city for designation of any area that is within both the city and the county as eligible for wildlife habitat special assessment.

(4) The Director may designate land described in subsection (1) or (2) of this section as eligible for wildlife habitat special assessment only if the Director finds that designation will promote the objectives of the program and the implementation requirements of these rules.

(5) Any county that did not forbid, by a resolution or other decision of the county governing body, the establishment of wildlife habitat conservation and management plans as of January 1, 2003, shall be deemed to have the land described in OAR 635-430-0025(1)(a) as eligible for wildlife habitat special assessment.

(6) The governing body of the city or county that requested designation under section OAR 635-430-0025 may request that the Director of the State Fish and Wildlife Department remove that designation.

(7) The Director shall remove the designation if:

(a) The city or county demonstrates that the designation creates an economic burden for the city or county; and

(b) The Director finds that the economic burden is significant.

(8) In making its determination under subsection (7) of this section, the Director shall give significant weight to the demonstration of economic burden made by the city or county.

(9) A determination by the Director of the State Fish and Wildlife Department to designate land as eligible for the wildlife special assessment or to remove that designation shall for property tax purposes be effective as of the tax year beginning the July 1 immediately following the determination.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: Ch. 308A, HB 3616, 2003
Hist.: DFW 115-2004, f. & cert. ef. 11-26-04; DFW 42-2006 f. & cert. ef. 6-14-06

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Department of Human Services, Advisory Council on Child Abuse Assessment Chapter 417

Rule Caption: Changing OARs affecting Child Welfare Programs.
Adm. Order No.: ACCAA 1-2006
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 5-1-06
Rules Amended: 417-001-0001
Subject: OAR 417-001-0001 concerning Notices of Proposed Rulemaking is being amended to indicate Chapter 417 will be following the Department-wide rules on this topic being adopted at OAR 407-001-0000 and 407-001-0005.
Rules Coordinator: Annette Tesch—(503) 945-6067

417-001-0001
Notice of Rulemaking

See the current version of OAR 407-001-0000 and 407-001-0005 which apply to notices of rulemaking for rules in chapter 417.

Stat. Auth.: ORS 183.335, 183.341, 409.050
Stats. Implemented: ORS 183.325, 183.330, 183.335, 183.341, 409.050, 409.120
Hist.: ACCAA 2-1998, f. & cert. ef. 12-23-98; ACCAA 1-2006, f. & cert. ef. 6-1-06

Department of Human Services,
Child Welfare Programs
Chapter 413

Rule Caption: Changing OARs affecting Child Welfare programs.
Adm. Order No.: CWP 10-2006
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 5-1-06
Rules Amended: 413-001-0000
Rules Repealed: 413-001-0005
Subject: OAR 413-001-0000 concerning Notices of Proposed Rulemaking is being amended and OAR 413-001-0005 concerning model rulemaking rules is being repealed. Services in Chapter 413 will be following the Department-wide rules on these topics being adopted at OAR 407-001-0000 and 407-001-0005.
Rules Coordinator: Annette Tesch—(503) 945-6067

413-001-0000
Notice of Rulemaking

See the current version of OAR 407-001-0000 and 407-001-0005 which apply to notices of rulemaking for rules in chapter 413.

Stat. Auth.: ORS 183.341, 409.050 & 418.005
Stats. Implemented: ORS 183.330, 183.335, 183.341 & 409.050
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; CWP 10-2006, f. & cert. ef. 6-1-06

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

Rule Caption: Medicaid Drug Rebate Program list from CMS letter dated March 15, 2006.
Adm. Order No.: OMAP 12-2006
Filed with Sec. of State: 5-26-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-121-0157
Subject: The Pharmaceutical Services program rules govern Office of Medical Assistance Programs' (OMAP) payments for services provided to clients. Having temporarily amended rule 410-121-0157 to reference the updated information regarding participating pharmaceutical companies to the Medicaid Drug Rebate Program, in compliance with federal regulations, OMAP permanently amended this rule. Updates include information from CMS Release #140, dated March 15, 2006, indicating the changes to be effective April 1, 2006.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-121-0157
Participation in the Medicaid Drug Rebate Program

(1) The Oregon Medicaid Pharmaceutical Services Program is a participant in the Centers for Medicare and Medicaid Services (CMS) Medicaid Drug Rebate Program, created by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS's Center for Medicaid and State Operations (CMSO). Pharmaceutical companies participating in this program have signed agreements with CMS to provide rebates to the Office of Medical Assistance Programs (OMAP) on all their drug products. OMAP will reimburse providers only for outpatient drug products manufactured or labeled by companies participating in this program.

(2) Documents in rule by reference: Names and Labeler Code numbers for participants in the Medicaid Drug Rebate Program are the responsibility of and maintained by CMS. OMAP receives this information from CMS in the form of numbered and dated Releases. Subsequently, OMAP produces and updates Master Pharmaceutical Manufacturer's Rebate Lists (Lists), alphabetical and numeric, by manufacturer. These lists are used by OMAP providers to bill for services. OMAP includes in rule by reference, the following CMS Releases and subsequent OMAP Master Pharmaceutical Manufacturer's Rebate Lists: Release #128, dated January 21, 2004 – Lists updated February 10, 2004; Release #129, dated February 19, 2004 and Release #130, dated April 30, 2004 – Lists updated May 13, 2004; Release #132, dated June 22, 2004 – Lists updated July 19, 2004; Release #133, dated August 13, 2004 – Lists updated August 24, 2004; Release #134, dated November 18, 2004 – Lists updated December 16, 2004; Release #135, dated December 10, 2004 – Lists updated February 14, 2005; Release #136, dated February 17, 2005 – Lists updated March 30, 2005; Release #137, dated May 13, 2005 and Lists updated June 23, 2005; Release #138, dated August 5, 2005, and Lists updated August 19, 2005, and; Release #140, dated March 15, 2006, and Lists updated March 17, 2006. All CMS Releases are available on the Department of Human Services' website: www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html, and on the CMS website: www.cms.hhs.gov/medicaid/drugs/drughmpg.asp and the subsequent OMAP Master Pharmaceutical Manufacturer's Rebate Lists, are available on the Department of Human Services' website: www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html.

(3) Retroactive effective dates: The CMS Medicaid Drug Rebate Program experiences frequent changes in participation and often this information is submitted to OMAP after the effective date(s) of some changes. Therefore, certain participant additions and deletions may be effective retroactively. See specific instructions in the CMS Releases for appropriate effective date(s) of changes.

(4) OMAP contracts with First Health Services to manage the Medicaid Rebate Dispute Resolution program. Pharmacy providers must verify the accuracy of their Medicaid pharmacy claims with First Health Services within 30 days of request in instances where drug manufacturers dispute their claim information. Verification can be photocopies of drug invoices showing that the billed products were in stock during the time of the date of service.

(5) The actual National Drug Code (NDC) dispensed and the actual metric decimal quantity dispensed, must be billed.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 16-1991(Temp), f. 4-12-91, cert. ef. 4-15-91; HR 22-1991, f. & cert. ef. 5-16-91; HR 23-1991(Temp), f. 6-14-91, cert. ef. 6-17-91; HR 31-1991, f. & cert. ef. 7-16-91; HR 36-1991(Temp), f. 9-16-91, cert. ef. 10-1-91; HR 45-1992, f. & cert. ef. 10-16-91; HR 50-1991(Temp), f. & cert. ef. 10-29-91; HR 1-1992, f. & cert. ef. 1-2-92; HR 13-1992, f. & cert. ef. 6-1-92; HR 21-1992, f. 7-31-92, cert. ef. 8-1-92; HR 31-1992, f. & cert. ef. 10-1-92; HR 34-1992, f. & cert. ef. 12-1-92; HR 4-1993, f. 3-10-93, cert. ef. 3-11-93; HR 7-1993 (Temp), f. & cert. ef. 4-1-93; HR 14-1993, f. & cert. ef. 7-2-93; HR 24-1993, f. & cert. ef. 10-1-93; HR 17-1994, f. & cert. ef. 4-1-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 14-1995, f. 6-29-95, cert. ef. 7-1-95; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96; HR 22-1997, f. & cert. ef. 10-1-97; HR 27-1997, f. & cert. ef. 12-1-97; OMAP 2-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2000(Temp), f. 12-29-00, cert. ef. 1-1-01 thru 5-1-01; OMAP 3-2001, f. & cert. ef. 3-16-01; OMAP 24-2001(Temp) f. 5-9-01, cert. ef. 5-10-01 thru 11-1-01; OMAP 25-2001(Temp) f. 6-28-01, cert. ef. 7-1-01 thru 12-1-01; OMAP 27-2001(Temp) f. 7-30-01, cert. ef. 8-1-01 thru 1-26-02; OMAP 48-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-1-02; OMAP 56-2001(Temp), f. & cert. ef. 11-1-01 thru 4-15-02; OMAP 57-2001(Temp), f. 11-28-01, cert. ef. 12-1-01 thru 4-15-02; OMAP 66-2001(Temp), f. 12-28-01, cert. ef. 1-1-02 thru 5-15-02; OMAP 4-2002(Temp), f. & cert. ef. 3-5-02 thru 8-1-02; OMAP 16-2002(Temp) f. & cert. ef. 4-12-02 thru 9-1-02; OMAP 20-2002(Temp), f. & cert. ef. 5-15-02 thru 10-1-02; OMAP 34-2002(Temp), f. & cert. ef. 8-14-02 thru 1-15-03; OMAP 67-2002(Temp), f. & cert. ef. 11-1-02 thru 3-15-03; OMAP 6-2003(Temp), f. & cert. ef. 2-14-03 thru 7-1-03; OMAP 38-2003, f. & cert. ef. 5-9-03; OMAP 39-2003(Temp), f. & cert. ef. 5-15-03; OMAP 48-2003, f. & cert. ef. 7-7-03; OMAP 74-2003, f. & cert. ef. 10-1-03; OMAP 5-2004(Temp), f. & cert. ef. 2-4-04 thru 6-15-04; OMAP 24-2004, f. & cert. ef. 3-30-04; OMAP 31-2004(Temp), f. & cert. ef. 5-14-04 thru 10-15-04; OMAP 42-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 53-2004(Temp), f. & cert. ef. 9-10-04 thru 2-15-05; OMAP 82-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 1-2005(Temp), f. & cert. ef. 1-14-05 thru 6-1-05; OMAP 6-2005, f. 3-1-05, cert. ef. 3-31-05; OMAP 7-2005(Temp), f. 3-1-05, cert. ef. 4-1-05 thru 8-1-05; OMAP 30-2005, f. & cert. ef. 6-6-05; OMAP 55-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 5-2006, f. 3-22-06, cert. ef. 4-1-06; OMAP 7-2006(Temp), f. 3-29-06, cert. ef. 4-1-06 thru 9-15-06; OMAP 12-2006, f. 5-26-06, cert. ef. 6-1-06

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Rule Caption: CMS Federal Upper Limits for Drug Payments listing for April 2006.
Adm. Order No.: OMAP 13-2006
Filed with Sec. of State: 5-26-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-121-0300
Subject: The Pharmaceutical Rules govern Office of Medical Assistance Programs' payment for pharmaceutical products provided to clients. OMAP, having temporarily amended 410-121-0300 to update the CMS Federal Upper Limits for Drug Payments listing, permanently amended the rule. OMAP updated Transmittal #37, with the March 10, 2006 Title XIX State Agency Letter, including changes to the list. These changes are effective for services rendered on or after April 10, 2006, to revise drug products information in compli-

ance with federal regulations from Centers for Medicare and Medicaid Services (CMS).
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-121-0300
CMS Federal Upper Limits for Drug Payments

(1) The Centers for Medicare and Medicaid Services (CMS) Federal Upper Limits for Drug Payments listing of multiple source drugs meets the criteria set forth in 42 CFR 447.332 and 1927(e) of the Act as amended by OBRA 1993.

(2) Payments for multiple source drugs must not exceed, in the aggregate, payment levels determined by applying to each drug entity a reasonable dispensing fee (established by the State and specified in the State Plan), plus an amount based on the limit per unit. CMS has determined the amount based on the limit per unit to be equal to a 150 percent applied to the lowest price listed (in package sizes of 100 units, unless otherwise noted) in any of the published compendia of cost information of drugs.

(3) The FUL drug listing is published in the State Medicaid Manual, Part 6, Payment for Services, Addendum A. The most current Transmittals and subsequent changes are posted to the CMS website (contact OMAP for most current website address). The FUL price listing will be updated approximately every six months.

(4) The most current CMS Federal Upper Limits for Drug Payments Listing, includes changes to Transmittal #37, Title XIX State Agency Letter with changes to be effective on or after April 10, 2006, and is available for downloading on OMAP's Website, (contact OMAP for most current website address). To request a hard copy, call OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 3-1990(Temp), f. & cert. ef. 2-23-90; HR 13-1990, f. & cert. ef. 4-20-90, Renumbered from 461-016-0330; HR 20-1990, f. & cert. ef. 7-9-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 45-1990, f. & cert. ef. 12-28-90; HR 10-1991, f. & cert. ef. 2-19-91; HR 37-1991, f. & cert. ef. 9-16-91; HR 13-1992, f. & cert. ef. 6-1-92; HR 28-1992, f. & cert. ef. 9-1-92; HR 35-1992(Temp), f. & cert. ef. 12-1-92; HR 1-1993(Temp), f. & cert. ef. 1-25-93; HR 3-1993, f. & cert. ef. 2-22-93; HR 5-1993(Temp), f. 3-10-93, cert. ef. 3-22-93; HR 8-1993(Temp), f. & cert. ef. 4-1-93; HR 11-1993, f. 4-22-93, cert. ef. 4-26-93; HR 15-1993(Temp), f. & cert. ef. 7-2-93; HR 20-1993, f. & cert. ef. 9-1-93; HR 25-1993(Temp), f. & cert. ef. 10-1-93; HR 14-1994, f. & cert. ef. 3-1-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 14-1995, f. 6-29-95, cert. ef. 7-1-95; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96; HR 22-1997, f. & cert. ef. 10-1-97; HR 27-1997, f. & cert. ef. 12-1-97; OMAP 2-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 43-1998(Temp), f. & cert. ef. 11-20-98 thru 5-1-99; OMAP 5-1999, f. & cert. ef. 2-26-99; OMAP 42-2000(Temp), f. & cert. ef. 12-15-00 thru 5-1-01; OMAP 1-2001(Temp), f. & cert. ef. 2-1-01 thru 6-1-01; OMAP 2-2001(Temp), f. 2-14-01, cert. ef. 2-15-01 thru 7-1-01; OMAP 18-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 23-2001(Temp), f. & cert. ef. 4-16-01 thru 8-1-01; OMAP 26-2001(Temp), f. & cert. ef. 6-6-01 thru 1-2-02; OMAP 51-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-15-01; OMAP 58-2001, f. 11-30-01, cert. ef. 12-1-01; OMAP 67-2001(Temp), f. 12-28-01, cert. ef. 1-1-02 thru 5-15-02; OMAP 3-2002(Temp), f. & cert. ef. 2-15-02 thru 6-15-02; OMAP 5-2002(Temp) f. & cert. ef. 3-5-02 thru 6-15-02; OMAP 19-2002(Temp), f. & cert. ef. 4-22-02 thru 9-15-02; OMAP 29-2002(Temp), f. 7-15-02, cert. ef. 8-1-02 thru 1-1-03; OMAP 71-2002(Temp), f. & cert. ef. 12-1-02 thru 5-15-03; OMAP 10-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 11-2003(Temp), f. 2-28-03, cert. ef. 3-1-03 thru 8-15-03; OMAP 41-2003, f. & cert. ef. 5-29-03; OMAP 51-2003, f. & cert. ef. 8-5-03; OMAP 54-2003(Temp), f. & cert. ef. 8-15-03 thru 1-15-03; OMAP 75-2003, f. & cert. ef. 10-1-03; OMAP 83-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 4-15-04; OMAP 2-2004, f. 1-23-04, cert. ef. 2-1-04; OMAP 32-2004(Temp), f. & cert. ef. 5-14-04 thru 10-15-04; OMAP 43-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 93-2004(Temp), f. & cert. ef. 12-10-04 thru 5-15-05; OMAP 2-2005, f. 1-31-05, cert. ef. 2-1-05; OMAP 23-2005(Temp), f. & cert. ef. 4-1-05 thru 9-1-05; OMAP 29-2005, f. & cert. ef. 6-6-05; OMAP 56-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 59-2005(Temp), f. 11-8-05, cert. ef. 11-12-05 thru 5-1-06; OMAP 68-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 8-2006(Temp), f. 3-29-06, cert. ef. 4-1-06 thru 9-15-06; OMAP 13-2006, f. 5-26-06, cert. ef. 6-1-06

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Rule Caption: Hospital Tax Rate Modification.
Adm. Order No.: OMAP 14-2006
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 12-1-05
Rules Amended: 410-050-0861
Subject: The tax rate stated in OAR 410-050-0861 is .68% and does not have an end date. The proposed amendment sets an end date of June 30, 2006 for the .68% tax rate and the Department of Human Services Director sets a new tax rate of .82% beginning July 1, 2006.
Rules Coordinator: Jennifer Bittel—(503) 947-5250

410-050-0861
Tax Rate

The Tax rate for the period beginning January 1, 2005 and ending June 30, 2006 is 0.68 percent. The tax rate for the period beginning July 1, 2006 is .82 percent.

Stat. Auth.: ORS 409
Stats. Implemented: OL 2003, Ch. 736
Hist.: OMAP 28-2005(Temp), f. & cert. ef. 5-10-05 thru 11-5-05; OMAP 34-2005, f. 7-8-05, cert. ef. 7-11-05; OMAP 14-2006, f. 6-1-06, cert. ef. 7-1-06

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Rule Caption: July 2006 rule corrections and additional detail for policy clarification.
Adm. Order No.: OMAP 15-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-120-0000, 410-120-1180, 410-120-1200, 410-120-1210, 410-120-1230, 410-120-1260, 410-120-1280, 410-120-1340, 410-120-1400, 410-120-1460, 410-120-1560, 410-120-1855, 410-120-1960
Subject: The General Rules Program administrative rules govern Office of Medical Assistance Programs' (OMAP) payments for services provided to clients. OMAP amended the following rules for housekeeping and clarification purposes: 410-120-0000 to correct the citation number for the CAWEM benefit package and update the federal change from Professional Review Organization (PRO) to Quality Improvement Organization (QIO); 410-120-1230 to correct a table reference; 410-120-1400 and 410-120-1460 to update the federal reference change from PRO to QIO; and 410-120-1560 to clarify claim reconsideration consistent with 410-120-1570. OMAP will provide additional detail for policy clarification: 410-120-1180 to add language to non-emergent out-of-state services regarding services provided to clients who are Medicare beneficiaries; 410-120-1200 to correct the PRO to QIO federal reference and to delete the comorbidity exception from the fertility and sexual dysfunction exclusion consistent with CMS policy; 410-120-1210 to correct the CAWEM benefit package citation; 410-120-1260 to allow retroactive provider enrollment according to federal regulations with OMAP's discretion to consider extenuating circumstances; 410-120-1280 to specify: (1) the waiver requirement including the OMAP allowable and (2) extent of appeal of Medicare coverage before billing OMAP; 410-120-1340 to change rate-setting for physician administered drugs; 410-120-1855 and 410-120-1960 to add a client responsibility to advise the caseworker of insurance coverage changes within 10 days.
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 (AAAs), 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 (AI/AN) clinic — Clinics recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(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 (BP) or performing Provider for medical assistance programs related non-health care services but which does not meet the definition of health care Provider for National Provider Identification (NPI) purposes.

(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 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 Electronic Data Interchange (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 (OHP) 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 410-120-1210(3)(f).

(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' CPT 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 (OMAP).

(50) Department of Human Services (DHS) — DHS 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 International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the primary Diagnosis Code is shown in all billing claims, unless specifically excluded in individual Provider rule(s). Where they exist, Diagnosis Codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(53) Diagnosis Related Group (DRG) — A system of classification of diagnoses and procedures based on the 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. (See OARs in Chapter 410, Division 001)

(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)(f)(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 (EPSDT) Services (also Medicheck) — The Title XIX program of EPSDT Services for eligible Clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required Medically Appropriate health care services and to help 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 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) Fully Dual Eligible — For the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare Clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by DHS for full medical assistance coverage.

(68) General Assistance (GA) — Medical Assistance administered and funded 100% with State of Oregon funds through OHP.

(69) 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.

(70) 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.

(71) 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.

(72) 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.

(73) 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.

(74) 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.

(75) 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.

(76) 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.

(77) 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.

(78) 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 CMS 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.

(79) 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 OMAP.

(80) 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.

(81) Indian Health Program — Any Indian Health Service facility, any Federally recognized Tribe or Tribal organization, or any FQHC with a 638 designation.

(82) Individual Adjustment Request (OMAP 1036) Form 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' (SPD) 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) International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) – Diagnosis Codes including volumes 1, 2, and 3, as revised annually.

(88) Laboratory — A facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare, to provide Laboratory Services within or a part

from a Hospital. An entity is considered a Laboratory if materials are derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings. If an entity performs even one Laboratory test, including waived tests for these purposes, it is considered under the Clinical Laboratory Improvement Act (CLIA), to be a Laboratory.

(89) 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.

(90) Licensed Direct Entry Midwife — A practitioner licensed by DHS' Office of Public Health as a Licensed Direct Entry Midwife.

(91) 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.

(92) 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).

(93) 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.

(94) Medicaid — A federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by DHS.

(95) Medical Assistance Eligibility Confirmation — Verification through the AIS, an authorized DHS representative, an EEVS vendor or through presentation of a valid Medical Care Identification that a Client has an open assistance case, which includes medical benefits.

(96) Medical Services — Care and treatment provided by a licensed medical Provider directed at preventing, diagnosing, treating or correcting a medical problem.

(97) Medical Transportation — Transportation to or from covered Medical Services.

(98) Medically Appropriate — Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an OHP Client or a Provider of the service or medical supplies; and

(d) The most Cost Effective of the alternative levels of Medical Services or medical supplies which can be safely provided to an OMAP Client or Primary Care Manager (PCM) Member in the PHP's or PCM's judgment.

(99) Medicare — A federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

(a) Hospital Insurance (Part A) for Inpatient services in a Hospital or skilled Nursing Facility, home health care, and Hospice care; and

(b) Medical Insurance (Part B) for Physicians' services, Outpatient Hospital services, home health care, end-stage renal dialysis, and other Medical Services and supplies;

(c) Prescription drug coverage (Part D) — Covered Part D drugs include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act; also includes medical supplies associated with the injection of insulin; Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). (See OAR 410, Division 121 for limitations).

(100) Medicheck for Children and Teens — See EPSDT.

(101) National Provider Identification (NPI) – Federally directed Provider number mandated for use on HIPAA covered transactions; individuals, Provider Organizations and Subparts of Provider Organizations that meet the definition of health care Provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

(102) Naturopath — A person licensed to practice naturopathy pursuant to State law.

(103) Naturopathic Services — Services provided within the scope of practice as defined under State law.

(104) 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, Excluded Services and Limitations; and,

(b) 410-120-1210, Medical Assistance Benefit Packages and Delivery System;

(c) 410-141-0480, OHP Benefit Package of Covered Services;

(d) 410-141-0520, Prioritized List of Health Services; and

(e) The individual OMAP Provider rules.

(105) 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.

(106) 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.

(107) 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.

(108) Nursing Facility — A facility licensed and certified by the DHS' SPD defined in 411-070-0005.

(109) 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.

(110) 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.

(111) Occupational Therapist — A person licensed by the State Board of Examiners for Occupational Therapy.

(112) 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.

(113) 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

(114) Office of Mental Health and Addiction Services (OMHAS) — An Office within DHS administering mental health and addiction programs and services.

(115) Optometric Services — Services provided, within the scope of practice of optometrists as defined under State law.

(116) Optometrist — A person licensed to practice optometry pursuant to State law.

(117) Oregon Medical Professional Review Organization (OMPRO) — OMPRO is the Oregon Quality Improvement Organization (QIO) for Medicare and contracts with OMAP to provide Hospital Utilization Review and other services for the medical assistance programs. A QIO is an organization established under federal law by DHHS for the purpose of utilization review and quality assurance.

(118) 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.

(119) 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.

(120) 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.

(121) 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).

(122) Overdue Claim — A Valid Claim that is not paid within 45 days of the date it was received.

(123) 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.

(124) 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.

(125) Panel — The Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(126) 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.

(127) 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.

(128) Pharmacist — A person licensed to practice pharmacy pursuant to state law.

(129) 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.

(130) Physical Therapist — A person licensed by the relevant State licensing authority to practice Physical Therapy.

(131) 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.

(132) 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.

(133) 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.

(134) Physician Services — Services provided, within the scope of practice as defined under state law, by or under the personal supervision of a Physician.

(135) Podiatric Services — Services provided within the scope of practice of Podiatrists as defined under state law.

(136) Podiatrist — A person licensed to practice podiatric medicine pursuant to state law.

(137) 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.

(138) 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.

(139) Premium Sponsorship — Premium donations made for the benefit of one or more specified OMAP Clients (See 410-120-1390).

(140) 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 OHP. PHP's may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(141) 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.

(142) 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.

(143) 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 PA.

(144) 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.

(145) 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.

(146) Provider — An individual, facility, institution, corporate entity, or other organization which supplies health care services or items, also termed a performing Provider, or bills, obligates and receives reimbursement on behalf of a performing Provider of services, also termed a Billing Provider (BP). The term Provider refers to both Performing Providers and BPs unless otherwise specified.

(147) 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)

(148) Public Health Clinic — A clinic operated by county government.

(149) 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.

(150) Qualified Medicare Beneficiary (QMB) — A Medicare beneficiary, as defined by the Social Security Act and its amendments.

(151) Qualified Medicare and Medicaid Beneficiary (QMM) — A Medicare Beneficiary who is also eligible for OMAP coverage.

(152) 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.

(153) Recipient — A person who is currently eligible for medical assistance (also known as a Client).

(154) 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.

(155) 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.

(156) 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.

(157) 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.

(158) Retroactive Medical Eligibility — Eligibility for medical assistance granted to a Client retroactive to a date prior to the Client's application for medical assistance.

(159) Sanction — An action against Providers taken by OMAP in cases of Fraud, misuse or Abuse of OMAP requirements.

(160) 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.

(161) Seniors and People with Disabilities (SPD) — An Office of DHS responsible for the administration of programs for seniors and people with disabilities.

(162) Service Agreement — An agreement between 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.

(163) 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.

(164) Social Worker — A person licensed by the Board of Clinical Social Workers to practice clinical social work.

(165) Speech-Language Pathologist — A person licensed by the Oregon Board of Examiners for Speech Pathology.

(166) 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.

(167) 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.

(168) State Facility — A Hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

(169) 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.

(170) Subrogation — Right of the State to stand in place of the Client in the collection of Third Party Resources (TPR).

(171) 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.

(172) Surgical Assistant — A person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(173) 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.

(174) 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.

(175) 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.

(176) 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.

(177) Transportation — See Medical Transportation.

(178) Type A Hospital — A Hospital identified by the Office of Rural Health as a Type A Hospital.

(179) Type B AAA Unit — A Type B Area Agency on Aging (AAA) funded by Oregon Project Independence (OPI), Title III — Older Americans Act, and Title XIX of the Social Security Act.

(180) Type B Hospital — A Hospital identified by the Office of Rural Health as a Type B Hospital.

(181) Usual Charge (UC) — The lesser of the following unless prohibited from billing by federal statute or regulation:

(a) The Provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;

(b) The Provider's lowest charge per unit of service on the same date that is advertised, quoted or posted. The lesser of these applies regardless of the payment source or means of payment;

(c) Where the Provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.

(182) 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.

(183) 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 TPR; and

(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).

(184) 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; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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 Oregon Administrative Rules (OAR) 410-120-1260, Provider Enrollment. Out-of-State Providers must provide services and bill in compliance with all of these General Rules and the 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) For enrolled non-contiguous, Out-of-State Providers, OMAP reimburses for covered services under any of the following conditions:

(a) The service was emergent; or

(b) A delay in the provision of services until the Client is able to return to Oregon could reasonably be expected to result in prolonged impairment, or in increased risk that treatment will become more complex or hazardous, or in substantially increased risk of the development of chronic illness;

(c) 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 (PA) for non-emergency out-of-state services provided by a non-contiguous enrolled Provider, under the following conditions:

(a) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage, or

(b) OMAP covers the service or item under the specific Client's benefit package; and

(c) The service or item is not available in the State of Oregon or provision of the service or item by an Out-of-State Provider is Cost Effective, as determined by OMAP (or, for those Clients covered by a managed care plan, the plan will make that determination); and

(d) The service or item is deemed Medically Appropriate and is recommended by a referring Oregon Physician;

(e) If a Client has coverage through a managed care plan, a PHP, the request for non-emergency services must be referred to the PHP. Payment for these services is the responsibility of the PHP.

(5) Laboratory analysis of specimens sent to out-of-state independent or hospital-based Laboratories is a covered service and does not require PA. The Laboratory must meet the same certification requirements as Oregon Laboratories and must bill in accordance with 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 & 461-013-0046; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0120, 410-120-0140 & 410-120-0160; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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, for example, OMAP's Medical Director, medical consultants, dental consultants or Quality Improvement Organizations (QIO);

(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 and 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 (PA), 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,

(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, Maternity Case Management as described in OAR 410-130-0595; and where applicable for Telemedicine as described in OAR 410-130-0610;

(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;

(ii) Medicare Part D covered prescription drugs or classes of drugs, and any cost sharing for those drugs, for Medicare-Medicaid Fully Dual Eligible Clients, even if the Fully Dual Eligible Client is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for Benefit Package.

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; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1210
Medical Assistance Benefit Packages and Delivery System

(1) The services Clients are eligible to receive are based upon the Benefit Package for which they are eligible. The letters in field 9b "Benefit Packages" of the Medical Care ID identify each Client's Benefit Package. 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) The Office of Medical Assistance Programs (OMAP) Benefit Package names, and the Clients eligible to receive the various packages, are identified as follows:

(a) Oregon Health Plan (OHP) Plus Benefit Package — Clients on this Benefit Package 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 federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program and also meets Department of Human Services' (DHS) adopted income and other eligibility criteria;

(b) Qualified Medicare Beneficiary (QMB) + OHP with limited drug Benefit Package — Clients on this Benefit package are Medicare beneficiaries who meet DHS adopted income standard and other eligibility criteria for full medical assistance coverage, and are Fully Dual Eligible for purposes of Medicare Part D; DHS identifies these Clients through the Benefit Package identifier BMM;

(c) OHP with limited drug Benefit Package — Clients on this Benefit Package are Medicare beneficiaries, other than QMBs in (2)(b) of this rule, who meet DHS adopted income standard and other eligibility criteria for full medical assistance coverage, and are Fully Dual Eligible for purposes of Medicare Part D; DHS identifies these Clients through the Benefit Package identifier BMD;

(d) OHP Standard Benefit Package — Clients on this Benefit Package are eligible for OHP through the Medicaid expansion waiver granted on October 15, 2002. These Clients are adults and childless couples who meet DHS adopted income and other eligibility criteria; DHS identifies these Clients through the program acronym, OHP-OPU;

(e) Qualified Medicare Beneficiary (QMB)-Only Benefit Package — Clients on this limited Benefit Package are Medicare beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage. These Clients have coverage through Medicare Parts A and B for most covered services;

(f) Citizen/Alien-Waived Emergency Medical (CAWEM) Benefit Package — Clients on this limited Benefit Package 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 the services listed in section (3)(f) of this rule.

(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 Benefit Package 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) QMB + OHP with limited drug Benefit Package coverage includes any service covered by Medicare, except that drugs or classes of drugs covered by Medicare Part D Prescription Drug are only covered by Medicare. Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, except as limited in (E) below. 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 based on the Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(C) Chemical dependency services provided through a local alcohol and drug treatment Provider;

(D) Ancillary services, (OAR 410-141-0480);

(E) Cost sharing may apply to some covered services, however, cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the Benefit Package;

(F) OMAP will continue to coordinate benefits for drugs covered under Medicare Part B, subject to Medicare's benefit limitations and OMAP Provider rules;

(G) OMAP will cover drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR 410 Division 121 for specific limitations). The drugs include but are not limited to:

(i) Benzodiazepines;

(ii) Over-the-Counter (OTC) drugs;

(iii) Barbiturates;

(c) OHP with limited drug Benefit Package for Fully Dual Eligible Clients includes any service covered by Medicare, except that drugs or classes of drugs covered by Medicare Part D Prescription Drug are only covered by Medicare. Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, except as limited in (E) below. 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 based on the Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(C) Chemical dependency services provided through a local alcohol and drug treatment Provider.

(D) Ancillary services, (OAR 410-141-0480);

(E) Cost sharing may apply to some covered services, however cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the Benefit Package;

(F) OMAP will continue to coordinate benefits for drugs covered under Medicare Part B, subject to Medicare's benefit limitations and OMAP Provider rules;

(G) OMAP will cover drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR 410 division 121 for specific limitations). The drugs include but are not limited to:

(i) Benzodiazepines;

(ii) Over-the-Counter (OTC) drugs;

(iii) Barbiturates;

(d) 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.

(e) 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.

(f) The Citizen/Alien-Waived Emergency Medical Assistance (CAWEM) Benefit Package provides limited services:

(A) Emergency medical services and labor and delivery services; 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 covered health 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 (PCM):

(A) These Clients are enrolled with a 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; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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 (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 section (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 OAR 410-120-1400 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 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:

(A) The name and address of each person with an ownership or control interest in the Provider, or in any subcontractor in which the Provider has a direct or indirect ownership interest of 5 percent or more;

(B) Whether any of the persons so named is related to another as spouse, parent, child, or sibling; and

(C) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

(c) All Providers must agree to furnish to the Department or to the U.S. Department of Health and Human Services on request, information related to certain business transactions: A Provider must submit, within 35 days of the date of a request, full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request;

(d) OMAP may refuse to enter into or renew a Provider's enrollment agreement, or contract for Provider services, with a Provider if any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal

offense related to that person's involvement in any program established under Medicare, Medicaid 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) of this rule.

(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;

(c) OMAP reserves the right to retroactively enroll the Provider outside the 12 month period in (b) based upon extenuating circumstances outside the control of the Provider, and consistent with federal Medicaid regulations.

(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 section(10)(a) of this rule, 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) Noncontiguous Out-of-State pharmacy Providers must be licensed to provide pharmacy services by the Oregon Board of Pharmacy;

(c) The Provider bills only for services provided within the Provider's scope of licensure or certification;

(d) For noncontiguous Out-of-State Providers, the services provided must be authorized, in the manner required under these rules for Out-of-State Services (OAR 410-120-1180) or other applicable DHS rules:

(A) For a specific Oregon Medicaid Client who is temporarily outside Oregon or the contiguous area of Oregon; or

(B) For foster care or subsidized adoption children placed out of state; or

(C) The Provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) Clients.

(e) The services for which the Provider bills are covered services under the Oregon Health Plan (OHP);

(f) Facilities, including but not restricted to Hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, Psychiatric Hospitals, and residential care facilities, will be enrolled as Providers only if the facility is enrolled as a Medicaid Provider in the state in which the facility is located or is licensed as a facility Provider of services by the State of Oregon;

(g) Out-of-State Providers may provide contracted services per OAR 410-120-1880.

(12) Enrollment of Billing Providers:

(a) 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 and 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 section (12)(b) (A) of this rule 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 EDI 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 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 DHS, Federal or State regulations that are applicable to the Provider.

(C) When no claims have been submitted in an 18-month period. The Provider must reapply for enrollment.

(16) When a Provider fails to meet one or more of the requirements governing a Provider's participation in Oregon's medical assistance programs, the Provider's 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 OMAP Administrator 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; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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, 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.

(d) OMAP adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology – CPT) and on the CMS website (Healthcare Common Procedural Coding System – HCPCS) to be effective January 1, 2006. This code adoption 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 service 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.

(i) If Medicare is the primary payer and Medicare denies payment, Medicare appeals must be timely pursued and Medicare denial must be obtained prior to submitting the claim for payment to OMAP. Medicare denial on the basis of failure to submit a timely appeal may result in OMAP reducing from the amount of the claim any amount OMAP determines could have been paid by Medicare.

(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.

[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; OMAP 67-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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 (FFS) payment rates.

(3) All FFS payment rates are the rates in effect on the date of service that are the lesser of the amount billed, the 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 at http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml, and updated periodically:

(A) For all CPT/HCPCS codes assigned a Relative Value Unit (RVU) weight 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 (CMS) mandates;

(E) All approved Ambulatory Surgical Center (ASC) procedures are priced using Medicare's Group assignment for each surgical procedure;

(F) Physician administered drugs billed under a HCPCS code are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate will be based upon Average Wholesale Price (AWP). Pricing information for AWP is provided by First Data Bank. These rates may change periodically based on drug costs;

(G) All procedures used for vision materials and supplies are based on contracted rates which include acquisition cost plus shipping and handling;

(c) Individual Provider rules may specify reimbursement rates for particular services or items.

(4) 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 (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services (OAR 410 Division 121) and Home Enteral/Parenteral Nutrition and IV Services Provider rules, (OAR 410 Division 148);

(b) Physical Therapy, Speech Therapy, and Occupational Therapy provided by a non-employee of the Nursing Facility within the appropriate program Provider rules, (OAR 410 division 131 and 129);

(c) Continuous oxygen which exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment and Medical Supplies Provider rules, (OAR 410 division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services Provider rules, (OAR 410 division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services Provider rules, (OAR 410 division 130);

(f) Medical services provided by Physician or other Provider of medical services, such as radiology and Laboratory, as outlined in the Medical-Surgical Services Provider rules, (OAR 410 division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment and Medical Supplies Provider rules, (OAR 410 division 122).

(10) 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 DHS or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. Payment may be denied or subject to recovery if medical review, audit or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

[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, 461-013-0175 & 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040, 410-120-0220, 410-120-0200, 410-120-0240 & 410-120-0320; HR 2-1994, f. & cert. ef. 2-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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 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; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1460
Type and Conditions 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 licensing boards or a Quality Improvement Organization (QIO); 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 section (5) of this rule 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 OARs 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 OMAP Providers;

(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; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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 including Prior Authorization (PA) decisions, 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, claim decision including PA decision, 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 461-013-0191; 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; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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 Primary Care Practitioner (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 (DHS);

(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 and Provider(s) if there is any other insurance available, changes of insurance coverage including Private Health Insurance (PHI) according to OAR 410-120-1960, and to complete required periodic documentation of such insurance coverage in a timely manner;

(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 TPR 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; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

410-120-1960
Payment of Private Insurance Premiums

(1) Payment of insurance policy premiums for Medicaid Clients or eligible applicants will allow for the purchase of, or continuation of a Client or eligible applicant's coverage by another third party.

(2) For purposes of this rule, an eligible applicant may be a non-Medicaid individual, for whom the Office of Medical Assistance Programs (OMAP) would pay the premium if it is necessary in order to enroll the OMAP Client in the health plan in accordance with this rule. OMAP may pay health insurance policy premiums or otherwise enter into agreements with other health insurance plans that comply with ORS 414.115 to 414.145 on behalf of eligible individuals when:

(a) The policy is a major medical insurance policy; and

(b) The payment of premiums and/or co-insurance and deductibles is likely to be Cost Effective, as determined under section (4) of this rule, i.e., that the estimated net cost to OMAP will be less than the estimated cost of paying Providers on a Fee-for-Service (FFS) or other basis.

(c) An eligible applicant may be a non-Medicaid individual in the household if payment of the premium including that individual is cost effective, and if it is necessary to include that individual in order to enroll the OMAP Client in the health plan.

(3) OMAP will not pay private health insurance premiums for:

(a) Non-SSI institutionalized and waivered Clients whose income deduction is used for payment of health insurance premiums;

(b) Clients eligible for reimbursement of Cost-Effective, employer-sponsored health insurance (OAR 461-135-0990).

(4) OMAP will assure that all Medicaid covered services continue to be made available to Medicaid-eligible individuals for whom OMAP elects to purchase insurance.

(5) Assessment of Cost Effectiveness will include:

(a) The past utilization experience of the Client or eligible applicant as determined by past OMAP and third party insurance utilization and claims data; and

(b) The current and probable future health status of the Client or eligible applicant based upon existing medical conditions, previous medical history, age, number of dependents, and other relevant health status indicators; and

(c) The coverage of benefits, premium costs, copayments and coinsurance provisions, restrictions and other policies of the health insurance plans being considered.

(6) OMAP may purchase documents or records necessary to establish or maintain the Client's eligibility for other insurance coverage.

(7) OMAP will not make payments for any benefits covered under the private health insurance plan, except as follows:

(a) OMAP will calculate OMAP's allowable payment for a service. The amount paid by the other insurer will be deducted from the OMAP allowable. If the OMAP allowable exceeds the third party payment, OMAP will pay the Provider of service the difference;

(b) The payment made by OMAP will not exceed any co-insurance, Copayment or deductible due;

(c) OMAP will make payment of co-insurance, Copayments or deductibles due only for covered services provided to Medicaid-eligible Clients.

(8) OMAP payment under this rule requires the Client to promptly inform the DHS worker, within 10 days, of any change of insurance coverage to minimize overpayment.

(9) As a condition of eligibility, Clients are required to pursue assets (OAR 461-120-0330), and required to obtain medical coverage (OAR 461-120-0345). Failure to notify the DHS worker of insurance coverage or changes in such coverage, and failure to provide periodic required documentation for PHI may impact continued eligibility.

(10) The Client or eligible applicant's receipt of payment under this rule is intended for the express purpose of insurance premium payment, or reimbursement of Client paid insurance premium.

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; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: Pharmaceutical Rule Revisions for July 1, 2006.
Adm. Order No.: OMAP 16-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-121-0030, 410-121-0060, 410-121-0100, 410-121-0140, 410-121-0147, 410-121-0150, 410-121-0155, 410-121-0160
Subject: The Pharmaceutical Rules govern Office of Medical Assistance Programs payment for pharmaceutical products provided to certain clients. All rules listed above were amended to make necessary housekeeping corrections, otherwise, OMAP amended rules as follows:

410-121-0060: to clarify that if a client is enrolled in managed care and the particular pharmacy is not a participating provider with the managed care plan, the pharmacist should inform the client of that fact and should also inform the client he or she can contact their managed care plan for a list of participating providers.

410-121-0100: to clarify that a dispensing pharmacist may offer to counsel a client's caregiver rather than the client presenting the new prescription if the pharmacist determines that it is appropriate under the circumstances.

410-121-0140: to delete the definition of Durable Medical Equipment (DME) and instead refer to the definition of DME located in the OMAP DMEPOS administrative rule 410-122-0010.

410-121-0147: to delete subsection (10) that says OMAP will not cover drug products and drug product quantities that do not need OMAP guidelines. OMAP Pharmacy Program rules clearly indicate coverage for drugs and drug quantities.

410-121-0160: to clarify that an institutional pharmacy must send to OMAP a copy of its institutional license along with its provider application in order to qualify for the enhanced institutional reimbursement.

Rules Coordinator: Darlene Nelson—(503) 945-6927

410-121-0030
Practitioner-Managed Prescription Drug Plan (PMPDP)

(1) The Practitioner-Managed Prescription Drug Plan (PMPDP) is a plan that ensures that fee for service clients of the Oregon Health Plan will have access to the most effective prescription drugs appropriate for their clinical conditions at the best possible price:

(a) Licensed health care practitioners (informed by the latest peer reviewed research), make decisions concerning the clinical effectiveness of the prescription drugs;

(b) The licensed health care practitioners also consider the health condition of a client or characteristics of a client, including the client's gender, race or ethnicity.

(2) PMPDP Plan Drug List (PDL):

(a) The PDL is the primary tool that the Department of Human Services (DHS) has developed to inform licensed health care practitioners about the results of the latest peer-reviewed research and cost effectiveness of prescription drugs;

(b) The PDL consists of prescription drugs in selected classes that DHS, in consultation with the Health Resources Commission (HRC), has determined represent effective drug(s) available at the best possible price;

(c) For each selected drug class, the PDL will identify a drug(s) as the benchmark drug that DHS determines to be the most effective drug(s) available for the best possible price;

(d) The PDL will include other drugs in the class that are Medicaid reimbursable and which the Food and Drug Administration (FDA) has determined to be safe and effective if the relative cost is less than the benchmark drug(s). If pharmaceutical manufacturers enter into supplemental discount agreements with DHS that reduce the cost of their drug below that of the benchmark drug for the class, DHS will include their drug in the PDL;

(e) A copy of the current PDL is available on the web at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/.

(3) PMPDP PDL Selection Process:

(a) DHS will utilize the recommendations made by the HRC, which result from an evidence-based evaluation process, as the basis for identifying the most effective drug(s) within a selected drug class;

(b) DHS will determine the drug(s) identified in (3)(a) that is (are) available for the best possible price and will consider any input from the HRC about other FDA-approved drug(s) in the same class that are available for a lesser relative price. DHS will determine relative price using the methodology described in subsection (4);

(c) DHS will review drug classes and selected drug(s) for the drug classes periodically:

(A) Review will occur more frequently at the discretion of DHS if new safety information or the release of new drugs in a class or other information makes a review advisable;

(B) DHS will not add new drugs to the PDL until they have been reviewed by the HRC;

(C) DHS will make all changes or revisions to the PDL, using the rulemaking process and will publish the changes on DHS's Pharmaceutical Services provider rules Web page.

(4) Relative cost and best possible price determination:

(a) DHS will determine the relative cost of all drugs in each selected class that are Medicaid reimbursable and that the FDA has determined to be safe and effective;

(b) DHS may also consider dosing issues, patterns of use and compliance issues. DHS will weigh these factors with any advice provided by the HRC in reaching a final decision;

(c) DHS will determine the benchmark drug based on (4)(b) and on the Estimated Acquisition Cost (EAC) on the first of the month (OAR 410-121-0155) in which DHS reviews that specific drug class;

(d) Once the cost of the benchmark drug is determined, DHS will recalculate the cost of the other FDA-approved drugs in the class using the EAC in effect for retail pharmacies on the first of the month in which DHS reviews that specific drug class less average available rebate. DHS will include drugs with prices under the benchmark drug cost on the PDL.

(5) Regardless of the PDL, pharmacy providers shall dispense prescriptions in the generic form, unless the practitioner requests otherwise, subject to the regulations outlined in OAR 410-121-0155. Table 121-0030-1, PMPDP PDL (updated effective 7/1/06)

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 25-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 31-2002, f. & cert. ef. 8-1-02; OMAP 36-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 35-2003, f. & cert. ef. 5-1-03; OMAP 47-2003, f. & cert. ef. 7-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 70-2003(Temp), f. 9-15-03, cert. ef. 10-1-03 thru 3-15-04; OMAP 82-2003, f. 10-31-03, cert. ef. 11-1-03; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 29-2004, f. 4-23-04 cert. ef. 5-1-04; OMAP 34-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 45-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 81-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 32-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 58-2005, f. 10-27-05, cert. ef. 11-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0060
How to Get Prior Authorization for Drugs

(1) A prescriber electing to order a drug requiring PA may have any licensed medical personnel in their office call the Managed Access Program (MAP) Help Desk to request the PA. The PA request may also be transmitted to the MAP Help Desk by FAX using the request form shown in the Pharmaceutical Services Supplemental Information on the Department of Human Services website.

(2) PA approval:

(a) If the PA request is approved, the MAP Help Desk will notify the pharmacy when the dispensing pharmacy information will be available.

(A) PA approvals are given for a specific date of service and for specific NDC numbers or products.

(B) PA approvals do not guarantee eligibility or reimbursement.

(b) It is the pharmacist's responsibility to check whether the drugs are covered, whether the client is eligible, and to note restrictions such as date ranges and quantities before dispensing any medications that require PA.

(c) The pharmacy must also check whether the client's prescribed medications are covered by a managed care plan because an enrollment may have taken place after PA was received. If the client is enrolled in a managed care plan and the pharmacy receiving the PA is not a participating pharmacy provider in the managed care plan's network, the pharmacy must inform the client that it is not a participating provider in the managed care plan's network and must also recommend that the client contact his or her managed care plan for a list of pharmacies participating in its network..

(d) After a PA request is approved, the patient will be able to fill the prescription at any Medicaid pharmacy provider, if consistent with all other applicable administrative rules. There is no need for a PA number.

(3) If the PA request has been denied, the MAP Help Desk will notify the pharmacy when the dispensing pharmacy information will be available.

(4) Emergency Need: The Pharmacist may request an emergent or urgent dispensing from First Health when the client is eligible for covered fee-for-service drug prescriptions.

(a) Clients who do not have a PA pending may receive an emergency dispensing for a 96-hour supply.

(b) Clients who do have a PA pending may receive an emergency dispensing up to a seven-day supply.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0180; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 2-1995, f. & cert. ef. 2-1-95; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0100
Drug Use Review

(1) Drug Use Review (DUR) in Oregon Medical Assistance Programs (OMAP) is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program shall include, but is not limited to, education in relation to overutilization, underutilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse.

(a) Information collected in a DUR program that identifies an individual is confidential and may not be disclosed by OMAP's DUR Board or Retrospective DUR Council to any person other than health care providers appearing on a recipient's medication profile.

(b) Staff of the DUR Board and Retrospective DUR Council may have access to identifying information to carry out intervention activities approved by OMAP, after signing an agreement to keep the information confidential. The identifying information may not be released to anyone other than staff members of the DUR Board or Retrospective DUR Council, or health care providers appearing on a recipient's medication profile. For purposes of DUR activities, identifying information is defined as the names of prescribing providers, pharmacy providers, and clients.

(2) Prospective DUR is the screening for potential drug therapy problems before each prescription is dispensed. It is performed at the point of sale by the dispensing pharmacist.

(a) Dispensing pharmacists must offer to counsel each OMAP client receiving benefits who presents a new prescription, unless the client refuses such counsel. Pharmacists must document these refusals.

(A) Dispensing pharmacists may offer to counsel the client's caregiver rather than the client presenting the new prescription if the dispensing pharmacist determines that it is appropriate in the particular instance.

(B) Counseling must be done in person whenever practicable.

(C) If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide access to toll-free services (for example, some mail order pharmacy services) and must provide access to toll-free service for long-distance client calls in relation to prescription counseling.

(b) Prospective DUR is not required for drugs dispensed by Fully Capitated Health Plans (FCHPs).

(c) Oregon Board of Pharmacy rules defining specific requirements relating to patient counseling, record keeping and screening must be followed.

(3) Retrospective DUR is the screening for potential drug therapy problems based on paid claims data. OMAP provides a professional drug therapy review for Medicaid clients through this program.

(a) The criteria used in retrospective DUR are compatible with those used in prospective DUR. The drug therapy review is carried out by a panel of physicians and pharmacists who are licensed in Oregon and appointed by OMAP's Administrator. Members of this panel are referred to as council members.

(b) If therapy problems are identified by the Retrospective DURCouncil, an educational letter is mailed to the prescribing provider, the dispensing provider, or both. Other forms of education are carried out under this program with OMAP approval.

(4) The DUR Board is a group of individuals who comprise an advisory committee to OMAP.

(a) The DUR Board is comprised of health care professionals with recognized knowledge and expertise in one or more of the following areas:

(A) Clinically appropriate prescribing of outpatient drugs covered by Medicaid;

(B) Clinically appropriate dispensing and monitoring of outpatient drugs covered by Medicaid;

(C) Drug use review, evaluation and intervention; or

(D) Medical quality assurance.

(b) The DUR Board's membership is made up of at least one-third, but not more than 51 percent, licensed and actively practicing physicians and at least one-third licensed and actively practicing pharmacists. The DUR Board is composed of the following:

(A) Four practicing pharmacists;

(B) Five practicing physicians;

(C) Two persons who represent people on Medical Assistance; and

(D) One person actively practicing dentistry.

(c) The Retrospective DUR Council coordinator will attend board meetings in an ex officio capacity.

(d) Appointments to the DUR Board are made by OMAP's Administrator.

(A) Nominations for DUR Board membership may be sought from various professional associations and each member may serve a two-year term.

(B) When a vacancy occurs, a new member is appointed to serve the remainder of the unexpired term.

(C) An individual appointed to the DUR Board may be reappointed upon the completion of the member's current term of service.

(e) Members of the DUR Board receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties.

(f) Members of the DUR Board attend quarterly meetings, two of which must be attended in person.

(5) The DUR Board is designed to develop policy recommendations in the following areas in relation to Drug Use Review:

(a) Appropriateness of criteria and standards for prospective DUR and needs for modification of these areas. DUR criteria are predetermined elements of health care based upon professional expertise, prior experience, and the professional literature with which the quality, medical appropriateness, and appropriateness of health care service may be compared. Criteria and standards will be consistent with the following compendia:

(A) American Hospital Formulary Services Drug Information;

(B) US Pharmacopeia-Drug Information;

(C) American Medical Association Drug Evaluations;

(D) Peer-reviewed medical literature; or

(E) Drug DEX.

(b) Recommendations for continued maintenance of patient confidentiality will be sought;

(c) The use of different types of education and interventions to be carried out or delegated by the DUR Board and the evaluation of the results of this portion of the program; and

(d) The preparation of an annual report on Oregon Medicaid DUR Program which describes:

(A) The nature and scope of the DUR Board and the activities carried out by the DUR Board, including:

(i) A description of how pharmacies without computers comply with prospective DUR;

(ii) Detailed information on new criteria and standards in use; and

(iii) Changes in state policy in relation to DUR requirements for residents in nursing homes.

(B) A summary of the education/intervention strategies developed; and

(C) An estimate of the cost savings in the pharmacy budget and indirect savings due to changes in levels of physician visits and hospitalizations.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 38-1992, f. 12-31-92, cert. ef. 1-1-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0140
Definition of Terms

(1) Actual Acquisition Cost: The net amount paid per invoice line item to a supplier. This net amount does not include separately identified discounts for early payment.

(2) Automated Information System (AIS): A computer system that provides on-line Medicaid eligibility information. AIS is accessed through the provider's touch-tone telephone by dialing 1-800-522-2508.

(3) Bulk Dispensing: Multiple doses of medication packaged in one container labeled as required by pertinent Federal and State laws and rules.

(4) Community Based Care Living Facility: For the purposes of the OMAP Pharmacy Program, "community based care living facilities" include:

(a) Supportive Living Facilities;

(b) 24-Hour Residential Services;

(c) Foster Care;

(d) Semi-independent Living Programs; and

(e) Assisted Living and Residential Care Facilities.

(5) Compounded Prescriptions: A prescription that is prepared at the time of dispensing and involves the weighting of at least one solid ingredient that must be a reimbursable item or a legend drug in a therapeutic amount. Compounded prescription is further defined to include the Oregon Board of Pharmacy definition of Compounding.

(6) Dispensing: Issuance of a prescribed quantity of an individual drug entity by a licensed pharmacist.

(7) Drug Order/Prescription:

(a) A medical practitioner's written or verbal instructions for a patient's medications; or

(b) A medical practitioner's written order on a medical chart for a client in a nursing facility.

(8) Durable Medical Equipment and supplies (DME): Equipment and supplies as defined in OAR 410-122-0010, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. (9) Estimated Acquisition Cost (EAC): The estimated cost at which the pharmacy can obtain the product listed in OAR 410-121-0155.

(10) Managed Access Program (MAP): The Managed Access Program (MAP) is a system of determining, through a series of therapeutic and clinical protocols, which drugs require authorizations prior to dispensing.

(a) The drugs or categories of drugs requiring prior authorization (PA) are listed in OAR 410-121-0040.

(b) The practitioner, or practitioner's licensed medical personnel listed in OAR 410-121-0060, may request a PA.

(11) Nursing Facilities: The term "Nursing Facility" refers to an establishment which is licensed and certified by DHS Seniors and People with Disabilities cluster as a Nursing Facility.

(12) Point-of-Sale (POS): A computerized, claims submission process for retail pharmacies which provides on-line, real-time claims adjudication.

(13) Prescription Splitting: Any one or a combination of the following actions:

(a) Reducing the quantity of a drug prescribed by a licensed practitioner for prescriptions not greater than a 34-day (See OAR 410-121-0146);

(b) Billing the agency for more than one dispensing fee when the prescription calls for one dispensing for the quantity dispensed;

(c) Separating the ingredients of a prescribed drug and billing the agency for separate individual ingredients, with the exception of compounded medications (see OAR 410-121-0146); or

(d) Using multiple 30-day cards to dispense a prescription when a lesser number of cards will suffice.

(14) Unit Dose: A sealed, single unit container of medication, so designed that the contents are administered to the patient as a single dose, direct from the container, and dispensed following the rules for unit dose dispensing system established by the Oregon Board of Pharmacy.

(15) Unit Dose Delivery System: OMAP currently recognizes two types of unit dose dispensing systems in a nursing facility or community based living facility. Both the True and Modified Unit Dose delivery systems are described in OAR 410-121-0148.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 818(Temp), f. 10-22-76, ef. 11-1-76; PWC 831, f. 2-18-77, ef. 3-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 28-1982, f. 6-17-81, ef. 7-1-81; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82; AFS 54-1985(Temp), f. 9-23-85, ef. 10-1-85 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 42-1986(Temp), f. 6-10-86, ef. 7-1-86; AFS 11-1987, f. 3-3-87, ef. 4-1-87; AFS 2-1989(Temp), f. 1-27-89, cert. ef. 2-1-89; AFS 17-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 42-1989, f. & cert. ef. 7-20-89; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0010; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0190; HR 52-1991(Temp), f. 11-29-91, cert. ef. 12-1-91; HR 6-1992, f. & cert. ef. 1-16-92; HR 28-1992, f. & cert. ef. 9-1-92; HR 14-1993, f. & cert. ef. 7-2-93; HR 20-1993, f. & cert. ef. 9-1-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 6-1996(Temp), f. & cert. ef. 8-1-96; HR 27-1996, f. 12-11-96, cert. ef. 12-15-96; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 49-2001, f. 9-28-01, cert. ef. 10-1-01 thru 3-15-02; OMAP 59-2001, f. & cert. ef. 12-11-01; OMAP 37-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 9-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 18-2003(Temp), f. 3-14-03, cert. ef. 4-1-03 thru 9-1-03 (Suspended by OMAP 27-2003, f. 3-31-03, cert. ef. 4-1-03 thru 4-15-03); OMAP 32-2003(Temp), f. & cert. ef. 4-15-03 thru 9-15-03; OMAP 42-2003(Temp), f. 5-30-03, cert. ef. 6-1-03 thru 11-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 72-2003(Temp), f. 9-23-03, cert. ef. 11-1-03 thru 4-15-04; OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0147
Exclusions and Limitations

The following items are not covered for payment by the Office of Medical Assistance Programs (OMAP):

(1) Drug Products for diagnoses below the funded line on the Health Services Commission Prioritized List;

(2) Home pregnancy kits;

(3) Fluoride for individuals over 18 years of age;

(4) Expired drug products;

(5) Drug Products from Non-Rebatable Manufacturers;

(6) Drug products that are not assigned a National Drug Code (NDC) number;

(7) Drug products that are not approved by the Federal Drug Administration (FDA);

(8) Drug products dispensed for Citizen/Alien-Waived Emergency Medical client benefit type;

(9) DESI drugs (see OAR 410-121-0420);

(10) Medicare Part D covered drugs or classes of drugs for fully dual eligible clients;

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 22-1993(Temp),f. & cert. ef. 9-1-93; HR 34-1993(Temp), f. & cert. ef. 12-1-93; HR 11-1994, f. 2-25-94, cert. ef. 2-27-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 22-1997, f. & cert. ef. 10-1-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0150
Billing Requirements

(1) When billing the Office of Medical Assistance Programs (OMAP) for drug products, the provider must not bill in excess of the usual and customary charge to the general public.

(2) The National Drug Code (NDC), as it appears on the package from which the prescribed medications are dispensed, must be indicated.

(3) Actual metric decimal quantity dispensed, must be billed.

(4) The provider must accurately furnish all information required on the 5.1 Universal Claims Form if submitting a paper claim.

(5) The prescribing provider's Medicaid Provider Identification (ID) Number is mandatory on all fee-for-service client drug prescription claims. Claims will deny for a missing or invalid prescriber Medicaid Provider ID Number. Exceptions to this include, but are not limited to, the following:

(a) A miscellaneous Medicaid provider number – 999999, may be used for:

(A) Out-of-state prescribing providers; and

(B) Inactive Oregon Medicaid Providers;

(b) Prescribing providers who do not have a Medicaid Provider ID Number for billing, but who prescribe for fee-for-service prescriptions for clients under prepaid health plans (PHP), long-term care, or other capitated contracts are to be identified with the:

(A) Non-billing Provider ID Number assigned for prescription writing only;

(B) Clinic or facility Medicaid Provider ID Number until an individual Non-billing Provider ID Number is obtained; or

(C) Supervising physician's Provider ID Number when billing for prescriptions written by the physician assistant, physician students, physician interns, or medical professionals who have prescription writing authority.

(c) A miscellaneous Medicaid Provider ID Number - 999999 may not be used for psychotropic prescriptions for children under the age of six.

(6) When clients have private insurance, providers are required to bill the private insurance as primary and OMAP as secondary.

(7) When clients have Medicare prescription drug coverage, providers are required to bill Medicare as primary and OMAP as secondary.

(8) Billing for Death With Dignity services – Death With Dignity:

(a) Claims for Death With Dignity services cannot be billed through the Point-of-Sale system.

(b) Services must be billed directly to OMAP, even if the client is in a PHP.

(c) Prescriptions must be billed on a 5.1 Universal Claims Form paper claim form using an NDC number.

(d) Claims must be submitted on paper billing forms to OMAP at PO Box 14165, Salem, Oregon 97308-0992.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 15-1987, f. 3-31-87, ef. 4-1-87; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0093; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0240; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 44-1998(Temp), f. 12-1-98, cert. ef. 12-1-98 thru 5-1-99; OMAP 11-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 25-1999, f. & cert. ef. 6-4-99; OMAP 5-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 7-2002, f. & cert. ef. 4-1-02; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 43-2003(Temp), f. 6-10-03, cert. ef. 7-1-03 thru 12-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0155
Reimbursement

Payment for covered fee-for-service drug products will be the lesser of the usual and customary amount billed or the Estimated Acquisition Cost (EAC) of the generic form, minus any applicable copayments, plus a professional dispensing fee. Refer to OAR 410-120-1230 for client copayment details.

(1) EAC is the lesser of:

(a) The Centers for Medicare and Medicaid Services' (CMS) federal upper limits (FUL) for payment;

(b) The Oregon Maximum Allowable Cost (OMAC);

(c) Retail pharmacies: eighty-five percent of Average Wholesale Price (AWP) of the drug; or

(d) Unit dose or modified unit dose pharmacies: eighty-nine percent of AWP for long-term care clients in a nursing facility or community based living facility; or

(d) Contracted mail order pharmacy: seventy-nine percent of AWP for brand (trade) name drugs, forty percent of AWP for generic drugs and eighty-two percent of AWP for injectable drugs.

(2) The Office of Medical Assistance Programs (OMAP) shall revise its estimated acquisition cost file weekly.

(3) Pharmacies must make available to OMAP any information necessary to determine the pharmacy's actual acquisition cost of drug products dispensed to OMAP clients.

(4) Payment for trade name forms of multisource products will be the lesser of the amount billed or the EAC of the trade name form of the product, minus applicable copayments, plus a professional dispensing fee only if the prescribing practitioner has received a prior authorization for a trade name drug.

(5) Payment for individual special admixtures, fluids or supplies shall be limited to the lesser of:

(a) Eighty percent of the usual and customary charges to the general public;

(b) The amount Medicare allows for the same product or service;

(c) The amount the agency negotiates with an individual provider, less any amount paid or payable by another third party; or

(d) The amount established or determined by OMAP.

(6) No professional dispensing fee is allowed for dispensing:

(a) Condoms, contraceptive foams, suppositories, inserts, jellies, and creams;

(b) Pill splitters/cutters;

(c) Medical supplies and equipment; and

(d) Oral nutritional supplements.

(7) Over-the-counter contraceptive drugs and devices will be reimbursed at the lesser of billed amount or EAC, plus fifty percent of EAC;

(8) Oral nutritional supplements will be reimbursed at the lesser of billed amount or EAC, plus one third of EAC.

(9) Pill splitters/cutters with a National Drug Code (NDC) number will be reimbursed at the lesser of billed amount, or EAC. A practitioner prescription is not required. The limit is one per client in a twelve-month period.

Stat. Auth.: ORS 184.750, 184.770, 409, 411 & 414

Stats. Implemented: ORS 414.065
Hist.: PWC 818(Temp), f. 10-22-76, ef. 11-1-76; PWC 831, f. 2-18-77, ef. 3-1-77; PWC 846(Temp), f. & ef. 7-1-77; PWC 858, f. 10-14-77, ef. 11-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 15-1979(Temp), f. 6-29-79, ef. 7-1-79; AFS 41-1979, f. & ef. 11-1-79; AFS 15-1981, f. 3-5-81, ef. 4-1-81; AFS 35-1981(Temp), f. 6-26-81, ef. 7-1-81; AFS 53-1981(Temp), f. & ef. 8-14-81; AFS 70-1981, f. 9-30-81, ef. 10-1-81; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices. AFS 74-1982 (Temp), f. 7-22-81, ef. 8-1-82; AFS 99-1982, f. 10-25-82, ef. 11-1-82; AFS 113-1982(Temp), f. 12-28-82, ef. 1-1-83; AFS 13-1983, f. & ef. 3-21-83; AFS 51-1983(Temp), f. 9-30-83, ef. 10-1-83; AFS 56-1983, f. 11-17-83, ef. 12-1-83; AFS 18-1984, f. 4-23-84, ef. 5-1-84; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 42-1986(Temp), f. 6-10-86, ef. 7-1-86; AFS 52-1986, f. & ef. 7-2-86; AFS 12-1987, f. 3-3-87, ef. 4-1-87; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0100; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0250; HR 20-1991, f. & cert. ef. 4-16-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 61-2001(Temp), f. 12-13-01, cert. ef. 12-15-01 thru 3-15-02; OMAP 1-2002, cert. ef. 2-15-02; OMAP 32-2002, f. & cert. ef. 8-1-02; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

410-121-0160
Dispensing Fees

(1) Pharmacy providers must apply for an Office of Medical Assistance Programs (OMAP) review of their pharmacy dispensing fee level by completing a Pharmacy Prescription Survey (OMAP 3062) when one of the following situations occurs:

(a) The pharmacy initiates dispensing medications to clients in facilities and the most recent two months worth of dispensing data is available. OMAP will only accept the most recent two months worth of data;

(b) The pharmacy discontinues dispensing medications to clients in facilities. The pharmacy provider is required to notify OMAP within 60 days and complete a new Pharmacy Prescription Survey with the most recent two-months worth of dispensing data available. OMAP will only accept the most recent two months worth of data; or

(c) A completed Pharmacy Prescription Survey signed by the pharmacist in charge must be submitted to OMAP to initiate a review of dispensing fees.

(2) Unless otherwise provided, the professional dispensing fee allowable for services is as follows:

(a) $3.50 - Retail Pharmacies.

(b) $3.91 - Institutional Pharmacies operating with a True or Modified Unit Dose Delivery System as defined by OMAP and that are enrolled with OMAP as an institutional pharmacy by sending a copy of its institutional pharmacy license with its provider application.

(A) This dispensing fee applies to prescriptions dispensed to clients identified on DHS case files as residing in a Long Term Care Nursing Facility or for clients covered by the Centers for Medicare and Medicaid Services community based waiver.

(B) All other dispensing fees for institutional pharmacies will be at the retail rate.

(c) $7.50 — Compound prescriptions with two or more ingredients.

(3) The True or Modified Unit Dose Delivery System applies to those providers who give this service to over fifty percent of their patient population base associated with a particular Medicaid provider number.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 51-1983(Temp), f. 9-30-83, ef. 10-1-83; AFS 56-1983, f. 11-17-83, ef. 12-1-83; AFS 41-1984(Temp), f. 9-24-84, ef. 10-1-84; AFS 1-1985, f. & ef. 1-3-85; AFS 54-1985(Temp), f. 9-23-85, ef. 10-1-85; AFS 66-1985, f. 11-5-85, ef. 12-1-85; AFS 13-1986(Temp), f. 2-5-86, ef. 3-1-86; AFS 36-1986, f. 4-15-86, ef. 6-1-86; AFS 52-1986, f. & ef. 7-2-86; AFS 12-1987, f. 3-3-87, ef. 4-1-87; AFS 28-1987(Temp), f. & ef. 7-14-87; AFS 50-1987, f. 10-20-87, ef. 11-1-87; AFS 41-1988(Temp), f. 6-13-88, cert. ef. 7-1-88; AFS 64-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0101; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 20-1990, f. & cert. ef. 7-9-90, Renumbered from 461-016-0260; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 21-1993(Temp), f. & cert. ef. 9-1-93; HR 12-1994, f. 2-25-94, cert. ef. 2-27-94; OMAP 5-1998(Temp), f. & cert. ef. 2-11-98 thru 7-15-98; OMAP 22-1998, f. & cert. ef. 7-15-98; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 50-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-1-02; OMAP 60-2001, f. & cert. ef. 12-11-01; OMAP 32-2003(Temp), f. & cert. ef. 4-15-03 thru 9-15-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 7-2004, f. 2-13-04 cert. ef. 3-15-04; OMAP 19-2004(Temp), f. & cert. ef. 3-15-04 thru 4-14-04; OMAP 21-2004, f. 3-15-04, cert. ef. 4-15-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: DME, IME, upper payment limit and additional changes to rules awaiting CMS approval.
Adm. Order No.: OMAP 17-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-125-0141, 410-125-0142, 410-125-0155, 410-125-0181, 410-125-0190, 410-125-0195, 410-125-0220, 410-125-0221, 410-125-0600, 410-125-0720, 410-125-2080
Subject: The Hospital Services program rules govern payments for the Office of Medical Assistance Programs' (OMAP) for services provided to certain clients. OMAP will amend rules listed above for housekeeping and clarification purposes, if necessary, otherwise OMAP will amend:

410-125-0220, 410-125-0600, 410-125-0720, and 410-125-2080, to update form names and titles for accuracy. Also, with implementation contingent upon receipt of approval from Centers for Medicare and Medicaid Services (CMS), OMAP amended as follows:

410-125-0141, 410-125-0142, 410-125-0220, and 410-125-0221, to eliminate Direct Medical Education (DME) and Indirect Medical Education (IME) settlements to hospitals for teaching expenses.

410-125-0155, to clarify calculation of the upper payment limit related to the elimination of DME and IME and to make explicit the inclusion of outpatient in the UPL.

410-125-0181, 410-125-0190, and 410-125-0195, to comply with an agreement with the Oregon Association of Hospitals and Health Systems to eliminate maternity case management interim reimbursement from payment by Fee-For-Service fee schedule.

The implementation date for the rule revisions, awaiting CMS approval, is not operational and a basis for reimbursement until OMAP determines federal approval has been obtained. Following CMS approval, OMAP will implement the rule revisions and file the rules permanently. On or before the effective date, the permanent rules will be available on OMAP's website at: http://www.dhs.state.or.us/policy/healthplan/guides/main.html
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-125-0141
DRG Rate Methodology

(1) Diagnosis Related Groups:

(a) Diagnosis Related Groups (DRG) is a system of classification of diagnoses and procedures based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM);

(b) The DRG classification methodology assigns a DRG category to each inpatient service, based on the patient's diagnoses, age, procedures performed, length of stay, and discharge status.

(2) Medicare Grouper: The Medicare Grouper is the software used to assign an individual claim to a DRG category. Medicare revises the Grouper program each year in October. The Office of Medical Assistance Programs (OMAP) uses the Medicare Grouper program in the assignment of inpatient hospital claims. The most recent version of the Medicare grouper will be installed each year within 90 days of the date it is implemented by Medicare. Where better assignment of claims is achieved through changes to the grouper logic, OMAP may modify the logic of the grouper program. OMAP will work with representatives of hospitals that may be affected by grouper logic changes in reaching a cooperative decision regarding changes. OMAP DRG weight tables can be found on the DHS web site.

(3) DRG Relative Weights:

(a) Relative weights are a measure of the relative resources required in the treatment of the average case falling within a specific DRG category;

(b) For most DRGs, OMAP establishes a relative weight based on federal Medicare DRG weights. For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs, Oregon Title XIX fee-for-service claims history is used. To determine whether enough claims exist to establish a reasonable weight for each state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRG, OMAP uses the following methodology: Using the formula N = where Z = 1.15 (a 75% confidence level), S is the standard deviation, and R = 10% of the mean. OMAP determines the minimum number of claims required to set a stable weight for each DRG (N must be at least 5). For state-specific Rehabilitation, Neonate, and Adolescent Psychiatric DRGs lacking sufficient volume, OMAP sets a relative weight using:

(A) OMAP non-Title XIX claims data; or

(B) Data from other sources expected to reflect a population similar to the OMAP Title XIX caseload.

(c) When a test shows at the 90% confidence level that an externally derived weight is not representative of the average cost of services provided to the OMAP Title XIX population in that DRG, the weight derived from OMAP Title XIX claims history is used instead of the externally derived weight for that DRG.

(d) Those relative weights based on Federal Medicare DRG weights, will be established when changes are made to the DRG Grouper logic. State specific relative weights shall be adjusted, as needed, as determined by OMAP. When relative weights are recalculated, the overall Case Mix Index (CMI) will be kept constant. Reweighing of DRGs or the addition or modification of the grouper logic will not result in a reduction of overall payments or total relative weights.

(4) Case Mix Index: The hospital-specific case mix index is the total of all relative weights for all services provided by a hospital during a period, divided by the number of discharges.

(5) Unit Value: Hospitals larger than fifty (50) beds are reimbursed using the Diagnosis Related Grouper (DRG) as described in (2). Effective for services on or after:

(a) March 1, 2004, the Unit Value payment is 80% of the 2004 Medicare Unit Value and related data published in Federal Register/Vol.68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge.

(b) August 15, 2005, the operating unit payment is 100% of 2004 Medicare and related data published in Federal Register/Vol. 68, No. 148, August 1, 2003. The unit value is also referred to as the operating unit per discharge.

(6) DRG Payment: The DRG payment to each Oregon DRG hospital is calculated by adding the unit value to the capital amount, then multiplied by the claim assigned DRG relative weight (out of state hospitals do not receive the capital amount).

(7) Cost Outlier Payments:

(a) Cost outlier payments are an additional payment made to in-state and contiguous hospitals for exceptionally costly services or exceptionally long lengths of stay provided to Title XIX and SF (State Facility) clients.

(b) For dates of service on and after March 1, 2004 the calculation to determine the cost outlier payment for Oregon DRG hospitals is as follows:

(A) Non-covered services (such as ambulance charges) are deducted from billed charges;

(B) The remaining billed charges are converted to hospital-specific costs using the hospital's cost-to-charge ratio derived from the most recent audited Medicare cost report and adjusted to the Medicaid caseload;

(C) If the hospital's net costs as determined above are greater than 270 percent of the DRG payment for the admission and are greater than $25,000, an additional cost outlier payment is made;

(D) Costs which exceed the threshold ($25,000 or 270% of the DRG payment, whichever is greater) are reimbursed using the following formula:

(i) Billed charges less non-covered charges, multiplied by;

(ii) Hospital-specific cost-to-charge ratio equals;

(iii) Net Costs, minus;

(iv) 270% of the DRG or $25,000 (whichever is greater), equals;

(v) Outlier Costs, multiplied by;

(vi) Cost Outlier Percentage, (cost outlier percentage is 50%), equals;

(vii) Cost Outlier Payment.

(E) Third party reimbursements are deducted from the OMAP calculation of the payable amount;

(F) When hospital cost reports are audited during the cost settlement process, an adjustment will be made to cost outlier payments to reflect the actual Medicaid hospital-specific cost-to-charge ratio during the time cost outlier claims were incurred. The cost-to-charge ratio in effect for that period of time will be determined from the audited Medicare Cost Report and OMAP 42, adjusted to reflect the Medicaid mix of services.

(8) Capital:

(a) The capital payment is a reimbursement to in-state hospitals for capital costs associated with the delivery of services to Title XIX, non-Medicare persons. OMAP uses the Medicare definition and calculation of capital costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) For the dates of service on and after March 1, 2004 the Capital cost per discharge is one hundred (100) percent of the published Medicare capital rate for fiscal year 2004, see (5). The capital cost is added to the Unit Value and paid per discharge.

(9) Direct Medical Education:

(a) The direct medical education payment is a reimbursement to in-state hospitals for direct medical education costs associated with the delivery of services to Title XIX eligible persons. The Office of Medical Assistance Programs uses the Medicare definition and calculation of direct medical education costs. These costs are taken from the Hospital Statement of Reimbursable Cost (Medicare Report);

(b) Direct Medical Education cost per discharge is calculated as follows:

(A) The direct medical education cost proportional to the number of Title XIX non-Medicare discharges during the period from July 1, 1986 through June 30, 1987 are divided by the number of Title XIX non-Medicare discharges. This is the Title XIX Direct Medical Education Cost per discharge;

(B) The Title XIX Direct Medical Education cost per discharge for this period is inflated forward to January 1, 1992, using the compounded HCFA-DRI market basket adjustment.

(c) Direct Medical Education Payment Per Discharge:

(A) The number of Title XIX non-Medicare discharges from each hospital for the quarterly period is multiplied by the inflated Title XIX cost per discharge. This determines the current quarter's Direct Medical Education costs. This amount is then multiplied by 85%. Payment is made within thirty days of the end of the quarter;

(B) The Direct Medical Education Payment per Discharge will be adjusted at an inflation factor determined by the Department in consideration of inflationary trends, hospital productivity and other relevant factors.

(C) Notwithstanding subsection (9) of this rule, this subsection becomes effective for dates of service on and after July 1, 2006 and thereafter Direct Medical Education payments will not be made to hospitals, but will not be operative as the basis for payments until OMAP determines all necessary federal approvals have been obtained.

(10) Indirect Medical Education:

(a) The indirect medical education payment is a reimbursement made to instate hospitals for indirect medical education costs associated with the delivery of services to Title XIX non-Medicare clients;

(b) Indirect medical education costs are those indirect costs identified by Medicare as resulting from the effect of teaching activity on operating costs;

(c) Indirect medical education payments are made to in-state hospitals determined by Medicare to be eligible for such payments. The indirect medical education factor in use by Medicare for each of these eligible hospitals at the beginning of the State's fiscal year is the Office of Medical Assistance Program's indirect medical education factor. This factor is used for the entire Oregon fiscal year;

(d) For dates of service on and after March 1, 2004 the calculation for the Indirect Medical Education quarterly payment is as follows: Total paid discharges during the quarter multiplied by the Case Mix Index, multiplied by the hospital specific February 29, 2004 Unit Value, multiplied by the Indirect Factor equals the Indirect Medical Education Payment;

(e) This determines the current quarter's Indirect Medical Education Payment. Indirect medical education payments are made quarterly to each eligible hospital. Payment for indirect medical education costs will be made within thirty days of the end of the quarter.

(d) Notwithstanding subsection (10) of this rule, this subsection becomes effective for dates of service on and after July 1, 2006 and thereafter Indirect Medical Education payment will not be made to hospitals, but will not be operative as the basis for payments until OMAP determines all necessary federal approvals have been obtained.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570, 461-015-0590, 461-015-0600 & 461-015-0610; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 42-1990, f. & cert. ef. 11-30-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840, 410-125-0880, 410-125-0900, 410-125-0920, 410-125-0960 & 410-125-0980; HR 35-1993(Temp), f. & cert. ef. 12-1-93; HR 23-1994, f. 5-31-94, cert. ef. 6-1-94; HR 11-1996(Temp), f. & cert. ef. 7-1-96; HR 22-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 45-1998, f. & cert. ef. 12-1-98; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 16-2003(Temp), f. & cert. ef. 3-10-03 thru 8-1-03; OMAP 37-2003, f. & cert. ef. 5-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 78-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; Administrative correction, 3-18-05; OMAP 21-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 37-2005(Temp) f. & cert. ef. 8-15-05 thru 1-15-06; OMAP 70-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0142
Graduate Medical Education Reimbursement for Public Teaching Hospitals

(1) Graduate Medical Education (GME) payment is reimbursement made to an institution for the costs of an approved medical training program. The State makes GME payments to any in-state public acute care hospital providing a major teaching program, defined as a hospital with more than 200 residents or interns. Funding for public teaching hospital GME is not included in the "capitation rates" paid to managed care plans under the Oregon Health Plan resulting in hospitals with medical teaching programs not being able to capture GME costs when contracting with managed care plans.

(2) For each qualifying public hospital, the payment amount is initially determined based on hospital specific costs for medical education as reported in the Medicare Cost Report for the most recent completed reporting year (becomes base year).

(3) The GME payment is calculated as follows:

(a) Total Direct Medical Education (DME) costs consist of the costs for medical residency and the paramedical education programs. Title XIX DME costs are determined based on the ratio of Title XIX days to total days applied to the total DME.

(b) Indirect Medical Education (IME) costs are derived by first computing the percent of IME to total Medicare inpatient payments. This is performed by dividing the IME Adjustment reported in the Medicare Cost Report by the sum of this amount and Medicare payments for DRG amount — other than outlier payments, inpatient program capital, and organ acquisition. The resulting percent is then applied to net allowable costs (total allowable costs less Total DME costs, computed as discussed in the previous paragraph). Title XIX IME costs are then determined based upon the ratio of Title XIX days to total days.

(c) The total net Title XIX GME is the sum of Title XIX IME and DME costs. The GME reimbursement is made quarterly. Reimbursement is limited to the availability of public funds, specifically, the amount of public funds available for GME attributable to the Title XIX patient population. GME is rebased yearly.

(4) Total GME payments will not exceed that determined by using Medicare reimbursement. The Medicare upper limit will be determined from the most recent Medicare Cost Report and performed for all inpatient acute hospitals and separately for State operated inpatient acute hospitals in accordance with 42 CFR 447.272(a) and (b). The upper limit review will be performed before the GME payment is made.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 30-1999(Temp), f. & cert. ef. 6-15-99 thru 11-1-99; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0155
Upper Limits on Payment (UPL) of Hospital Claims

(1) Payments will not exceed total of billed charges:

(a) Upper limits on payment of claims does not apply to Proportional Share (Pro-Share) eligible academic hospitals, as defined in OAR 410-125-0145 and 410-125-0215.

(b) The total reimbursement during each hospital's fiscal year for inpatient services, including the sum of DRG payments, cost outlier, capital, and graduate medical education payments shall not exceed the individual hospital's total billed charges for the period for these services;

(c) If the total billed charges for all inpatient claims during the hospital's fiscal year is less than the total OMAP payment for those services, the overpayment shall be recovered;

(d) For Type A, Type B, and Critical Access Hospitals, reimbursement shall be limited to the lesser of allowable costs or billed charges. This limitation shall be applied separately to inpatient and outpatient services.

(2) Payments will not exceed finally approved plan:

(a) Total reimbursements to a state-operated facility made during OMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in a finally approved plan;

(b) Total aggregate inpatient and outpatient reimbursements to all hospitals made during OMAP's fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in a finally approved plan.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 53-1991, f. & cert. ef. 11-18-91; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0181
Non-Contiguous and Contiguous Area Out-of-State Hospitals — Outpatient Services

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with the Office of Medical Assistance Programs (OMAP) regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(1) Laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services will be reimbursed under an OMAP fee schedule.

(2) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

(3) Notwithstanding subsections (1) – (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until OMAP determines all necessary federal approvals have been obtained. Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with OMAP regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(a) Clinical laboratory services will be reimbursed under an OMAP fee schedule;

(b) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04; OMAP 27-2004, f. 4-22-04 cert. ef. 5-1-04; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0190
Outpatient Rate Calculations — Type A, Type B, and Critical Access Oregon Hospitals

(1) The Office of Rural Health designates Type A, Type B, and Critical Access Oregon Hospitals.

(2) Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered outpatient services is as follows:

(a) Interim reimbursement for outpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services which are based on the Office of Medical Assistance Programs (OMAP) fee schedule;

(b) Retrospective cost-based reimbursement is made for all Fee-For-Service covered outpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect Medicaid mix of services.

(3) Notwithstanding subsection (2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until OMAP determines all necessary federal approvals have been obtained. Reimbursement to Type A, Type B, and Critical Access Oregon Hospitals for covered outpatient services is as follows:

(a) Interim reimbursement for outpatient covered services is the hospital specific cost to charge percentage from the last finalized cost settlement, except clinical laboratory, which are based on the Office of Medical Assistance Programs (OMAP) fee schedule;

(b) Retrospective cost-based reimbursement is made for all Fee-For-Service covered outpatient services during the annual cost settlement period;

(c) Cost-based reimbursement is derived from the most recent audited Medicare Cost Report and adjusted to reflect Medicaid mix of services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540 & 461-015-0550; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780 & 410-125-0800; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0195

Outpatient Services In-State DRG Hospitals

In-State DRG Hospitals DRG hospital outpatient services are reimbursed under a cost based methodology.

(1) Interim reimbursement:

(a) For dates of service on and after March 1, 2004 the interim reimbursement percentage is developed using the cost-to-charge ratio methodology, derived from the Medicare cost report, and applied to billed charges. The interim payment is the estimated percentage needed to achieve 80% of hospital cost in aggregate. This interim percentage is applied to all outpatient charges except for the following services: for laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management;

(b) The OMAP fee schedule is used as interim reimbursement for laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services.

(2) Settlement reimbursement:

(a) For Title XIX/Title XXI clients; an adjustment to 80 percent of outpatient costs for dates of service on and after March 1, 2004. This adjustment is made during the cost settlement process;

(b) For GA clients; outpatient hospital services are reimbursed at 50 percent of billed charges or 59 percent of costs, whichever is less.

(3) Notwithstanding subsection (1) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until OMAP determines all necessary federal approvals have been obtained. Interim reimbursement:

(a) For dates of service on and after March 1, 2004 the interim reimbursement percentage is developed using the cost-to-charge ratio methodology, derived from the Medicare cost report, and applied to billed charges. The interim payment is the estimated percentage needed to achieve 80% of hospital cost in aggregate. This interim percentage is applied to all outpatient charges except for clinical laboratory;

(b) The OMAP fee schedule is used as interim reimbursement for clinical laboratory.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540 & 461-015-0550; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780 & 410-125-0800; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 16-2003(Temp), f. & cert. ef. 3-10-03 thru 8-1-03; OMAP 37-2003, f. & cert. ef. 5-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 78-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; Administrative correction, 3-18-05; OMAP 21-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0220

Services Billed on the Electronic 837I or on the Paper CMS 1450 (UB-92) and Other Claim Forms

(1) All inpatient and outpatient services provided by the hospital or hospital employees, unless otherwise specified below, are billed on the electronic 837I (837 Institutional) or on the paper CMS 1450 (UB-92) claim form.(2) Professional staff and other providers: Services provided by other providers or professional staff with whom the hospital has a contract or agreement regarding provision of services and whom the hospital reimburses a salary or a fee are billed on the electronic 837I or paper CMS 1450 (UB-92) along with other inpatient or outpatient charges if such costs are reported on the hospital's Medicare Cost Report as a hospital cost.

(3) Residents and medical students: Professional services provided by residents or medical students serving in the hospital as residents or students at the time services are provided are reimbursed by OMAP through graduate medical education, for the hospitals that qualify (See OAR 410-125-0141) for payments and may not be billed on the electronic 837I or paper CMS 1450 (UB-92).

(4) Diagnostic and similar services provided by another provider or facility outside the hospital: When diagnostic or short-term services are provided to an inpatient by another provider or facility because the admitting hospital does not have the equipment or facilities to provide all services required and the patient is returned within 24 hours to the admitting hospital, the admitting hospital should add the following charges to the inpatient electronic 837I or paper CMS 1450 (UB-92) claim:

(a) Charges from the other provider or hospital under the appropriate Revenue Code. The admitting hospital is responsible for reimbursing the other provider or hospital. Office of Medical Assistance Programs (OMAP) will not reimburse the other provider or hospital; and

(b) Charges for transportation to the other facility or provider. These must be billed under Revenue Code 542. No prior authorization of the transport is required. The hospital will arrange for the transport and pay the transportation provider for the transport. OMAP will not reimburse the transportation provider. This is the only instance in which transportation charges can be billed on the electronic 837I or paper CMS 1450 (UB-92).

(5) Orthotics, prosthetics, durable medical equipment and implants:

(a) When a provider of orthotic or prosthetic devices provides services or materials to an inpatient through an agreement or arrangement with the hospital, the cost of those services will be billed by the hospital on the electronic 837I or the paper CMS 1450 (UB-92), along with all other inpatient services. The hospital is responsible for reimbursing the provider. Office of Medical Assistance Programs (OMAP) will not reimburse the provider;

(b) Wheelchairs provided to the client for the client's use after discharge from the hospital may be billed separately by the Durable Medical Equipment supplier or by the hospital if the hospital is the supplier.

(6) Pharmaceutical and Home Parenteral/ Enteral Services: All hospital pharmaceutical charges must be billed on the electronic 837I or paper UB-92, except home parenteral and enteral services and medications provided to patients who are in nursing homes:

(a) Home parenteral and enteral services, including home hyperalimentation, Home IV Antibiotics, home IV analgesics, home enteral therapy, home IV chemotherapy, home IV hydrational fluids, and other home IV drugs, require prior authorization and must be billed on the Pharmacy Invoice Form in accordance with the rules in the Home Enteral/Parenteral rules (chapter 410 division 148);

(b) Medications provided to clients who are in nursing homes must be billed on the Pharmacy Invoice Form in accordance with the rules in the Pharmaceutical Services rules (chapter 410 division 121).

(7) Dental services: Dental services provided by hospitals are billed on the electronic 837I or paper CMS 1450 (UB-92). Reimbursement for dental services provided by hospitals is restricted to those identified in the Dental Services rules (chapter 410 division 123) as covered services.

(8) End-stage renal dialysis facilities: Hospitals providing end-stage renal dialysis and free-standing end-stage renal dialysis facilities will bill on the electronic 837I or paper CMS 1450 (UB-92) as described in these rules and instructions and will be reimbursed at the hospital's interim rate.

(9) Maternity case management:

(a) Hospital clinics may serve as maternity case managers for pregnant clients. The Medical-Surgical rules (chapter 410 division 130) contain information on the scope of services, definition of program terms, procedure codes, and provider qualifications. These services are billed by hospitals on the electronic 837I or paper CMS 1450 (UB-92); and

(b) Providers must bill using Revenue Code 569.

(10) Home health care services. Hospitals that operate home health care services must obtain a separate provider number and bill for these services in accordance with the Home Health Care Services rules (chapter 410 division 127).

(11) Hospital operated air and ground ambulance services. A hospital which operates an air or ground ambulance service may apply to OMAP for a provider number as an air or ground ambulance provider. If costs for staff and equipment are reported on the Medicare Cost Report, these costs must be identifiable. OMAP will remove these costs from the Medicare Cost Report in calculating the hospital's cost-to-charge ratio for outpatient services. These services are billed on the electronic 837P (837 Professional) claim form or the paper CMS-1500 in accordance with the rules and restrictions contained in the Medical Transportation rules (chapter 410 division 136).

(12) Supervising physicians providing services in a teaching setting:

(a) Services provided on an inpatient or outpatient basis by physicians who are on the faculty of teaching hospitals may be billed on the electronic 837I or paper CMS 1450 (UB-92) with other inpatient or outpatient charges only when:

(A) The physician is serving as an employee of the hospital, or receives reimbursement from the hospital for provision of services, during the period of time when services are provided; and

(B) The hospital does not report these services as a direct medical education cost on the Medicare and OMAP cost report.

(b) The services of supervising faculty physicians are not to be billed to OMAP on either the electronic 837P, the paper CMS-1500 or the electronic 837I or paper CMS 1450 (UB-92) if the hospital elects to report the cost of these professional services as a direct medical education cost on the Medicare and OMAP cost report; and

(c) The services of supervising faculty physicians are billed on the electronic 837P or the paper CMS-1500 if the physician is serving in a private capacity during the period of time when services are provided, i.e., the physician is receiving no reimbursement from the hospital for the period of time during which services are provided. Refer to the Medical-Surgical Services rules (chapter 410 division 130) or additional information on billing on the electronic 837P or the paper CMS-1500.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 30-1982, f. 4-26-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 44-1985, f. & ef. 7-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0055, 461-015-0130, 461-015-0135; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0260, 461-015-0290, 461-015-0300, 461-015-0310, 461-015-0320, 461-015-0420, 461-015-0430; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0280, 410-125-0300, 410-125-0320, 410-125-0340, 410-125-0540 & 410-125-0560; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 13-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0221
Payment in Full

The payment made by Medicaid towards any inpatient or outpatient services, including cost outlier, disproportionate share, and capital payments, constitutes payment in full for the service.

Stat. Auth.: ORS 184.750, 184.770, 411 & 414
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989 (Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989 (Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0020 & 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990 (Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0840; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0600
Non-Contiguous Out-of-State Hospital Services

(1) Non-contiguous out-of-state hospitals are those hospitals located more than 75 miles from the Oregon border.

(2) The hospital must be enrolled as a provider with Oregon Medical Assistance Programs to receive payment. Contact OMAP for information on enrollment.

(3) Billings are sent to Office of Medical Assistance Programs.

(4) When the service provided is emergent or urgent, no prior authorization is required. The claim should be sent to OMAP along with documentation supporting the emergent or urgent requirement for treatment.

(5) In a non-emergency situation, prior authorization is required for all services. Contact: OMAP.

(6) Claims must be billed on the electronic 837I or on a paper CMS 1450 (UB-92), unless other arrangements are made for billing through the OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0450; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-0720
Adjustment Requests

(1) Most overpayment and under-payments are resolved through the adjustment process. Only paid claims can be adjusted. If no payment was made, the claim must be submitted using a CMS 1450 (UB-92) for processing. All overpayments must be reported. Overpayments will be taken from future payments.

(2) Much of the information required on the Adjustment Request Form is printed on the paper Remittance Advice or the electronic 835. Documentation may be submitted to support the request. Attach a copy of the claim and paper Remittance Advice or the electronic 835 to the Adjustment Request (OMAP 1036). Adjustment requests must be submitted in writing to Office of Medical Assistance Programs.

(3) Complete adjustment instructions can be found in Hospital Services Supplemental Information.

[Publications: Publications referenced are available from the agency.]
Stat Auth.: ORS 184.750, 184.770, 411 & 414
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21 1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0510; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

410-125-2080
Administrative Errors

(1) If a hospital has been given incorrect information by Office of Medical Assistance Programs, Children, Adults, and Families Programs, or Seniors and People with Disabilities/staff, and services were provided on the basis of this information, and payment has been denied as a result, the hospital may submit a request for payment as an Administrative Error.

(2) Include the following:

(a) An explanation of the problem;

(b) Any documents supporting the request for payment;

(c) A copy of any paper Remittance Advice or electronic 835 printouts received on this claim;

(d) A copy of the original claim.

(3) Send the request: Office of Medical Assistance Programs, Provider Inquiry, Administrative Errors, 500 Summer Street NE, E-44, Salem, OR 97301-1077.

Stat. Auth.: ORS 184.750, 184.770, 411 & 414
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0730; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: July 2006 -- Current Procedural Terminology code updates for Speech-language pathology, Audiology and Hearing Aid Services.
Adm. Order No.: OMAP 18-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-129-0200, 410-129-0240, 410-129-0260, 410-129-0280
Subject: The Speech-language pathology, Audiology, and Hearing Aid Services Administrative rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP amended 410-129-0200, 410-129-0240, 410-129-0260, and 410-129-0280 to update the Current Procedural Terminology (CPT) codes.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-129-0200
Speech-Language Pathology Procedure Codes

(1) Inclusion of a CPT/HCPCS code in the following tables does not imply a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) Speech Therapy Services codes: Table 200-1.

(3) Other Speech Services codes: Table 200-2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 6-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 14-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

410-129-0240
Audiologist and Hearing Aid Procedure Codes

(1) Inclusion of a CPT/HCPCS code on the following tables does not imply that a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage.

(2) Audiologist and Hearing Aid Procedure Codes: Table 0240-1.

(3) Special Otorhinolaryngologic Services codes: Table 0240-2. These codes only apply to services for cochlear implants. These services include medical diagnosis evaluation by the otology physician.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 14-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

410-129-0260
Hearing Aids and Hearing Aid Technical Service and Repair

(1) Hearing Aids must be billed to the Office of Medical Assistance Programs at the provider's Acquisition Cost, and will be reimbursed at such rate. For purposes of this rule, Acquisition Cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item.

(2) Submit history of hearing aid use and an audiogram when requesting payment authorization for hearing aids.

(3) Procedure codes: Table 129-0260.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

410-129-0280
Hearing Testing for Diagnostic Purposes (On Physician's Referral Only)

A physician's referral is required for the tests shown in this rule. The tests may only be performed and billed by a licensed audiologist or a licensed physician. Procedure codes: Table 0280.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 18-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: July 2006 -- Current Procedural Terminology code updates for Physical and Occupational Therapy Services.
Adm. Order No.: OMAP 19-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-131-0280
Subject: The Physical and Occupational Therapy Services program administrative rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP will amend 410-131-0280 to update the Current Procedural Terminology (CPT) codes for this program.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-131-0280
Occupational and Physical Therapy Codes

(1) Occupational therapists and physical therapists should use any of the following codes which are applicable according to their Licensure and Professional Standards.

(2) Inclusion of a CPT/HCPCS code on the following tables does not imply that a code is covered. Refer to OARs 410-141-0480, 410-141-0500, and 410-141-0520 for information on covered services.

(3) Services that do not require payment authorization appear on Table 280-1.

(4) Services that require payment authorization include the following:

(a) Modalities — need to be billed in conjunction with a therapeutic procedure code;

(b) Supervised — The application of a modality that does not require direct (one-on-one) client contact by the provider. Each individual code in this series may be reported only once for each client encounter. See Table 280-2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92; HR 43-1994, f. 12-30-94, cert. ef. 1-1-95; HR 8-1995, f. 3-31-95, cert. ef. 4-1-95; HR 4-1996, f. & cert. ef. 5-1-96; HR 2-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 8-1998, f. & cert. ef. 3-2-98; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 3-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 16-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 53-2002, f. & cert. ef. 10-1-02; OMAP 64-2003, f. 9-8-03, cert. ef. 10-1-03; OMAP 14-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 59-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 15-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 19-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: Updating medical transportation billing codes and billing form information.
Adm. Order No.: OMAP 20-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-136-0320, 410-136-0340, 410-136-0350, 410-136-0360, 410-136-0420
Subject: The Department of Human Services, Office of Medical Assistance Programs administers the medical transportation program for Oregon Health Plan clients. OMAP will update information in rules listed above in order to comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Healthcare Common Procedure Coding System (HCPCS) to ensure continuity of payments for transportation services provided to clients.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-136-0320
Billing

(1) Medical transportation services must be billed on the CMS-1500 or the 837P using the billing instructions and procedure codes found in the **Medical Transportation Services Provider Guide**.

(2) Completed CMS-1500s or 837Ps should be submitted to the Office of Medical Assistance Programs.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

410-136-0340
Billing for Clients Who Have Both Medicare and Medicaid Coverage

(1) For services provided to clients with both Medicare and coverage through the Office of Medical Assistance Programs, bill Medicare first, except when the items are not covered by Medicare.

(2) OMAP services not covered by Medicare should be billed directly to OMAP on either the OMAP-505, CMS-1500 or the 837P.

(3) OMAP may be billed directly (on an OMAP-505 or the 837P) for Aid Call.

(4) OMAP may be billed directly (on a CMS-1500 or the 837P) for the following medical transportation services:

(a) Taxi;

(b) Secured Transport;

(c) Wheelchair Car/Van;

(d) Stretcher Car (including stretcher car services provided by an ambulance).

(5) Except for Aid Call, all services listed above require authorization by the appropriate Department of Human Services office.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93; HR 28-1994, f. & cert. ef. 9-1-94; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96; HR 14-1996(Temp), f. & cert. ef. 7-1-96; HR 25-1996, f. 11-29-96, cert. ef. 12-1-96; 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 66-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

410-136-0350
Billing for Base Rate — Each Additional Client

(1) Billings must be submitted to OMAP on a separate CMS-1500 or the 837P.

(2) Bill using the appropriate procedure code found in the Procedure Code Section of the Medical Transportation Services Provider Guide.

(3) All required billing information must be included on the claim for the additional client.

(4) Ensure a completed Transportation Order for the additional client has been forwarded by the branch for retention in the Provider Record.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 30-1993, f. & cert. ef. 10-1-93; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

410-136-0360
Billing — Ambulance

The CMS-1500 or the 837P and the OMAP-505 or the 837P forms are the required billing forms for medical transportation. Refer to the appropriate Department of Human Services website for information on completion of both forms.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93; OMAP 66-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

410-136-0420
Emergency Medical Transportation Procedure Codes

Ambulance Service — Bill the following codes using Type of Service "E":

(1) Basic Life Support (BLS) — Bill using the following procedure codes:

(a) A0429 — Ambulance service, BLS, emergency transport (BLS-emergency);

(b) A0425 — Ground mileage, per statute mile;

(c) A0424 — Extra ambulance attendant, ALS or BLS (requires medical review).

(2) Advanced Life Support (ALS) — Bill using the following procedure codes:

(a) A0427 — Ambulance service, ALS, emergency transport, level 1 (ALS1-emergency);

(b) A0433 — Ambulance service, ALS, emergency transport, level 2 (ALS2-emergency);

(c) A0425 — Ground mileage, per statute mile;

(d) A0424 — Extra ambulance attendant, ALS or BLS (requires medical review).

(3) Neonatal Intensive Care — Bill using the following procedure codes:

(a) A0225 — Ambulance service, neonatal transport, base rate, emergency transport, one-way;

(b) A0425 — Ground mileage, per statute mile.

(4) Air Ambulance — Bill using the following procedure codes:

(a) A0430 — Ambulance service, conventional air services, transport, one-way (fixed wing);

(b) A0431 — Ambulance service, conventional air services, transport, one-way (rotary wing).

(5) Aid Call (Ambulance Response and Treatment, No Transport) — Bill procedure code A0998 for aid call.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; HR 30-1993, f. & cert. ef. 10-1-93; HR 9-1995, f. 3-31-95, cert. ef. 4-1-95; HR 14-1996(Temp), f. & cert. ef. 7-1-96; HR 25-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 14-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 55-2002, f. & cert. ef. 10-1-02; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05; OMAP 20-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: July 2006 rule corrections and additional detail for policy clarification.
Adm. Order No.: OMAP 21-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Adopted: 410-138-0600, 410-138-0610, 410-138-0620, 410-138-0640, 410-138-0660, 410-138-0680, 410-138-0700, 410-138-0710, 410-138-0720, 410-138-0740, 410-138-0760, 410-138-0780
Subject: The Targeted Case Management Services program administrative rules govern Office of Medical Assistance Programs (OMAP) payment for services provided to certain clients. OMAP, having temporarily adopted the above listed rules February 2006, permanently adopted these rules to describe the requirements applicable to qualified providers, establish reimbursement mechanisms, and authorize payment for targeted case management services by qualified providers. The Centers for Medicare and Medicaid Services, through approved State Medicaid Plan amendments (SPA), have authorized the TCM services for Oregon, and OMAP now aligns the SPA authorization with OMAP operations and existing practices.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-138-0600
Purpose — Federally Recognized Tribal Governments in Oregon

(1) The Targeted Case Management (TCM) Services program is a medical assistance program, that leverages Office of Medical Assistance Programs (OMAP) certified Case Management Provider Organization allowable tribal funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the OMAP (OAR 410 division 120). The TCM Services program rules are designed to assist the Case Management Provider Organization in matching allowable tribal and Federal Funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC § 1396n(g).

(2) The rules of the Federally Recognized Tribal Government Targeted Case Management program define Oregon Medicaid's program to reimburse the TCM services provided by a federally recognized tribal government located in the State of Oregon.

(3) TCM services include case management of non-medical services, which address health, psychosocial, economic, nutritional and other services.

(4) Provision of tribal TCM services may not restrict an eligible Client's choice of providers. Clients must have free choice of available tribal TCM service providers or other TCM service providers available to the eligible Client, subject to 42 USC 1396n. Eligible Clients must have free choice of the providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.085
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0610
Targeted Group — Federally Recognized Tribal Governments in Oregon

(1) The target group consists of Oregon Health Plan (OHP) Medicaid eligible individuals served by tribal programs within the State of Oregon, or receiving services from a Federally recognized Indian tribal government located in the State of Oregon, and not receiving case management services under other Title XIX programs. The target group includes elder care; individuals with diabetes; children and adults with health and social service care needs; and pregnant women. These services will be referred to as Tribal Targeted Case Management Services.

(2) An Oregon Health Plan (OHP) Medicaid-eligible individual means an individual who has been determined to be eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Department of Human Services. For purposes of these rules, an eligible individual will be referred to as a Client.

(3) This does not include TCM services funded by Title IV and XX of the Social Security Act, and federal and or state funded parole and probation, or juvenile justice programs.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 409.010
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0620
Definitions — Federally Recognized Tribal Governments in Oregon

(1) "Assessment" — After the need for tribal targeted case management services has been determined, the tribal case manager assesses the specific areas of concern, family strengths and resources, community resources and extended family resources available to resolve those identified issues. At assessment, the tribal case manager makes preliminary deci-

sions about needed medical, social, educational, or other services and the level or direction tribal case management will take.

(2) "Case Planning" — The tribal case manager develops a case plan, in conjunction with the Client and family (where applicable), to identify the goals and objectives, which are designed to resolve the issues of concern identified through the assessment process. Case planning includes setting of activities to be completed by the tribal case manager, the family and Client. This activity will include accessing medical, social, educational, and other services to meet the Clients' needs.

(3) "Case Plan Implementation" — The tribal case manager will link the Client and family with appropriate agencies and medical, social, educational or other services through calling or visiting these resources. The tribal case manager will facilitate implementation of agreed-upon services through assisting the Client and family to access them and through assuring the Clients and providers fully understand how these services support the agreed-upon case plan.

(4) "Case Plan Coordination" — After these linkages have been completed, the tribal case manager will ascertain, on an ongoing basis, whether or not the medical, social, educational, or other services have been accessed as agreed, and the level of involvement of the Client and family. Coordination activities include, personal, mail and telephone contacts with providers and others identified by the case plan, and well as meetings with the Client and family to assure that services are being provided and used as agreed.

(5) "Case Plan Reassessment" — In conjunction with the Client, the tribal case manager will determine whether or not medical, social, educational or other services continue to be adequate to meet the goals and objectives identified in the case plan. Reassessment decisions include those to continue, change or terminate those services. Reassessment will also determine whether the case plan itself requires revision. This may include assisting Clients to access different medical, social, educational or other needed services beyond those already provided. Reassessment activities include, staffing and mail, personal, and telephone contacts with involved parties.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 409.010
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0640
Provider Organizations — Federally Recognized Tribal Governments in Oregon

A Tribal Targeted Case Management (TCM) Provider must be an organization certified as meeting the following criteria:

(1) A minimum of three years experience of successful work with Native American children, families, and elders involving a demonstrated capacity to provide all core elements of tribal case management, including: Assessment, Case Planning, Case Plan Implementation, Case Plan Coordination, and Case Plan Reassessment;

(2) A minimum of three years case management experience in coordinating and linking community medical, social, educational or other resources as required by the target population;

(3) Administrative capacity to ensure quality of services in accordance with tribal, state, and Federal requirements;

(4) Maintain a sufficient number of case managers to ensure access to targeted case management services;

(5) A financial management capacity and system that provides documentation of services and costs;

(6) Capacity to document and maintain Client case records in accordance with state and federal requirements, including requirements for recordkeeping in OAR 410-120-1360, and confidentiality requirements in ORS 192.519 — 192.524, ORS 179.505, and 411.320, and HIPAA Privacy requirements in 45 CFR 160 and 164, if applicable;

(7) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program;

(8) Evidence that the TCM organization is a federally recognized tribe located in the State of Oregon;

(9) Enrollment as a TCM provider with the Office of Medical Assistance Programs.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0660
Qualifications of Case Managers within Provider Organizations — Federally Recognized Tribal Governments in Oregon

The following are qualifications of Case Managers within Provider Organizations:

(1) Completion of training in a case management curriculum;

(2) Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders, and issues around aging;

(3) Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication;

(4) Ability to learn and work with state, federal and tribal rules, laws and guidelines relating to Native American child, adult and elder welfare and to gain knowledge about community resources and link tribal members with those resources;

(5) Knowledge and understanding of these rules and the applicable State Medicaid Plan Amendment.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0680
Payment, Methodology, and Billing Instructions and Codes — Federally Recognized Tribal Governments in Oregon

(1) Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Targeted Case Management (TCM) services may not be reimbursed under this rule if the services are case management services funded by Title IV and XX of the Social Security Act, and federal and or state funded parole and probation, or juvenile justice programs.

(2) Payment Methodology for Tribal Targeted Case Management: For the purposes of these TCM rules, "Unit" is defined as a month. A unit consists of at least one documented contact with the Client (or other person acting on behalf of the Client) and any number of documented contacts with other individuals or agencies identified through the case planning process.

(3) Payment for tribal TCM services will be made using a monthly rate based on the total average monthly cost per Client served by the TCM Provider during the last fiscal year for which audited financial statements have been filed with the Department of Human Services (Department). The costs used to derive the monthly tribal TCM rate will be limited to the identified costs divided by the number of Clients served. Tribal TCM provider costs for direct and related indirect costs that are paid by other Federal or State programs must be removed from the cost pool. The cost pool must be updated, at a minimum, on an annual basis using a provider cost report. The rate is established on a prospective basis. In the first year, the rate will be based on estimates of cost and the number of Clients served. For subsequent years, the rate will be based on actual eligible TCM costs from the previous year. A cost report must be submitted to the Department at the end of each state fiscal year (at a minimum), and will be used to establish a new rate for the following fiscal year.

(4) Payment will be made to the enrolled tribal TCM organization as the performing provider for those services provided by the employed staff person.

(5) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations.

(6) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS).

(7) Targeted Case Management for the Office of Medical Assistance Programs (OMAP) certified case management providers, is a cost-sharing (Federal Financial Participation matching) program. In addition to the requirements set forth in subsections (1) through (6) of this rule, and pursuant to 42CFR433.10, DHS may monthly, but will no less than quarterly, invoice the TCM provider for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The TCM provider shall pay the amount stated in the invoice within 30 days of the date of the invoice:

(a) The TCM provider's share means the tribal funds share of the Medicaid payment amount. Pursuant to 42CFR433.51, tribal funds may be considered as the State's share in claiming federal financial participation if the tribal funds meet the following conditions: The tribal funds are transferred to DHS from a tribal government; and, the tribal funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be

based on the FMAP in effect at the time of the State's expenditure to the TCM provider;

(c) The TCM provider shall submit to OMAP an original signed document certifying that the allowable tribal funds transferred to OMAP (for the non-federal matching share) by the TCM provider under this rule are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds.

(8) Failure to timely remit the non-federal share described in subsections (1) will constitute an overpayment, and will make the provider subject to overpayment recoupment or other remedy pursuant to OMAP General Rules, OAR 410-120-1400 through 410-120-1685.

(9) Billing criteria for this program is as follows:

(a) The procedure code to be used for Federally Recognized Tribal Government — Targeted Case Management is "T1017." One of the activities listed below must occur in order to bill. Maximum billing code is one time per month per client:

(A) Assessment;

(B) Case Planning;

(C) Case Plan Implementation;

(D) Case Plan Coordination;

(E) Case Plan Reassessment.

(b) Any place of service (POS) is valid;

(c) Prior authorization is not required;

(d) Appropriate Diagnosis Code and Modifier must be used.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0700
Purpose — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) The Targeted Case Management (TCM) Services Program is a medical assistance program, that leverages Office of Medical Assistance Programs (OMAP) certified Case Management Provider Organization General Funds with matching Federal Funds for Oregon Health Plan (OHP) Medicaid eligible clients. These rules are to be used in conjunction with the OMAP General Rules Program (OAR 410 division 120). The TCM Services rules are designed to assist the Targeted Case Management Provider Organization in matching State and Federal Funds for TCM services defined by Section 1915(g) of the Social Security Act, 42 USC § 1396n(g).

(2) The rules of the Early Intervention/Early Childhood Special Education Targeted Case Management program define Oregon Medicaid's program to reimburse the TCM services provided under Early Intervention/Early Childhood Special Education. This TCM program provides services to eligible preschool children with disabilities, birth until eligible for public school.

(3) EI/ECSE TCM program services include management of non-medical services, which address health, psychosocial, economic, nutritional and other services.

(4) Provision of EI/ECSE TCM program services may not restrict an eligible child's choice of providers. Eligible children must have free choice of available EI/ECSE TCM service providers or other TCM service providers available to the eligible child, subject to 42 USC 1396n. Eligible children must have free choice of the available providers of other medical care within their benefit package of covered services.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.085
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0710
Target Group — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) These rules apply to the population of Oregon Health Plan (OHP) Medicaid eligible clients who are preschool children with disabilities, beginning from birth until eligibility for public school, and who are either eligible for Early Intervention services under OAR 581-015-0946(3); or Early Childhood Special Education services under OAR 581-015-0943(4), (EI/ECSE). For the purpose of these rules, children in this target group shall be referred to as "eligible children."

(2) An Oregon Health Plan (OHP) Medicaid-eligible child means a child who has been determined to be eligible for Medicaid or the Children's Health Insurance Program (CHIP) by the Department of Human Services.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 409.010
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0720
Definitions — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) "Case management" is provided to eligible children in the target group to assist and enable the eligible child to gain access to needed medical, social, educational, developmental and other appropriate services. The case manager (aka service coordinator) is responsible for assisting the child and family in gaining access to and coordinating all services across agency lines and serving as the single point of contact in helping the child and family obtain the services and assistance they need. Case management may be delivered in person, electronically, or by telephone for the purpose of enabling the child and family to gain access to and obtain the needed services. Case management services include:

(a) "Intake and Needs Assessment" — The systematic ongoing collection of data to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, social, behavioral, emotional, and mobility areas. Data sources include family interview, existing available records, and needs assessment;

(b) "Plan of Care: Development of the Targeted Case Management Plan Coordinated with the Individualized Family Service Plan (IFSP)" — The case manager (service coordinator) develops a targeted case management plan coordinated with the IFSP, in conjunction with the family and other IFSP team members to identify goals, objectives and issues identified through the targeted case management assessment process. Targeted case management case planning includes determining activities to be completed by the case manager, in support of the eligible child and family. These activities include accessing appropriate health and mental health, social, educational, vocational, and transportation services to meet the eligible child's needs.

(2) "Service Coordination and Monitoring":

(a) Linkages — establishing and maintaining a referral process with pertinent individuals and agencies which avoids duplication of services to the eligible child and family;

(b) Planning — Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion with the family and other IFSP team members;

(c) Implementation — Putting the targeted case management plan into action and monitoring its status;

(d) Support — Support is provided to assist the family to reach the goals of the plan, especially if resources are inadequate or the service delivery system is non-responsive;

(3) "Reassessment and Transitioning Planning": The case manager (service coordinator), in consultation with the family and other IFSP team members, determines whether or not the linked services continue to meet the eligible child and family's needs, and if not, adjustments are made and new or additional referrals are made to adequately meet the defined child and family needs. These services:

(a) Assist families of eligible children in gaining access to EI/ECSE services and other medical or social services identified in the targeted case management plan;

(b) Permit coordinating of EI/ECSE services and other medical or social services (such as medical services for other than diagnostic and evaluation purposes) that the eligible child needs or is being provided;

(c) Assist families in identifying available medical and social service providers;

(d) Permit coordination and monitoring the delivery of available medical or social services;

(e) Inform families of the availability of medical/social services;

(f) Maintain a record of targeted case management activities in each eligible child's record.

Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 409.010
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0740
Provider Organizations — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Qualifications of EI/ECSE TCM Provider Organizations: TCM Provider organizations must be contractors with the Oregon Department of Education in the provision of EI/ECSE services or be a sub-contractor with such a contractor, and must meet the following criteria:

(a) Demonstrated capacity (including sufficient number of staff) to provide TCM services;

(b) Demonstrated Case Management experience in coordinating and linking such community resources as required by the target population;

(c) Demonstrated experience with the target population;

(d) An administrative capacity to ensure quality of services in accordance with state and federal requirements;

(e) A financial management capacity and system that provides documentation of services and costs;

(f) Capacity to document and maintain individual case records in accordance with state and federal requirements, including requirements for recordkeeping in OAR 410-120-1360, and confidentiality requirements in the Individuals with Disabilities Education and Improvement Act, ORS 192.518 — 192.524, 179.505, and 411.320, and HIPAA Privacy requirements in 45 CFR 160 and 164, if applicable;

(g) Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program; and

(h) Enrollment as a TCM provider with the Office of Medical Assistance Programs.

(2) In addition to the requirements in subsection (1) of this rule, the EI/ECSE TCM Provider must either be a governmental entity or a subcontractor of a government entity. The TCM Provider must submit written documentation that a governmental entity is solely responsible for providing the TCM provider's share from public funds for purposes of OAR 410-138-0780 of this rule. If the TCM provider is a subcontractor of a governmental entity, the documentation shall include a copy of the subcontract that expressly identifies the State of Oregon Department of Human Services as a named third party beneficiary of the governmental entity's obligation to make the public fund payments. Such documentation is subject to approval by DHS.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0760
Provider Requirements — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Qualification of Case Managers (Service Coordinators).

(2) Case Managers (Service Coordinators) must:

(a) Be employees of the EI/ECSE contracting or subcontracting agency and meet the personnel standards requirements in OAR 581-015-1100;

(b) Have demonstrated knowledge and understanding about:

(A) The Oregon EI/ECSE program, including these rules and the applicable State Medicaid Plan Amendment.

(B) The Individuals with Disabilities Education Improvement Act;

(C) The nature and scope of services available under the Oregon EI/ECSE program, including the TCM services, and the system of payments for services and other pertinent information.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

410-138-0780
Payment, Payment Methodology, and Billing Instructions and Codes — Early Intervention/Early Childhood Special Education Targeted Case Management

(1) Payment for EI/ECSE TCM services, under these rules, will not duplicate payments made to public or private entities under other program authorities for this same purpose.

(2) Payment Methodology for EI/ECSE Targeted Case Management: Payment for Targeted Case Management will be based on a monthly encounter rate.

(a) The rate for reimbursement of the case management services is computed as follows. Compute the annual case manager salary and fringe benefits, plus other operating cost including travel, supplies, telephone, and occupancy cost, plus direct supervisory cost, plus average indirect administrative cost of provider organization; that will equal the total annual cost per case manager. Then divide by 12; that will equal the monthly cost per case manager. Then divide by the number of children to be served during the month, that will equal the total monthly cost per child;

(b) The total cost, per case manager, is the sum of the case manager's salary, direct supervisory costs, indirect administrative costs of the provider organization and other operating costs such as travel, supplies, occupancy, and telephone usage. Dividing the statewide average cost, per case manager, by twelve (12) months yields the average monthly cost per case manager. Dividing the monthly cost, per case manager, by the number of children to be served during the month results in the total monthly costs per child. This is the encounter rate to be used for the monthly billing whenever a Medicaid eligible client receives a TCM service during that month.

(3) Payment will be made to the enrolled Targeted Case Management Organization as the performing provider for those services provided by the employed staff person.

(4) Signing the Provider Enrollment Agreement sets forth the relationship between the State of Oregon, Department of Human Services and the TCM provider and constitutes agreement by the provider to comply with all applicable rules of the Medical Assistance Program, federal and state laws or regulations.

(5) The TCM provider will bill according to OAR 410 division 138 rules. Payments will be made through the Medical Management Information System (MMIS).

(6) Targeted Case Management for TCM Provider organizations certified as eligible to enroll under OAR 410-138-0740 is a cost-sharing (Federal Financial Participation matching) program. In addition to the requirements set forth in subsections (1) through (5) of this rule, and pursuant to 42CFR433.10, DHS may monthly, but will no less than quarterly, invoice the governmental TCM provider or the TCM Provider's responsible governmental entity for their non-federal matching share based on the current Federal Medical Assistance Percentage (FMAP) rate. The governmental TCM provider or its responsible governmental entity shall pay the amount stated in the invoice within 30 days of the date of the invoice.

(a) The TCM provider's share means the public funds share of the Medicaid payment amount. Pursuant to 42CFR433.51, public funds may be considered as the State's share in claiming federal financial participation, if the public funds meet the following conditions:

(A) The public funds are transferred to DHS from public agencies; and, the public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds;

(B) The public funds transferred to DHS may not be derived by the governmental entity from donations or taxes that would not otherwise be recognized as the non-federal share under 42 CFR 433 Subpart B;

(b) The TCM provider's non-federal matching share shall be based on the current Federal Medical Assistance Percentage (FMAP) rate for Oregon provided annually by the Centers for Medicare and Medicaid Services. This percentage can vary each federal fiscal year. The DHS invoice shall be based on the FMAP in effect at the time of the State's expenditure to the TCM provider;

(c) The governmental TCM provider or its responsible governmental entity shall submit to OMAP an original signed document certifying that the public funds transferred to OMAP (for the non-federal matching share) under this rule are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds, and that the transferred funds are not derived from donations or taxes that would not otherwise be recognized as the non-federal share under 42 CFR 433 Subpart B.

(7) Failure to timely remit the non-federal share described in subsection (6) or failure to comply with the public funds requirements of subsection (6) will constitute an overpayment, and will make the provider subject to overpayment recoupment or other remedy pursuant to OMAP General Rules, OAR 410-120-1400 through 410-120-1685. Failure to comply with the public funds requirements in this rule may result in termination of the TCM provider enrollment agreement.

(8) Billing criteria for this program is as follows:

(a) The procedure code to be used is "T2023" for Early Intervention/Early Childhood Special Education — Targeted Case Management. One of the activities listed below must occur in order to bill. Maximum billing code is one time per month per client:

(A) Intake and Needs Assessment;

(B) Plan of Care: Development of the Targeted Case Management Plan Coordinated with the Individual Family Service Plan (IFSP);

(C) Service Coordination and Monitoring;

(D) Reassessment and Transitioning Planning.

(b) Any place of service (POS) is valid;

(c) Prior authorization is not required;

(d) Diagnosis Code "V62.3" must be used.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-2006(Temp), f. & cert. ef. 2-7-06 thru 7-1-06; OMAP 21-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: July 2006 Current Procedural Code update and providers billing Medicare for visual.
Adm. Order No.: OMAP 22-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-140-0080, 410-140-0180
Subject: The Visual Services program administrative rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP amended 410-140-0080 to clarify that providers must bill Medicare before billing OMAP for Medicare covered visual services and 410-140-

0180 to update Current Procedural Terminology (CPT) codes for this program.

Rules Coordinator: Darlene Nelson—(503) 945-6927

410-140-0080

Medicare/Medicaid Assistance Program Claims

(1) When a client has both Medicare and coverage through the Office of Medical Assistance Programs (OMAP), optometrists and ophthalmologists must bill Medicare first for Medicare covered services.

(2) Refer to OAR 410-120-1210 (General Rules) for information on OMAP reimbursement.

(3) Medicare will automatically forward your claim to OMAP.

(4) In all of the following situations, bill OMAP on the OMAP 505 or 837P:

(a) If Medicare sends incorrect claim information to OMAP and no payment is made on the entire claim;

(b) If an out-of-state Medicare carrier or intermediary was billed;

(c) If Medicare does not cover the service:

(A) If submitting a paper claim, enter any Medicare payment received in the "Amount Paid" field (Field 28) or use the appropriate TPR explanation code in the "Other Health Insurance Coverage" (Field 9) portion on the OMAP 505. Be sure to enter the Medicare Maximum Allowable in Field 24H.

(B) If any billing corrections are needed and OMAP made payment, the provider must submit an Adjustment Request (OMAP 1036) to correct payment;

(d) If Medicare crosses the claim over incorrectly or it does not crossover.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0190; HR 37-1992, f. & cert. ef. 12-18-92; HR 15-1994, f. & cert. ef. 3-1-94; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 20-1999, f. & cert. ef. 4-1-99; OMAP 65-2004, f. 9-13-04, cert. ef. 10-1-04; OMAP 22-2006, f. 6-12-06, cert. ef. 7-1-06

410-140-0180

Ocular Prosthetics, Artificial Eye

(1) Ocular prosthesis and related services are covered for clients 20 years or younger with documentation of medical necessity in the client's medical record.

(2) The following CPT codes apply:

(a) V2623 Prosthetic Eye, Plastic custom after removal. Limited to one prosthesis every five years after age 20. Supplier must keep on file an order for the prosthesis that is signed and dated by the ordering physician;

(b) V2624 Polishing /resurfacing of ocular prosthesis. Limited to once a year after age 20;

(c) V2625 Enlargement of ocular prosthesis. One enlargement or reduction of the prosthesis is covered every five years after age 20;

(d) V2626 Reduction of ocular prosthesis. One enlargement or reduction of the prosthesis is covered every five years after age 20.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 75-1989, f. & cert. ef. 12-15-89; HR 15-1992, f. & cert. ef. 6-1-92, Renumbered from 461-018-0240; HR 1-1996, f. 1-12-96, cert. ef. 1-15-96; OMAP 22-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: July 2006 Oregon Health Plan Managed Care Rule Changes.

Adm. Order No.: OMAP 23-2006

Filed with Sec. of State: 6-12-2006

Certified to be Effective: 7-1-06

Notice Publication Date: 5-1-06

Rules Amended: 410-141-0000, 410-141-0060, 410-141-0070, 410-141-0085, 410-141-0115, 410-141-0180, 410-141-0300, 410-141-0320, 410-141-0400, 410-141-0405, 410-141-0410, 410-141-0420, 410-141-0480, 410-141-0860

Subject: The Oregon Health Plan (OHP-Division 141) Administrative rules govern the Office of Medical Assistance Programs' (OMAP) payments for products and services provided to clients. OMAP amended 410-141-0060 to clarify the policy for established relationship disenrollments and to update the Medicare Plan Election Form processing policy. OMAP amended 410-141-0000, 410-141-0070, 410-141-0085, 410-141-0115, 410-141-0180, 410-141-0300, 410-141-0320, 410-141-0400, 410-141-0405, 410-141-0410, 410-141-0420, 410-141-0480 and 410-141-0860 to take care of necessary housekeeping changes.

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 the Office of Medical Assistance Programs (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 Department of Human Services (DHS) hearing related to an Action, including a denial, reduction, or termination of benefits that is held when requested by the Oregon Health Plan (OHP) Client or 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 decisions and tells a doctor if 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 (SPD) 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 that provide care to OMAP Members under contract with the OMAP Member's PHP. Alternative Care Settings include but are not limited to urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, and outpatient surgicenters.

(7) Ancillary Services — Those medical services under the OHP not identified in the definition of a Condition/Treatment Pair, but Medically Appropriate to support a service covered under the OHP Benefit Package. A list of Ancillary Services and limitations is identified in OAR 410-141-0520, or specified in the Ancillary Services Criteria Guide.

(8) Appeal — A request for review of an Action as defined in this rule.

(9) Automated Information System (AIS) — A computer system that provides information on the current eligibility status for clients under the Medical Assistance Program by phone or by Web access.

(10) Blind — Individuals who meet eligibility criteria established by DHS' SPD for receipt of medical assistance because of a condition or disease that causes or has caused blindness.

(11) Capitated Services — Those Covered Services that a PHP or Primary Care Manager (PCM) agrees to provide for a Capitation Payment under an OMAP OHP 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 PCM to provide Primary Care Management Services for an OHP Client who is enrolled with the PCM. Payment is made on a per OHP Client, per month basis.

(13) Centers for Medicare and Medicaid Services (CMS) — The federal agency under the Department of Health and Human Services (DHHS), responsible for approving the waiver request to operate the OHP Medicaid Demonstration Project.

(14) CFR — Code of Federal Regulations.

(15) Chemical Dependency Organization (CDO) — a PHP that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as Capitated Services under the OHP. All Chemical Dependency Services covered under the OHP are covered as Capitated Services by the CDO.

(16) 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."

(17) Children's Health Insurance Program (CHIP) — A Federal and State funded portion of the Medical Assistance Program established by Title XXI of the Social Security Act and administered in Oregon by DHS' OMAP (see Medical Assistance).

(18) Children Receiving Children, Adults and Families (CAF) Child Welfare or Oregon Youth Authority (OYA) Services — Individuals who are receiving medical assistance under ORS 414.025(2)(f), (i), (j), (k) and (o), 418.034, and 418.187 to 418.970. These individuals are generally children in the care and/or custody of CAF, DHS, or OYA who are in placement outside of their homes.

(19) Claim — (1) A bill for services, (2) a line item of a service, or (3) all services for one Client within a bill.

(20) 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 Exceptional Needs Care Coordinator (ENCC), Complaint and Disenrollment for cause records which may reside in the PHP's administrative offices.

(21) Cold Call Marketing — Any unsolicited personal contact by a PHP with a Potential Member for the purpose of Marketing as defined in this rule.

(22) Comfort Care — The provision of medical services or items that give comfort and/or pain relief to an individual who has a Terminal Illness. Comfort care includes the combination of medical and related services designed to make it possible for an individual with Terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness. Comfort Care includes but is not limited to care provided through a hospice program (see Hospice rules), pain medication, and palliative services including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. Comfort Care includes nutrition, hydration and medication for disabled infants whose life-threatening conditions are not covered under Condition/Treatment Pairs. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable Comfort Care is provided consistent with Section 4751 OBRA 1990 — Patient Self Determination Act and ORS 127 relating to health care decisions as amended by the Sixty-Seventh Oregon Legislative Assembly, 1993. Comfort Care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness with the intent to prolong life.

(23) 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 (OMHAS).

(24) Co-morbid Condition — A medical condition/diagnosis (i.e., illness, disease and/or disability) coexisting with one or more other current and existing conditions/diagnoses in the same patient.

(25) 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 rule.

(26) 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 PHPs and to PCM Members take into consideration the Community Standard and be adequate to meet the needs of OMAP and PCM Members.

(27) 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 OMHAS Medicaid Procedure Codes and Reimbursement Rates, which, when paired by the Health Services Commission, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs may contain many diagnoses and treatments. The Condition/Treatment Pairs are referred to in OAR 410-141-0520.

(28) Continuing Treatment Benefit — A benefit for OHP Clients who meet criteria for having services covered that were either in a course of treatment or were scheduled for treatment on the day immediately prior to the date of conversion to an OHP Benefit Package that doesn't cover the treatment.

(29) 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.

(30) Contract — The Contract between the State of Oregon, acting by and through its DHS, OMAP and an FCHP, Dental Care Organization (DCO), Physician Care Organization (PCO), or a CDO, or between OMHAS and an MHO for the provision of Covered Services to eligible OMAP Members for a Capitation Payment. Also referred to as a Service Agreement.

(31) 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; 410-141-0120; 410-141-0520; and 10-141-0480; except as excluded or limited under 410-141-0500 and rules in chapter 410, division 120.

(32) Dentally Appropriate — Services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the OHP Member or a Provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to an OMAP Member.

(33) Dental Care Organization (DCO) — A PHP that provides and coordinates capitated dental services. All dental services covered under the OHP are covered as Capitated Services by the DCO; no dental services are paid by OMAP on a Fee-for-Service (FFS) basis for OHP Clients enrolled with a DCO Provider.

(34) 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 OMAP Member plus the development and implementation of a plan to ensure that eligible OMAP Members obtain Capitated Services.

(35) Dental Emergency Services — Dental services that may include but are not limited to severe tooth pain, unusual swelling of the face or gums, and an avulsed tooth.

(36) Dental Practitioner — A Practitioner who provides dental services to OMAP Members under an agreement with a DCO, or is a FFS Practitioner. Dental Practitioners are licensed and/or certified by the state in which they practice, as applicable, to provide services within a defined scope of practice.

(37) Department of Human Services (DHS) — DHS is made up of three program areas: CAF; Health Services; and SPD. They are supported by the Director's Office; Administrative Services; and Finance and Policy Analysis (FPA). OMAP and OMHAS are part of the Health Services Cluster.

(38) 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.

(39) Disabled — Individuals who meet eligibility criteria established by the DHS' SPDfor receipt of Medical Assistance because of a disability.

(40) Disenrollment — The act of discharging an OHP Client from a PHP's or PCM's responsibility. After the effective date of Disenrollment an OHP Client is no longer required to obtain Capitated Services from the PHP or PCM, nor be referred by the PHP for Medical Case Managed Services or by the PCM for PCM Case Managed Services.

(41) 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.

(42) 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.

(43) Enrollment — OHP Clients, subject to OAR 410-141-0060, become OMAP Members of a PHP or PCM Members of a PCM that con-

tracts 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 OHP Client's Enrollment with a PCM indicates that the PCM Member must obtain or be referred by the PCM for preventive and primary care and referred by the PCM for all PCM Case Managed Services subsequent to the effective date of Enrollment.

(4) Enrollment Area — Client Enrollment is based on the Client's residential address and zip code. The address is automatically assigned a county code or Federal Information Processing Standard (FIPS) code by the system, which indicates to the DHS worker that PHPs are in the area.

(45) Enrollment Year — A twelve-month period beginning the first day of the month of Enrollment of the OHP Client in a PHP and, for any subsequent year(s) of continuous Enrollment, beginning that same day in each such year(s). The Enrollment Year of OHP Clients who re-enroll within a calendar month of Disenrollment shall be counted as if there were no break in Enrollment.

(46) 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.

(47) Exceptional Needs Care Coordination (ENCC) — A specialized case management service provided by FCHPs to OMAP Members who are Aged, Blind or Disabled, consistent with OAR 410-141-0405. 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.

(48) Family Health Insurance Assistance Program (FHIAP) — A program in which the State subsidizes premiums in the commercial market for uninsured individuals and families with income below 185% of the Federal Poverty Level (FPL). FHIAP is funded with federal and states funds through Title XIX, XXI or both.

49) 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.

(50) Fee-for-Service (FFS) 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 PHPs or by PCMs. The client may seek such services from an appropriate FFS Provider. PCMs provide primary care services on a FFS basis and might also refer PCM Members to specialists and other Providers for FFS care. In some parts of the state, the State may not enter into contracts with any managed care Providers. OHP Clients in these areas will receive all services from FFS Providers.

(51) FPL — Federal Poverty Level.

(52) Free-Standing Mental Health Organization (MHO) — The single MHO in each county that provides only mental health services and is not affiliated with an FCHP for that service area. In most cases this "carve-out" MHO is a county CMHP or a consortium of CMHPs, but may be a private behavioral health care company.

(53) Fully Capitated Health Plan (FCHP) — PHPs that contract with OMAP to provide Capitated Services under the OHP. The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.

(54) Fully Dual Eligible — For the purposes of Medicare Part D coverage, Medicare Clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by DHS for full medical assistance coverage, including those not enrolled in a Medicare Part D plan.

(55) 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.

(56) 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.

(57) 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.

(58) Health Maintenance Unit (HMU) — The OMAP unit responsible for adjustments to enrollments, retroactive Disenrollment and Enrollment of newborns.

(59) Health Plan New/Noncategorical Client (HPN) — A person who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet eligibility requirements in OAR 461-136-1100(2), in addition to all other OHP eligibility requirements to become an OHP Client.

(60) 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.

(61) 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.

(62) Hospital Hold — A Hospital Hold is a process that allows a hospital to assist an individual who is admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the OHP due to inpatient hospitalization. OHP clients shall be exempted from mandatory enrollment with an FCHP if clients become eligible through a Hospital Hold process and are placed in the adults/couples category.

(63) Line Items — Condition/Treatment Pairs or categories of services included at specific lines in the Prioritized List of Services developed by the Health Services Commission for the OHP Medicaid Demonstration Project.

(64) Local and Regional Allied Agencies include the following: local Mental Health Authority; CMHPs; local DHS offices; Commission on Children and Families; OYA; Department of Corrections; Housing Authorities; local health departments, including WIC Programs; local schools; special education programs; law enforcement agencies; adult and juvenile criminal justices; developmental disability services; chemical dependency providers; residential providers; state hospitals, and other PHPs.

(65) Marketing — Any communication from a PHP to an OHP Client who is not enrolled in that PHP which can reasonably be interpreted as an attempt to influence the OHP Client:

(a) To enroll in that particular PHP;

(b) To either Disenroll or not to enroll with another PHP.

(66) 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.

(67) Medicaid — A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by DHS.

(68) Medical Assistance Program — A program for payment of health care provided to eligible Oregonians. Oregon's Medical Assistance Program includes Medicaid services including the OHP Medicaid Demonstration, and CHIP. The Medical Assistance Program is administered by OMAP, of DHS. Coordination of the Medical Assistance Program is the responsibility of OMAP.

(69) 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.

(70) 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.

(71) Medically Appropriate — Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an OHP Client or a Provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an OMAP Member or PCM Member in the PHP's or PCM's judgment.

(72) Medicare — The federal health insurance program for the Aged and Disabled administered by CMS under Title XVIII of the Social Security Act.

(73) Medicare HMO — A capitated health plan that meets specific referral lines and contracts with CMS to provide Medicare benefits to Medicare enrollees.

(74) 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.

(75) 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.

(76) Mental Health Organization (MHO) — A PHP under contract with OMHAS that provides mental health services as Capitated Services under the OHP. MHOs can be FCHPs, CMHPs or private behavioral organizations or combinations thereof.

77) Non-Capitated Services — Those OHP-covered services that are paid for on a FFS basis and for which a capitation payment has not been made to a PHP.

(78) Non-Covered Services — Services or items for which the Medical Assistance Program is not responsible for payment. Services may be covered under the Oregon Medical Assistance Program, but not covered under the OHP. Non-Covered Services for the OHP are identified in:

(a) OAR 410-141-0500;

(b) Exclusions and limitations described in OAR 410-120-1200; and

(c) The individual Provider administrative rules.

(79) Non-Participating Provider — A provider who does not have a contractual relationship with the PHP, i.e. is not on their panel of Providers.

(80) Office of Medical Assistance Programs (OMAP) — The Office of DHS responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration, in Oregon and 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.

(81) Office of Mental Health and Addiction Services (OMHAS) — The DHS office responsible for the administration of the state's policy and programs for mental health, chemical dependency prevention, intervention, and treatment services.

(82) OMAP Member — An OHP Client enrolled with a PHP.

(83) Ombudsman Services — Services provided by DHS to Aged, Blind and Disabled OHP Clients by DHS Ombudsman Staff who may serve as the OHP Client's advocate whenever the OHP Client, Representative, a physician or other medical personnel, or other personal advocate serving the OHP Client, is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider under the OHP. Ombudsman Services include response to individual complaints about access to care, quality of care or limits to care; and response to complaints about OHP systems.

(84) Oregon Health Plan (OHP) — The Medicaid demonstration project that expands Medicaid eligibility to eligible OHP Clients. The OHP relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

(85) Oregon Health Plan (OHP) Plus Benefit Package — A benefit package available to eligible OHP Clients as described in OAR 410-120-1210.

(86) Oregon Health Plan (OHP) Standard Benefit Package — A benefit package available to eligible OHP Clients who are not otherwise eligible for Medicaid (including families, adults and couples) as described in OAR 410-120-1210.

(87) Oregon Health Plan (OHP) Client — An individual found eligible by DHS to receive services under the OHP. The OHP categories eligible for enrollment are defined as follows:

(a) Temporary Assistance to Needy Families (TANF) are categorically eligible with income under current eligibility rules;

(b) CHIP — children under one year of age who have income under 185% FPL and do not meet one of the other eligibility classifications;

(c) Poverty Level Medical (PLM) Adults under 100% of the FPL are OHP Clients who are pregnant women with income under 100% of FPL;

(d) PLM Adults over 100% of the FPL are OHP Clients who are pregnant women with income between 100% and 185% of the FPL;

(e) PLM children under one year of age have family income under 133% of the FPL or were born to mothers who were eligible as PLM Adults at the time of the child's birth;

(f) PLM or CHIP children one through five years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;

(g) PLM or CHIP children six through eighteen years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;

(h) OHP Adults and Couples are OHP Clients aged 19 or over and not Medicare eligible, with income below 100% of the FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household;

(i) OHP Families are OHP Clients, aged 19 or over and not Medicare eligible, with income below 100% of the FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under the age of 19 in the household;

(j) General Assistance (GA) Recipients are OHP Clients who are eligible by virtue of their eligibility under the Oregon General Assistance program, ORS 411.710 et seq.;

(k) Assistance to Blind and Disabled (AB/AD) with Medicare Eligibles are OHP Clients with concurrent Medicare eligibility with income under current eligibility rules;

(l) AB/AD without Medicare Eligibles are OHP Clients without Medicare with income under current eligibility rules;

(m) Old Age Assistance (OAA) with Medicare Eligibles are OHP Clients with concurrent Medicare Part A or Medicare Parts A & B eligibility with income under current eligibility rules;

(n) OAA with Medicare Part B only are OAA eligibles with concurrent Medicare Part B only income under current eligibility rules;

(o) OAA without Medicare Eligibles are OHP Clients without Medicare with income under current eligibility rules;

(p) CAF Children are OHP Clients who are children with medical eligibility determined by CAF or OYA receiving OHP under ORS 414.025(2)(f), (I), (j), (k) and (o), 418.034 and 418.187 to 418.970. These individuals are generally in the care and/or custody of CAF or OYA who are in placement outside of their homes.

(88) Oregon Youth Authority (OYA) — The state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(89) Participating Provider — An individual, facility, corporate entity, or other organization which supplies medical, dental, chemical dependency services, or mental health services or medical and dental items and that has agreed to provide those services or items to OMAP Members under an agreement or contract with a PHP and to bill in accordance with the signed agreement or contract with a PHP.

(90) PCM Case Managed Services include the following: Preventive Services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, Rural Health Clinics (RHC), Migrant and Community Health Clinics, Federally Qualified Health Centers (FQHC), County Health Departments, Indian Health Service Clinics and Tribal Health Clinics, CMHPs, MHOs; inpatient hospital services; and outpatient hospital services except laboratory, X-ray, and maternity management services.

(91) PCM Member — An OHP Client enrolled with a PCM.

(92) PHP Coordinator — the DHS OMAP employee designated by OMAP as the liaison between OMAP and the PHP.

(93) Physician Care Organization (PCO) — PHP that contracts with OMAP to provide partially capitated health services under the OHP. The distinguishing characteristic of a PCO is the exclusion of inpatient hospital services.

(94) Post Hospital Extended Care Benefit — A 20-day benefit for non- Medicare OMAP Members enrolled in a FCHP who meet Medicare criteria for a post-hospital skilled nursing placement.

(95) Post Stabilization Services — Covered Services, related to an Emergency Medical Condition that are provided after an OMAP Member is stabilized in order to maintain the stabilized condition or to improve or resolve the OMAP Member's condition.

(96) 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.

(97) Practitioner — A person licensed pursuant to State law to engage in the provision of health care services within the scope of the Practitioner's license and/or certification.

(98) Prepaid Health Plan (PHP) — A managed health, dental, chemical dependency, physician care organization, or mental health care organization that contracts with OMAP and/or OMHAS on a case managed, prepaid, capitated basis under the OHP. PHPs may be DCOs, FCHPs, MHOs, PCOs or CDOs.

(99) Preventive Services — Those services as defined under Expanded Definition of Preventive Services for OHP Clients in OAR 410-141-0480, and 410-141-0520.

(100) Primary Care Management Services — Primary Care Management Services are services provided to ensure PCM Members obtain health care services necessary to maintain physical and emotional development and health. Primary Care Management Services include a comprehensive, ongoing assessment of medical needs plus the development, and implementation of a plan to obtain needed medical services that are preventive or primary care services or PCM Case Managed Services and follow-up, as appropriate, to assess the impact of care.

(101) Primary Care Manager (PCM) — A physician (MD or DO), nurse practitioner, physician assistant; or naturopath with physician backups, who agrees to provide Primary Care Management Services as defined in rule to PCM Members. PCMs may also be hospital primary care clinics, RHCs, Migrant and Community Health Clinics, FQHCs, County Health Departments, Indian Health Service Clinics or Tribal Health Clinics. The PCM provides Primary Care Management Services to PCM Members for a Capitation Payment. The PCM provides preventive and primary care services on a FFS basis.

(102) Primary Care Dentist (PCD) — A Dental Practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for OMAP Members. PCDs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.

(103) Primary Care Provider (PCP) — A Practitioner who has responsibility for supervising and coordinating initial and primary care within their scope of practice for OMAP Members. PCPs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.

(104) Prioritized List of Health Services — The listing of Condition and Treatment Pairs developed by the Health Services Commission for the purpose of implementing the OHP Demonstration Project. See OAR 410-141-0520, for the listing of Condition and Treatment Pairs.

(105) Proof of Indian Heritage — Proof of Native American and/or Alaska Native descent as evidenced by written identification that shows status as an "Indian" in accordance with the Indian Health Care Improvement Act (P.L. 94-437, as amended). This written proof supports his/her eligibility for services under programs of the Indian Health Service — services provided by Indian Health Service facilities, tribal health clinics/programs or urban clinics. Written proof may be a tribal identification card, a certificate of degree of Indian blood, or a letter from the Indian Health Service verifying eligibility for health care through programs of the Indian Health Service.

(106) Provider — An individual, facility, institution, corporate entity, or other organization which supplies medical, dental or mental health services or medical and dental items.

(107) Quality Improvement — Quality improvement is the effort to improve the level of performance of a key process or processes in health services or health care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement (as used in these rules) includes the goals of quality assurance, quality control, quality planning and quality management in health care where "quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge."

(108) Representative — A person who can make OHP related decisions for OHP Clients who are not able to make such decisions themselves. A Representative may be, in the following order of priority, a person who is designated as the OHP Client's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the OHP Client, the Individual Service Plan Team (for developmentally disabled clients), a DHS case manager or other DHS designee.

(109) Rural — A geographic area 10 or more map miles from a population center of 30,000 people or less.

(110) Seniors and People with Disabilities (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 GA and the Oregon Supplemental Income Program (OSIP); and

(c) Administration of the federal Older Americans Act.

(111) Service Area — The geographic area in which the PHP has identified in their Contract or Agreement with DHS to provide services under the OHP.

(112) Stabilize — No material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

(113) Terminal Illness — An illness or injury in which death is imminent irrespective of treatment, where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death.

(114) Triage — Evaluations conducted to determine whether or not an emergency condition exists, and to direct the OMAP Member to the most appropriate setting for Medically Appropriate care.

(115) Urban — A geographic area less than 10 map miles from a population center of 30,000 people or more.

(116) Urgent Care Services — Covered Services that are Medically Appropriate and immediately required in order to prevent a serious deterioration of an 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.

(117) Valid Claim:

(a) An invoice received by the PHP for payment of covered health care services rendered to an eligible Client that:

(A) Can be processed without obtaining additional information from the Provider of the service or from a third party; and

(B) Has been received within the time limitations prescribed in these Rules.

(b) A Valid Claim does not include a Claim from a Provider who is under investigation for fraud or abuse, or a Claim under review for Medical Appropriateness. A Valid Claim is synonymous with the federal definition of a Clean Claim as defined in 42 CFR 447.45(b).

(118) Valid Pre-Authorization — A request received by the PHP for approval of the provision of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and

(b) Has been received within the time limitations prescribed in these Rules.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000. f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 13-2002, f. & cert. ef. 4-1-02; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0060
Oregon Health Plan Managed Care Enrollment Requirements

(1) Enrollment of an Oregon Health Plan (OHP) Client, excluding the Health Plan 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).

(2) Enrollment of the HPN and CHIP Clients in PHPs shall be mandatory unless exempted from Enrollment by DHS under the terms in section (4) of this rule. Selection of PHPs in accordance with this rule is a condition of eligibility for HPN and CHIP Clients. If, upon reapplication, HPN or CHIP Clients do not select PHPs in accordance with this rule, PHPs will

be selected by DHS. This selection will be based on which PHPs the HPN or CHIP Clients were previously enrolled in.

(3) OHP Clients, except 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 Fully Capitated Health Plans (FCHP), Physician Care Organizations (PCO), and PCMs shall be called mandatory FCHP/PCO/PCM Service Areas. In mandatory FCHP/PCO/PCM Service Areas, an OHP Client shall select:

(A) An FCHP or PCO; or

(B) A PCM if exempt from FCHP or PCO Enrollment.

(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. In voluntary FCHP/PCO/PCM Service Areas, an OHP Client may choose to:

(A) Select any FCHP, PCO or PCM that is open for Enrollment; or

(B) 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. In voluntary DCO Service Areas, an OHP Client may choose to:

(A) Select any DCO open for Enrollment; or

(B) 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.OHP Clients will be enrolled in 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 section (4) of this rule, or as provided by OAR 410-141-0080.

(4) The following are exemptions to mandatory Enrollment in PHPs that 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) Clients who meet all of the criteria listed in section (4)(b)(A) through (C) are exempt from mandatory Enrollment:

(A) The OHP Client has an established relationship with an OMAP enrolled Practitioner from whom the Client receives ongoing treatment for a covered medical or dental condition, and;

(B) The OMAP enrolled Practitioner is not a member of the PHP's Participating Provider panel the OHP Client would be enrolled in, and;

(C) It would be detrimental to the health and continuity of care of the OHP Client, as determined by DHS through medical review, to change Practitioners and receive treatment from the PHP's Participating Provider Panel;

(D) 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;

(E) 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;

(F) 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 affect 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 (CAF) (Child Welfare Services), and the child is expected to be in a substitute care placement for less than 30 calendar days, unless:

(A) There is no FFS access; or

(B) There are 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 her 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;

(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) An OHP Client who is also 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 choose not to enroll in an FCHP or PCO;

(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 through medical review, 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 CAF), shall not enroll in an FCHP, PCO, DCO or MHO. A woman in the BCCM Program shall remain in the Medicaid FFS 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 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 in section (4) of this rule. 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 Medicare Advantage Plan Election form (OHP 7208M), described in subsection (5)(d) of this rule, is signed by someone other than the OHP Client, the OHP Client's Representative must complete and signthe Signature by Mark or State Approved Signature sections of the OHP 7208M.

(B) If the OHP Client is a Medicare beneficiary who is capable of making Enrollment decisions, the Client's 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 (Child Welfare 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, who is Medicare Advantage eligible, selects a FCHP or PCO that has a corresponding Medicare HMO, the OHP Client shall complete the 7208M, or other CMS approved Medicare plan election form:

(i) If the FCHP or PCO has not received the form 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 SPD branch manager. The letter shall:

(I) Explain the need for the completion of the form;

(II) Inform the OMAP Member that if the form is not received within 30 days, the FCHP or PCO may request Disenrollment; and

(III) Instruct the OMAP Member to contact their caseworker for other coverage alternatives.

(ii) The FCHP or PCO shall choose whether to disenroll or maintain Enrollment for all the OHP Clients from whom they do not receive a form at the end of 30 days, except as otherwise provided in this rule. The FCHP or PCO must notify the PHP Coordinator of the PHP's annual decision to disenroll or maintain Enrollment for the OHP Clients in writing. This notification must be submitted by January 31 of each year, or another date specified by OMAP. If the FCHP or PCO has decided to:

(I) Disenroll the OHP Clients and has not received an OMAP Client's form at the end of 30 days, the FCHP or PCO shall request Disenrollment. HMU will disenroll the OMAP Member effective the end of the month following the notification.

(II) Maintain Enrollment, the FCHP or PCO shall not request Disenrollment at the end of 30 days.

(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 Fully Dual Eligible (FDE) 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 OHP mental health benefits 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 as follows:

(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 effective 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.

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; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 10-2006(Temp), f. & cert. ef. 5-4-06 thru 10-27-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0070

Oregon Health Plan Fully Capitated Health Plan (FCHP) and Physician Care Organization (PCO) Pharmaceutical Drug List Requirements

(1) Prescription drugs are a Covered Service based on the funded Condition/Treatment Pairs. FCHPs and PCOs shall pay for prescription drugs, except:

(a) As otherwise provided, such as Class 7 & 11 medications (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank);

(b) Depakote, Lamictal and those drugs that the Office of Medical Assistance Programs (OMAP) specifically carved out from capitation according to sections (8) through (11) of this rule;

(c) Any applicable Co-payments;

(d) For drugs covered under Medicare Part D when the Client is Fully Dual Eligible.

(2) FCHPs and PCOs may use a restrictive drug list as long as it allows access to other drug products not on the drug list through some process such as prior authorization (PA). The drug list must:

(a) Include Federal Drug Administration (FDA)-approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the Provider of pharmaceutical services;

(b) Include at least one item in each therapeutic class of over-the-counter medications; and

(c) Be revised periodically to assure compliance with this requirement.

(3) FCHPs and PCOs shall provide their Participating Providers and their pharmacy subcontractor with:

(a) Their drug list and information about how to make non-drug listed requests;

(b) Updates made to their drug list within 30 days of a change that may include, but is not limited to:

(A) Addition of a new drug;

(B) Removal of a previously listed drug; and

(C) Generic substitution.

(4) If a drug cannot be approved within the 24-hour time requirement for prior authorization of drugs and the medical need for the drug is immediate, FCHPs and PCOs must provide for the dispensing of at least a 72-hour supply of a drug that requires prior authorization

(5) FCHPs and PCOs shall authorize the provision of a drug requested by the Primary Care Physician (PCP) or referring Provider, if the approved prescriber certifies medical necessity for the drug such as:

(a) The equivalent of the drug listed has been ineffective in treatment; or

(b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the OMAP Member.

(6) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act are excluded; payment is governed solely by OAR 410-121-0150.

(7) FCHPs and PCOs shall not authorize payment for any Drug Efficacy Study Implementation (DESI) Less-Than-Effective drugs which have reached the FDA Notice-of-Opportunity-for Hearing stage. The DESI Less-Than-Effective list is available at OMAP's Web site at <http://www.dhs.state.or.us/policy/healthplan/guides/pharmacy/misc_files/desi1.pdf>.

(8) OMAP may exclude (commonly called "carve out") drugs from FCHP and PCO capitation that are FDA approved to treat a serious mental health disorder, such as major depressive, bi-polar and schizophrenic disorders.

(9) In order for a drug to be considered for carve out from FCHP and PCO capitation for the January contract period, OMAP must receive the request for carve out from the FCHP or PCO no later than March 1 of the previous calendar year to be considered for carve out for the following January contract cycle. The request must include:

(a) The drug name;

(b) The FDA approved indications that include an FDA approved use to treat a severe mental health condition; and

(c) The reason that OMAP should consider this drug for carve out.

(10) OMAP determines whether or not to carve out a drug.

(11) OMAP will pay for a drug that is subject to carve out pursuant to the Pharmaceutical Services Rules (chapter 410, division 121). An FCHP or PCO may not reimburse Providers for carved out drugs.

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
Hist.: OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 57-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0085
Oregon Health Plan Disenrollment from Primary Care Managers

(1) PCM Member requests for Disenrollment:

(a) All PCM Member-initiated requests for Disenrollment from Primary Care Managers must be initiated by the primary person in the benefit group, where primary person and benefit group are defined in OAR 461-110-0110 and 461-110-0720, respectively. For PCM Members who are not able to request Disenrollment on their own, the request may be initiated by the PCM Member's Representative;

(b) Primary Person or Representative requests for Disenrollment shall be honored:

(A) During the first 30 days of Enrollment without cause. The effective date of Disenrollment shall be the first of the month following PCM Member notification to DHS;

(B) After six months of PCM Member's Enrollment without cause. The effective date of Disenrollment shall be the first of the month following PCM Member notification to DHS;

(C) Whenever a PCM Member's eligibility is re-determined by 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 PCM Member's eligibility is re-determined by DHS;

(D) At any other time with cause:

(i) OMAP shall determine if sufficient cause exists to honor the request for Disenrollment;

(ii) Examples of sufficient cause include but are not limited to:

(I) The PCM Member moves out of the Primary Care Manager Service Area;

(II) It would be detrimental to the PCM Member's health to remain enrolled with the Primary Care Manager;

(III) The PCM 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 delivery system.

(c) In addition to the Disenrollment constraints listed in subsection (b) of this section, PCM Member Disenrollment requests are subject to the following requirements:

(A) The PCM Member shall select another Primary Care Manager or Prepaid Health Plan, unless the PCM Member resides in a Service Area where Enrollment is voluntary;

(B) If the only Primary Care Manager or Prepaid Health Plan available in a PHP, PHP/ PCM or PCM mandatory Service Area is the PCM from which the PCM Member wishes to disenroll, the PCM Member may not disenroll without cause.

(2) Primary Care Manager requests for Disenrollment:

(a) Procedures for Primary Care Manager requests for Disenrollment are as follows:

(A) Requests by the Primary Care Manager for Disenrollment of specific PCM Members shall be submitted in writing to OMAP for approval prior to Disenrollment. The Primary Care Manager shall document the reason for the request, provide other records to support the request, and certify that the request is not due to an adverse change in the PCM Member's health. If the situation warrants, OMAP shall consider an oral request for Disenrollment, with written documentation to follow. OMAP shall approve Primary Care Manager requests for Disenrollment that meet OMAP criteria;

(B) OMAP shall respond to Primary Care Manager requests in a timely manner and in no event greater than 30 calendar days;

(C) The Primary Care Manager shall not disenroll or request Disenrollment of any PCM Member because of an adverse change in the PCM Member's health.

(b) OMAP may disenroll PCM Members for cause when requested by the Primary Care Manager:

(A) OMAP shall inform the PCM Member of:

(i) An approved Disenrollment decision;

(ii) Any requirement to select another Primary Care Manager;

(iii) Right to request an OMAP hearing if the Disenrollment decision by OMAP is disputed.

(B) Examples of cause include, but are no limited to the following:

(i) The PCM Member refuses to accept Medically Appropriate treatment and/or follow Medically Appropriate guidelines;

(ii) The PCM Member is unruly or abusive to others or threatens or commits an act of physical violence directed at a medical Provider, the Provider's staff or other patients;

(iii) The PCM Member has permitted the use of his or her OMAP Medical Care Identification by another person or used another person's Medical Care Identification;

(iv) The PCM Member has missed three appointments without canceling and/or without explanation and the Primary Care Manager has documented attempts to accommodate the PCM Member's needs and to counsel with or educate the PCM Member.

(c) If OMAP approves the Primary Care Manager request for Disenrollment of a PCM Member because the PCM Member is abusive to others or threatens or commits an act of physical violence, the following procedures shall apply:

(A) OMAP shall inform the PCM Member of the Disenrollment decision;

(B) The PCM Member shall be disenrolled. All PCM Members in the PCM Member's benefit group, as defined in OAR 461-110-0720, may be disenrolled;

(C) The effective date of Disenrollment shall be the date of the Primary Care Manager's request for Disenrollment;

(D) OMAP shall require the PCM Member and/or the benefit group to obtain services from fee-for-service Providers for six months;

(E) After six months the PCM Member and/or the benefit group shall be required to select another Primary Care Manager, if available in the Service Area;

(F) OMAP shall notify the new Primary Care Manager that the PCM Member and/or benefit group was previously disenrolled from another Primary Care Manager at the Primary Care Manager's request.

(3) OMAP may initiate and disenroll PCM Members as follows:

(a) If OMAP determines the PCM Member has third party resources through a private HMO, OMAP may disenroll the PCM Member. The effective date of Disenrollment shall be specified by OMAP and shall be the first of the month after OMAP determines the PCM Member should be disenrolled;

(b) If the PCM Member moves out of the Primary Care Manager's Service Area, the effective date of Disenrollment shall be the date specified by OMAP, which may be retroactive up to one month prior to the month OMAP notifies the Primary Care Manager;

(c) If the PCM Member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project, the effective date of Disenrollment shall be the date specified by OMAP;

(d) If the PCM Member dies, the effective date of Disenrollment shall be the date of death.

(4) Unless specified otherwise in this rule or at the time of notification of Disenrollment to the Primary Care Manager by OMAP all Disenrollments are effective the first of the month after the request for Disenrollment is approved by OMAP.

(5) Oregon Health Plan clients may request an OMAP hearing if they dispute a Disenrollment decision by OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & 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; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0115

Oregon Health Plan Primary Care Manager Member Satisfaction Survey

(1) OMAP may conduct a statistically valid PCM Member satisfaction survey each calendar year to survey PCM Members' satisfaction with respect to:

(a) Access to care;

(b) Quality of medical care; and

(c) General PCM Member satisfaction.

(2) Results of the survey shall be available not more than six months after the survey is conducted.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.725

Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

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 Providers 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 ORS 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:

(A) Incorrect data shall be crossed through with a single line;

(B) Correct and legible data shall be added followed by the date corrected and initials of the person making the correction;

(C) 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; and

(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; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

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
OHP: Oregon Health Plan
OMAP: Office of Medical Assistance Programs
OMHAS: Office of Mental Health and Addiction Services
PCD: Primary Care Dentist
PCO: Physician Care Organization
PCP: Primary Care Provider
PHP: Prepaid Health Plan (FCHP, PCO, DCO, CDO and MHO)

(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 Member's 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 Non-Participating Providers;

(W) Any restrictions on the OMAP Member's freedom of choice among Participating 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; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0320

Oregon Health Plan Prepaid Health Plan Member Rights and Responsibilities

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure OMAP Members have the rights and responsibilities included in this rule:

(a) PHPs shall communicate these policies and procedures to Participating Providers;

(b) PHPs shall monitor compliance with policies and procedures governing OMAP Member rights and responsibilities, take corrective action as needed, and report findings to the PHP's Quality Improvement Committee.

(2) OMAP Members shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by Participating Providers the same as other people seeking health care benefits to which they are entitled;

(c) To choose a PHP or PCM as permitted in OAR 410-141-0060, Oregon Health Plan Managed Care Enrollment Requirements, a Primary Care Physician (PCP) or service site, and to change those choices as permitted in OAR 410-141-0080, Oregon Health Plan Disenrollment from PHPs, and the PHP's administrative policies;

(d) To refer oneself directly to mental health, Chemical Dependency or Family Planning Services without getting a referral from a PCP or other Participating Provider;

(e) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(f) To be actively involved in the development of his/her treatment plan;

(g) To be given information about his/her condition and Covered and Non-Covered Services to allow an informed decision about proposed treatment(s);

(h) To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

(i) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(j) To have written materials explained in a manner that is understandable to the OMAP Member;

(k) To receive necessary and reasonable services to diagnose the presenting condition;

(l) To receive Covered Services under the Oregon Health Plan that meet generally accepted standards of practice and is Medically Appropriate;

(m) To obtain covered Preventive Services;

(n) To have access to urgent and emergency services 24 hours a day, 7 days a week as described in OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(o) To receive a referral to specialty practitioners for Medically Appropriate Covered Services;

(p) To have a Clinical Record maintained which documents conditions, services received, and referrals made;

(q) To have access to one's own Clinical Record, unless restricted by statute;

(r) To transfer of a copy of his/her Clinical Record to another Provider;

(s) 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;

(t) 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;

(u) To know how to make a Complaint or Appeal with the PHP and receive a response as defined in OAR 410-141-0260 to 410-141-0266;

(v) To request an Administrative Hearing with the Department of Human Services;

(w) To receive interpreter services as defined in OAR 410-141-0220, Oregon Health Plan Prepaid Health Plan Accessibility; and

(x) To receive a notice of an appointment cancellation in a timely manner.

(3) OMAP Members shall have the following responsibilities:

(a) To choose, or help with assignment to, a PHP or PCM as defined in 410-141-0060, Oregon Health Plan Enrollment Requirements, and a PCP or service site;

(b) To treat the PHP's, Practitioner's, and clinic's staff with respect;

(c) To be on time for appointments made with Practitioners and other Providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late;

(d) To seek periodic health exams and Preventive Services from his/her PCP or clinic;

(e) To use his/her PCP or clinic for diagnostic and other care except in an emergency;

(f) 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;

(g) To use urgent and Emergency Services appropriately and notify the PHP within 72 hours of an emergency;

(h) To give accurate information for inclusion in the Clinical Record;

(i) To help the Practitioner, Provider or clinic obtain Clinical Records from other Providers which may include signing an authorization for release of information;

(j) To ask questions about conditions, treatments and other issues related to his/her care that is not understood;

(k) To use information to make informed decisions about treatment before it is given;

(l) To help in the creation of a treatment plan with the Provider;

(m) To follow prescribed agreed upon treatment plans;

(n) To tell the Practitioner or Provider that his/her health care is covered under the Oregon Health Plan before services are received and, if requested, to show the Practitioner or other Provider the OMAP Medical Care Identification form;

(o) To tell the DHS worker of a change of address or phone number;

(p) To tell the DHS worker if the OMAP Member becomes pregnant and to notify the DHS worker of the birth of the OMAP Member's child;

(q) To tell the DHS worker if any family members move in or out of the household;

(r) To tell the DHS worker if there is any other insurance available;

(s) To pay for Non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(t) To pay the monthly OHP premium on time if so required;

(u) To assist the PHP in pursuing any third party resources available and to pay the PHP the amount of benefits it paid for an injury from any recovery received from that injury;

(v) To bring issues, or Complaints or Grievances to the attention of the PHP; and

(w) To sign an authorization for release of medical information so that DHS and the PHP 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 414.725
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 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 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0400
Oregon Health Plan Prepaid Health Plan Case Management Services

DCO: Dental Care Organization
FCHP: Fully Capitated Health Plan
MHO: Mental Health Organization
OHP: Oregon Health Plan
PCO: Physician Care Organization
PHP: Prepaid Health Plan

(1) Prepaid Health Plans provide Case Management Services under the Oregon Health Plan.

(2) Prepaid Health Plan Case Management Services are defined as follows:

(a) FCHPs and PCOs provide Medical Case Management as defined in OAR 410-141-0000, Definitions;

(b) DCOs provide Dental Case Management as defined in OAR 410-141-0000, Definitions. DCOs shall make Dental Case Management staff available for training, Regional OHP meetings, and case conferences involving their OMAP Members in all service areas; (c) MHOs provide Mental Health Case Management for Capitated and Non-Capitated mental health services as defined in OAR 410-141-0000, Definitions.

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 25-1997, f. & cert. ef. 10-1-97; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0405
Oregon Health Plan Fully Capitated Health Plan and Physician Care Organization Exceptional Needs Care Coordination (ENCC)

Fully Capitated Health Plans (FCHPs) and Physician Care Organizations (PCOs) provide Exceptional Needs Care Coordination (ENCC) under the Oregon Health Plan:

(1) FCHPs and PCOs shall make available ENCC services as defined in OAR 410-141-0000, Definitions, for all Capitated Services;

(2) FCHPs and PCOs shall make ENCC services available at the request of the Aged, Blind or Disabled OMAP Member, his or her Representative, a physician, or other medical personnel serving the OMAP Member, or the Aged, Blind or Disabled OMAP Member's agency case manager;

(3) FCHPs and PCOs shall make Exceptional Needs Care Coordinators available for training, Regional OHP meetings and case conferences involving their Aged, Blind and Disabled OMAP Members in all their Service Areas;

(4) FCHP and PCO staff who coordinate or provide ENCC services shall be trained to and exhibit skills in communication with and sensitivity to the unique health care needs of people who are Aged, Blind, Disabled or have special health care needs. FCHPs and PCOs shall have a written position description for the staff member(s) responsible for managing ENCC services and for staff who provide ENCC services;

(5) FCHPs and PCOs shall have written policies that outline how the level of staffing dedicated to ENCC is determined;

(6) FCHPs and PCOs shall make ENCC services available to OMAP Members who are Aged, Blind, Disabled or having special health care needs during normal office hours, Monday through Friday. Information on ENCC services shall be made available when necessary to an OMAP Member's Representative during normal business hours, Monday through Friday;

(7) FCHPs and PCOs shall provide the Aged, Blind, Disabled or special health care need OMAP Member or his or her Representative who requests ENCC services with an initial response by the next working day following the request, as appropriate;

(8) FCHPs and PCOs shall periodically inform all of their Practitioners and the Practitioner's staff of the availability of ENCC services, provide training for medical office staff on ENCC services and other support services available for serving the Aged, Blind, Disabled or special need OMAP Members; FCHPs and PCOs shall assure that the ENCCs name(s) and telephone number(s) are made available to both agency staff and OMAP Members or their Representatives;

(9) FCHPs and PCOs shall have written procedures that describe how they will respond to ENCC requests;

(10) FCHPs and PCOs shall make ENCC services available to coordinate the provision of Covered Services to Aged, Blind, Disabled or special need OMAP Members who exhibit inappropriate, disruptive or threatening behaviors in a Practitioner's office;

(11) Exceptional Needs Care Coordinators shall document ENCC services in OMAP Member medical records as appropriate and/or in a separate OMAP Member case file.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0410
Oregon Health Plan Primary Care Managers

(1) Primary Care Managers provide Primary Care Management Services under the Oregon Health Plan. Primary Care Managers provide Primary Care Management Services as defined in OAR 410-141-0000, Definitions, for the following PCM Services:

(a) 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;

(b) Inpatient hospital services; and

(c) Outpatient hospital services except laboratory, x-ray and maternity management services.

(2) Services which are not PCM Case Managed Services include, but are not limited to, the following:

(a) Anesthesiology services;
(b) Dental care services;
(c) Durable medical equipment;
(d) Family Planning Services;
(e) Immunizations, treatment for communicable diseases, and treatment for sexually transmitted diseases provided by a publicly funded clinic;
(f) Laboratory services;
(g) Maternity case management services;
(h) Medical transportation services;
(i) Mental health and Chemical Dependency Services;
(j) Pharmacy services;
(k) Physical therapy, occupational therapy, speech therapy, and audiology services;
(l) Preventive Services for acquired immune deficiency syndrome andhuman immuno-deficiency virus;
(m) Routine eye examinations and dispensing of vision materials;
(n) School-based services provided under an individual education plan or an individual family service plan;
(o) Targeted case management services; and
(p) Diagnostic imaging.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 69-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

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 14 calendar 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-Participating 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 pre-authorization; 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 rel-

evant 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 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; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0480

Oregon Health Plan Benefit Package of Covered Services

(1) OMAP Members are eligible to receive, subject to Section (11) of this rule, those treatments for the condition/treatment pairs funded on the Oregon Health Services Commission's Prioritized List of Health Services adopted under OAR 410-141-0520 when such treatments are Medically or Dentally appropriate, except that services must also meet the prudent layperson standard defined in OAR 410-141-0140. Refer to 410-141-0520 section (4) for funded line coverage information.

(2) Medical Assistance Benefit Packages follow practice guidelines adopted by the Health Services Commission (HSC) in conjunction with the Prioritized List of Health Services unless otherwise specified in rule.

(3) Diagnostic Services that are necessary and reasonable to diagnose the presenting condition of the OMAP Member are Covered Services, regardless of the placement of the condition on the Prioritized List of Health Services.

(4) Comfort care is a Covered Service for an OMAP Member with a Terminal Illness.

(5) Preventive Services promoting health and/or reducing the risk of disease or illness are Covered Services for OMAP Members. Such services include, but are not limited to, periodic medical and dental exams based on age, sex and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors, (See Prioritized List of Health Services, adopted in OAR 410-141-0520).

(6) Ancillary Services are covered, subject to the service limitations of the OHP Program rules, when the services are Medically or Dentally Appropriate for the treatment of a covered Condition/Treatment Pair, or the provision of Ancillary Services will enable the OMAP Member to retain or attain the capability for independence or self-care. A list of Ancillary Services is included in the Prioritized List of Health Services, adopted in OAR 410-141-0520.

(7) The provision of Chemical Dependency Services must be in compliance with the Office of Mental Health and Addiction Services (OMHAS) Administrative Rules, OAR 415-020-0000 to 0090 and 415-051-0000 to 0130 and the requirements in the Chemical Dependency subsection of the Statement of Work in the Fully Capitated Health Plan and Physician Care Organization contracts.

(8) In addition to the coverage available under section (1) of this rule, an OMAP Member may be eligible to receive, subject to section (12), services for treatments that are below the funded line or not otherwise excluded from coverage:

(a) Services can be provided if it can be shown that:

(A) The OHP Client has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and

(B) Concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and

(C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition;

(D) Ancillary Services that are excluded and other services that are excluded are not subject to consideration under this rule;

(E) Any unfunded or funded Co-Morbid Conditions or disabilities must be represented by an ICD-9-CM diagnosis code or when the condition is a mental disorder, represented by DSM-IV diagnosis coding to the highest level of axis specificity; and

(F) In order for the treatment to be covered, there must be a medical determination and finding by OMAP for fee-for-service OHP Clients or a finding by the Prepaid Health Plan (PHP) for OMAP Members that the terms of section (a)(A)-(C) of this rule have been met based upon the applicable:

(i) Treating physician opinion;

(ii) Medical research;

(iii) Community standards; and

(iv) Current peer review.

(b) Before denying treatment for an unfunded condition for any OMAP Member, especially an OMAP Member with a disability or with a Co-Morbid Condition, Providers must determine whether the OMAP Member has a funded Condition/Treatment Pair that would entitle the OMAP Member to treatment under the program and both the funded and unfunded conditions must be represented by an ICD- 9-CM diagnosis code; or, when the condition is a mental disorder, represented by DSM-IV diagnosis coding to the highest level of axis specificity.

(9) OMAP shall maintain a telephone information line for the purpose of providing assistance to Practitioners in determining coverage under the Oregon Health Plan Benefit Package of Covered Services. The telephone information line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need arises outside of regular business hours, OMAP shall make a retrospective determination under this subsection, provided OMAP is notified of the emergency situation during the next business day. If OMAP denies a requested service, OMAP shall provide written notification and a notice of the right to an Administrative

Hearing to both the OHP Client and the treating physician within five working days of making the decision.

(10) If a Condition/Treatment Pair is not on the Health Services Commission's Prioritized List of Health Services and OMAP determines the Condition/Treatment Pair has not been identified by the Commission for inclusion on the list, OMAP shall make a coverage decision in consultation with the Health Services Commission.

(11) Coverage of services available through the Oregon Health Plan Benefit Package of Covered Services is limited by OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients.

(12) General anesthesia for dental procedures which are Medically and/or Dentally Appropriate to be performed in a hospital or ambulatory surgical setting, is to be used only for those OMAP Members with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure as outlined below:

(a) Children under three years old with dental needs determined by the dentist or oral surgeon as requiring general anesthesia;

(b) Children over three years old requiring substantial dental care determined by the dentist or oral surgeon as requiring general anesthesia that may protect the child from unnecessary trauma;

(c) OMAP Members with physical, mental or medically compromising conditions;

(d) OMAP Members with dental needs for who local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;

(e) Acute situational anxiety, fearfulness, extremely uncooperative or uncommunicative client with dental needs, determined by the dentist or oral surgeon, sufficiently important that dental care cannot be deferred;

(f) OMAP Members who have sustained extensive orofacial and dental trauma; or

(g) OMAP Members with dental needs who otherwise would not obtain necessary dental care when, in the decision of the dentist or oral surgeon, the need for dental treatment outweighs the risks of general anesthesia. The OMAP Member's dental record must clearly document the justification for the level of anesthesia and why, in the estimation of the dentist or oral surgeon, the treatment in an office setting is not possible.

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 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 26-1995, f. 12-29-95, cert. ef. 1-1-96; HR 19-1996, f. & cert. ef. 10-1-96; HR 1-1997(Temp), f. 1-31-97, cert. ef. 2-1-97; HR 12-1997, f. 5-30-97, cert. ef. 6-1-97; HR 15-1997, f. & cert. ef 7-1-97; HR 26-1997, f. & cert. ef. 10-1-97; OMAP 17-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 32-1998, f. & cert. ef. 9-1-98; OMAP 39-1998, 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 53-2001, f. & cert. ef. 10-1-01; OMAP 88-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 79-2003(Temp), f. & cert. ef. 10-2-03 thru 3-15-04; OMAP 81-2003(Temp), f. & cert. ef. 10-23-03 thru 3-15-04; OMAP 94-2003, f. 12-31-03 cert. ef. 1-1-04; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 51-2004, f. 9-9-04, cert. ef. 10-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

410-141-0860
Oregon Health Plan Primary Care Manager Provider Qualification and Enrollment

(1) Primary Care Managers shall be trained and certified or licensed, as applicable under Oregon statutes and administrative rules, in one of the following disciplines:

(a) Doctors of medicine;
(b) Doctors of osteopathy;
(c) Naturopathic physicians;
(d) Nurse Practitioners;
(e) Physician assistants.

(2) The following entities may enroll as Primary Care Managers:

(a) Hospital primary care clinics;
(b) Rural Health Clinics;
(c) Community and Migrant Health Clinics;
(d) Federally Qualified Health Clinics;
(e) Indian Health Service Clinics;
(f) Tribal Health Clinics.

(3) Naturopaths must have a written agreement with a physician that is sufficient to support the provision of primary care, including prescription drugs, as well as the necessary referrals for hospital care.

(4) All applicants for enrollment as Primary Care Managers must:

(a) Be enrolled as Oregon OMAP Providers;

(b) Make arrangements to ensure provision of the full range of PCM Managed Services, including prescription drugs and hospital admissions;

(c) Complete and sign the Primary Care Manager Application (OMAP 3119 (12/93)).

(5) If OMAP determines that the Primary Care Manager or an applicant for enrollment as a Primary Care Manager does not comply with the OHP Administrative Rules pertaining to the PCM program and/or OMAP General Rules; or if OMAP determines that the health or welfare of OMAP Members may be adversely affected or in jeopardy; OMAP may:

(a) Deny the application for enrollment as a Primary Care Manager;

(b) Close enrollment with an existing Primary Care Manager; and/or

(c) Transfer the care of those PCM Members enrolled with that Primary Care Manager until such time it can be determined that the Primary Care Manager is in compliance.

(6) OMAP may terminate the PCM Agreement without prejudice to any obligations or liabilities of either party already accrued prior to such termination, except when the obligations or liabilities result from the Primary Care Manager's failure to terminate care for those PCM Members. The Primary Care Manager shall be solely responsible for its obligations or liabilities after the termination date when the obligations or liabilities result from the Primary Care Manager's failure to terminate care for those PCM Members.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: Updating administrative medical examination billing code information.
Adm. Order No.: OMAP 24-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Amended: 410-150-0120
Subject: The Administrative Examination Services Program administrative rules govern Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP updated OAR 410-150-0120 in order to comply with the Healthcare Common Procedure Coding System (HCPCS) and ensure continuity of payments for professional medical services provided to clients.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-150-0120
Procedure Code Table — Medical and Ancillary Services Providers

Table — 150-0120 identifies the codes available for Administrative Examinations and Reports.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 27-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 7-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 47-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 15-2002, f. & cert. ef. 4-1-02; OMAP 60-2002, f. & cert. ef. 10-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 67-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 24-2006, f. 6-12-06, cert. ef. 7-1-06

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Rule Caption: July 2006 rule updates for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program.
Adm. Order No.: OMAP 25-2006
Filed with Sec. of State: 6-14-2006
Certified to be Effective: 7-1-06
Notice Publication Date: 5-1-06
Rules Adopted: 410-122-0515
Rules Amended: 410-122-0010, 410-122-0040, 410-122-0080, 410-122-0180, 410-122-0204, 410-122-0240, 410-122-0300, 410-122-0320, 410-122-0325, 410-122-0330, 410-122-0340, 410-122-0400, 410-122-0510, 410-122-0525, 410-122-0700
Subject: The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Program administrative rules govern Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP revised rules as follows:

410-122-0515 *Neuromuscular Electrical Stimulator (NMES)*, is adopted and text regarding coverage criteria for this device is moved from 410-122-0510, Electronic Stimulators, to this new rule. Rule text is added to reflect evidence-based clinical practice guidelines.

410-122-0010: to add definitions for activities of daily living, durable medical equipment, medical records, medical supplies, mobility-related activities of daily living, and prosthetic and orthotic devices.

410-122-0040: to change the rule title to more accurately reflect the rule content and to specify information contained in OMAP's fee schedule.

410-122-0080: to change the rule title and add language regarding limitations and restrictions. These changes assist DMEPOS providers in making appropriate dispensing and billing decisions.

410-122-0180: to change the rule title to more accurately reflect the procedure codes used in this division. This amendment also adds specific coding information.

410-122-0204: to add general conditions of coverage and documentation requirements that did not exist previously. Coverage information is based on evidence-based clinical practice guidelines and will assist DMEPOS providers in making appropriate dispensing and billing decisions.

410-122-0240: is rewritten to reflect current generally accepted standards of medical practice regarding apnea monitors for infants. Amendments assist providers in making appropriate dispensing and billing decisions.

410-122-0300: to replace code S9098 (Home visit, phototherapy services (e.g., bili-lite), including equipment rental, nursing services, blood draw, supplies and other services, per diem) with code E0202 (Phototherapy (bilirubin) light with photometer) and to add rule text for this service. DMEPOS providers typically do not provide all the services included in S9098, but do provide the services included in E0202.

410-122-0320, 410-122-0325, 410-122-0330 and 410-122-0340 is revised to:

1) Ensure Medicaid clients have access to medically appropriate wheeled mobility devices and related options/accessories that provide the greatest possible functional value;

2) Ensure program integrity, i.e., outlays for wheeled mobility devices are consistent with statute and regulations;

3) Support the Centers for Medicare and Medicaid Services (CMS) intent to strengthen oversight and fiscal soundness surrounding mobility products;

4) Develop a set of clinical and functional characteristics that are evidence based and will better predict who would benefit from a powered mobility device;

5) Reduce historical fraud, waste and abuse in the wheeled mobility device benefit; and,

6) Allow for provision of clear evaluation procedures and coverage criteria based on accepted current standards of professional practice, and by proposing skilled and knowledgeable professionals conduct these evaluations.

7) Assure compliance with Medicare policy.

Also, some text in OAR 410-122-0320 is moved to OAR 410-122-0340 to further clarify (not change) benefits.

410-122-0400: is rewritten to reflect current generally accepted standards of medical practice regarding pressure reducing support surfaces. Amendments assist providers in making appropriate dispensing and billing decisions.

410-122-0510: to change the rule title, remove rule text regarding neuromuscular electrical stimulator, clarify coverage criteria for an osteogenesis stimulator and add some definitions to the rule.

410-122-0525: to update coverage criteria for an external insulin infusion pump based on clinical practice guidelines and replace an incorrect supplies code with the correct code.

410-122-0700: is rewritten to reflect current generally accepted standards of medical practice regarding negative pressure wound therapy. Amendments assist providers in making appropriate dispensing and billing decisions.

All rules are revised to take care of necessary "housekeeping" corrections.

Rules Coordinator: Darlene Nelson—(503) 945-6927

410-122-0010
Definitions

(1) Activities of daily living (ADL's) — Activities related to personal care. Personal care services include activities such as bathing, dressing, grooming, hygiene, eating, elimination, etc. that are necessary to maintain or improve the client's health, when possible.

(2) Buy up — "Buy-up" refers to a situation in which a client wants to upgrade to a higher level of service than he or she is eligible for; e.g., a heavy duty walker instead of a regular walker.

(3) Consecutive Months — Any period of continuous use where no more than a 60-day break occurs.

(4) Durable Medical Equipment — Equipment, furnished by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or a home health agency that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a client in the absence of an illness or injury and is appropriate for use in the home. Some examples include wheelchairs, crutches and hospital beds. Durable medical equipment extends to supplies and accessories that are necessary for the effective use of covered durable medical equipment.

(5) Home — For purposes of purchase, rental and repair of durable medical equipment that is used primarily as a supportive measure to support a client's basic daily living activities, home is a place of permanent residence, such as an assisted living facility (includes the common dining area), a 24-hour residential care facility, an adult foster home, a child foster home or a private home. This does not include hospitals or nursing facilities or any other setting that exists primarily for the purpose of providing medical/nursing care.

(6) Lifetime need — 99 months or more.

(7) Manufacturer Part Number (MPN):

(a) Each manufacturer provides an MPN to identify that manufacturer's part. It is a specification used by the manufacturer to store a part in an illustrated part catalog (graphics and text);

(b) An MPN uniquely identifies a part when used together with manufacturer code (external manufacturer), which is the own name used by the manufacturer and not the manufacturer name provided by other.

(8) Medical Records — Include the physician's office records, hospital records, nursing facility records, home health agency records, records from other healthcare professionals, diagnostic and test reports. This documentation must be made available to the Office of Medical Assistance Programs (OMAP) on request.

(9) Medical Supplies — Generally nonreusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing. Some medical supplies may also be used on a repeated, limited duration basis.

(10) Mobility-related activities of daily living (MRADL's) — Include toileting, eating, dressing, grooming and bathing.

(11) Morbidity — A diseased state, often used in the context of a "morbidity rate" (i.e. The rate of disease or proportion of diseased people in a population). In common clinical usage, any disease state, including diagnosis and complications is referred to as morbidity.

(12) Morbidity Rate — The rate of illness in a population. The number of people ill during a time period divided by the number of people in the total population.

(13) OMAP's Maximum Allowable Rate — The maximum amount paid by OMAP for a service.

(14) Practitioner — A person licensed pursuant to Federal and State law to engage in the provision of health care services within the scope of the practitioner's license and certification.

(15) Prosthetic and Orthotic Devices — Devices that replace all or part of an internal body organ, including ostomy bags and supplies directly related to ostomy care, and replacement of such devices and supplies. Prosthetic and orthotic devices also include leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the client's physical condition.

(16) Purchase price — Includes:

(a) Delivery;

(b) Assembly;

(c) Adjustments, if needed; and

(d) Training in the use of the equipment or supply.

(17) Rental fees — Include:

(a) Delivery;

(b) Training in the use of the equipment;

(c) Pick-up;

(d) Routine service, maintenance and repair; and

(e) Moving equipment to new residence, if coverage is to continue.

(18) Technician — A DMEPOS provider staff professionally trained through product or vendor-based training, technical school training (e.g., electronics) or through apprenticeship programs with on-the-job training.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 54-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0040
Prior Authorization Requirements

(1) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers must obtain prior authorization (PA) for HCPCS Level II codes when indicated, unless otherwise noted in a specific rule.

(2) Providers must request PA as follows (see the DMEPOS Supplemental Information for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Department of Human Services (DHS) MFCU;

(b) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, from the MCM contractor;

(c) For clients enrolled in a prepaid health plan (PHP), from the PHP;

(d) For all other clients, from the Office of Medical Assistance Programs (OMAP).

(3) For clients with Medicare coverage, PA is only required for DMEPOS not covered by Medicare.

(4) For DMEPOS provided after normal working hours, providers must submit PA requests within five working days from the initiation of service.

(5) See OAR 410-120-1320 for more information about PA.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 3-1982, f. 1-20-82, ef. 2-1-82; AFS 14-1984 (Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 13-1991, f. & cert. ef. 3-1-91, Renumbered from 461-024-0010; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 6-2004, f. 2-10-04 cert. ef. 3-15-04; OMAP 20-2004(Temp), f. & cert. ef. 3-15-04 thru 4-30-04; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 26-2004, f. 4-15-04 cert. ef. 5-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0080
Conditions of Coverage, Limitations, Restrictions and Exclusions

(1) The Office of Medical Assistance Programs (OMAP) may cover durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) for payment when the item meets all the criteria in this rule, including all of the following conditions:

(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;

(b) Is reasonable and medically appropriate for the individual client;

(c) Is primarily and customarily used to serve a medical purpose;

(d) Is generally not useful to a person in the absence of illness or injury;

(e) Is appropriate for use in a client's home; (f) Specifically, for durable medical equipment, can withstand repeated use; i.e., could normally be rented, and used by successive clients;

(g) Meets the coverage criteria as specified in this division and subject to service limitations of OMAP rules;

(h) Is requested in relation to a diagnosis and treatment pair that is above the funding line on the Prioritized List of Health Services, OAR 410-141-0520, consistent with treatment guidelines for the Prioritized List of Health Services, and not otherwise excluded under OAR 410-141-0500; and

(i) Is included in the OHP Client's benefit package of covered services.

(2) Conditions for Medicare-Medicaid Services

(a) When Medicare is the primary payer for a covered service and when OMAP DMEPOS coverage criteria differs from Medicare coverage criteria, OMAP DMEPOS coverage criteria are waived, except as provided in subsection (b) of this section, and only if the item is requested in relation to a diagnosis and treatment pair that is above the funding line on the Prioritized List of Health Services, OAR 410-141-0520, consistent with treatment guidelines for the Prioritized List of Health Services, and not otherwise excluded under OAR 410-141-0500; and included in the OHP Client's benefit package of covered services;

(b) If Medicare is the primary payer and Medicare denies payment, Medicare appeals must be timely filed prior to submitting the claim for payment to OMAP. Medicare denial on the basis of failure to submit a timely appeal may result in OMAP reducing from the amount of the claim any amount OMAP determines could have been paid by Medicare;

(c) If Medicare denies coverage on appeal, OMAP will apply DMEPOS coverage criteria in this rule to determine whether the item or service is covered under the Oregon Health Plan.

(3) OMAP will not cover DMEPOS when the item or the use of the item meets any of the following charactertistics:

(a) Not primarily medical in nature; (b) For personal comfort or convenience of client or caregiver; (c) Inappropriate or unsuitable for home use;

(d) A self-help device; (e) Not therapeutic or diagnostic in nature;

(f) Used for precautionary reasons (e.g., pressure-reducing support surface for prevention of decubitus ulcers);

(g) Inappropriate for client use in the home (e.g., institutional equipment like an oscillating bed);

(h) For a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines; or

(i) Reimbursed as part of the all-inclusive rate in a nursing facility, or as part of a home and community based care waiver service, or by any other public, community or third party resource.

(4) Particular coverage criteria, limitations and restrictions for durable medical equipment, prosthetics, orthotics and supplies are specified in the appropriate rule. If prior authorization is required, the request must document that prior authorization was obtained in compliance with the rules in this division.

(5) DMEPOS providers must have documentation on file that supports coverage criteria are met.

(6) Billing records must demonstrate that the provider has not exceeded any limitations and restrictions in rule. OMAP may require additional claim information from the provider consistent with program integrity review processes.

(7) Documentation described in (4), (5) and (6) above must be made available to OMAP on request.

(8) 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;

(b) Reimbursement is based on OMAP's maximum allowable rate, manufacturer's suggested retail price or usual charge, whichever is the lowest;

(c) To identify non-covered items at a code level, providers can refer to OMAP's fee schedule for further assistance.

(9) Some benefit packages do not cover equipment and supplies (see OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System).

(10) 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.

(11) Equipment purchased by OMAP is the property of the client.

(12) Rental charges, starting with the initial date of service, regardless of payer, apply to the purchase price.

(13) Before renting, providers should consider purchase for long-term requirements.

(14) 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.

(15) Medical supplies are not separately payable while a client is under a hospice plan of care where 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.

(16) The items listed in Table 122-0080 generally do not meet the requirements under DMEPOS rules for purchase, rent or repair of equipment or items. A request for equipment or an item on this list must meet all criteria in this rule.

(17) Table 122-0080:

[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; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0180
Healthcare Common Procedure Coding System (HCPCS) Level II Coding

(1) The Healthcare Common Procedure Coding System (HCPCS) level II is a comprehensive and standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing. For each alphanumeric HCPCS code, there is descriptive terminology that identifies a category of like items. These codes

are used primarily for billing purposes. The Centers for Medicare and Medicaid Services (CMS) maintain and distribute HCPCS Level II Codes.

(2) HCPCS is a system for identifying items and services. It is not a methodology or system for making coverage or payment determinations. The existence of a code does not, of itself, determine coverage or non-coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or revision of HCPCS codes are made independently of the process for making coverage and payment determinations for medical services.(3) The Office of Medical Assistance Programs (OMAP) uses the HCPCS Level II Code Set to ensure that claims are processed in an orderly and consistent manner.

(4) When requesting authorization and submitting claims, DMEPOS providers must use these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code.

(5) This rule division may not contain all code updates needed to report medical services and supplies.

(6) For the most up-to-date information on code additions, changes, or deletions, refer to the fee schedule posted on OMAP's Web site.

(7) The OMAP fee schedule lists all of the current HCPCS codes in an alphanumeric index.

(8) Newly established temporary codes and effective dates for their use are also posted on the OMAP Web site at http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml.

(9) CMS updates permanent national codes annually on January 1st.

(10) CMS may add, change, or delete temporary national codes on a quarterly basis.

(11) The statistical analysis durable medical equipment carrier (SADMERC) is responsible for assisting DMEPOS providers and manufacturers in determining which HCPCS code should be used to describe DMEPOS items. SADMERC assistance is available by calling 1-877-735-1326 between 9 AM to 4 PM (EST). In addition, the SADMERC has a product classification list on its Web site www.palmettogba.com that lists individual items to code categories.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 7-1990, f. 3-30-89, cert. ef. 4-1-89, Renumbered from 461-024-0200; HR 13-1991, f. & cert. ef. 3-1-91, Renumbered from 410-122-0100; 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 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 12-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 26-1999, f. & cert. ef. 6-4-99; 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 54-2001(Temp), f. 10-31-01, cert. ef. 11-1-01 thru 4-15-02; OMAP 63-2001, 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 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0204
Nebulizer

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) Equipment:

(A) Small Volume Nebulizer:

(i) A small volume nebulizer and related compressor may be covered to administer inhalation drugs based on evidence-based clinical practice guidelines;

(ii) When appropriate, the physician must have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, the MDI was not sufficient for the administration of needed inhalation drugs;

(B) Large Volume Nebulizer:

(i) A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or saline (A4217 or A7018) may be covered when it is medically appropriate to deliver humidity to a client with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent;

(ii) Combination code E0585 will be covered for the same indications as in (1)(a)(B)(i);.

(C) OMAP will consider other uses of compressors/generators individually on a case by case basis, to determine their medical appropriateness, such as a battery powered compressor (E0571);

(b) Accessories:

(A) A large volume pneumatic nebulizer (E0580) and water or saline (A4217 or A7018) are not separately payable and should not be separately billed when used for clients with rented home oxygen equipment;

(B) OMAP does not cover use of a large volume nebulizer, related compressor/generator, and water or saline when used predominately to provide room humidification;

(C) A non-disposable unfilled nebulizer (A7017 or E0585) filled with water or saline (A4217 or A7018) by the client/caregiver is an acceptable alternative to the large volume nebulizer when used as indicated in (1)(a)(B)(i) of this rule;

(D) Kits and concentrates for use in cleaning respiratory equipment are not covered;

(E) Accessories are separately payable if the related aerosol compressor and the individual accessories are medically appropriate. The following table lists each covered compressor/ generator and its covered accessories. Other compressor/generator/accessory combinations are not covered;

(F) Compressor/Generator (Related Accessories): E0565 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7017, A7525, E1372), E0570 (A7003, A7004, A7005, A7006, A7013, A7015, A7525), E0571 (A7003, A7004, A7005, A7006, A7013, A7015, A7525), E0572 (A7006, A7014), E0585 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7525);

(G) This array of accessories represents all possible combinations but it may not be appropriate to bill any or all of them for one device;

(H) The following table lists the usual maximum frequency of replacement for accessories. OMAP will not cover claims for more than the usual maximum replacement amount unless the request has been prior approved by the Office of Medical Assistance Programs (OMAP) before dispensing. The provider must submit requests for more than the usual maximum replacement amount to OMAP for review; Table 122-0204-1

(2) Coding Guidelines:

(a) Accessories:

(A) Code A7003, A7005, and A7006 include the lid, jar, baffles, tubing, T-piece and mouthpiece. In addition, code A7006 includes a filter;

(B) Code A7004 includes only the lid, jar and baffles;

(C) Code A7012 describes a device to collect water condensation, which is placed in line with the corrugated tubing, used with a large volume nebulizer;

(D) Code E0585 is used when a heavy-duty aerosol compressor (E0565), durable bottle type large volume nebulizer (A7017), and immersion heater (E1372) are provided at the same time. If all three items are not provided initially, the separate codes for the components would be used for billing.

(E) Code A7017 is billed for a durable, bottle type nebulizer when it is used with a E0572 compressor or a separately billed E0565 compressor.

(F) Code A7017 would not be separately billed when an E0585 system was also being billed. Code E0580 (Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flow meter) describes the same piece of equipment as A7017, but should only be billed when this type of nebulizer is used with a client-owned oxygen system;

(b) Equipment:

(A) In this policy, the actual equipment (i.e., electrical device) will generally be referred to as a compressor (when nebulization of liquid is achieved by means of air flow). The term nebulizer is generally used for the actual chamber in which the nebulization of liquid occurs and is an accessory to the equipment. The nebulizer is attached to an aerosol compressor in order to achieve a functioning delivery system for aerosol therapy;

(B) Code E0565 describes an aerosol compressor, which can be set for pressures above 30 psi at a flow of 6-8 L/m and is capable of continuous operation;

(C) A nebulizer with compressor (E0570) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It is only AC powered;

(D) A portable compressor (E0571) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It must have battery or DC power capability and may have an AC power option;

(E) A light duty adjustable pressure compressor (E0572) is a pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow of 6-8 L/m, but is capable only of intermittent operation.

(3) Documentation Requirements:

(a) When billing and dispensing for an item in Table 122-0204, medical records must corroborate that all criteria in this rule are met;

(b)When a battery powered compressor (E0571) is dispensed, supporting documentation which justifies the medical appropriateness must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider;

(c) The DMEPOS provider must maintain these medical records and make them available to OMAP on request.

(4) Table 122-0204-1.

[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 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04;

OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0240
Apnea Monitors for Infants

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) For infants less than 12 months of age with documented apnea, or who have known risk factors for life-threatening apnea, OMAP may cover home apnea monitors and related supplies for any of the following indications:

(A) Up to three months for:

(i) Apnea of prematurity: Sudden cessation of breathing that lasts for at least 20 seconds, is accompanied by bradycardia (heart rate less than 80 beats per minute), or is accompanied by oxygen desaturation (O2 saturation less than 90 % or cyanosis) in an infant younger than 37 weeks gestational age;

(ii) Apparent life-threatening event (ALTE): An episode that is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking, or gagging;

(iii) Documented gastroesophageal reflux disease (GERD) that results in apnea, bradycardia, or oxygen desaturation;

(iv) Documented prolonged apnea of greater than 20 seconds in duration;

(v) Documented apnea accompanied by bradycardia to less than 80 beats per minute;

(vi) Documented apnea accompanied by oxygen desaturation (below 90 %), cyanosis or pallor;

(vii) Documented apnea accompanied by marked hypotonia;

(viii) When off medication for bradycardia previously treated with caffeine, theophylline, or similar agents;

(B) Upon discharge from an acute care facility for up to one month post-diagnosis for diagnosis of pertussis, with positive cultures;

(C) As the later sibling of an infant who died of Sudden Infant Death Syndrome (SIDS), until the later sibling is one month older than the age at which the earlier sibling died and remains event-free;

(D) On a case by case basis for:

(i) Infants with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise;

(ii) Infants with neurologic or metabolic disorders affecting respiratory control;

(iii) Infants with chronic lung disease (bronchopulmonary dysplasia), especially those requiring supplement*al oxygen, continuous positive airway pressure, or mechanical ventilation;

(b) Infant apnea monitors are usually considered medically appropriate for no longer than approximately three months except for specific conditions listed above;

(c) The rental fee includes all training, instruction, assistance, 24-hour on-call support and any other needed services for effective use of the apnea monitor, including cardiopulmonary resuscitation training. The durable medical equipment prosthetics orthotics and supplies (DMEPOS) provider is responsible for ensuring delivery of these services;

(d) OMAP may cover related supplies necessary for the effective functioning of the apnea monitorfor a three-month period, based on the following limitations:

(A) Electrodes, per pair (A4556) – 3 units;

(B) Lead wires, per pair (A4557) – 2 units;

(C) Conductive paste or gel (A4558) – 1 unit;

(D) Belts (A4649) – 2 units;

(e) The cost of apnea monitor rental includes the cost of cables;

(f) OMAP does not cover apnea monitors with memory recording (E0619) when the attending physician is monitoring the infant with ongoing sleep studies and pneumograms.

(2) Coding Guidelines: For billing purposes, use diagnosis code 798.0, Sudden Infant Death Syndrome (SIDS), for later siblings of infants who died of SIDS.

(3) Documentation Requirements: Submit the following information with the prior authorization request:

(a) Documentation (medical records including hospital records, sleep studies, physician's progress notes, physician-interpreted report from an apnea monitor with memory recording, etc.) of the episode or episodes that led to the diagnosis;

(b) An order from the physician who has diagnosed the infant as having clinically significant apnea or known risk factors for life-threatening apnea. The physician's order must indicate the specific type of apnea monitor (with or without recording feature) and detailed information about the type and quantity of related supplies needed;

(c) For an apnea monitor with recording feature (E0619), submit documentation that supports why an apnea monitor without recording feature (E0618) is not adequate to meet the medical need;

(d) When dispensing and billing for an item in Table 122-0240, the provider must ensure that documentation corroborates that all criteria in this rule are met;

(e) The DMEPOS provider must maintain documentation and make it available to the Office of Medical Assistance Programs (OMAP) on request.

(4) Table 122-0240

[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 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 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 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0300
Light Therapy

(1) Phototherapy (bilirubin light therapy):

(a)The Office of Medical Assistance Programs (OMAP) may cover home phototherapy for a term or near-term infant whose elevated bilirubin is not due to a primary hepatic disorder or other hemolytic disorder that requires inpatient care;

(b) E0202 includes equipment rental, supplies, delivery, set-up, pick-up, training, instruction and 24 hour on-call service necessary for the effective use of the equipment;

(c) Documentation by the treating physician must indicate home phototherapy is an appropriate treatment modality;

(d) The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must make supporting documentation available to OMAP on request.

(2) Table 122-0300

[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; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; 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 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 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0320
Manual Wheelchair Base

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) The Office of Medical Assistance Programs (OMAP) may cover a manual wheelchair when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADL) entirely; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform a MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADL;

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for use of the manual wheelchair that is being requested;

(D) Use of a manual wheelchair will significantly improve the client's ability to move within the home to the areas customarily used for their MRADL so that the client can complete these MRADLs within a reasonable time frame;

(E) The client is willing to use the requested manual wheelchair in the home, and will use it on a regular basis in the home;

(F) The client has either:

(i) Sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the requested manual wheelchair in the home, during a typical day. Proper assessment of upper extremity function should consider limitations of strength, endurance, range of motion, coordination, presence of pain, and deformity or absence of one or both upper extremities; or

(ii) A caregiver who is available, willing, and able to provide assistance with the wheelchair;

(b) OMAP may also authorize a manual wheelchair when any of the following conditions are met:

(A) When the wheelchair can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits and the client is compliant with treatment;

(i) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a manual wheelchair will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a manual wheelchair may be considered for coverage;

(ii) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of a manual wheelchair coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a manual wheelchair;

(B) When a client's current wheelchair is no longer medically appropriate, or repair and/or modifications to the wheelchair exceed replacement cost;

(C) When a covered, client-owned wheelchair is in need of repair (for one month's rental of a wheelchair). See OAR 410-122-0184 Repairs, Maintenance, Replacement and Delivery);

(c) OMAP does not reimburse for another wheelchair if the client has a medically appropriate wheelchair, regardless of payer;

(d) 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;

(e) OMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, and wheelchair gloves;

(f) 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, pick-up and delivery for repairs/modifications, education, and ongoing assistance with the use of the wheelchair;

(g) OMAP may cover an adult tilt-in-space wheelchair (E1161) when a client meets all of the following conditions:

(A) Is dependent for transfers;

(B) Spends a minimum of four hours a day continuously in a wheelchair;

(C) The client's 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;

(h) OMAP may cover a standard hemi (low seat) wheelchair (K0002) when a client requires a lower seat height (17" to 18") because of short stature or needing assistance to place his/her feet on the ground for propulsion;

(i) OMAP may cover a lightweight wheelchair (K0003) 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;

(j) High-strength lightweight wheelchair (K0004):

(A) OMAP may cover a high-strength lightweight wheelchair (K0004) when a client:

(i) Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; and/or

(ii) 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;

(B) If the expected duration of need is less than three months (e.g., post-operative recovery), a high-strength lightweight wheelchair is rarely medically appropriate;

(k) OMAP may cover an ultralightweight wheelchair (K0005) when a client has medical needs that require determination on acase by case basis;

(l) OMAP may cover a heavy-duty wheelchair (K0006) when a client weighs more than 250 pounds or has severe spasticity;

(m) OMAP may cover an extra heavy-duty wheelchair (K0007) when a client weighs more than 300 pounds;

(n) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184 Repairs, Maintenance, Replacement and Delivery;

(o) A manual wheelchair for use only outside the home is not covered.

(2) Coding Guidelines:

(a) Adult manual wheelchairs (K0001-K0007, K0009, E1161) 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 so that the user can self-propel the wheelchair;

(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 pounds; 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 pounds; and

(ii) Seat height: Less than 19"; and

(iii) Weight capacity: 250 pounds or less;

(D) Lightweight wheelchair (K0003):

(i) Weight: 34-36 pounds; and

(ii) Weight capacity: 250 pounds or less;

(E) High strength, lightweight wheelchair (K0004):

(i) Weight: Less than 34 pounds; and

(ii) Lifetime warranty on side frames and crossbraces;

(F) Ultralightweight wheelchair (K0005):

(i) Weight: Less than 30 pounds;

(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) Coverage of all adult manual wheelchairs includes the following features:

(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;

(e) Codes K0003-K0007 and E1161 include any seat height;

(f) For individualized wheelchair features that are medically appropriate to meet the needs of a particular client, use the correct codes for the wheelchair base, options and accessories (see 410-122-0340 Wheelchair Options/Accessories);

(g) For wheelchair frames that are modified in a unique way to accommodate the client, submit the code for the wheelchair base used and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified);

(h) Wheelchair "poundage" (pounds) 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) For more information on other features included in the allowance for the wheelchair base, see 410-122-0340 Wheelchair Options/Accessories;

(k) For guidance on correct coding, contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC). See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information..

(3) Documentation Requirements: (a) Wheelchair and Seating Justification and Prescription Form (OMAP 3125):

(A) Providers must submit this form or a reasonable facsimile for purchase and modifications of all manual wheelchairs except for K0001, K0002, or K0003 (unless modifications are required).

(B) Information must include, but is not limited to:

(i) Medical justification, needs assessment, prescription, and specifications for the wheelchair, completed by a physical therapist, occupational therapist or treating physician. The person who provides this information must have no direct or indirect financial relationship, agreement or contract with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider requesting authorization; and

(ii) Client identification and rehab technology supplier identification information which may be completed by the DMEPOS provider; and

(iii) Signature and date by the treating physician and physical or occupational therapist.

(C) If the information on this form includes all the elements of an order, the provider may submit the completed form in lieu of an order; and

(b) Additional Documentation:

(A) Information from a physical therapist, occupational therapist or treating physician that specifically indicates:

(i) The client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(B) Pertinent information from a physical therapist, occupational therapist or treating physician about the following elements that support coverage criteria are met for a manual wheelchair, Only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs, or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and a manual wheelchair or power mobility device;

(II) Walking around their home – to bathroom, kitchen, living room, etc. – provide information on distance walked, speed, and balance; and

(C) Documentation from a physical therapist, occupational therapist or treating physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since OMAP determines coverage of a wheelchair solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home; and

(D) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options; and

(E) 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; and

(F) Documentation that the DMEPOS provider or a health care clinician has performed a physical environmental assessment of the client's living quarters This assessment must support that the client's environment can accommodate and allow for the effective use of the equipment.

(i) The assessment must include, but is not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps), electrical service, etc.;

(ii) The DMEPOS provider may document information about whether the client's home can accommodate a manual wheelchair; and

(G) All Healthcare Common Procedure Coding System (HCPCS) codes to be billed on this request (including both codes that require authorization and those that do not require authorization);; and

(c) A written order by the treating physician, identifying the specific type of manual wheelchair needed. If the order does not specify the type requested by the DMEPOS provider on the authorization request, the provider must obtain another written order which lists the specific manual wheelchair that is being ordered and any options and accessories requested. The DMEPOS provider may enter the items on this order. This order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority; and

(d) For purchase of K0001, K0002 or K0003 (without modifications):

(A) Information from a physical therapist, occupational therapist or treating physician that specifically indicates:

(i) The client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(B) Pertinent information from a physical therapist, occupational therapist or treating physician about the following elements that support coverage criteria are met for a manual wheelchair. Only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Neck, trunk, and pelvic posture and flexibility;

(IV) Sitting and standing balance;

(v) Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and a manual wheelchair or power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance; and

(C) Documentation from a physical therapist, occupational therapist or treating physician that clearly distinguishes the client's abilities and needs within the home from any additional needs for use outside the home since OMAP's coverage of a wheelchair is determined solely by the client's mobility needs within the home, even though a client who qualifies for coverage of a manual wheelchair may use the wheelchair outside the home; and

(D) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options; and

(E) 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;

(F) The OMAP 3125 (Wheelchair and Seating Justification and Prescription) form or a reasonable facsimile is not required.

(e) For a K0005 wheelchair, documentation from a physical therapist, occupational therapist or treating physician that includes 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; and

(f) When code K0009 requested, all information from a physical therapist, occupational therapist or treating physican that justifies the medical appropriateness for the item; and

(g) Any additional documentation that supports indications of coverage are met as specified in this policy; and

(h) The above documentation must be kept on file by the DMEPOS provider; and

(i) Documentation that the coverage criteria have been met must be present in the client's medical records and this documentation must be made available to OMAP on request.

(4) Table 122-0320.

[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. l2-30- 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; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0325

Motorized/Power Wheelchair Base

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Office of Medical Assistance Programs (OMAP) may cover a power wheelchair when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs) entirely; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADLs;

(B) An appropriately fitted cane or walker cannot sufficiently resolve the client's mobility limitation;

(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day;

(i) Assessment of upper extremity function should consider limitations of strength, endurance, range of motion, or coordination, presence of pain, and deformity or absence of one or both upper extremities;

(ii) An optimally-configured manual wheelchair an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories;

(D) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the power wheelchair that is being requested;

(E) Use of a power wheelchair will significantly improve the client's ability to move within the home to the areas customarily used for their MRADLs to allow completion of these activities within a reasonable time frame;

(F) The client is willing to use the requested power wheelchair in the home, and the client will use it on a regular basis in the home;

(G) The client has either:

(i) Strength, postural stability, or other physical or mental capabilities insufficient to safely operate a power-operated vehicle (POV) in the home; or

(ii) Living quarters that do not provide adequate access between rooms, maneuvering space, and surfaces for the operation of a POV with a small turning radius;

(H) The client has either:

(i) Sufficient mental and physical capabilities to safely operate the power wheelchair that is being requested; or

(ii) A caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is being requested;(b) OMAP may also authorize a power wheelchair when its use can be reasonably expected to improve the client's ability to complete MRADLs by compensating for other limitations in addition to mobility deficits, and the client is compliant with treatment;

(A) Besides MRADLs deficits, when other limitations exist, and these limitations can be ameliorated or compensated sufficiently such that the additional provision of a power wheelchair will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home, a power wheelchair may be considered for coverage;

(B) If the amelioration or compensation requires the client's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of a power wheelchair coverage if it results in the client continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of a power wheelchair;

(c) For a power wheelchair to be covered, the treating physician must conduct a face-to-face examination of the client before writing the order and the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device;

(A)When this examination is performed during a hospital or nursing home stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(B) The physician may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination;

(i) If the client was referred to the PT/OT before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the client and perform any additional examination that is needed. The report of the physician's visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician must provide the DMEPOS provider with a copy of both examinations within 45 days after the face-to-face examination with the physician;

(ii) If the physician saw the client to begin the examination before referring the client to a PT/OT, then if the physician sees the client again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider. The 45-day period begins when the physician signs and dates the PT/OT examination;

(iii) If the power wheelchair is a replacement of a similar item that was previously covered by OMAP or when only power wheelchair accessories are being ordered and all other coverage criteria in this rule are met, a face to face examination is not required;

(d) OMAP may authorize a new wheelchair when a client's current wheelchair is no longer medically appropriate, or when repair and/or modifications to the wheelchair exceed replacement costs;

(e) OMAP does not reimburse for another chair if a client has a medically appropriate wheelchair, regardless of payer;

(f) If a covered client-owned wheelchair is in need of repair, OMAP may pay for one month's rental of a wheelchair (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) OMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, head lights, and tail lights;

(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, pick-up and delivery for repairs/modifications, education and on-going assistance with use of the wheelchair;

(j) A power wheelchair for use only outside the home is not covered.

(2) Coding Guidelines:

(a) Motorized/power wheelchair bases K0010, K0011, K0012, and K0014 are characterized by a seat width and a seat depth of 15" or greater;

(b) In addition, a lightweight power wheelchair (K0012) is characterized by:

(A) Weight less than 80 pounds with back and seat but without front riggings or battery; and

(B) Folding back or collapsible frame;

(c) 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;

(d) A power wheelchair with a seat width or depth of 14" or less is considered a pediatric power wheelchair base and is coded E1239, power wheelchair, pediatric size, not otherwise specified;

(e) 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;

(f) For individualized wheelchair features that are medically appropriate to meet the needs of a particular client, use the appropriate codes for the wheelchair base, options and accessories (see OAR 410-122-0340, Wheelchair Options /Accessories).

(g) If the frame of the wheelchair is modified in a unique way to accommodate the client, use the appropriate code for the wheelchair base and use code K0108 (wheelchair component or accessory, not otherwise specified) for the modification.

(3) Documentation Requirements: Submit all of the following documentation with the prior authorization (PA) request:

(a) A copy of the written report of the face-to-face examination of the client by the physician

(A) This report must include information related to the following:

(i) This client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(iii) Why a manual wheelchair can't meet this client's mobility needs in the home;

(iv) Why a POV (scooter) can't meet this client's mobility needs in the home;

(v) This client's physical and mental abilities to operate a power wheelchair safely in the home;

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in ADLs, how these conditions will be ameliorated or compensated by use of the wheelchair.

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of mobility assistive equipment (MAE) will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home.

(B) The face-to-face examination should provide pertinent information about the following elements, but may include other details. Each element does not have to be addressed in every evaluation:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. provide information on distance walked, speed, and balance;

(C) Although a client who qualifies for coverage of a power wheelchair may use that device outside the home, because OMAP's coverage of a wheelchair is determined solely by the client's mobility needs within the home, the examination must clearly distinguish the client's abilities and needs within the home from any additional needs for use outside the home;

(b) The physician's written order, received by the DMEPOS provider within 30 days after the physician's face-to-face examination. The order must include all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general – e.g., "power wheelchair" or "power mobility device" or may be more specific;

(i) If this order does not identify the specific type of power wheelchair that is being requested, the DMEPOS provider must clarify this by obtaining another written order which lists the specific power wheelchair that is being ordered and any options and accessories requested.

(ii) The items on this clarifying order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 30 days following the face-to-face examination;

(C) Date of the face-to-face examination;

(D) Pertinent diagnoses/conditions and diagnosis codes that relate specifically to the need for the power wheelchair;

(E) Length of need;

(F) Physician's signature;

(G) Date of physician signature;

(c) For all requested equipment and accessories, the manufacturer's name, product name, model number, standard features, specifications, dimensions and options;

(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable;

(e) A written evaluation of the client's living quarters, performed by the DMEPOS provider This assessment must support that the client's home can accommodate and allow for the effective use of a power wheelchair. Assessment must include, but is not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) 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); and

(g) Any additional documentation that supports indications of coverage are met as specified in this rule;

(h) The DMEPOS provider must keep the above documentation on file;

(i) Documentation that the coverage criteria have been met must be present in the client's medical records and made available to OMAP on request.

(4) Table 122-0325

[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 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; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0330
Power-Operated Vehicle

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Office of Medical Assistance Programs (OMAP) may cover a power-operated vehicle (POV) when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs) entirely; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADLs;

(B) An appropriately fitted cane or walker cannot resolve the client's mobility limitation;

(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day;

(i) Assessment of upper extremity function should consider limitations of strength, endurance, range of motion, or coordination, presence of pain, and deformity or absence of one or both upper extremities;

(ii) An optimally-configured manual wheelchair features an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories;

(D) The client has sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV in the home;

(E) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the POV being requested;

(F) Use of a POV will significantly improve the client's ability to move within the home to the areas customarily used for their MRADLs to allow completion of these activities within a reasonable time frame;(G) The client is willing to use the requested POV in the home, and the client will use it on a regular basis in the home;

(b) For a POV to be covered, the treating physician must conduct a face-to-face examination of the client before writing the order.

(A)The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device.

(B) When this examination is performed during a hospital or nursing home stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(C) The physician may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination;

(i) If the client was referred to the PT/OT before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the client and perform any additional examination that is needed. The report of the physician's visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician must provide the DMEPOS provider with a copy of both examinations within 45 days after the face-to-face examination with the physician;

(ii) If the physician saw the client to begin the examination before referring the client to a PT/OT, then if the physician sees the client again in

person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider. The 45-day period begins when the physician signs and dates the PT/OT examination;

(iii) If the POV is a replacement of a similar item that was previously covered by OMAP or when only POV accessories are being ordered and all other coverage criteria in this rule are met, a face-to-face examination is not required;

(c) OMAP may authorize a new POV when a client's existing POV is no longer medically appropriate; or repair and/or modifications to the POV exceed replacement costs;

(d) If a client has a medically appropriate POV regardless of payer, OMAP will not reimburse for another POV;

(e) The cost of the POV includes all options and accessories that are provided at the time of initial purchase, including but not limited to batteries, battery chargers, seating systems, etc.;

(f) Reimbursement for the POV includes all labor charges involved in the assembly of the POV and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education and on-going assistance with use of the POV;

(g) If a patient-owned POV meets coverage criteria, medically appropriate replacement items, including but not limited to batteries, may be covered;

(h) If a POV is covered, a manual or power wheelchair provided at the same time or subsequently will usually be denied as not medically appropriate;

(i) OMAP will cover one month's rental of a POV if a client-owned POV is being repaired;

(j) A POV for use only outside the home is not covered.

(2) Coding Guidelines:

(a) Code E1230 is used only for POVs that can be operated inside the home;

(b) Code E1230 is not used for a manual wheelchair with an add-on tiller control power pack;

(c) A replacement item, including but not limited to replacement batteries, should be requested using the specific wheelchair option or accessory code if one exists (see 410-122-0340, Wheelchairs Options/Accessories). If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified);

(d) For guidance on correct coding, DMEPOS providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC). See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements: Submit all of the following documentation with the prior authorization (PA) request:

(a) A copy of the written report of the face-to-face examination of the client by the physician.

(A) The report must include information related to the following:

(i) This client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(iii) Why a manual wheelchair can't meet this client's mobility needs in the home;

(iv) This client's physical and mental abilities to operate a POV (scooter) safely in the home;

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in MRADLs, how these conditions will be ameliorated or compensated.

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of mobility assistive equipment (MAE) will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home.

(B) The face-to-face examination should provide pertinent information about the following elements, but may include other details. Each element does not have to be addressed in every evaluation:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III)Presence of abnormal tone or deformity of arms, legs or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and power mobility device;

(II) Walking around their home – to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Although a client who qualifies for coverage of a POV may use that device outside the home, because OMAP's coverage of a POV is determined solely by the client's mobility needs within the home, the examination must clearly distinguish the client's abilities and needs within the home from any additional needs for use outside the home;

(b) The physician's written order, received by the DMEPOS provider within 30 days after the physician's face-to-face examination, which includes all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general — e.g., "POV" or "power mobility device" — or may be more specific;

(i) If this order does not identify the specific type of POV that is being requested, the DMEPOS provider must clarify this by obtaining another written order which lists the specific POV that is being ordered and any options and accessories requested;

(ii) The items on this order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating physician, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 30 days following the face-to-face examination;

(C) Date of the face-to-face examination;

(D) Pertinent diagnoses/conditions and diagnosis codes that relate specifically to the need for the POV;

(E) Length of need;

(F) Physician's signature;

(G) Date of physician signature;

(c) For all requested equipment and accessories, include the manufacturer's name, product name, model number, standard features, specifications, dimensions and options;

(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable;

(e) A written evaluation of the client's living quarters, performed by the DMEPOS provider. This assessment must support that the client's home can accommodate and allow for the effective use of a POV, including, but is not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) All 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); and

(g) Any additional documentation that supports indications of coverage are met as specified in this rule;

(h) The above documentation must be kept on file by the DMEPOS provider;

(i) Documentation that the coverage criteria have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to OMAP on request.

(4) E1230 — Power operated vehicle (3 or 4 wheel, non-highway):

(a) PA required;

(b) OMAP will purchase, rent and repair;

(c) Item considered purchased after 13 months of rent.

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 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0340

Wheelchair Options/Accessories

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Office of Medical Assistance Programs (OMAP) may cover options and accessories for covered wheelchairs when the following criteria are met:

(A) The client has a wheelchair that meets OMAP coverage criteria; and

(B) The client requires the options/accessories to accomplish their mobility-related activities of daily living (MRADLs) in the home. See 410-122-0010 Definitions for definition of MRADLs;

(b) OMAP does not cover options/accessories whose primary benefit is allowing the client to perform leisure or recreational activities;

(c) Arm of Chair

(A) Adjustable arm height option (E0973, K0017, K0018, K0020) may be covered when the client:

(i) Requires an arm height that is different than what is available using nonadjustable arms; and

(ii) Spends at least two hours per day in the wheelchair;

(B) An arm trough (K0106) is covered if the client has quadriplegia, hemiplegia, or uncontrolled arm movements;

(d) Footrest/Legrest:

(A) Elevating legrests (E0990, K0046, K0047, K0053, K0195) may be covered when:

(i) The client has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or

(ii) The client has significant edema of the lower extremities that requires having an elevating leg rest; or

(iii) The client meets the criteria for and has a reclining back on the wheelchair;

(B) Elevating leg rests that are used with a wheelchair that is purchased or owned by the patient are coded E0990. This code is per leg rest;

(C) Elevating leg rests that are used with a capped rental wheelchair base should be coded K0195. This code is per pair of leg rests;

(e) Nonstandard Seat Frame Dimensions:

(A) For all adult wheelchairs (E1161, K0001-K0007, K0009, K0010-K0012, K0014), OMAP includes payment for seat widths and/or seat depths of 15-19 inches in the payment for the base code. These seat dimensions must not be separately billed;

(B) Codes E2201-E2204 and E2340-E2343 describe seat widths and/or depths of 20 inches or more for manual or power wheelchairs;

(C) A nonstandard seat width and/or depth (E2201-E2204 and E2340-E2343) is covered only if the patient's dimensions justify the need;

(f) Rear Wheels for Manual Wheelchairs: Code K0064 (flat free insert) is used to describe either:

(A) A removable ring of firm material that is placed inside of a pneumatic tire to allow the wheelchair to continue to move if the pneumatic tire is punctured; or

(B) Nonremovable foam material in a foam filled rubber tire;

(C) K0064 is not used for a solid self-skinning polyurethane tire;

(g) Batteries/Chargers:

(A) Up to two batteries (E2360-E2365) at any one time are allowed if required for a power wheelchair;

(B) Batteries/chargers for motorized/power wheelchairs are separately payable from the purchased wheelchair base;

(h) Seating:

(A) OMAP may cover a general use seat cushion and a general use wheelchair back cushion for a client whose 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; hemiplegia due to stroke, traumatic brain injury, or other etiology; muscular dystrophy; torsion dystonias; spinocerebellar disease;

(D) A combination skin protection and positioning seat cushion may be covered when a client meets the criteria for both a skin protection seat cushion and a positioning seat cushion;

(E) Separate payment is allowed for a seat cushion solid support base (E2618) with mounting hardware when it is used on an adult manual wheelchair (K0001-K0009, E1161) or ligh0tweight 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;

(F) There is no separate payment for a solid insert (E0992) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion;

(G) There is no separate payment for mounting hardware for a seat or back cushion;

(H) There is no separate payment for a headrest (E0955, E0966) on a captain's seat on a power wheelchair;

(I) A custom fabricated seat cushion (E2609) and a custom fabricated back cushion (E2617) are cushions that are individually made for a specific patient.

(i) Basic materials include liquid foam or a block of foam and sheets of fabric or liquid coating material;

(I) A custom fabricated cushion may include certain prefabricated components (e.g., gel or multi-cellular air inserts); these components must not be billed separately;

(II) The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface;

(ii) The cushion must be fabricated using molded-to-patient-model technique, direct molded-to-patient technique, CAD-CAM technology, or detailed measurements of the patient used to create a configured cushion;

(I) If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual client, the cushion must be billed as a prefabricated cushion, not custom fabricated;

(II) The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion;

(iii) If a custom fabricated seat and back are integrated into a one-piece cushion, code as E2609 plus E2617;

(J) A custom fabricated seat cushion may be covered if criteria (I) and (III) are met. A custom fabricated back cushion may be covered if criteria (II) and (III) are met:

(I) Client meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion;

(II) Client meets all of the criteria for a prefabricated positioning back cushion;

(III) There is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs;

(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;

(K) A headrest extension (E0966) is a sling support for the head. Code E0955 describes any type of cushioned headrest;

(L) 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;

(M) 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;

(N) 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;

(i) OMAP will only cover accessories billed under the following codes when SADMERC has made written confirmation of use of the code for the specific product(s) being billed: E2601-E2608, E2611-E2616, E2620, E2621; E2609 and E2617 (brand-name products), K0108 (for wheelchair cushions).

(A) Information concerning the documentation that must be submitted to the SADMERC for a Coding Verification Request can be found on the SADMERC Web site or by contacting the SADMERC;

(B) A Product Classification List with products which have received a coding verification can be found on the SADMERC Web site;

(j) Code E1028 (swingaway or removable mounting hardware upgrade) may be billed in addition to codes E0955-E0957. It must not be billed in addition to code E0960. It must not be used for mounting hardware related to a wheelchair seat cushion or back cushion code;

(k) Power seating systems:

(A) A power tilt seating system (E1002):

(i) Includes all the following:

(I) A solid seat platform and a solid back; any frame width and depth;

(II) Detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or swingaway detachable leg rests;

(IV) Fixed or flip-up footplates;

(V) Motor and related electronics with or without variable speed programmability;

(VI) Switch control 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;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability for the supplier to adjust the seat to back angle;

(IV) Ability to support patient weight of at least 250 pounds.

(B) A power recline seating system (E1003-E1005):

(i) Includes all the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth;

(III) Detachable or flip-up fixed height or adjustable height arm rests;

(IV) Fixed or swingaway detachable leg rests;

(V) Fixed or flip-up footplates;

(VI) A motor and related electronics with or without variable speed programmability;

(VII) A switch control 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;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to recline to greater than or equal to 150 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability to support patient weight of at least 250 pounds.

(C) A power tilt and recline seating system (E1006-E1008)

(i) Includes the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth; detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or 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;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Ability to recline to greater than or equal to 150 degrees from horizontal;

(III) Back height of at least 20 inches; ability to support patient weight of at least 250 pounds.

(D) A mechanical shear reduction feature (E1004 and E1007) consists of two separate back panels. As the posterior back panel reclines or raises, a mechanical linkage between the two panels allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(E) A power shear reduction feature (E1005 and E1008) consists of two separate back panels. As the posterior back panel reclines or raises, a separate motor controls the linkage between the two panels and allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(F) A power leg elevation feature (E1010) involves a dedicated motor and related electronics with or without variable speed programmability which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s);

(j) Codes E2310 and E2311 (Power Wheelchair Accessory):(A) Describe the electronic components that allow the client to control two or more of the following motors from a single interface (e.g., proportional joystick, touchpad, or nonproportional interface): power wheelchair drive, power tilt, power recline, power shear reduction, power leg elevation, power seat elevation, power standing;

(B) Include a function selection switch which allows the client to select the motor that is being controlled and an indicator feature to visually show which function has been selected;

(C) When the wheelchair drive function 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;

(D) Payment for the code includes an allowance for fixed mounting hardware for the control box and for the display box (if present);

(E) When a switch is medically appropriate and a client has adequate hand motor skills, a switch would be considered the least costly alternative;

(F) E2310 or E2311 may be considered for coverage when a client does not have hand motor skills or presents with cognitive deficits, contractures or limitation of movement patterns that prevents operation of a switch;

(G) In addition, an alternate switching system must be medically appropriate and not hand controlled (not running through a joystick);

(H) If a wheelchair has an electrical connection device described by code E2310 or E2311 and if the sole function of the connection is for a power seat elevation or power standing feature, it is not covered;

(k) 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):

(i) Is used in the following situations:

(I) Due to a change in the client's condition an integrated joystick and controller is being replaced by another drive control interface – e.g., remote joystick, head control, sip and puff, etc.; or

(II) The client has a drive control interface described by codes E2320-E2322, E2325, or E2327-E2330 and both the interface (e.g., joystick, head control, sip and puff) and the controller electronics are being replaced due to irreparable damage;

(ii) The KC modifier is never used at the time of initial issue of a wheelchair;

(iii) The KC modifier specifically states replacement, therefore, the RP modifier is not required. The KC modifier is not used when billing code E2399;

(l) 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.);

(m) 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 documentation that supports coverage criteria in this rule are met and the specified information 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;

(C) Dated and clear photographs;

(D) Body contour measurements;

(e) Documentation that the coverage criteria in this rule have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to OMAP on request.

(3) Table 122-0340

[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; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0400
Pressure Reducing Support Surfaces

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) Group 1 (A4640, E0180-E0182, E0184-E0189, and E0196-E0199):

(A) The Office of Medical Assistance Programs (OMAP) may cover a Group 1 support surface when the client meets:

(i) Criterion (I), or;

(ii) Criteria (II) or (III) and at least one of criteria (IV)-(VII):

(I) Completely immobile — i.e., client cannot make changes in body position without assistance;

(II) Limited mobility — i.e., client cannot independently make changes in body position significant enough to alleviate pressure;

(III) Any stage pressure ulcer on the trunk or pelvis;

(IV) Impaired nutritional status;

(V) Fecal or urinary incontinence;

(VI) Altered sensory perception;

(VII) Compromised circulatory status;

(B) The DMEPOS provider must provide a support surface in which the client does not "bottom out";

(C) OMAP does not cover foam overlays or mattresses without a waterproof cover, since these are not considered durable;

(D) OMAP does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(E) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(b) Group 2 (E0193, E0277, and E0371-E0373):

(A) A Group 2 support surface may be covered for up to an initial three month rental period when the client meets:

(i) Criterion (I) and (II) and (III), or;

(ii) Criterion (IV), or;

(iii) Criterion (V) and (VI);

(I) Multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02 -707.05);

(II) Client has been on a comprehensive ulcer treatment program for at least the past month which includes the following: use of an appropriate Group 1 support surface; education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers; regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer); appropriate turning and positioning; appropriate wound care (for a stage II, III, or IV ulcer); appropriate management of moisture/incontinence; and nutritional assessment and intervention consistent with the overall plan of care;

(III) The ulcers have worsened or remained the same over the past month;

(IV) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02 -707.05);

A large wound is generally any wound of eight square centimeters (length x width) or more. Individual client circumstances may be weighed. Undermining and/or tunneling, anatomic location on the body and the size of the client may be taken into account;

(V) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) (ICD-9 707.02 - 707.05);

(VI) The client has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days);

(B) The DMEPOS provider must provide a support surface in which the patient does not "bottom out";

(C) When a Group 2 surface is requested following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery;

(D) OMAP may cover continued use of a Group 2 support surface if healing continues;

(E) OMAP does not cover pressure reducing support surfaces for the prevention of pressure ulcers or pain control;

(F) The allowable rental fee includes all equipment, supplies and services for the effective use of the pressure reducing support surface;

(c) Group 3: Air-fluidized beds (E0194) are not covered.

(2) Definitions for Group 1 and Group 2:

(a) Bottoming out: Finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the patient's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the client in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position;

(b) Plan of care: Written guidelines developed to identify specific problems and needs of the client and interventions/regimen necessary to assist the client to achieve optimal health potential. Developing the plan of care includes establishing measurable client and nursing goals with time lines and determining nursing/caregiver/other discipline-assigned interventions to meet care objectives;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I - Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II — Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III — Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV — Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers;

(3) Guidelines:

(a) Group 1:

(A) Codes E0185 and E0197-E0199 termed "pressure pad for mattress" describe nonpowered pressure reducing mattress overlays and are designed to be placed on top of a standard hospital or home mattress;

(B) A gel/gel-like mattress overlay (E0185) is characterized by a gel or gel-like layer with a height of two inches or greater;

(C) An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of three inches or greater that are inflated with an air pump;

(D) A water mattress overlay (E0198) is characterized by a filled height of three inches or greater;

(E) A foam mattress overlay (E0199) is characterized by all of the following:

(i) Base thickness of two inches or greater and peak height of three inches or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least three inches if it is a non-convoluted overlay; and

(ii) Foam with a density and other qualities that provide adequate pressure reduction; and

(iii) Durable, waterproof cover;

(F) Codes E0184, E0186, E0187 and E0196 describe nonpowered pressure reducing mattresses;

(G) A foam mattress (E0184) is characterized by all of the following:

(i) Foam height of five inches or greater;

(ii Foam with a density and other qualities that provide adequate pressure reduction;

(iii) Durable, waterproof cover; and

(iv) Can be placed directly on a hospital bed frame;

(H) An air, water or gel mattress (E0186, E0187, E0196) is characterized by all of the following:

(i) Height of five inches or greater of the air, water, or gel layer (respectively);

(ii) Durable, waterproof cover; and

(iii) Can be placed directly on a hospital bed frame;

(I) Codes E0180, E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss) and are characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 2 1/2 inches or greater; and

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate client lift, reduce pressure and prevent bottoming out;

(J) Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0180, E0181, E0182, and A4640;

(K) Code A4640 or E0182 may only be billed when they are provided as replacement components for a client-owned E0180 or E0181 mattress overlay system;

(L) A Column II code is included in the allowance for the corresponding Column I code when provided at the same time: Column I (Column II), E0180 (A4640, E0182), E0181 (A4640, E0182);

(b) Group 2:

(A) Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following:

(a) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;

(b) Inflated cell height of the air cells through which air is being circulated is five inches or greater;

(c) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and

air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;

(d) A surface designed to reduce friction and shear; and

(e) Can be placed directly on a hospital bed frame;

(B) Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above;

(C) Code E0371 describes an advanced non-powered pressure-reducing mattress overlay which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevent bottoming out;

(ii) Total height of three inches or greater;

(iii) A surface designed to reduce friction and shear; and

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces;

(D) Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

(i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay;

(ii) Inflated cell height of the air cells through which air is being circulated is 3 1/2 inches or greater;

(iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out; and

(iv) A surface designed to reduce friction and shear;

(E) Code E0373 describes an advanced nonpowered pressure reducing mattress which is characterized by all of the following:

(i) Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevent bottoming out;

(ii) Total height of five inches or greater;

(iii) A surface designed to reduce friction and shear;

(iv) Documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces; and

(v) Can be placed directly on a hospital bed frame;

(F) The only products that may be coded and billed using code E0371 or E0373 are those products for which a written coding determination specifying the use of these codes has been made by the statistical analysis durable medical equipment carrier (SADMERC);

(G) Alternating pressure mattresses and low air loss mattresses are coded using code E0277;

(H) Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with three powered air cells on top of a three foam base would be coded as a powered overlay (code E0180 or E0181), not as a powered mattress (E0277).

(3) Documentation Requirements: For all pressure reducing support surfaces, other than a Group 2 surface following a myocutaneous flap or skin graft, submit the following information with the prior authorization request:

(a) Initial Request:

(A) An order for each item requested, signed and dated by the attending physician;

(B) Documentation that supports conditions of coverage are met as specified in this rule;

(C) A plan of care which has been established by the client's physician or home care nurse (by the RN resident care manager for a client in a nursing facility), which generally includes the following:

(i) Education of the client, if appropriate, and caregiver on the prevention and/or management of pressure ulcers;

(ii) Regular assessment by a nurse, physician, or other licensed healthcare practitioner;

(iii) Appropriate turning and positioning including the number of hours per 24-period that the client will utilize the support surface;

(iv) Appropriate wound care (for a stage II, III, or IV ulcer);

(v) Appropriate management of moisture/incontinence;

(vi) Nutritional assessment and intervention consistent with the overall plan of care by a licensed healthcare practitioner (by a registered dietitian for a client in a nursing facility) within the last 90 days;

(vii) Client's weight and height (approximation is acceptable, if unable to obtain);

(viii) Description of all pressure ulcers, which includes:

(I) Number;

(II) Locations;

(III) Stages;

(IV) Sizes;

(V) Dated photographs;

(ix) Lab reports, if relevant;

(x) Other treatments and products that have been tried and why they were ineffective;

Interventions and goals for stepping down the intensity of support surface therapy;

(xi) For pressure ulcers on extremities, why pressure cannot be relieved by other methods;

(D) For a Group 2 surface following a myocutaneous flap or skin graft only, submit the following information with the prior authorization request:

(i) An order for each item requested, signed and dated by the treating physician;

(ii) Operative report;

(iii) Hospital discharge summary;

(iv) Plan of care;

(E) Required documentation may not be completed by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or anyone in a financial relationship of any kind with the DMEPOS provider;

(F) Medical records must corroborate that all criteria in this rule are met when dispensing and billing for an item in Table 122-0400-1 and Table-122-400-2;

(G) Medical records must be kept on file by the DMEPOS provider and made available to the Office of Medical Assistance Programs (OMAP) upon request;

(b) Subsequent Request: May be authorized contingent on progress towards healing:

For all pressure reducing support surfaces, other than a Group 2 surface following a myocutaneous flap or skin graft, submit the following information with the prior authorization request:

(i) Progress notes from the attending physician;

(ii) Description of all pressure ulcers, including progress towards healing, by a licensed healthcare practitioner (by the RN resident care manager for a client in a nursing facility) which includes:

(I) Number;

(II) Locations;

(III) Stages;

(IV) Sizes;

(V) Dated photographs;

(iii) Current plan of care;

(iv) Any other relevant documentation;

(v) For a Group 2 surface following a myocutaneous flap or skin graft only, submit the following information with the prior authorization request:

(I) Progress notes from the attending physician;

(II) Current plan of care;

(III) Any other relevant documentation.

(4) Table 122-0400-1 — Group 1

(5) Table 122-0400-2 — Group 2

[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 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 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0510
Osteogenesis Stimulator

(1) Definitions:

(a) An electrical osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair.

(b) A noninvasive electrical stimulator is characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.

(c) An ultrasonic osteogenesis stimulator is a noninvasive device that emits low intensity, pulsed ultrasound signals to stimulate fracture healing. The device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via conductive coupling gel to stimulate fracture healing; (2) Indications of Coverage and Medical Appropriateness:

(a) Nonspinal Electrical Osteogenesis Stimulator:

(A) The Office of Medical Assistance Programs (OMAP) may cover a non-spinal electrical osteogenesis stimulator (E0747) when any of the following criteria are met:

(i) Non-union of a long bone fracture (defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenenisis stimulator);

(ii) Failed fusion of a joint other than in the spine, where a minimum of nine months has elapsed since the last surgery;

(iii) Congenital pseudarthrosis;

(B) Non-union of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by the treating physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;

(C) A long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal or metatarsal.

(b) Spinal Electrical Osteogenesis Stimulator:

(A) OMAP may cover a spinal electrical osteogenesis stimulator (E0748) when any of the following criteria are met:

(i) Failed spinal fusion where a minimum of nine months has elapsed since the last surgery;

(ii) Following a multilevel spinal fusion surgery;

(iii) Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site;

(B) A multilevel spinal fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.);

(c) Ultrasonic Osteogenesis Stimulator:

(A) OMAP may cover an ultrasonic osteogenesis stimulator (E0760) only when all of the following criteria are met:

(i) Non-union of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenic stimulator, each separated by a minimum of 90 days. Each radiograph must include multiple views of the fracture site accompanied by a written interpretation by the treating physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; and

(ii) The stimulator is intended for use with cast immobilization;

(B) Use of an ultrasonic osteogenic stimulator is not covered:

(i) For non-union fractures of the skull or vertebrae;

(ii) For tumor-related fractures;

(iii) For the treatment of a fresh fracture or delayed union; or

(iv) When used concurrently with other noninvasive osteogenic devices;

(C) OMAP may cover ultrasonic conductive coupling gel as a separate service when an ultrasonic osteogenesis stimulator is covered.

(2) Coding Guidelines: Use E1399 for ultrasonic conductive coupling gel.

(3) Documentation Requirements:

(a) Submit the following with the prior authorization (PA) request:

(A) Documentation that supports the coverage criteria specified in this rule for the stimulator requested are met;

(B) Copies of x-ray and operative reports;

(b) For an electrical osteogenic stimulator, a Certificate of Medical Necessity (CMN) which has been completed, signed and dated by the treating physician may substitute for a written order if it contains all the required elements of an order;

(c) Additional medical records may be requested by the Office of Medical Assistance Programs (OMAP);

(d) The client's medical records must reflect the need for the stimulator requested. The client's medical records include, but are not limited to, the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test/diagnostic reports.

(4) Table 122-0510

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: 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; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; 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 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0515

Neuromuscular Electrical Stimulator (NMES)

Indications and Limitations of Coverage and Medical Appropriateness:

(1) A neuromuscular electrical stimulator (NMES) uses electrodes to transmit an electrical impulse to the skin over selected muscle groups. There are two broad categories of NMES.

(2) NMES for Treatment of Muscle Atrophy.

(3) NMES devices in this category stimulate the muscle when the client is in a resting state to treat muscle atrophy.

(4) The Office of Medical Assistance Programs (OMAP) will cover NMES to treat muscle atrophy specific to disuse atrophy where nerve supply to the muscle is intact (including brain, spinal cord and peripheral nerves) and to treat other non-neurological reasons for disuse atrophy. Some examples would be casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery (until orthotic training begins).

(5) NMES to Enhance Functional Activity of Neurologically Impaired Clients: Specifically, OMAP will cover NMES used to improve the ability to walk in clients with Spinal Cord Injury (SCI).

(6) This type of NMES is commonly referred to as functional electrical stimulation (FES). FES devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

(7) OMAP will only cover NMES/FES for SCI clients for walking, who meet the following criteria:

(a) Client has completed at least 32 physical therapy sessions, directly performed one-on-one with the physical therapist with the NMES/FES device over a trial period of three months, with the specific goal of using the NMES/FES device to achieve walking, not to reverse or retard muscle atrophy.

(b) Therapists with the sufficient skills to provide these services are only employed at inpatient hospitals; outpatient hospitals; comprehensive outpatient rehabilitation facilities; and outpatient rehabilitation facilities;

(c) The physician treating the client for SCI will use this trial period to properly evaluate the person's ability to use the NMES/FES frequently and for the long term; and

(d) The client meets all of the following characteristics:

(e) Intact lower motor units (L1 and below) (both muscle and peripheral nerve);

(f) Muscle and joint stability for weight bearing at upper and lower extremities that demonstrates balance and control to maintain an upright support posture independently;

(g) Demonstrated brisk muscle contraction to NMES and sensory perception of electrical stimulation sufficient for muscle contraction;

(h) High motivation, commitment and cognitive ability to use NMES/FES devices for walking;

(i) Can transfer independently and demonstrates independent standing tolerance for at least three minutes;

(j) Demonstrated hand and finger function to manipulate controls;

(k) At least six-month post recovery spinal cord injury and restorative surgery;

(l) Hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and

(m) Demonstrated willingness to use the device long-term;

(n) NMES/FES for walking is not covered in an SCI client with any of the following:

(A) Cardiac pacemaker;

(B) Severe scoliosis or severe osteoporosis;

(C) Skin disease or cancer at area of stimulation;

(D) Irreversible contracture;

(E) Autonomic dysflexia; or

(F) Treatment of muscle weakness due to the following conditions (not all-inclusive):

(i) Stroke; spinal cord injury; peripheral nerve injury; other central nervous system, spinal or peripheral nerve disease/condition affecting motor and/or sensory pathways to/from the muscles being stimulated;

(ii) Documentation Requirements: Submit documentation that supports coverage criteria as specified in this rule are met.

(8) Procedure Codes:

(a) A4595, Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES) — Includes all supplies necessary for the effective use of the device — OMAP will purchase — Prior authorization (PA) required;

(b) E0745, Neuromuscular stimulator, electronic shock unit — OMAP will rent — Purchased after no more than 13 months of rental — PA required.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0525

External Insulin Infusion Pump

(1) Indications and Limitations of Coverage and Medical Appropriatenes

(a) The Office of Medical Assistance Programs (OMAP) may cover an external insulin infusion pump for the administration of continuous subcutaneous insulin for the treatment of diabetes mellitus when criterion (A) or (B) is met and criterion (C) or (D) is met:

(A) C-peptide testing requirement:

(i) The C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method; or

(ii) For a client with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 per cent of the lower limit of normal of the laboratory's measurement method; and

(iii) A fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl;

(B) Beta cell autoantibody test is positive;

(C) The client has:

(i) Completed a comprehensive diabetes education program; and

(ii) Been on a program of multiple daily injections of insulin (i.e., at least three injections per day), with frequent self-adjustments of insulin dose for at least six months prior to initiation of the insulin pump; and

(iii) Documented frequency of glucose self-testing an average of at least four times per day during the two months prior to initiation of the insulin pump, and meets one or more of the following criteria while on the multiple injection regimen:

(I) Glycosylated hemoglobin level (HbA1C) greater than 7 percent;

(II) History of recurring hypoglycemia;

(III) Wide fluctuations in blood glucose before mealtime;

(IV) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL;

(V) History of severe glycemic excursions;

(D) The client has:

(i) Been on an external insulin infusion pump prior to enrollment in the medical assistance program, and;

(ii) Documented frequency of glucose self-testing an average of at least four times per day during the month prior to medical assistance program enrollment;

(b) For continued coverage of an external insulin pump and supplies, the client must be seen and evaluated by the treating physician at least every three months;

(c) The external insulin infusion pump must be ordered and follow-up care rendered by a physician who manages multiple clients on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy;

(d) OMAP may cover supplies (including dressings) used with an external insulin infusion pump during the period of covered use of an infusion pump. These supplies are billed with codes A4221 and K0552;

(e) Code A4221 includes catheter insertion devices for use with external insulin infusion pump infusion cannulas and are not separately payable.

(f) A4221 is limited to one unit of service per week.

(2) Coding Guidelines:

(a) Code A4221 includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784);

(b) Code K0552 describes a syringe-type reservoir that is used with the external insulin infusion pump (E0784).

(3) Documentation Requirements:

(a) With the request for prior authorization (PA), the DMEPOS provider must submit medical justification which supports that the criteria in this rule are met;

(b) When billing and dispensing for an item in Table 122-0525, the DMEPOS provider must ensure that medical records corroborate that all criteria in this rule are met;

(c) The DMEPOS provider must keep medical records on file and make them available to the OMAP on request.

(4) Table 122-0525

[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 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 25-2006, f. 6-14-06, cert. ef. 7-1-06

410-122-0700

Negative Pressure Wound Therapy Pumps

(1) Indications and Limitations of Coverage and Medical Appropriateness — Initial Coverage: The Office of Medical Assistance Programs (OMAP) may cover a negative pressure wound therapy (NPWT) pump and supplies on a monthly basis when either criterion (a) or (b) is met:

(a) Ulcers and wounds in the home setting or nursing facility:

(A) The client has a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology;

(B) A complete wound therapy program described by criterion (i) and criteria (ii), (iii), or (iv), as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT:

(i) For all ulcers or wounds, the wound therapy program must include a minimum of all of the following general measures, which have either been addressed, applied, or considered and ruled out prior to application of NPWT:

(I) Documentation in the client's medical record of evaluation, care, and wound measurements by a licensed medical professional;

(II) Application of dressings to maintain a moist wound environment;

(III) Debridement of necrotic tissue if present;

(IV) Evaluation of and provision for adequate nutritional status;

(ii) For Stage III or IV pressure ulcers:

(I) Appropriate turning and positioning of the client;

(II) Use of a Group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see 410-122-0400 Pressure Reducing Support Surfaces). If the ulcer is not on the trunk or pelvis, a Group 2 or 3 support surface is not required; and

(III) Appropriate management of the client's moisture and incontinence;

(iii) For neuropathic (for example, diabetic) ulcers:

(I) The client has been on a comprehensive diabetic management program, and;

(II) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities;

(iv) For venous insufficiency ulcers:

(I) Compression bandages and/or garments have been consistently applied, and;

(II) Leg elevation and ambulation have been encouraged;

(b) Ulcers and wounds encountered in an inpatient setting:

(A) An ulcer or wound as described in subsection (1)(a) is encountered in the inpatient setting and, after wound treatments described in subsection (1)(a) have been tried or considered and ruled out, NPWT is initiated because the treating physician considers it the best available treatment option;

(B) The client has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical appropriateness for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the client that will not allow for healing times achievable with other topical wound treatments);

(c) In either situation described in subsection (1)(b), NPWT will be covered when treatment continuation is ordered beyond discharge to the home setting;

(d) If criterion in subsection (1)(a) or (1)(b) above is not met, the NPWT pump and supplies are not covered;

(e) NPWT pumps (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on a client. A request for more than one NPWT pump per client for the same time period is not covered;

(f) For the purposes of this rule, a licensed health care professional may be a physician, physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or physical therapist (PT). The practitioner must be licensed to assess wounds and/or administer wound care.

(2) Indications and Limitations of Coverage and Medical Appropriateness — Continued Coverage: For wounds and ulcers described in subsection (1)(a) or (1)(b), for clients placed on an NPWT pump and supplies, OMAP will only approve continued coverage when the licensed medical professional does all the following duties:

(a) On a regular basis:

(A) Directly assesses the wound(s) being treated with the NPWT pump; and

(B) Supervises or directly performs the NPWT dressing changes

(b) On at least a monthly basis, documents changes in the ulcer's dimensions and characteristics.

(3) Coverage for a NPWT pump and supplies ends when any of the following occur:

(a) Criteria in section (2) are not met;

(b) The treating physician determines that adequate wound healing has occurred for NPWT to be discontinued;

(c) Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound;

(d) Four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using an NPWT pump in the treatment of the most recent wound. Coverage beyond four months will be given individual consideration based upon required additional documentation;

(e) Equipment or supplies are no longer being used for the client, whether or not by the physician's order.

(4) OMAP will not cover NPWT pump and supplies if one or more of the following are present:

(a) Necrotic tissue with eschar in the wound, if debridement is not attempted;

(b) Untreated osteomyelitis within the vicinity of the wound;

(c) Cancer present in the wound;

(d) The presence of a fistula to an organ or body cavity within the vicinity of the wound.

(5) OMAP will only cover NPWT pumps and their supplies that have been specifically designated as being qualified for use of HCPCS codes E2402, A6550 and A7000 via written instructions from the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

(6) OMAP covers a maximum of 15 dressing kits (A6550) per wound per month, unless there is documentation that the wound size requires more than one dressing kit for each dressing change.

(7) OMAP covers a maximum of 10 canister sets (A7000) per month, unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day). For high-volume exudative wounds, a stationary pump with the largest capacity canister must be used. OMAP does not cover excess use of canisters related to equipment failure (as opposed to excessive volume drainage).

(8) Guidelines:

(a) Equipment:

(A) Negative pressure wound therapy (NPWT) is the controlled application of subatmospheric pressure to a wound. Specifically, an electrical pump (described in the definition of code E2402) intermittently or continuously conveys subatmospheric pressure through connecting tubing to a specialized wound dressing (described in the descriptor of HCPCS code A6550). The dressing includes a resilient, open-cell foam surface dressing, sealed with an occlusive dressing that is meant to contain the subatmospheric pressure at the wound site and thereby promote wound healing. Drainage from the wound is collected in a canister (described in the definition of HCPCS code A7000);

(B) Code E2402 describes a stationary or portable NPWT electrical pump which provides controlled subatmospheric pressure that is designed for use with NPWT dressings, (A6550) to promote wound healing. Such an NPWT pump is capable of being selectively switched between continuous and intermittent modes of operation and is controllable to adjust the degree of subatmospheric pressure conveyed to the wound in a range from 25 to greater than or equal to 200 mm Hg subatmospheric pressure. The pump can sound an audible alarm when desired pressures are not being achieved (that is, where there is a leak in the dressing seal) and when its wound drainage canister (A7000) is full. The pump is designed to fill the canister to full capacity;

(b) Supplies:

(A) Code A6550 describes a dressing set which is used in conjunction with a stationary or portable NPWT pump (E2402), and contains all necessary components, including but not limited to a resilient, open-cell foam surface dressing, drainage tubing, and an occlusive dressing which creates a seal around the wound site for maintaining subatmospheric pressure at the wound;

(B) Code A7000 describes a canister set which is used in conjunction with a stationary or portable NPWT pump (E2402) and contains all necessary components, including but not limited to a container, to collect wound exudate. Canisters may be various sizes to accommodate stationary or portable NPWT pumps;

(c) The staging of pressure ulcers used in this rule is as follows:

(A) Stage I — Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues;

(B) Stage II — Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater;

(C) Stage III — Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue;

(D) Stage IV — Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

(9) Documentation Requirements: Submit the following information with the prior authorization request:

(a) For Initial Coverage:

(A) A statement from the attending physician which describes the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care as specified in subsection (1)(a);

(B) From the treating clinician, history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being requested to include the following:

(i) Changes in wound conditions, including precise, quantitative measurements of wound characteristics (wound length and width (surface area), and depth), quantity of exudates (drainage), presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.);

(ii) Dated photographs of ulcers or wounds with specific location(s) identified within the last 30 days;

(iii) Length of sessions of use;

(iv) Dressing types and frequency of change;

(v) Wound healing progress;

(b) For Continued Coverage:

(A) Progress notes from the attending physician within the last 30 days;

(B) Updated wound measurements and what changes are being applied to effect wound healing including information specified in paragraph (9)(a)(B);

(c) For both initial and continued coverage of an NPWT pump and supplies, any other medical records which corroborate that all criteria in this rule are met;

(d) When requesting quantities of supplies greater than those specified in this rule as the usual maximum amounts, include documentation supporting the medical appropriateness for the higher utilization.

(10) Table 122-0700.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: 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 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 25-2006, f. 6-14-06, cert. ef. 7-1-06

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Rule Caption: July 2006 -- Current Procedural Terminology code updates for Medical-Surgical Services.

Adm. Order No.: OMAP 26-2006

Filed with Sec. of State: 6-14-2006

Certified to be Effective: 7-1-06

Notice Publication Date: 5-1-06

Rules Amended: 410-130-0180, 410-130-0190, 410-130-0200, 410-130-0220, 410-130-0225, 410-130-0240, 410-130-0255, 410-130-0580, 410-130-0585, 410-130-0587, 410-130-0595, 410-130-0670, 410-130-0680, 410-130-0700

Subject: The Medical-Surgical Services program rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP amended rules as follows: 410-130-0180, to require providers to add the National Drug Code (NDC) of drugs administered in their offices to the 837P billing format and remove reference to covered codes; 410-130-0190, to remove references to covered codes; 410-130-0200, to remove codes deleted from HCPCS; 410-130-0220, to remove deleted codes and add new CPT codes; 410-130-0255, to add vaccine codes supplied by the Vaccines for Children's Program; 410-130-0580, to remove billing instructions and to clarify that the person obtaining consent cannot sign the Sterilization Consent form retroactively; 410-130-0595, to add requirement to assist in making referrals for dental services; to clarify all mandatory topics must be reviewed for Full Case Management, and to add Mercury Consumption of fish to the training topics in Table 130-0595-2. Rules listed above are amended for necessary housekeeping corrections.

Rules Coordinator: Darlene Nelson—(503) 945-6927

410-130-0180
Drugs

(1) The Office of Medical Assistance Programs' (OMAP) Medical-Surgical Services Program reimburses practitioners for drugs only when administered by the practitioner in the office, clinic or home settings. OMAP does not reimburse practitioners for drugs that are self-administered by the client, EXCEPT contraceptives such as birth control pills, spermicides and patches:

(a) Use an appropriate CPT therapeutic injection code for administration of injections;

(b) Use an appropriate HCPCS code for the specific drug. Do not bill for drugs under code 99070;

(c) When billing unclassified drugs and other drug codes listed below, bill at acquisition cost (purchase price plus postage) and use the following codes:

(A) J1815-J1816;

(B) J3490;

(C) J7699;

(D) J7799;

(E) J8499;

(F) J8999

(G) J9999;

(H) Include the name of the drug, NDC number, and dosage. (d) Do not bill for local anesthetics. Reimbursement is included in the payment for the tray and/or procedure.

(2) The Office of Medical Assistance (OMAP) requires both the NDC number and HCPCS codes for claim submission on the electronic 837P form.

(3) For Not Covered/Bundled services or Prior Authorization Requirements refer to OAR 410-130-0200 Table 130-0200-1 and OAR 410-130-0220 Table 130-0220-1.

(4) Not covered services include:

(a) Laetrile;

(b) Home pregnancy kits and products designed to promote fertility;

(c) DMSO, except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis;

(d) Infertility drugs;

(e) Sodium hyaluronate and Synvisc (J7317 and J7320).

(5) Follow criteria outlined in the following:

(a) Billing Requirements — OAR 410-121-0150;

(b) Brand Name Pharmaceuticals — OAR 410-121-0155;

(c) Prior Authorization Procedures — OAR 410-121-0060;

(d) Drugs and Products Requiring Prior Authorization — OAR 410-121-0040;

(e) Drug Use Review — OAR 410-121-0100;

(f) Participation in Medicaid's Prudent Pharmaceutical Purchasing Program — OAR 410-121-0157.

(6) Clozapine Therapy:

(a) Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications;

(b) Clozapine Supervision is the management and record keeping of Clozapine dispensing as required by the manufacturer of Clozapine:

(A) Providers billing for Clozapine supervision must document all of the following:

(i) Exact date and results of White Blood Counts (WBC), upon initiation of therapy and at recommended intervals per the drug labeling;

(ii) Notations of current dosage and change in dosage;

(iii) Evidence of an evaluation at intervals recommended per the drug labeling requirements approved by the FDA;

(iv) Dates provider sent required information to manufacturer.

(B) Only one provider (either a physician or pharmacist) may bill per week per client;

(C) Limited to five units per 30 days per client;

(D) Use code 90862 with modifier TC to bill for Clozapine supervision.

[ED. NOTE: Tables 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; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0620; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 33-2002, f. & cert. ef. 8-1-02; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 52-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0190
Tobacco Cessation

(1) Tobacco treatment interventions may include one or more of these services: basic, intensive, and telephone calls.

(2) Basic tobacco cessation treatment includes the following services:

(a) Ask — systematically identify all tobacco users — usually done at each visit;

(b) Advise — strongly urge all tobacco users to quit;

(c) Assess — the tobacco user's willingness to attempt to quit using tobacco within 30 days;

(d) Assist — with brief behavioral counseling, treatment materials and the recommendation/prescription of tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);

(e) Arrange — follow-up support and/or referral to more intensive treatments, if needed.

(3) When providing basic treatment, include a brief discussion to address client concerns and provide the support, encouragement, and counseling needed to assist with tobacco cessation efforts. These brief interventions generally are provided during a visit for other conditions, and additional billing is not appropriate.

(4) Intensive tobacco cessation treatment is on the Health Services Commission's Prioritized List of Health Services and is covered if a documented quit date has been established. This treatment is limited to ten sessions every three months. Treatment should be reserved for those clients who are not able to quit using tobacco with the basic intervention measures.

(5) Intensive tobacco cessation treatment includes the following services:

(a) Multiple treatment encounters (up to ten in a 3 month period);

(b) Behavioral and tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);

(c) Individual or group counseling.

(6) Telephone calls: A telephone call intended as a replacement for face-to-face contact with clients who are in intensive treatment may be reimbursed as it is considered a reasonable adjunct to, or replacement for, scheduled counseling sessions:

(a) The call should last five to ten minutes and provides support and follow-up counseling;

(b) The call should be conducted by the provider or other trained staff under the direction or supervision of the provider;

(c) Enter proper documentation of the service in the client's chart.

(7) Diagnosis Code ICD-9-CM 305.1 (Tobacco Use Disorder):

(a) Use as the principal diagnosis code when the client is enrolled in a tobacco cessation program or if the primary purpose of the visit is for tobacco cessation services;

(b) Use as a secondary diagnosis code when the primary purpose of this visit is not for tobacco cessation or when the tobacco use is confirmed during the visit.

(8) Billing Information: Managed care plans may have tobacco cessation services and programs. This rule shall not limit or prescribe services a Prepaid Health Plan provides to clients receiving the Basic Health Care Package.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 36-1992, f. & cert. ef. 12-1-92; OMAP 15-1998, f. & cert. ef. 5-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; 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 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0200
Prior Authorization/Prior Notification

(1) Prior Authorization:

(a) Prior authorization (PA) for services provided to clients enrolled in a prepaid health plan (PHP) must be obtained from the appropriate PHP. Contact the PHP for their PA requirements and billing instructions.

(b) PA is not required for services covered by Medicare to clients who have both Medicare and Medical Assistance Program coverage. However, PA is required for most transplants, even if they are covered by Medicare.

(c) PA is not required for kidney and cornea transplants unless they are performed out-of-state.

(d) PA must be obtained from the Office of Medical Assistance Program's (OMAP) Transplant Coordinator for transplants and non-emergent, non-urgent out-of-state services. Refer to the OMAP Transplant Services rules (Chapter 410, Division 124) for further information on transplants and refer to the OMAP General Rules (Chapter 410, Division 120) for further information concerning out-of-state services.

(e) PA must be obtained from the Department of Human Services (DHS) Medically Fragile Children's Unit (MFCU) for services provided to MFCU clients.

(f) PA for services provided to clients enrolled in the fee-for-service (FFS) High Risk Medical Case Managed program must be obtained from the Case Management Contractor shown on the client's Medical Care ID. See the Medical-Surgical Services Supplemental Information guide for details.

(g) PA is required for all procedure codes listed in Table 130-0200-1 in this rule. PA for these procedures must be obtained from the Oregon Medical Professional Review Organization (OMPRO) regardless of the setting they are performed in. A second opinion may be requested by OMAP or OMPRO before PA is given for a surgery;

(h) PA is not required for hospital admissions unless the procedure requires PA;

(i) PA is not required for emergent or urgent procedures or services;

(j) PA must be obtained by the treating and performing practitioners;

(k) Refer to Table 130-0200-1 for all services/procedures requiring prior authorization.

(2) Prior Notification:

(a) Prior notification is required before performing the following radiology tests:

(A) MRIs;

(B) MRAs;

(C) CTs;

(D) CTAs; and

(E) SPECT scans.

(b) Prior notification is not required when these tests are performed during an emergency department visit or an inpatient stay;

(c) Providers ordering these tests must submit a prior notification form to OMAP prior to the performance of the tests;

(d) Refer to the Medical-Surgical Supplemental Information guide for instructions and forms;

(e) Refer to Table 130-0200-2 for radiology codes requiring prior notification. Table 130-0200-1, Table 130-0200-2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 868, f. 12-30-77, ef. 2-1-78; AFS 65-1980, f. 9-23-80, ef. 10-1-80; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 23-1986, f. 3-19-86, ef. 5-1-86; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0045; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0630; HR 25-1990(Temp), f. 8-31-90, cert. ef. 9-1-90; HR 44-1990, f. & cert. ef. 11-30-90; HR 17-1991(Temp), f. 4-12-91, cert. ef. 5-1-91; HR 24-1991, f. & cert. ef. 6-18-91; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; 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 50-2005, f. 9-30-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

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) Psychotherapy services (covered only through local Mental Health Clinics and Mental Health Organizations);

(b) Routine postoperative visits (included in the payment for the surgery) during 90 days following major surgery (global period) or 10 days following minor surgery;

(c) Services provided at the client's request in a location other than the practitioner's office that are normally provided in the office;

(d) 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; HR 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; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0225
Teaching Physicians

(1) Supervising faculty physicians in a teaching hospital may not bill the Office of Medical Assistance Programs (OMAP) on a CMS-1500 or 837P when serving as an employee of the hospital during the time the service was provided or when the hospital reports the service as a direct medical education cost on the Medicare and OMAP cost report.

(2) For requirements for the provision of services, including documentation requirements, follow Medicare guidelines for Teaching Physician Services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; Renumbered from 410-130-0370, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0240
Medical Services

(1) All medical and surgical services requiring prior authorization (PA) are listed in OAR 410-130-0200 PA Table 130-0200-1, and services that are Not Covered/Bundled services are listed in OAR 410-130-0220 Table 130-0220-1. Table 130-0220-1 only contains clarification regarding some services that are not covered. Refer to the Health Services List of Prioritized Services for additional information regarding not covered services.

(2) Acupuncture may be performed by a physician, a physician's employee-acupuncturist under the physician's supervision, or a licensed acupuncturist, and billed using CPT 97810-97814.

(3) Chiropractic services must be billed using 99202 and 99212 for the diagnostic visits and 98940-98942 for manipulation. Use CPT lab and radiology codes which most accurately identify the services performed.

(4) Maternity Care and Delivery:

(a) Use Evaluation and Management codes when providing three or fewer antepartum visits;

(b) For births performed in a clinic or home setting, use CPT codes that most accurately describe the services provided. HCPCS supply code S8415 may be billed in addition to the CPT procedure code. Code S8415 includes all supplies, equipment, staff assistance, birthing suite, newborn screening cards, topical and local anesthetics. Bill medications (except topical and local anesthetics) with HCPCS codes that most accurately describe the medications;

(c) For labor management only, bill 59899 and attach a report;

(d) For multiple births, bill the highest level birth with the appropriate CPT code and the other births under the delivery only code. For example, for total OB with cesarean delivery of twins, bill 59510 for the first delivery and 59514 for the second delivery.

(5) Mental Health and Psychiatric Services:

(a) For Administrative Exams and reports for psychiatric or psychological evaluations, refer to the Administrative Exam rules;

(b) Psychiatrists can be reimbursed by OMAP for symptomatic diagnosis and services, which are somatic (physical) in nature. Contact the local Mental Health Department for covered psychiatric and psychological services;

(c) Mental Health Services — Must be provided by local Mental Health Clinics or a client's Mental Health Organization (MHO). Not payable to private physicians, psychologists, and social workers.

(6) Neonatal Intensive Care Unit (NICU) procedure codes:

(a) Are reimbursed only to neonatologists and pediatric intensivists for services provided to infants when admitted to a Neonatal or Pediatric Intensive Care Unit (NICU/PICU). All other pediatricians must use other CPT codes when billing for services provided to neonates and infants;

(b) Consultations by specialists other than neonatologists and pediatric intensivists are payable in addition to these codes;

(c) Neonatal intensive care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use specific CPT ECMO codes.

(7) Neurology/Neuromuscular — Payment for polysomnographs and multiple sleep latency test (MSLT) are each limited to two in a 12-month period.

(8) Ophthalmology Services–Routine eye exams for the purpose of glasses or contacts are limited to one examination every 24 months for

adults. All materials and supplies must be obtained from OMAP's contractor. Refer to the Vision Program Rules for more information.

(9) Speech & Hearing:

(a) HCPCS codes V5000-V5299 are limited to speech-language pathologists, audiologists, and hearing aid dealers;

(b) Refer to the Speech and Hearing Program Rules for detailed information;

(c) Payment for hearing aids and speech therapy must be authorized before the service is delivered;

(d) CPT 92593 and 92595 are only covered for children under age 21.

(10) Massage therapy is covered only when provided with other modalities during the same physical therapy session. Refer to Physical and Occupational Therapy Services administrative rules (chapter 410 division 131) for other restrictions.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 839(Temp), f. & ef. 4-28-77; PWC 849, f. 7-15-77, ef. 8-1-77; PWC 868, f. 12-30-77, ef. 2-1-78; AFS 14-1978(Temp), f. 4-14-78, ef. 4-15-78; AFS 31-1978, f. & ef. 8-1-78; AFS 26-1980, f. 5-21-80, ef. 6-1-80, AFS 56-1980(Temp), f. 8-29-80, ef. 9-1-80; AFS 2-1981, f. 1-9-81, ef. 2-1-81; AFS 36-1981, f. 6-29-81, ef. 7-1-81; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 38-1983, f. & ef. 8-1-83; AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0021 & 461-014-0056; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0650, 461-014-0690 & 461-014-0700; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 18-1991(Temp), f. 4-12-91, cert. ef. 4-15-91; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 24-1991, f. & cert. ef. 6-18-91; HR 2-1992, f. & cert. ef. 1-2-92; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 18-1992, f. & cert. ef. 7-1-92; HR 36-1992, f. & cert. ef. 12-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 16-1993, f. & cert. ef. 7-2-93; HR 6-1994, f. & cert. ef. 2-1-94, Renumbered from 410-130-0320, 410-130-0340, 410-130-0360 & 410-130-0740; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 88-2004, f. 11-24-04, cert. ef. 12-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

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) The Office of Medical Assistance Programs (OMAP) covers Synagis (palivizumab-rsv-igm) only for high-risk infants and children as defined by the American Academy of Pediatric guidelines. Bill 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. OMAP will not reimburse the cost of privately purchased vaccines that are provided through the VFC Program, but will reimburse for the administration of those vaccines;

(b) Only providers enrolled in the VFC Program can receive free vaccine serums. To enroll as a VFC provider, contact the Public Health Immunization Program. For contact information, see the Medical-Surgical Supplemental Information;

(c) OMAP will reimburse providers for the administration of any vaccine provided by the VFC Program. Whenever a new vaccine becomes available through the VFC Program, administration of that vaccine is also covered by OMAP;

(d) Refer to Table 130-0255-1 for immunization codes provided through the VFC Program. Recommendations as to who may receive influenza vaccines vary from season to season and may not be reflected in Table 130-0255-1;

(e) 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; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0580
Hysterectomies and Sterilization

(1) Refer to OAR 410-130-0200 Prior Authorization, Table 130-0200-1 and OAR 410-130-0220 Not Covered/Bundled Services, Table 130-0220-1.

(2) Hysterectomies performed for the sole purpose of sterilization are not covered.

(3) All hysterectomies, except radical hysterectomies, require prior authorization (PA).

(4) A properly completed Hysterectomy Consent form (OMAP 741) or a statement signed by the performing physician, depending upon the following circumstances, is required for all hysterectomies:

(a) When a woman is capable of bearing children:

(A) Prior to the surgery, the person securing authorization to perform the hysterectomy must inform the woman and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing;

(B) The woman or her representative, if any, must sign the consent form to acknowledge she received that information.

(b) When a woman is sterile prior to the hysterectomy, the physician who performs the hysterectomy must certify in writing that the woman was already sterile prior to the hysterectomy and state the cause of the sterility;

(c) When there is a life-threatening emergency situation that requires a hysterectomy in which the physician determines that prior acknowledgment is not possible, the physician performing the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible and describe the nature of the emergency.

(5) In cases of retroactive eligibility:

(a) The physician who performs the hysterectomy must certify in writing one of the following:

(A) The woman was informed before the operation that the hysterectomy would make her permanently incapable of reproducing;

(B) The woman was previously sterile and state the cause of the sterility;

(C) The hysterectomy was performed because of a life-threatening emergency situation in which prior acknowledgment was not possible and describe the nature of the emergency.

(b) Additional supplies of the Hysterectomy Consent form (OMAP 741) may be obtained through the DHS Distribution Center.

(6) Do not use the Consent to Sterilization form (OMAP 742) for hysterectomies.

(7) Mail a copy of the Hysterectomy consent form to the Office of Medical Assistance Programs (OMAP).

(8) Do not submit a copy of the Hysterectomy consent form with the claim.

(9) Sterilization Male & Female: A copy of a properly completed Consent to Sterilization form (OMAP 742), the consent form in the federal brochure DHHS Publication No. (05) 79-50062 (Male), DHHS Publication No. (05) 79-50061 (Female) or another federally approved form must be submitted to OMAP for all sterilization. The original consent form must be retained in the clinical records. Prior authorization is not required.

(10) Voluntary Sterilization:

(a) Consent for sterilization must be an informed choice. The consent is not valid if signed when the client is:

(A) In labor;

(B) Seeking or obtaining an abortion; or

(C) Under the influence of alcohol or drugs.

(b) Ages 15 years or older who are mentally competent to give informed consent:

(A) At least 30 days, but not more than 180 days, must have passed between the date of the informed written consent (date of signature) and the date of the sterilization except:

(i) In the case of premature delivery by vaginal or cesarean section the consent form must have been signed at least 72 hours before the sterilization is performed and more than 30 days before the expected date of confinement;

(ii) In cases of emergency abdominal surgery (other than cesarean section), the consent form must have been signed at least 72 hours before the sterilization was performed.

(B) The client must sign and date the consent form before it is signed and dated by the person obtaining the consent. The date of signature must meet the above criteria. The person obtaining the consent must sign the consent form anytime after the client has signed but before the date of the sterilization. If an interpreter is provided to assist the individual being sterilized, the interpreter must also sign the consent form on the same date as the client;

(C) The client must be legally competent to give informed consent. The physician performing the procedure, and the person obtaining the consent, if other than the physician, must review with the client the detailed information appearing on the Consent to Sterilization form regarding effects and permanence of the procedure, alternative birth control methods, and explain that withdrawal of consent at any time prior to the surgery will not result in any loss of other program benefits.

(11) Involuntary Sterilization — Clients who lack the ability to give informed consent and are 18 years of age or older:

(a) Only the Circuit Court of the county in which the client resides can determine that the client is unable to give informed consent;

(b) The Circuit Court must determine that the client requires sterilization;

(c) When the court orders sterilization, it issues a Sterilization Order. The order must be attached to the billing invoice. No waiting period or additional documentation is required.

(12) Submitting the Consent to Sterilization Form:

(a) After the sterilization is performed, a copy of the completed Consent to Sterilization form (OMAP 742) should be mailed by the performing surgeon to OMAP;

(b) OMAP will review the form for errors and either call the provider or mail the form back if there are discrepancies.

(c) The Consent to Sterilization form must be completed in full:

(A) Consent forms submitted to OMAP without signatures and/or dates of signature by the client or the person obtaining consent are invalid;

(B) The client and the person obtaining consent may not sign or date the consent retroactively;

(C) The performing physician must sign the consent form. The date of signature must be either the date the sterilization was performed or a date following the sterilization.

(d) Do not submit the OMAP 742 with the claim;

(13) Initial claims by the surgeon, anesthesiologist and hospital will be paid without review of the consent form. OMAP will review all sterilization claims during a post-payment audit. If the OMAP 742 is missing or invalid, OMAP will recoup payments directly related to the sterilization from the surgeon, anesthesiologist and hospital.

[ED. NOTE: Forms referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 803(Temp), f. & ef. 7-1-76; PWC 813, f. & ef. 10-1-76; PWC 834, f. 3-31-77, ef. 5-1-77; PWC 868, f. 12-30-77, ef. 2-1-78; AFS 4-1979(Temp), f. & ef. 3-8-79; AFS 11-1979, f. 6-18-79, ef. 7-1-79; AFS 50-1981(Temp), f. & ef. 8-5-81; AFS 79-1981, f. 11-24-81, ef. 12-1-81; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 42-1985, f. & ef. 7-1-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; Renumbered from 461-014-0030, AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0840; HR 43-1991, f. & cert. ef. 10-1-91; HR 23-1992, f. 7-31-92, cert. ef. 8-1-92; HR 6-1994, f. & cert. ef. 2-1-94; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0585
Family Planning Services

(1) Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size.

(2) The Office of Medical Assistance Programs (OMAP) covers family planning services 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 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) with a "Y" on the CMS-1500 claim form or 837P.

(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: Forms 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; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

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) OMAP will reimburse Family Planning Clinics 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 family planning (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 an 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 Prepaid Health Plan, mark the family planning Box 24 H on the CMS-1500 billing form or 837P.

[ED. NOTE: Forms 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; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0595
Maternity Case Management (MCM)

(1) The primary purpose of the MCM program is to optimize pregnancy outcomes including reducing the incidence of low birth weight babies. MCM services are tailored to the individual client needs. These services are provided face-to-face, unless specifically indicated in this rule, throughout the client's pregnancy.

(2) This program:

(a) Is available to all pregnant clients receiving Medical Assistance Program coverage;

(b) Expands perinatal services to include management of health, economic, social and nutritional factors through the end of pregnancy and a two-month postpartum period;

(c) Must be initiated during the pregnancy and before delivery;

(d) Is an additional set of services over and above medical management of pregnant clients;

(e) Allows for billing for intensive nutritional counseling services.

(3) Any time there is a significant change in the health, economic, social, or nutritional factors of the client, the prenatal care provider must be notified.

(4) In situations where multiple providers are seeing one client for MCM services, the case manager must coordinate care to ensure duplicate claims are not submitted to the Office of Medical Assistance Programs (OMAP) if services are duplicated.

(5) Definitions:

(a) Case Management — An ongoing process to assist the individual client in obtaining access to and effective utilization of necessary health, social, economic, nutritional, and other services as defined in the Client Service Plan (CSP) or other documentation;

(b) Case Management Visit — A face-to-face encounter between a maternity case manager and the client that must include two or more specific training and education topics, addresses the CSP and provides ongoing relationship development between the client and the case manager;

(c) Client Service Plan (CSP) — A written systematic, client coordinated plan of care which lists goals and actions required to meet the needs of the client as identified in the Initial Assessment and includes a client discharge plan/summary;

(d) High Risk Case Management — Intensive case management services provided to a client identified and documented by the maternity case manager or prenatal care provider as being high risk;

(e) High Risk Client — Includes clients who have current (within the last year) documented alcohol, tobacco or other drug (ATOD) abuse history, or who are 17 or under, or have other conditions identified in the initial assessment or during the course of service delivery;

(f) Home/Environmental Assessment — A visit to the client's primary place of residence to assess health and safety of the client's living conditions;

(g) Initial Assessment — Documented, systematic collection of data with planned interventions as outlined in a CSP to determine current status and identify needs and strengths, in physical, psychosocial, behavioral, developmental, educational, mobility, environmental, nutritional, and emotional areas;

(h) Nutritional Counseling — Intensive nutritional counseling for clients who have at least one of the conditions listed under Nutritional Counseling (14);

(i) Prenatal/Perinatal Care Provider — The physician, licensed physician assistant, nurse practitioner, certified nurse midwife, or licensed direct entry midwife providing prenatal or perinatal (including labor and delivery) and/or postnatal services to the client;

(j) Telephone Case Management Visit — A non-face-to-face encounter between a maternity case manager and the client providing identical services of a Case Management Visit (G9012).

(6) Maternity Case Manager Qualifications:

(a) Maternity case managers must be currently licensed as a:

(A) Physician;

(B) Physician Assistant;

(C) Nurse Practitioner;

(D) Certified Nurse Midwife;

(E) Direct Entry Midwife;

(F) Social Worker; or

(G) Registered Nurse.

(b) All of the above must have a minimum of two years related and relevant work experience;

(c) Other paraprofessionals may provide specific services with the exclusion of the initial assessment (G9001) while working under the supervision of one of the practitioners listed in (6)(a)(A-G) of this rule;

(d) Specific services not within the recognized scope of practice of the provider of MCM services must be referred to an appropriate discipline.

(7) Nutritional Counselor Qualifications — Nutritional counselors must:

(a) Be a registered dietician; or

(b) Have a bachelor's degree in a nutrition-related field with two years of related work experience.

(8) Documentation Requirements:

(a) Documentation is required for all MCM services in accordance with OMAP General Rules 410-120-1360; and

(b) A correctly completed OMAP form 2470, 2471, 2472 and 2473 or their equivalents meet minimum documentation requirements for Maternity Case Management Services.

(9) G9001 — Initial Assessment must be performed by a licensed Maternity Case Manager as defined under (6)(a):

(a) Services include:

(A) Client assessment as outlined in the "Definitions" section of this rule;

(B) Development of a CSP which addresses needs identified;

(C) Making and assisting with referrals as needed to:

(i) A prenatal care provider;

(ii) A dental health provider.

(D) Forwarding the initial assessment and other relevant information to the prenatal care provider;

(E) Communicating pertinent information to others participating in the client's medical and social care.

(b) Data sources relied upon may include:

(A) Initial assessment;

(B) Client interviews;

(C) Available records;

(D) Contacts with collateral providers;

(E) Other professionals; and

(F) Other parties on behalf of the client.

(c) The client's record must reflect the date and to whom the initial assessment was sent;

(d) Billable once per pregnancy per provider. No other MCM service can be performed until after an initial assessment has been completed. No other maternity management codes except a Home/Environmental Assessment (G9006) and a Case Management Visit (G9012) may be billed the same day as an initial assessment.

(10) G9002 — Case Management (Full Service) — Includes:

(a) Face-to-face client contacts;

(b) Implementation and monitoring of a CSP:

(A) The client's records must include a CSP and written updates to the plan;

(B) The CSP activities involve determining the client's strengths and needs, setting specific goals and utilizing appropriate resources in a cooperative effort between the client and the maternity case manager.

(c) Referral to services included in the CSP:

(A) Make referrals, provide information and assist the client in self-referral;

(B) Maintain contact with resources to ensure service delivery, share information, and assist with coordination.

(d) Ongoing nutritional evaluation with basic counseling and referrals to nutritional counseling, as indicated;

(e) Utilization and documentation of the "5 A's" brief intervention protocol for addressing tobacco use (US Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2000). Routinely:

(A) Ask all MCM clients about smoking status;

(B) Advise all smoking clients to quit;

(C) Assess for readiness to try to quit;
(D) Assist all those wanting to quit by referring them to the Quitline and/or other appropriate tobacco cessation counseling and provide motivational information for those not ready to quit;
(E) Arrange follow-up for interventions.
(f) Provide training and education on all mandatory topics - Refer to Table 130-0595-2;
(g) Provide linkage to labor and delivery services;
(h) Provide linkage to family planning services as needed;
(i) CSP coordination as follows:
(A) Contact with Department of Human Services worker, if assigned;
(B) Contact with prenatal care provider;
(C) Contact with other community resources/agencies to address needs.
(j) Client advocacy as necessary to facilitate access. The case manager serves as a client advocate and intervenes with agencies or persons to help the client receive appropriate benefits or services;
(k) Assist client in achieving the goals in the CSP. The case manager will advocate for the client when resources are inadequate or the service delivery system is non-responsive;
(l) Billable once per pregnancy.
(m) Billable after the delivery when more than three months of service were provided. Services must be initiated during the prenatal period and carried through the date of delivery.
(11) G9009 — Case Management (Partial Service):
(a) Can be billed when the CSP has been developed and case management services (G9002) were initiated during the prenatal period and partially completed;
(b) Provided case management services to the client for three months or less.
(12) G9005 — High Risk Case Management (Full Service):
(a) Enhanced level of services which are more intensive and are provided in addition to G9002;
(b) Provided at least eight Case Management Visits;
(c) Provided high risk case management services to the client for more than three months;
(d) Billable after the delivery and only once per pregnancy;
(e) Can be billed in addition to G9002.
(13) G9010 — High Risk Case Management (Partial Service):
(a) Are the same enhanced level of services provided in G9005 but the client became “high risk” during the latter part of the pregnancy or intensive high risk MCM services were initiated and partially completed but not carried through to the date of delivery;
(b) Provided less than eight Case Management Visits;
(c) Provided high risk case management services to the client for three months or less;
(d) Billable after the delivery and once per pregnancy;
(e) Can be billed in addition to G9002 or G9009.
(14) S9470 — Nutritional Counseling:
(a) Available for clients who have at least one of the following conditions:
(A) Chronic disease such as diabetes or renal disease;
(B) Hematocrit (Hct) less than 34 or hemoglobin (Hb) less than 11 during the first trimester, or Hct less than 32 or Hb less than 10 during the second or third trimester;
(C) Pre-gravida weight under 100 pounds or over 200 pounds;
(D) Pregnancy weight gain outside the appropriate WIC guidelines;
(E) Eating disorder;
(F) Gestational diabetes;
(G) Hyperemesis;
(H) Pregnancy induced hypertension (pre-eclampsia); or
(I) Other conditions identified by the maternity case manager, physician or prenatal care provider for which adequate services are not accessible through another program.
(b) Documentation must include all of the following:
(A) Nutritional assessment;
(B) Nutritional care plan;
(C) Regular client follow-up.
(c) Can be billed in addition to other MCM services;
(d) Billable once per pregnancy.
(15) G9006 — Home/Environment Assessment:
(a) Includes an assessment of the health and safety of the client’s living conditions with training and education of all topics as indicated in Table 130-0595-1;
(b) One Home/Environment Assessment may be billed per pregnancy. Additional Home/Environment Assessments may be billed with documentation of problems which necessitate a follow-up assessment or when a client moves. Documentation must be submitted with the claim to support the additional home/environment assessment.
(16) G9011 — Telephone Case Management Visit:
(a) A non-face-to-face encounter between a maternity case manager and the client, meeting all requirements of a Case Management Visit (G9012) and when a face-to-face Case Management Visit is not possible or practical;
(b) In lieu of a Case Management visit and counted towards the total number of Case Management Visits (see G9012 for limitations).
(17) G9012 — Case Management Visit:
(a) Each Case Management Visit must include an evaluation and/or revision of objectives and activities addressed in the CSP and at least two training and education topics listed in Table 130-0595-2;
(b) Four Case Management Visits may be billed per pregnancy. Telephone contacts (G9011) are included in this limitation;
(c) Six additional Case Management Visits may be billed if the client is identified as High Risk. These additional visits may not be billed until after delivery. Bills for these additional six visits may only be submitted with or after High-Risk Full (G9005) or Partial (G9010) case management has been billed. Telephone contacts (G9011) are included in this limitation;
(d) May be provided in the client’s home or other site. Table 130-0595-1, Table 130-0595-2

[ED. NOTE: Tables & Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 57-1987, f. 10-29-87, ef. 11-1-87; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0200 & 461-014-0201; AFS 54-1989(Temp), f. 9-28-89, cert. ef. 10-1-89; AFS 71-1989, f. & cert. ef. 12-1-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0580; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; 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 34-1998, f. & cert. ef. 10-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; Renumbered from 410-130-0100, OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0670
Death With Dignity

(1) All Death with Dignity services must be billed directly to the Office of Medical Assistance Programs (OMAP), even if the client is in a managed care plan.
(2) Death with Dignity is a covered service, incorporated in the “comfort care” condition/treatment line on the Health Services Commission’s Prioritized List of Health Services.
(3) The following physician visits and medical encounters are billable when performed by a licensed physician or psychologist:
(a) The medical confirmation of the terminal condition;
(b) The two visits in which the client makes the oral request;
(c) The visit in which the written request is made;
(d) The visit in which the prescription is written;
(e) Counseling consultation(s); and
(f) Medication and dispensing.
(4) More than one of the services listed in sections (3)(a) through (3)(f) may be provided during the same visit. Additional visits for discussion or counseling are also covered for payment.
(5) Billing:
(a) All claims for Death with Dignity services must be made on a paper CMS-1500 billing form;
(b) Do not submit a claim for Death with Dignity services electronically or on an 837P;
(c) Claims must be submitted using appropriate CPT or HCPCS codes;
(d) OMAP unique diagnosis code PAD-00 must be entered in Field 21 of the CMS-1500 billing form. Do not list any additional diagnosis codes in this field;
(e) Claims must be submitted only on paper to: OMAP, PO Box 992, Salem, Oregon 97308-0992;
(f) Prescriptions must be billed only with OMAP unique code 8888-PAID-00. This code must be entered in Field 24D of the CMS-1500. In addition, the actual NDC number of the drug dispensed and the dosage must be listed below the prescription code;
(g) OMAP may be billed for prescription services only when the pharmacy has been properly notified by the physician in accordance with OAR 847-015-0035. This OAR requires the physician to have the client’s written consent to contact and inform the pharmacist of the purpose of the prescription.

[ED. NOTE: Forms referenced available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

Hist.: OMAP 46-1998, f. & cert. ef.12-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 2-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0680
Laboratory and Radiology

(1) The following tables list the medical and surgical services that:

(a) Require prior authorization (PA) — OAR 410-130-0200 Table 130-0200-1 (PET scans require PA and are included in the table), and;

(b) Require prior notification (PN) — OAR 140-130-0200 Table 130-0200-2 (MRIs, MRAs, CTs, CTAs, and SPECT scans require PN and are included in the table), and;

(c) Are not covered/bundled — OAR 410-130-0220 Table 130-0220-1.

(2) Newborn screening (NBS) kits and collection and handling for newborn screening (NBS) tests performed by the Oregon State Public Health Laboratory (OSPHL) are considered bundled into the delivery fee and, therefore, must not be billed separately. Replacement of lost NBS kits may be billed with code S3620 with modifier –TC. The loss must be documented in the client's medical record. NBS confirmation tests performed by reference laboratories at the request of the OSPHL shall be reimbursed only to the OSPHL.

(3) The Office of Medical Assistance Programs (OMAP) covers lab tests performed in relation to a transplant only if the transplant is covered and if the transplant has been authorized. See the OMAP Transplant Services administrative rules (chapter 410, division 124).

(4) All lab tests must be specifically ordered by, or at the direction of a licensed medical practitioner within the scope of their license.

(5) If a lab sends a specimen to a reference lab for additional testing, the reference lab may not bill for the same tests performed by the referring lab.

(6) When billing for lab tests, use the date that the specimen was collected as the date of service (DOS) even if the tests were not performed on that date.

(7) Reimbursement for drawing/collecting or handling samples:

(a) OMAP will reimburse providers once per day regardless of the frequency performed for drawing/collecting the following samples:

(A) Blood — by venipuncture or capillary puncture, and;

(B) Urine — only by catheterization.

(b) OMAP will not reimburse for the collection and/or handling of other specimens, such as PAP or other smears, voided urine samples, or stool specimens. Reimbursement is bundled in the reimbursement for the exam and/or lab procedures and is not payable in addition to the laboratory test.

(8) Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinic are not covered for payment and are not to be billed to OMAP.

(9) Only the provider who performs the test(s) may bill OMAP.

(10) Clinical Laboratory Improvement Amendments (CLIA) Certification:

(a) OMAP will only reimburse laboratory services to providers who are CLIA certified by the Centers for Medicare and Medicaid Services (CMS);

(b) CLIA requires all entities that perform even one test, including waived tests on... "materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings" to meet certain Federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory;

(c) Providers must notify OMAP of the assigned ten-digit CLIA number;

(d) Payment is limited to the level of testing authorized by the CLIA certificate at the time the test is performed.

(11) Organ Panels:

(a) OMAP will only reimburse panels as defined by the CPT codes for the year the laboratory service was provided. Tests within a panel may not be billed individually even when ordered separately. The same panel may be billed only once per day per client;

(b) OMAP will pay at the panel maximum allowable rate if two or more tests within the panel are billed separately and the total reimbursement rate of the combined codes exceeds the panel rate, even if all the tests listed in the panel are not ordered or performed.

(12) Radiology:

(a) Provision of diagnostic and therapeutic radionuclide(s), HCPCS A9500-A9699, are payable only when given in conjunction with radiation oncology and nuclear medicine codes 77401-79999;

(b) HCPCS codes R0070 through R0076 are covered.

(13) Reimbursement of contrast and diagnostic-imaging agents is bundled in the radiology procedure except for low osmolar contrast materials (LOCM).

(14) Supply of LOCM may be billed in addition to the radiology procedure only when the following criteria are met:

(a) Prior adverse reaction to contrast material, with the exception of a sensation of heat, flushing or a single episode of nausea or vomiting;

(b) History of asthma or significant allergies;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction or pulmonary hypertension;

(d) Decrease in renal function;

(e) Diabetes;

(f) Dysproteinemia;

(g) Severe dehydration;

(h) Altered blood brain barrier (i.e., brain tumor, subarachnoid hemorrhage);

(i) Sickle cell disease, or;

(j) Generalized severe debilitation.

(15) X-ray and EKG interpretations in the emergency room:

(a) OMAP reimburses only for one interpretation of an emergency room patient's x-ray or EKG. The interpretation and report must have directly contributed to the diagnosis and treatment of the patient;

(b) OMAP considers a second interpretation of an x-ray or EKG to be for quality control purposes only and will not be reimbursed;

(c) Payment may be made for a second interpretation only under unusual circumstances, such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; Renumbered from 461-014-0056, AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0800; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 27-1992(Temp), f. & cert. ef. 9-1-92; HR 33-1992, f. 10-30-92, cert. ef. 11-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 15-1998, f. & cert. ef. 5-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 50-2005, f. 9-30-05, cert. ef. 10-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

410-130-0700
HCPCS Supplies and DME

(1) Use appropriate HCPCS codes to bill all supplies and DME.

(2) For items that do not have specific HCPCS codes:

(a) Use unlisted HCPCS code;

(b) Bill at acquisition cost, purchase price plus postage.

(3) CPT code 99070 is no longer billable for supplies and materials. Use HCPCS codes.

(4) Use S3620 with modifier TC for lost newborn screening (NBS) kits.

(5) The Office of Medical Assistance Programs (OMAP) bundles reimbursement for office surgical suites and office equipment in the reimbursement of surgical procedures.

(6) Contraceptive Supplies — Refer to OAR 410-130-0585.

(7) A4000-A9999:

(a) All "A" codes listed in Table 130-0700-1 are covered under this program;

(b) All "A" codes not listed in Table 130-0700-1 must be referred to a Durable Medical Equipment (DME) provider;

(c) Do not use A4570, A4580 and A4590 for splint and cast materials. Use codes Q4001-Q4051;

(d) A9150-A9999 (administrative, investigational, and miscellaneous) are not covered, except for A9500-A9699. Refer to OAR 410-130-0680.

(8) B4000-B9999:

(a) HCPCS codes B4034-B4036 and B4150-B9999 are not covered for medical-surgical providers;

(b) Refer these services to home enteral/parenteral providers.

(9) C1000-C9999 are not covered.

(10) E0100-E1799: OMAP covers only the following DME HCPCS codes for medical-surgical providers when provided in an office setting:

(a) E0100-E0116;

(b) E0602;

(c) E0191;

(d) E1399;

(e) Refer all other items with "E" series HCPCS codes to DME providers.

(11) J0000-J9999 HCPCS codes — Refer to OAR 410-130-0180 for coverage of drugs.

(12) K0000-K9999 HCPCS codes — Refer all items with "K" series to DME providers.

(13) L0000-L9999:

(a) Refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies program Administrative rules for coverage criteria for orthotics and prosthetics;

(b) Refer to Table 130-0220-1 for a list of "L" codes that are not covered;

(c) Reimbursement for orthotics is a global package, which includes:

(A) Measurements;

(B) Moldings;

(C) Orthotic items;

(D) Adjustments;

(E) Fittings;

(F) Casting and impression materials.

(d) Evaluation and Management codes are covered only for the diagnostic visit where the medical appropriateness for the orthotic is determined and for follow-up visits unrelated to the fitting of the orthotic.

(14) Refer to Table 130-0700-1 for supplies and DME covered in the office setting.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-3084, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; Renumbered from 461-014-0056, AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0810; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 4-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06

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Rule Caption: Clarification of current FQHC and RHC policies, indlucing enrollment, covered services and encounter rate determination.

Adm. Order No.: OMAP 27-2006

Filed with Sec. of State: 6-14-2006

Certified to be Effective: 7-1-06

Notice Publication Date: 5-1-06

Rules Amended: 410-147-0020, 410-147-0040, 410-147-0060, 410-147-0080, 410-147-0085, 410-147-0120, 410-147-0125, 410-147-0140, 410-147-0160, 410-147-0180, 410-147-0200, 410-147-0220, 410-147-0240, 410-147-0280, 410-147-0320, 410-147-0360, 410-147-0400, 410-147-0460, 410-147-0480, 410-147-0500, 410-147-0540, 410-147-0610, 410-147-0620

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 amended 410-147-0020, 410-147-0040, 410-147-0060, 410-147-0080, 410-147-0085, 410-147-0120, 410-147-0125, 410-147-0140, 410-147-0160, 410-147-0180, 410-147-0200, 410-147-0220, 410-147-0240, 410-147-0280, 410-147-0320, 410-147-0360, 410-147-0400, 410-147-0460, 410-147-0480, 410-147-0500, 410-147-0540, 410-147-0610, and 410-147-0620 to remove duplicate and outdated information, clarify language, and add reference to OARs for individual service programs. In 410-147-0460, language is added for a pilot program for Prepaid Health Plan supplemental payments that OMAP will make to clinics, according to an expedited process.

Rules Coordinator: Darlene Nelson—(503) 945-6927

410-147-0020
Professional Ambulatory Services

(1) Providers must use the following rules in conjunction with all individual program rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages: Medical, EPSDT, Diagnostic, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Chemical Dependency, Maternity Case Management, Speech, Hearing, and Home Health services are governed by the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules (OAR 410 Division 147), General Rules (OAR 410 Division 120), OHP Administrative Rules (OARs 410-141-0480, 410-141-0500, and 410-141-0520), and the Health Services Commission's (HSC) Prioritized List of Health Services (List).

(2) Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification. See also OAR 410-147-0120(6). For the purposes of this rule, a clinic's "scope" refers to authorization or certification to provide services if required:

(a) For FQHCs only, services must be provided in accordance with the FQHC's scope as approved by the Health Resources and Services Administration (HRSA) Notice of Grant Award Authorization; and

(b) Both FQHCs and RHCs must provide services within the scope of the Office of Mental Health and Addiction Services (OMHAS) certification for the facility, if required. See OAR 410-147-0320(3) and (5).

(3) Clinics must bill all services provided using diagnoses that meet national coding standards unless otherwise directed in Oregon Administrative Rule.

(4) Primary Care Manager (PCM) case management services, as defined in OHP Administrative Rules (OAR 410-141-0700) and previously provided under a PCM contract with OMAP, are included in the above listing of professional services.

(a) Clinics cannot bill OMAP for PCM case management services for coordinating medical care for a client as a stand-alone service since PCM case management is included in a clinic's all-inclusive Prospective Payment System (PPS) encounter rate;

(b) Clinics will report case management services as an allowed administrative program cost on a clinic's cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Cost Statement (OMAP 3027) Instructions.

(5) Clinics cannot bill sign language and oral interpreter services as a stand-alone service since they are professional services included in a clinic's all-inclusive PPS encounter rate. Clinics must report this service as an allowed administrative program cost on a cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Cost Statement (OMAP 3027) Instructions.

(6) Clinics cannot bill supportive rehabilitation services including, but not limited to, environmental intervention, supported housing and employment, or skills training and activity therapy to promote community integration and job readiness as stand-alone services. These services are included in a clinic's all-inclusive PPS encounter rate. Clinics will report these services as allowed administrative program costs on a cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Cost Statement (OMAP 3027) Instructions.

(7) The date of service determines the appropriate version of the FQHC and RHC rules, General Rules, and HSC Prioritized List to determine coverage.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0500; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0140; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0040
ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes

(1) The appropriate diagnosis code or codes from 001.0 through V99.9 must be used to identify:

(a) Diagnoses;

(b) Symptoms;

(c) Conditions;

(d) Problems;

(e) Complaints; or

(f) Other reasons for the encounter/visit.

(2) The Office of Medical Assistance Program (OMAP) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three

additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-9-CM. Use a three-digit diagnosis code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. OMAP considers a diagnosis code invalid if it has not been coded to its highest specificity. (5) OMAP requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for calendar years 2005 and 2006 for the date the service(s) was provided:

(a) Use codes on Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association for dental services;

(b) Use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) for physician services and other health care services. These services include, but are not limited to, the following:

(A) Physician services;

(B) Physical and occupational therapy services;

(C) Radiology procedures;

(D) Clinical laboratory tests;

(E) Other medical diagnostic procedures;

(F) Hearing and vision services.

(6) OMAP maintains unique coding and claim submission requirements for Administrative Exams and Death With Dignity services. Refer to OAR 410 Division 150, Administrative Examination and Billing Services, and OAR 410-130-0670, Death with Dignity Services for specific requirements.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert, ef, 4-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0020; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0060; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0060
Prior Authorization

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Clients who are not enrolled in a PHP, receive services on an “open card” or “fee-for-service” (FFS) basis. The current month’s Medical Care Identification specifies the client’s status.

(2) Prior Authorization (PA) is not required for covered services provided within a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) to a “fee-for-service” client, with the exception of pharmacy services and hospital dentistry. Refer to OAR 410-147-0280 Drugs, OAR 410 Division 121 Pharmaceutical Services and OAR 410 Division 125, Hospital Services.

(3) Clients who are enrolled in a PHP can receive family planning services, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services (excludes any treatment for HIV or AIDS) through an FQHC or RHC without PA from the PHP as provided under the terms of Oregon’s Section 1115 (CMS) Waiver. If the FQHC or RHC does not have a contract or other arrangements with a PHP, and the PHP denies payment, the Office of Medical Assistance Programs (OMAP) will reimburse for these services per a clinic’s encounter rate (see OAR 410-147-0120(12)(b)).

(4) If a client is enrolled in a PHP there may be PA requirements for some services that are provided through the PHP. It is the FQHC or RHC’s responsibility to comply with the PHP’s PA requirements or other policies necessary for reimbursement from the PHP before providing services to any OHP Client enrolled in a PHP. The FQHC or RHC needs to contact the client’s PHP for specific instructions.

(5) If a client receives services on “fee-for-service” basis, a PA may be required for certain services. An FQHC or RHC assumes full financial risk in providing services to a “fee-for-service” client prior to receiving authorization, or in providing services that are not in compliance with Oregon Administrative Rules (OARs). Some covered services or items require authorization by OMAP before the service can be provided or before payment will be made. See OAR 410-120-1320 Authorization of Payment.

(6) If the service or item is subject to Prior Authorization, the FQHC or RHC must follow and comply with PA requirements in these rules, the General Rules and applicable program rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in the provider’s files to adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with those services provided; and

(d) The services are provided within the timeframe specified on the authorization of payment document.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0640; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0080; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0080
Prepaid Health Plans (PHPs)

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Clinics serving eligible OHP clients who are enrolled in a PHP must secure authorization from the PHP prior to providing PHP-covered services or case management services. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) must request an authorization or referral from the PHP before providing any services to clients enrolled in a PHP unless the FQHC or RHC have contracted with the PHP to provide PHP-covered services. If an FQHC or RHC has an arrangement or contract with a PHP, the clinic is responsible to follow PHP rules and prior authorization requirements. See OAR 410 Division 141 for OHP Program Rules and; OAR 410-147-0060, Prior Authorization.

(2) The Office of Medical Assistance Programs (OMAP) encourages FQHCs and RHCs to contact each PHP in their local service area for the purpose of requesting inclusion in their panel of providers.

(3) PHPs contracting with FQHCs or RHCs, for the provision of providing services to their clients, are required by 42 USC 1396b(m)(2)(A)(ix) to provide payment to the FQHC or RHC that is not less than the level and amount of payment which the PHP would make for services furnished by a non-FQHC/RHC provider.

(4) Payment for services provided to PHP-enrolled clients is a matter between the FQHC or RHC and the PHP authorizing the services except as otherwise provided in OAR 410-141-0410, OHP Primary Care Managers. If a PHP denies payment to an FQHC or RHC because arrangements were not made with the PHP prior to providing the service, OMAP will not reimburse the FQHC or RHC under the encounter rate, except as outlined in Section (5) of this rule (see OAR 410-141-0120, OHP PHP Provision of Health Care Services).

(5) FQHCs and RHCs can provide family planning services or HIV/AIDS prevention services to eligible OHP clients enrolled in PHPs without authorization or a referral from the PHP. The FQHC and RHC must bill the PHP first. If the PHP will not reimburse for the service, then the clinic may bill OMAP. Refer to ORS 414.153, Authorization for payment for certain point of contact services.

(6) PHPs will execute agreements with publicly funded providers, unless cause can be demonstrated to OMAP’s satisfaction why such an agreement is not feasible for authorization of payment for point of contact services in the following categories (refer to ORS 414.153):

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases.

(7) PHPs are responsible to ensure the provision of qualified sign language and oral interpreter services for covered medical, mental health or dental care visits, for their enrolled OMAP Members with a hearing impairment or who are non-English speaking. Services must be sufficient for the FQHC or RHC provider to be able to understand the OMAP Member’s complaint; to make a diagnosis; respond to the OMAP Member’s questions and concerns; and to communicate instructions to the OMAP Member. See OAR 410-141-0220(7), Oregon Health Plan Prepaid Health Plan Accessibility.

(8) The Provider assumes full financial risk in serving a person not confirmed by OMAP as eligible on the date(s) of service. (See OAR 410-120-1140). It is the responsibility of the Provider to verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided;

(b) Whether a client receives services on a fee-for-service (open card) basis or is enrolled with a PHP; and

(c) Whether the service is covered by a third party resource (TPR), a PHP, or if OMAP reimburses on a fee-for-service basis.

(9) OMAP requires the following of a FQHC or RHC under contract with a PHP:

(a) Clinic must maintain reimbursement and documentation records that will permit calculation of supplemental payments according to OAR 410-147-0460. According to OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Record Keeping, a PHP's participating providers shall maintain a clinical record keeping system with 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. See also OAR 410-120-1360, Requirements for Financial, Clinical and Other Records;

(b) Clinics are subject to ongoing performance review by the PHP. According to OAR 410-141-0200, Oregon Health Plan Prepaid Health Plan Quality Improvement (QI) System, PHPs must maintain an effective process for monitoring, evaluating, and improving the access, quality and appropriateness of services provided to OMAP Members. The QI program must include QI projects that are designed to improve the access, quality and utilization of services;

(c) Clinics are subject to program review by OMAP, the Department of Human Services' Audit Unit, and the Department of Justice Medicaid Fraud Unit for the purposes of assuring program integrity and:

(A) Compliance with Oregon Revised Statutes, Oregon Administrative Rules and Federal laws and regulations;

(B) Accurate and complete encounter and fee-for-service claims data, and supporting clinical documentation, is used for calculating PHP supplemental payments and compensation for out-stationed outreach workers;

(C) Adequate records are maintained for cost reimbursed services 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.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1993, f. & cert. ef. 7-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0155; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0100; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0085
Client Copayments

(1) The OMAP Medical Care Identification will indicate which Oregon Health Plan (OHP) clients are responsible for copayments for services.

(2) OMAP requires copayments from clients with certain benefit packages. See OAR 410-120-1230, Client Copayment, and Table 120-1230-1 for specific details.

(3) A client may owe more than one copayment during a 24-hour period. OMAP may require copayments for each medical, dental, mental health or alcohol and chemical dependency encounter on the same date of service. Refer to OAR 410-147-0140, Multiple Encounters.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 90-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0120
Encounter

(1) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) encounters billed to the Office of Medical Assistance Programs (OMAP) must meet the definition in Sections (2) and (3) of this rule and are limited to OMAP Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(2) For the provision of services defined in Titles XIX and XXI and provided through an FQHC or RHC, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. An encounter includes all services, items and supplies provided to a client during the course of an office visit except as excluded in Section (11) of this rule. Section (3) of this rule outlines limitations for telephone contacts that qualify as encounters.

(3) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and OAR 410-130-0190, Tobacco Cessation. See also OAR 410-120-1200(2)(y). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(4) Encounters with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. For exceptions to this rule, refer to OAR 410-147-0140 for reporting multiple encounters.

(5) Refer to Table 147-0120-1 for a list of procedure codes used to report encounters when billing OMAP directly for non-PHP-enrolled, or open card, clients. OMAP will reimburse a clinic at their all-inclusive Prospective Payment System (PPS) encounter rate for the following services when billed as an encounter and include any related medical supplies provided during the course of the encounter. (Refer to individual program administrative rules for service limitations.):

(a) Medical (OAR 410 Division 130);

(b) Diagnostic: OMAP covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, OMAP will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-147-0220);

(d) Dental — Refer to OAR 410-147-0125, Table 147-0120-1, and OAR 410 Division 123;

(e) Vision (OAR 410 Division 140);

(f) Physical Therapy (OAR 410 Division 131);

(g) Occupational Therapy (OAR 410 Division 131);

(h) Podiatry (OAR 410 Division 130);

(i) Mental Health (OAR 309 Division 16);

(j) Alcohol, Chemical Dependency, and Addiction services (OAR 415 Divisions 50 and 51). Requires a letter or licensure of approval by the Office of Mental Health and Addiction Services (OMHAS). Refer to OAR 410-147-0320 (3)(j) and (5)(i);

(k) Maternity Case Management (OAR 410-147-0200);

(l) Speech (OAR 410 Division 129);

(m) Hearing (OAR 410 Division 129);

(n) OMAP considers a home visit for assessment, diagnosis, treatment or Maternity Case Management (MCM) as an encounter. OMAP does not consider home visits for MCM as Home Health Services;

(o) Professional services provided in a hospital setting;

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid State Plan Amendment and OMAP Administrative Rules.

(6) The following practitioners are recognized by OMAP:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed Physician Assistants;

(c) Dentists;

(d) Dental Hygienists who hold a Limited Access Permit (LAP) — may provide dental hygiene services without the supervision of a dentist in certain settings. See the section on Limited Access Permits, ORS 680.200 and OAR 818-035-0065 through 818-035-0100 for more information;

(e) Pharmacists;

(f) Nurse Practitioners;

(g) Nurse Midwives;

(h) Other specialized nurse practitioners;

(i) Registered nurses — may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by OMAP in this section and who is authorized to independently diagnose and treat according to OAR 851 Division 45);

(j) Psychiatrists;

(k) Licensed Clinical Social Workers;

(l) Clinical psychologists;

(m) Acupuncturists (refer to OAR 410 Division 130 for service coverage and limitations); and

(n) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(i) Their individual provider's certification or license; or

(ii) A clinic's mental health certification or alcohol and other drug program approval or licensure by the Office of Mental Health and Addiction Services (OMHAS). Refer to OAR 410-147-0320(3) and (5).

(7) The clinic must not bill for drugs or medication treatments provided during a clinic visit since they are part of the encounter rate. For example, a hypertensive drug or drug sample dispensed by a clinic to treat a client with high blood pressure during an office visit is included in the all-inclusive encounter rate.

(8) OMAP considers medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace) used during an office visit to

be part of the cost of an encounter. Clinics cannot bill these items separately as fee-for-service charges;

(9) Clinics cannot bill Primary Care Manager (PCM) case management services for coordinating medical care for a client separately as fee-for-service since such services are included in the cost of an encounter. See also OAR 410-147-0020(4), Professional Services.

(10) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound clients (limited to areas in which the Secretary has determined that there is a shortage of home health agencies — Code of Federal Regulations 42 § 405.2417), and any other ambulatory services covered by OMAP are also reimbursable as permitted within the clinic's scope of services (see OAR 410-147-0020).

(11) OMAP excludes the following from the definition of an FQHC or RHC encounter:

(a) Laboratory and Radiology services including nuclear medicine;

(b) Clinics cannot bill separately for venipuncture for lab tests since it is part of the encounter. When a client is seen at the clinic for a lab test only use the appropriate CPT code. OMAP does not deem a visit for lab test only as a clinic encounter;

(c) Durable medical equipment or medical supplies (e.g. diabetic supplies) not generally provided during the course of a clinic visit.

(d) Pharmaceutical or biologicals not generally provided during the clinic visit. For example, sample medications are part of the encounter but dispensing a prescription is billed separately under the fee-for-service pharmacy program. Clinics cannot bill OMAP or the PHP for samples provided at no cost to the clinic. Prescriptions are not included in the encounter rate and qualified enrolled pharmacy providers must bill OMAP through the pharmacy. Refer to OAR 410 Division 121, Pharmaceutical Services Program Rulebook for specific information;

(e) Administrative medical examinations and report services (See OAR 410 Division 150);

(f) Death with Dignity services (See OAR 410-130-0670);

(g) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) clients. (See OAR 410-120-1210, OAR 461-135-1070 and OAR 410-130-0240);

(h) Services provided to Qualified Medicare Beneficiary (QMB) only clients. Refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System. Specific billing information is located in the FQHC and RHC Supplemental Information billing guide;

(i) Targeted Case Management (TCM) services (See OAR 410 Division 138); and

(j) Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act.

(12) OAR 410-120-1210 describes OHP's benefit packages and delivery system. Most OHP clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Non-PHP-enrolled clients, receive services on an "open card" or "fee-for-service" (FFS) basis. The current month's Medical Care Identification specifies the client's status.

(a) OMAP is responsible for making payment for services provided to open card clients. The provider will bill OMAP the clinic's encounter rate for Medicaid-covered services provided to these clients according to their OHP benefit package. Refer to 410-147-0360, Encounter Rate Determination.

(b) A PHP is responsible for providing, arranging and making reimbursement arrangements for covered services for their OMAP members. Refer to OAR 410-120-0250, and OAR 410 Division 141, OHP Administrative Rules governing PHPs. The provider must bill the PHP directly for services provided to an enrolled client. See also OAR 410-147-0080, Prepaid Health Plans, and OAR 410-147-0460, PHP Supplemental Payment. Clinics must not bill OMAP an encounter for PHP-covered services provided to eligible OHP clients enrolled in PHPs. Exceptions include:

(i) Family planning services provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060); and

(ii) HIV/AIDS prevention provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060).

(13) 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. Providers must make reasonable efforts to obtain payment first from other resources before billing OMAP. For the purposes of this rule "reasonable efforts" include, but are not limited to:

(a) Asking the client if they have coverage from Medicare, private insurance or another resource;

(b) Using an insurance database such as Electronic Eligibility Verification Services (EEVS) available to the Provider; or

(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.

(14) 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. See OARs 410-120-1280 Billing and 410-120-1340 Payment.

(15) Codes for encounters: Due to the unique billing and payment methodology, and the implementation of the Health Insurance Portability and Accountability Act (HIPAA), OMAP selected specific CPT and HCPCS codes for clinics to report encounters. Providers must bill OMAP with the procedure codes indicated in Table 147-0120-1 for FQHC and RHC services eligible for reimbursement per a clinic's encounter rate. For services that are not included in the all-inclusive encounter rate, refer to the appropriate OMAP provider rules for billing instructions.

(16) It is the Health Services Commission's (HSC) intent to cover reasonable diagnostic services to determine diagnoses on the HSC Prioritized List of Health Services (List), regardless of their placement on the HSC List. See also Section (5)(b) of this rule. Table 147-0120-1

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 13-1993, f. & cert. ef. 71-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0390; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0150; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0125
OHP Standard Emergency Dental Benefit

(1) The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth. Refer to OAR 410-123-1670 OHP Standard Limited Emergency Dental Benefit.

(2) Services are limited to those procedures listed in OAR 410-123-1670, Table 123-1670-1 and are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain; and

(d) Tooth re-implantation when clinically appropriate.

(3) An FQHC billing OMAP directly for dental services provided to an open card OHP Standard client, must bill the covered service(s) in accordance with Section (2) of this rule, using a dental procedure code as listed in Table 147-0120-1, FQHC/RHC encounter codes.

(4) An FQHC is not limited to the FQHC/RHC encounter procedure codes listed in Table 147-0120-1 when billing a Dental Care Organization (DCO), Medicare, or any other Third Party Resource (TPR).

(5) Hospital Dentistry is not a covered benefit for the OHP Standard population except for covered services authorized in accordance with Section (2) of this rule when provided to:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia; or

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia.

(6) Any limitations or prior authorization requirements for services listed in OAR 410-123-1260 will also apply to services in the OHP Standard benefit when provided by an FQHC or RHC.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0140
Multiple Encounters

(1) An encounter is defined in OAR 410-147-0120.

(2) The following services may be considered as multiple encounters when two or more service encounters are provided on the same date of service with distinctly different diagnoses (Refer to OAR 410-147-0120 and individual program rules listed below for specific service requirements and limitations):

(a) Medical (Section (4) of this rule, and OAR 410 Division 130);

(b) Dental (OAR 410-147-0125, Table 147-0120-1, and OAR 410 Division 123);

(c) Mental Health (OAR 309 Division 016). If a client is also seen for a medical office visit and receives a mental health diagnosis, then providers must report only one encounter;

(d) Addiction and Alcohol and Chemical Dependency (OAR 415 Divisions 50 and 51). If a client is also seen for a medical office visit and receives an addiction diagnosis, then providers must report only one encounter;

(e) Ophthalmologic services — fitting and dispensing of eyeglasses are included in the encounter when the practitioner performs a vision examination. (OAR 410 Division 140);

(f) Maternity Case Management MCM (OAR 410-147-0200);

(g) Physical or occupational therapy (PT/OT) — If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter (OAR 410 Division 131); and

(h) Immunizations — if no other medical office visit occurs on the same date of service.

(3) OMAP expects that multiple encounters will occur on an infrequent basis.

(4) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:

(a) After the first Medical service encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit with a medical professional within a 24-hour period and receiving distinctly different diagnoses may be reported as two encounters. This does not imply that if a client is seen at a single office visit with multiple problems that the provider can bill for multiple encounters;

(b) The patient has two or more encounters as described in Section (2) of this rule.

(5) A mental health encounter and an addiction and alcohol and chemical dependency encounter provided to the same client on the same date of service will only count as multiple encounters when provided by two separate health professionals and each encounter has a distinctly different diagnosis.

(6) Similar services, even when provided by two different health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A mental health and addiction encounter with similar diagnoses;

(d) A prenatal visit and a delivery procedure;

(e) A cesarean delivery and surgical assist;

(f) Any time a client receives only a partial service with one provider and partial service from another provider, this would be considered a single encounter.

(7) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service. A recipient may obtain medical, dental or other health services from any provider approved by OMAP, and/or contracts with the recipient's PHP, if the FQHC/RHC is not the recipient's primary care manager.

(8) Clinics may not "unbundle" services that are normally rendered during a single visit for the purpose of generating multiple encounters:

(a) Clinics are prohibited from asking the patient to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary to do so;

(b) Medical necessity must be clearly documented in the patient's record.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0520; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0155; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0160
Modifiers

(1) The Office of Medical Assistance Programs (OMAP) uses HIPAA compliant modifiers for many services. The modifiers listed in the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules represent those that are required.

(2) For a list of all required modifiers: Refer to OAR 410-147-0120 Table 147-0120-1.

(3) When billing for services that are reimbursed outside a clinic's encounter rate, a clinic must use the required modifier(s) listed in their individual program Administrative Rules.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0180
Vaccines for Children (VFC) Program

(1) The Office of Medical Assistance Programs (OMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the administration of vaccines to eligible clients. Costs associated with vaccines are included in the definition of an encounter and are not billed separately to OMAP.

(2) The VFC program supplies federally purchased free vaccines for immunizing eligible clients ages 0 through 18 at no cost to participating health care providers. For more information on how to enroll in the VFC program, contact the Department of Human Services Immunization Program. Refer to the FQHC and RHC Supplemental Information for instructions.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0540; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0160; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0200
Maternity Case Management Services

(1) OMAP will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for Maternity Case Management (MCM) services. Refer to OAR 410-147-0120 Encounter, and Table 147-0120-1.

(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to a client enrolled in an PHP, determine if the PHP covers MCM services:

(a) If the PHP does not cover MCM services, the provider can bill OMAP directly per the clinic's PPS encounter rate. Prior authorization is not required if the PHP does not provide coverage for MCM services;

(b) If the PHP does cover MCM services, the provider needs to request the necessary authorizations from the PHP.

(3) Clients' records must clearly document all MCM services provided including all mandatory topics. Refer to OAR 410-130-0595, Maternity Case Management (MCM) for specific requirements.

(4) The primary purpose of the MCM program is to optimize pregnancy outcomes, including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant.

(a) MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation;

(b) Clients are not eligible for MCM services if the provider has not completed the MCM initial evaluation the day before delivery;

(c) No other MCM service can be performed until an initial assessment has been completed.

(5) Multiple MCM contacts in a single day cannot be billed as multiple encounters.

(6) A medical encounter and an MCM encounter can occur on the same day only under the following two circumstances:

(a) The practitioner can bill a prenatal visit and a MCM service on the same day as separate encounters only if the MCM service is the initial evaluation visit;

(b) After the initial evaluation visit, the practitioner can bill the nutritional counseling MCM service if provided on the same day as a prenatal visit as two separate encounters. See Section (7)(c) of this rule for limitations.

(7) MCM Services limitations:

(a) OMAP reimburses the initial evaluation one time per pregnancy per provider;

(b) Providers may bill OMAP for case management visits four times per pregnancy. In addition, if a client is identified as high risk; the practitioner may bill six additional case management visits;

(c) OMAP reimburses Nutritional Counseling one time per pregnancy if a client meets the criteria in OAR 410-130-0595(14); and

(d) OMAP reimburses a Home/Environmental Assessment one time per pregnancy, and is included in the total number of case management visits in Section (7)(b) of this rule.

(8) A client may only participate in a single case management program. OMAP does not allow multiple case management billings. This

includes Maternity Case Management (MCM), and any Targeted Case Management (TCM) Program outlined in OAR 410 Division 138.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0560; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0180; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0220
Tobacco Cessation

(1) OMAP will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for tobacco cessation services under the encounter rate. Bill procedure codes G9016 for tobacco cessation counseling and S9075 for tobacco cessation treatment, with diagnosis code 305.1 (Tobacco Use Disorder). Refer to Table 147-0120-1.

(2) Refer to OAR 410-130-0190 for specific requirements and treatment limitations.

(3) Practitioners may not report Tobacco Cessation, a specific OMAP prevention program, as a separate encounter when a medical, dental, mental health or addiction service encounter occurs on the same date of service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01;OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0580; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0200; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0240
Administrative Medical Examinations and Reports

(1) The Office of Medical Assistance Programs (OMAP) does not reimburse Administrative Medical Examinations and Reports at a clinic's encounter rate. OMAP reimburses providers for Administrative Examinations and Reports on a fee-for-service basis.

(2) Refer to OAR 410 Division 150, Administrative Examination and Billing Services, for specific requirements. See Administrative Exams Supplemental Information for more detailed information on procedure codes and descriptions.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-620; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0220; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0280
Drugs

(1) OMAP excludes pharmaceutical or biologicals not generally provided during a clinic visit from the definition of an FQHC or RHC encounter.

(a) Providers cannot bill separately for drugs or medication treatments dispensed by a clinic to treat a client during an office visit since OMAP includes them in the all-inclusive encounter rate for the office visit;

(b) Prescriptions are not included in the encounter rate and a qualified enrolled pharmacy must bill OMAP through the pharmacy program.

(2) Clinics may directly bill OMAP only for contraceptive supplies and contraceptive medications outside of the pharmacy program:

(a) Clinics must bill the Prepaid Health Plan (PHP) first for clients enrolled in a PHP. If the PHP will not reimburse for the contraceptive supply or contraceptive medication, then the clinic can bill OMAP fee-for-service at the clinic's acquisition cost. See also OAR 410-130-0585, Family Planning Services;

(b) Clinics can directly bill OMAP fee-for-service at the clinic's acquisition cost for contraceptive supplies and contraceptive medications dispensed by a clinic to a non-PHP-enrolled client. See also OAR 410-130-0585, Family Planning Services.

(3) Refer to OAR 410 Division 121, Pharmaceutical Services Program Rulebook for specific information.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0600; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0240; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0320
Federally Qualified Health Center (FQHC)/Rural Health Clinics (RHC) Enrollment

(1) This rule outlines the Office of Medical Assistance Programs (OMAP) enrollment requirements for Federally Qualified Health Centers (FQHC) and Independent-based Rural Health Clinics (RHC). Refer also to OAR 410-120-1260 Provider Enrollment:

(a) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act and for certain facilities serving urban American Indians, providers should refer to the program rules for American Indian/Alaska Native (AI/AN) Services, OAR 410 Division 146, for enrollment details;

(b) Provider-based RHCs, located in a small rural hospital of less than 50 beds, should refer to the program rules for Hospital Services, OAR 410 Division 125, for enrollment details.

(2) To enroll with OMAP as an FQHC, a health center must comply with one of the following:

(a) Receive Public Health Service (PHS) grant funds under the authority of Section 330 as:

(i) Migrant Health Center;

(ii) Community Health Center;

(iii) Health Care for the Homeless; or

(b) Have received FQHC Look-Alike designation from CMS, based on the recommendation of the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC).

(3) Eligible FQHCs who want to enroll with OMAP as an FQHC, and be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed OMAP Provider Application Form 3117 for an Agency;

(b) Completed Cost Statement(s) (OMAP 3027):

(i) One each for medical, dental and mental health (including addiction, alcohol and chemical dependency). See also OAR 410-147-0360;

(ii) Complete a cost statement for each FQHC-designated site, unless specifically exempted in writing by OMAP to file a consolidated cost report. See OAR 410-147-0340 regarding multiple provider numbers.

(c) Completed copy of the grant proposal submitted to HRSA/BPHC detailing the clinic's service and geographic scope;

(d) Copy of the HRSA Notice of Grant Award Authorization for Public Health Services Funds under Section 330, or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC;

(e) A copy of the clinic's trial balance. See OAR 410-147-0500, Total Encounters for Cost Reports;

(f) Audited financial statements. Refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations";

(g) Depreciation schedules;

(h) Overhead cost allocation schedule;

(i) A copy of the clinic's Office of Mental Health and Addiction Services (OMHAS) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or psychiatric nurse practitioner is providing mental health services. Refer to OAR 309-012-0130 through 309-012-0220, Certificates of Approval for Mental Health Services; OAR 309-032-0525 through 309-032-0605, Standards for Adult Mental Health Services; OAR 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; and OAR 309-039-0500 through 309-039-0580, Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services;

(j) A copy of the clinic's OMHAS letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services. Refer to OAR 415 Division 12, Standards for Approval/Licensure of Alcohol and other Abuse Programs;

(k) A list of all Prepaid Health Plan (PHP) contracts;

(l) A list of names and individual OMAP provider numbers for all practitioners contracted with or employed by the FQHC; and

(m) A list of all clinics affiliated or owned by the FQHC including any clinics that do not have FQHC status along with all OMAP provider numbers assigned to these clinics.

(4) For enrollment with OMAP as an RHC, a clinic must:

(a) Be designated by CMS as an independent RHC.

(b) Maintain Medicare certification and be in compliance with all Medicare requirements for certification.

(5) Eligible RHCs who want to enroll with OMAP as an RHC, and be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed OMAP Provider Application Form 3117 for an Agency;

(b) Copy of Medicare's letter certifying the clinic as an independent RHC;

(c) Medicare Cost Report for RHC or completed Cost Statement(s) (OMAP 3027). See also OAR 410-147-0360. Complete a cost statement for each RHC-designated site, unless specifically exempted in writing by OMAP to file a consolidated cost report. See OAR 410-147-0340 regarding multiple provider numbers.

(d) A copy of the clinic's trial balance. See OAR 410-147-0500, Total Encounters for Cost Reports (only if completing Cost Statement OMAP 3027);

(e) Audited financial statements. Refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations" (only if completing Cost Statement OMAP 3027);

(f) Depreciation schedules (only if completing Cost Statement OMAP 3027);

(g) Overhead cost allocation schedules (only if completing Cost Statement OMAP 3027);

(h) A copy of the clinic's Office of Mental Health and Addiction Services (OMHAS) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or psychiatric nurse practitioner is providing mental health services. Refer to OAR 309-012-0130 through 309-012-0220, Certificates of Approval for Mental Health Services; OAR 309-032-0525 through 309-032-0605, Standards for Adult Mental Health Services; OAR 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; and OAR 309-039-0500 through 309-039-0580, Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services;

(i) A copy of the clinic's OMHAS letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services. Refer to OAR 415 Division 12, Standards for Approval/Licensure of Alcohol and other Abuse Programs;

(j) A list of all Prepaid Health Plan (PHP) contracts;

(k) A list of names and individual OMAP provider numbers for all practitioners contracted with or employed by the RHC; and

(l) A list of all clinics affiliated or owned by the RHC including any clinics that do not have RHC status along with all OMAP provider numbers assigned to these clinics.

(6) The FQHC/RHC Program Manager, upon receipt of the required items as listed in Section (3) of this rule for FQHCs and Section (5) of this rule for RHCs, will review all documents for compliance with program rules, completeness and accuracy.

(7) OMAP prohibits an established, enrolled FQHC or RHC that adds or opens a new clinic site from submitting claims for services rendered at the new site under their FQHC or RHC OMAP provider number, and according to the PPS encounter rate, prior to OMAP's acknowledgment. An FQHC or RHC is required to immediately submit to the attention of the FQHC/RHC Program Manager, OMAP:

(a) For FQHCs only, a copy of the recent HRSA Notice of Grant Award including the new site under the main FQHC's scope;

(b) For RHCs only, a copy of Medicare's letter certifying the new clinic as an independent RHC;

(c) A recent list of all Prepaid Health Plan (PHP) contracts; and

(d) A recent list of names and individual OMAP provider numbers for all practitioners contracted with or employed by the new FQHC or RHC site.

(8) If an established and enrolled RHC or FQHC changes ownership, the new owner must submit:

(a) Cost Statement (OMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated; or in writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership;

(b) Failure to submit a cost statement (OMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit all rights to calculation of a PPS encounter rate(s) at a later date. The PPS encounter rate(s) calculated under the former ownership will in effect be reassigned to the new ownership;

(c) Notice of a change in tax identification number;

(d) A recent list of all Prepaid Health Plan (PHP) contracts;

(e) A recent list of names and individual OMAP provider numbers for all practitioners contracted with or employed by the FQHC or RHC; and

(f) A recent list of all clinics affiliated or owned by the FQHC or RHC including any clinics that do not have FQHC or RHC status along with all OMAP provider numbers assigned to these clinics.

(9) FQHCs that are involved with a Sub-recipient must provide documentation. Sub-recipient contracts with an FQHC must enroll as an FQHC and submit the same required documentation as outlined under the enrollment sections of this rule.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0010; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0360
Encounter Rate Determination

(1) The Office of Medical Assistance Programs (OMAP) will coincide enrollment of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) with the calculation of a clinic's Prospective Payment System (PPS) encounter rate:

(a) OMAP will enroll a clinic as an FQHC or RHC effective the date OMAP determines the clinic's PPS encounter rate. The encounter rate may be used to bill for services provided on or after the coinciding effective dates of enrollment as an FQHC or RHC with OMAP and determination of the clinic's encounter rate.

(b) Consistent with OAR 410-120-1260, Provider Enrollment, only enrolled providers can submit claims to OMAP for providing specific care, item(s), or service(s) to OMAP clients. A clinic or individual provider needs to bill fee-for-service for services provided prior to enrollment as an FQHC or RHC with OMAP, according to applicable service program's enrollment and billing Oregon Administrative Rules (OARs).

(2) To determine the PPS encounter rate(s), an FQHC must submit all financial documents listed in OAR 410-147-0320 for each Medical, Dental and Mental Health (including Addiction, Alcohol and Chemical Dependency) Services.

(a) Effective October 1, 2004, for FQHCs only, OMAP will calculate three separate PPS encounter rates for clinics newly enrolling as an FQHC with OMAP:

(i) Medical;

(ii) Dental; and

(iii) Mental Health, to include addiction, alcohol and chemical dependency services.

(b) FQHCs enrolled with OMAP prior to October 1, 2004, with a single PPS medical encounter rate, will have a separate encounter rate calculated if the clinic adds a service category listed in either Section (2)(a)(ii) or (iii) of this rule. Refer also to Section (16) of this rule.

(3) To determine the PPS encounter rate, a RHC must submit all financial documents listed in OAR 410-147-0320.

(a) OMAP will accept an uncertified Medicare Cost Report;

(b) If the clinic's Medicare Cost Report, provided to OMAP, does not include all covered Medicaid costs provided by the clinic, the clinic must submit additional cost information. OMAP will include these costs when determining the PPS encounter rate.

(c) OMAP will remove the Medicare productivity screen and any other Medicare payment caps from the RHC's Medicare encounter rate;

(d) An RHC can submit OMAP's cost statement form 3027 as a substitute to the Medicare Cost Report.

(4) FQHCs or RHCs that have an additional clinic site(s) under the main FQHC or RHC designation, must file the required financial documentation for each clinic site unless specifically exempted in writing by OMAP. If exempted from this requirement by OMAP, an FQHC or RHC may file a consolidated cost report. See OAR 410-147-0340 regarding multiple provider numbers.

(5) FQHCs and RHCs cannot include costs associated with non-FQHC or non-RHC designated sites in the cost report.

(6) FQHCs and RHCs cannot include costs associated with non-covered Medicaid services. OMAP does not allow the inclusion of indirect or direct costs for non-covered Medicaid services in the clinic's cost report/statement as allowed expenses. Refer to OAR 410-120-1200 Excluded Services and Limitations.

(7) An out-of-state FQHC or RHC will only include expenses associated with Medicaid covered services provided at clinic sites serving OMAP clients when completing the Cost Statement (OMAP 3027). For RHCs only, the Medicare Cost Report can only include financial documents for Medicaid-covered services provided at clinic sites that see OMAP clients. Do not include costs associated with non-FQHC or RHC designated sites, or clinic sites that do not serve OMAP clients in the Cost Statements (OMAP 3027) or Medicare Cost Reports for RHCs.

(8) At any time, if OMAP determines that the costs provided by the clinic for calculating the PPS encounter rate(s) were inflated, OMAP may:

(a) Request corrected cost reports and any other financial documents in order to review and adjust the encounter rate(s); and

(b) Impose sanctions as defined in OARs 410-147-0560 and 410-120-1400.

(9) Effective January 1, 2001, OMAP determines FQHC and RHC encounter rates in compliance with 42 USC 1396a(bb). In general, the PPS encounter rate is calculated by dividing total costs of Medicaid covered services furnished by the FQHC/RHC during fiscal years 1999 and 2000 by the total number of clinic encounters during the two fiscal years.

(10) Clinics existing in 1999 and 2000, and enrolled with OMAP as a FQHC or RHC as of January 1, 2001, receive payment from OMAP for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness.

(11) Clinics first qualifying as an FQHC or RHC after fiscal year 2000, will receive payment from OMAP for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during the fiscal year the clinic first qualifies as an FQHC or RHC. Coinciding with enrollment as an FQHC or RHC with OMAP, a clinic will have a PPS encounter rate:

(a) Established by reference to payments to other clinics located in the same or adjacent areas, and of similar caseload; or

(b) In the absence of such clinic, through cost reporting methods based on tests of reasonableness.

(12) Beginning in fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the PPS encounter rate(s) payment amount to which the clinic was entitled under Section 42 USC 1396a(bb) in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI).

(13) For established, enrolled clinics with a change of ownership, the new owner can submit:

(a) A Cost Statement (OMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership for review by OMAP to determine if a new PPS encounter rate will be calculated as otherwise described in this rule; or

(b) In writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership, including notice if there is a change to the clinic's tax identification number;

(c) Failure to submit a cost statement (OMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit the opportunity for calculation of a PPS encounter rate(s) at a later date. The PPS encounter rate(s) calculated under the former ownership will be reassigned to the new ownership.

(14) The Centers for Medicare and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and amount of services. Clinics must submit a request for change in scope to OMAP for review.

(15) OMAP may establish a separate PPS encounter rate if a FQHC adds Dental or Mental Health (including addiction, and alcohol and chemical dependency) services. A separate PPS encounter rate will be calculated by OMAP for the added service element if:

(a) Costs associated with the added service element were not included on the original cost statements for the initial PPS encounter rate determination;

(b) The addition of the service element has been approved by the Health Resources and Services Administration (HRSA) and is included in the notice of grant award issued by HRSA;

(c) The FQHC is certified by the Office of Mental Health and Addiction Services (OMHAS) to provide mental health services (if mental health services are provided by un-licensed providers), or has a letter or licensure of approval by OMHAS to provide addiction, and alcohol and chemical dependency services;

(i) Certification by OMHAS of an FQHC's outpatient mental health program is required if mental health services are provided by non-licensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements

(iii) A letter of licensure or approval by OMHAS is required for FQHCs providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320(3)(j) and (5)(i);

(16) If an FQHC meets the criteria as outlined in Section (15) of this rule for the addition of Dental or Mental Health (including addiction, and alcohol and chemical dependency) services, after the initial encounter rate determination, OMAP will determine the PPS encounter rate for the newly added service element using the date the scope change was approved by HRSA. For example: the clinic submitted 1999 & 2000 cost reports. In 2001 the clinic added a dental clinic. The cost report would be from 2001 (the most appropriate months) with the MEI adjusted for 2002, 2003 and 2004.

(17) When an FQHC shares the same space for multiple services, then OMAP will use square footage to determine the percent of the indirect cost associated with each encounter rate.

(18) A clinic may be exempt from this requirement if an FQHC has minimal utilization for a particular service such as "Look Alike" clinics and is located in an isolated area. Submit an exemption request with appropriate documentation to OMAP's FQHC Program Manager for consideration.

Stat. Auth.: ORS 409
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0400
Compensation for Outstationed Outreach Activities

(1) This rule provides reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices. Reasonable compensation may be provided to eligible Federally Qualified Health Centers (FQHCs) for outreach activities performed by Outstationed Outreach Workers (OSOW) that is equal to 100% of direct costs:

(a) OMAP will calculate an OSOW rate based on reasonable direct costs described in Section (6) of this rule, and reported by a clinic per Section (3) of this rule;

(b) The OSOW rate will be added to the clinic's current base medical Prospective Payment System (PPS) encounter rate.

(2) An FQHC must have a current Outreach Agreement with the State of Oregon, Department of Human Services, Office of Medical Assistance Programs (OMAP) to be eligible for compensation under this rule.

(3) Clinics must submit a cost statement for the preceding fiscal year no earlier than October 1, and no later than October 31, of each year to OMAP for review of the clinic's OSOW direct costs for approval before any OSOW compensation is added to the PPS encounter rate:

(a) Any change to the OSOW rate, based on the October cost statement submission, will be effective January 1st of the following year;

(b) If, it is determined that the OSOW rate is inflated, the clinics OSOW rate will be adjusted effective immediately.

(4) For staff employed by a clinic and performing outreach activities at less than full time, the clinic must calculate the percent of time spent performing OSOW services and maintain adequate documentation to support the percentage of time claimed. The percent must be used to calculate personnel expenses incurred by an FQHC as outlined in Section (6)(c) of this rule and that are directly attributed to outreach activities performed by the employee.

(5) Clinic locations with limited operating hours, or that limit access to the general public during their regular operating hours must calculate the actual time an OSOW meets face-to-face with the general public for receipt and the initial processing of applications. For example, if a clinic employs an OSOW at a satellite school-based health center (SBHC), and the SBHC can only be accessed by the general public outside of the school's normal hours of operation, use the percent of time an OSOW is available to meet face-to-face with potential applicants when reporting compensation as outlined in Section (6)(c) of this rule.

(a) Clinics must display a notice in a prominent place that advises potential applicants when an outstation outreach worker will be available;

(b) The notice must include a telephone number that applicants may call for assistance.

(6) Direct cost expenses allowed for OSOW reimbursement:

(a) Travel expenses incurred by the FQHC for OMAP training on OSOW activities;

(b) Phone bills, if a dedicated line. Otherwise an estimate of telephone usage and resulting costs;

(c) Personnel costs for OSOWs:

(A) Wages;

(B) Taxes;

(C) Fringe Benefits provided to OSOW;

(D) Premiums paid by the FQHC for Private Health Insurance.

(d) Reasonable equipment necessary to perform outreach activities. Do not include expenses for replacing equipment if the original cost of the equipment was reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(e) Rent or space costs. Do not include rent or space costs if 100% of facility costs were reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(f) Reasonable office supplies necessary to perform outreach activities; and

(g) Postage.

(7) OMAP excludes indirect costs relating to OSOW activities from calculation of the OSOW rate. Excluded indirect costs include and are not limited to the following:

(a) Any costs included in the initial calculation of a clinic's Prospective Payment System (PPS) encounter rate;

(b) Contracted interpretation services;

(c) Administrative overhead costs; and

(d) Operating expenses including utilities, building maintenance and repair, and janitorial services.

(8) A Public Health Department designated as an FQHC or a School Based Health Center (SBHC) within the scope of an FQHC designation cannot participate in the Medicaid Administrative Claiming (MAC) program.

(9) If a clinic fails to submit the OSOW budget by November 1 of the required year, a clinic may not be eligible for compensation of OSOW costs as of January 1 for the coming year.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1993, f. & cert. ef. 71-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0330; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0460
Prepaid Health Plan Supplemental Payments

(1) Effective January 1, 2001, the Office of Medical Assistance Programs (OMAP) is required by 42 USC 1396a(bb), to make supplemental payments to eligible Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) that contract with Prepaid Health Plans (PHP).

(2) The PHP Supplemental Payment represents the difference, if any, between the payment received by the FQHC/RHC from the PHP(s) for treating the PHP enrollee and the payment to which the FQHC/RHC would be entitled if they had billed OMAP directly for these encounters according to the clinic's Medicaid Prospective Payment System (PPS) encounter rate. Refer to OAR 410-147-0360.

(3) In accordance with federal regulations the Provider must take all reasonable measures to ensure that in most instances Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP. Refer to OAR 410-147-0120(13).

(4) When any other coverage is known to the provider, the provider must bill the other resource(s) prior to billing the PHP. When a Provider receives a payment from any source prior to the submission of a claim to the PHP, the amount of the payment must be shown as a credit on the claim in the appropriate field. See also OAR 410-120-1280 Billing and OAR 410-120-1340 Payment.

(5) Supplemental payment by OMAP for encounters submitted by FQHC/RHCs for purposes of this rule is reduced by any and all payments received by the FQHC/RHC from outside resources, including Medicare, private insurance or any other coverage. Therefore, FQHC/RHCs are required to report all payments received on the Managed Care Data Submission Worksheet, including:

(a) Medicaid PHPs;

(b) Medicare Advantage Managed Care Organizations (MCO);

(c) Medicare, including Medicare MCO supplemental payments; and

(d) Any Third Party Resource(s) (TPR).

(6) OMAP will calculate the PHP Supplemental Payment in the aggregate of the difference between total payments received by the FQHC/RHC, to include payments as listed in Section (5) of this rule and the payment to which the FQHC/RHC would have been eligible to claim as an encounter if they had billed OMAP directly per their PPS encounter rate.

(7) Effective July 1, 2006, FQHC/RHCs must submit their clinic's data beginning with dates of service January 1, 2006 and after, using the Managed Care Data Submission Template developed by OMAP to report all PHP encounter and payment activity.

(8) To facilitate OMAP processing PHP supplemental payments, the FQHC or RHC must submit the following:

(a) To PHPs:

(A) Claims within the required timelines outlined in the contract with the PHP and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment Under the Oregon Health Plan;

(B) The FQHC or RHC clinic number must be used when submitting all claims to the PHPs.

(b) To OMAP:

(A) Report total payments for all services submitted to the PHP, including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; excluding any bonus or incentive payments;

(B) Report total payments for each category listed in the "Amounts Received During the Settlement Period" section of the Managed Care Data Submission Template Coversheet;

(C) Payments are to be reported at the detail line level on the Managed Care Data Submission Template Worksheet, except for capitated payments, or per member per month and risk pool payments received from the PHP;

(D) The total number of actual encounters, excluding all laboratory, radiology, nuclear medicine, and diagnostic ultrasound encounters. An encounter represents all services for a like service element (Medical, Dental, Mental Health, or Alcohol and Chemical Dependency) provided to an individual client on a single date of service. The total number of encounters is not the total number of clients assigned to the FQHC or RHC or the total detail lines submitted on the Managed Care Data Submission Template Worksheet;

(E) All individual OMAP performing provider numbers assigned to practitioners associated with the FQHC or RHC. "Associated" refers to a practitioner who is either subcontracted or employed by the FQHC or RHC. A practitioner associated with an FQHC or RHC can only retain their individual performing provider number under one of the two situations:

(i) The practitioner maintains a private practice; or

(ii) The practitioner is also employed by a non-FQHC or RHC site.

(F) A current list of all PHP contracts. An updated list of all PHP contracts must be submitted annually to OMAP no later than October 31 of each year.

(9) PHP Supplemental Payment process:

(a) OMAP will process PHP Supplemental Payments on a quarterly basis;

(A) Quarterly processing of PHP Supplemental Payments includes a final reconciliation for the reported time period;

(B) For an FQHC or RHC approved by OMAP to participate in a pilot project, PHP Supplemental Payments will be processed at the discretion of OMAP in collaboration with health centers.

(b) Upon processing a clinic's data and the PHP Supplemental Payment, OMAP will:

(A) Send a check to the clinic for PHP Supplemental Payment calculated from clinic data OMAP was able to process;

(B) Provide a cover letter and summary of the payment calculation; and

(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by OMAP.

(c) The FQHC or RHC is responsible for reviewing the data OMAP was unable to process for accuracy and completeness. The clinic has 30 days from the date of OMAP's cover letter under Section (9)(b) of this rule to make any corrections to the data and resubmit to OMAP for processing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by OMAP prior to expiration of the 30 days, and must:

(A) Be requested in writing;

(B) Accompanied by a cover letter fully explaining the reason for the late submission; and

(C) Provide an anticipated date for providing OMAP the clinic's resubmitted data and supporting documentation.

(d) Within 30 days of OMAP's receipt of the re-submitted data, OMAP will:

(A) Review the data and issue a check for all encounters OMAP verifies to be valid; and

(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check.

(e) The FQHC or RHC should submit data to OMAP within the timelines provided by OMAP.

(10) Clinics must carefully review in a timely fashion the data that OMAP was unable to process and returns to the FQHC or RHC. If clinics do not bring any incomplete, inaccurate or missing data to OMAP's attention within the time frames outlined, OMAP will not process an adjustment.

(11) OMAP encourages FQHCs and RHCs to request PHP Supplemental Payment in a timely manner.

(12) Clinics must exclude from a clinic's data submission for PHP supplemental payment, clinic services provided to a PHP-enrolled client when the clinic does not have a contract or agreement with the PHP. This may not apply to family planning services, or HIV/ AIDS prevention services. Family Planning and HIV/AIDS prevention services provided to a PHP-enrolled client when a clinic does not have a contract or agreement with the PHP:

(a) Must be reported in the clinic's data submission for PHP Supplemental Payment if the clinic receives payment from the PHP.

(b) Cannot be reported in the clinic's data submission for PHP Supplemental Payment if the clinic is denied payment by the PHP. If the PHP denies payment to the clinic, the clinic can bill these services directly to OMAP. (See also OAR 410-147-0060).

(13) If a PHP denies payment to an FQHC or RHC for all services, items and supplies provided to a client on a single date of service and meeting the definition of an "encounter" as defined in OAR 410-147-0120, for the reason that all services, items and supplies are non-covered by the plan, OMAP is not required to make a supplemental payment to the clinic. The following examples are excluded from the provision of this rule:

(a) Encounters that will later be billed to the PHP as a covered global procedure (e.g. Obstetrics Global Encounter);

(b) Had payment received by Medicare, and any other third party resource not have exceeded the payment the PHP would have made, the PHP would have made payment;

(c) At least one of the detail lines reported for all services, items and supplies provided to a client on a single date of service and represents an "encounter," has a reported payment amount by the PHP.

(14) If an FQHC or RHC has been denied payment by a PHP because the clinic does not have a contract or agreement with the PHP, OMAP is not required to make a supplemental payment to the clinic. OMAP is only required to make a PHP supplement payment when the FQHC or RHC has a contract with a PHP.

(15) OMAP will not reimburse some Medicaid covered services that are only reimbursed by PHPs, and are not reimbursed by OMAP. OMAP will not make PHP supplemental payment for these services, as OMAP does not reimburse these services when billed directly to OMAP.

(16) It is the responsibility of the FQHC or RHC to refer PHP-enrolled clients back to their PHP if the FQHC or RHC does not have a contract with the PHP, and the service to be provided is not family planning or HIV/AIDS prevention. The Provider assumes full financial risk in serving a person not confirmed by OMAP as eligible on the date(s) of service. See OAR 410-120-1140. It is the responsibility of the Provider to verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided; and

(b) Whether a client is enrolled with a PHP or receives services on an "open card" or "fee-for-service" basis.

Stat. Auth.: ORS 409
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0480
Cost Statement (OMAP 3027) Instructions

(1) The Office of Medical Assistance Programs (OMAP) requires Federally Qualified Health Centers (FQHC) to submit Cost Statements (OMAP 3027).

(2) OMAP reimburses some services, items and supplies fee-for-service, outside of a FQHC or RHC's Prospective Payment System (PPS) encounter rate. For this reason, clinics must exclude the costs for the following items from the cost statement:

(a) Laboratory and radiology services including nuclear medicine. Refer to OAR 410-147-0120(11);

(b) Contraceptive supplies and contraceptive medications. Refer to OAR 410-147-0280;

(c) Pharmacy. Requires separate enrollment, refer to OAR 410 Division 121, Pharmaceutical Services Program Rulebook for specific information;

(d) Durable Medical Equipment and Supplies. Requires separate enrollment, refer to OAR 410 Division 122, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); and

(e) Targeted Case Management (TCM) services. Requires separate enrollment, refer to OAR 410-147-0610, and 410 Division 138, Targeted Case Management for specific information.

(2) Rural Health Clinics (RHC) have a choice of submitting either their Medicare Cost Report or the Cost Statement (OMAP 3027). If the RHC files a Medicare Cost Report, OMAP may request additional information.

(3) Reimbursement is based upon the actual reasonable allowable cost per encounter as defined in the FQHC and RHC rules. In general, a Prospective Payment System (PPS) encounter rate is calculated by dividing the total costs of Medicaid-covered services furnished by the FQHC/RHC by the total number of clinic encounters. The clinics must submit the Cost Statement (OMAP 3027) to OMAP:

(a) For established clinics during an adjustment to the clinic's rate based on a change in scope of clinic services. Refer to OAR 410-147-0360;

(b) For new clinics. Refer also to OAR 410-147-0360; or

(c) If there is a change of ownership, the new owner can submit the Cost Statement (OMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated. See also OAR 410-147-0320(8).

(4) The Cost Statement (OMAP 3027) must include all documents required by OAR 410-147-0320.

(5) Each section must be completed if applicable.

(6) Page 1 — Statistical Information:

(a) Enter the full name of the FQHC or RHC, the address and telephone number, the fiscal reporting period, the OMAP provider number, the name of the persons or organizations having legal ownership of the FQHC or RHC; and all provider and health care practitioners as defined on the OMAP 3027 Cost Statement.

(b) The Cost Statement (OMAP 3027) must be prepared, signed and dated by both the FQHC or RHC accountant and an authorized responsible officer.

(7) Page 2 — Part A — FQHC or RHC Practitioner Staff and Visits:

(a) FTE Personnel: List the total number of staff by position;

(b) Encounters: List the number of on-site and off-site encounters by staff. Refer also to OAR 410-147-0500, Total Encounters for Cost Reports. Exclude the following types of encounters from your total encounters:

(A) Outstationed Outreach Workers;

(B) Administration; and

(C) Support staff, or any staff members who do not meet the criteria of OAR 410-147-0120(6) or the qualification or certification requirements under a clinic's mental health certification or alcohol and other drug program approval or licensure by the Office of Mental Health and Addiction Services (OMHAS). Refer to OAR 410-147-0320.

(8) Pages 3-4 — Reclassification and Adjustment of Trial Balance of Expenses:

(a) Record the expenses for covered health care costs, non-reimbursable program costs, allowable overhead costs, and non-reimbursable overhead costs:

(A) Covered health care (program) costs include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. Whether OMAP allows the costs is subject to the regulations prescribing the treatment of specific items under the Medicaid program. Refer also to OAR 410-147-0020 Professional Services. Covered health care (program) and direct health care costs include but are not limited to:

(i) Personnel costs, including Medical record and medical receptionist costs;

(ii) Administrative costs;

(iii) Employee pension plan costs;

(iv) Normal standby costs;

(v) Medical practitioner salaries; and

(vi) Malpractice insurance costs.

(B) Non-reimbursable program costs are costs that are not related to patient care and which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs that are not necessary include costs that usually are not common or accepted occurrences in the field of the provider's activity. Non-reimbursable program costs include, but are not limited to:

(i) Women, Infants and Children (WIC);

(ii) Community Services/Housing Projects. Refer to OAR 410-120-1200;

(iii) Environmental external maintenance costs (e.g. landscaping, pesticide application);

(iv) Research;

(v) Public Education; and

(vi) Outside services.

(C) Allowable overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Below are examples of overhead costs:

(i) Administrative costs;

(ii) Billing department expenses;

(iii) Audit costs;

(iv) Reasonable data processing expenses (not including computers, software or databases not used solely for patient care or clinic administration purposes);

(v) Space costs (rent and utilities); and

(vi) Liability insurance costs.

(D) Non-reimbursable overhead costs:

(i) Entertainment;

(ii) Fines and penalties;

(iii) Fundraising;

(iv) Goodwill;

(v) Gifts and contributions;

(vi) Political contributions;
(vii) Bad debts;
(viii) Other interest expense;
(ix) Advertising;
(x) Membership dues for public relations purposes, including country or fraternal club memberships;
(xi) Cost of personal use of motor vehicles;
(xii) Cost of travel incurred in connection with non-patient care related purposes; and
(xiii) Costs applicable to services, facilities, and supplies furnished by a related organization (Related Party Transactions) in excess of the lower of cost to the related organization, or the price of comparable service as rendered by a non-related entity. Refer to OAR 410-147-0540.
(b) Attach expense documentation from financial accounting records and an explanation for allocations, and allocation method used;
(c) Enter any reclassified expenses, adjustments (increase/decrease) of actual expenses in accordance with the FQHC and RHC Administrative rules on allowable costs. A schedule of any reported reclassification of trial balance expense, whether an increase or decrease, must include:
(A) A reference to the line number on either page 3 or 4;
(B) A description of the reclassification or adjustment;
(C) The amount of the debit or credit; and
(D) The total for each debit and credit.
(d) Net expenses must equal the combined reclassified trial balance taking into account the adjustment amount on each detail line;
(e) Enter the totals from each column in the "Total" fields;
(9) Page 5 — Determinations — Determination of Overhead Applicable to FQHC and RHC Services:
(a) Parts A and B: Enter all totals from the previous pages of the Cost Statement (OMAP 3027) as requested under overhead applicable to FQHC or RHC services and FQHC or RHC rate;
(b) Part C: If applicable, complete by entering the wages for Outstationed Outreach Workers on line C1, divide the wages by the number of billable OMAP encounters to determine the rate per encounter. See also OAR 410-147-0400.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0400; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0500
Total Encounters for Cost Reports

(1) Each Federally Qualified Health Center (FQHC) is required to report total encounters as defined in the Bureau of Primary Health Care's Uniform Data System Manual, Definitions. Each Rural Health Clinic is required to report total encounters as defined by Medicare definitions. All encounters, that meet the definition, including encounters for clients who are enrolled in a Prepaid Health Plan (PHP), must be included in total reported encounters. Except as excluded in Section (3) of this rule. Report total encounters as required in OAR 410-147-0320. Encounters must reconcile with UDS or other comparable reports.
(2) Encounters are defined in OAR 410-147-0120. Reportable encounters also include:
(a) Encounters for the Family Planning Expansion Program (FPEP);
(b) Encounters for administering immunizations/vaccinations, including those administered by a Registered or Licensed Practical Nurse.
(3) Under the following circumstances, the encounter criteria is not met and services must be excluded from total number of reported encounters on the cost statement:
(a) Services performed under the auspices of a Women, Infant and Children (WIC) program or a WIC contract;
(b) Services provided by patient advocates/ombudsmen and Outstationed Outreach Workers, employed by or under contract with the FQHC or RHC, for the primary purpose of providing outreach and/or group education sessions;
(c) Provider participation in a community meeting or group session that is not designed to provide clinical services. This includes, and is not limited to, information sessions for prospective Medicaid beneficiaries, and information presentations about available health services at the FQHC or RHC;
(d) Case management services for coordinating medical care for a client. This service is an allowed administrative program cost and should be reported on a clinic's cost statement. Refer to OAR 410-147-0480, Costs Statement (OMAP 3027) Instructions;
(e) Enabling services, including but not limited to, sign language and oral interpreter services. This service is an allowed administrative program cost and should be reported on a clinic's cost statement. Refer to OAR 410-147-0480, Costs Statement (OMAP 3027) Instructions;
(f) Supportive, rehabilitation services including, but not limited to, environmental intervention, and supported housing and employment; skills training and activity therapy to promote community integration and job readiness. This service is an allowed administrative program cost and should be reported on a clinic's cost statement. Refer to OAR 410-147-0480, Costs Statement (OMAP 3027) Instructions;
(g) Services provided without the client present;
(h) When the only services provided are lab tests, x-rays, TB tests and/or prescription refills;
(i) Health service provided is part of a large-scale "free to the public" or "nominal fee" effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
(4) Clinics must maintain for five years all documentation relied upon by the clinic to calculate the number of encounters reported on the cost statement (OMAP 3027).
(a) All documentation supporting the number of encounters reported on the cost statement must be sufficient to withstand an audit; and
(b) The total number of encounters calculated from all sources of documentation must reconcile to the total number of encounters reported on the cost statement, and subtotaled encounters must reconcile to each documentation source relied upon.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0380; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0540
Related Party Transactions

(1) A "related party" is an individual or organization that is associated or affiliated with, or has control of, or is controlled by the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) furnishing the services, facilities, or supplies:
(a) "Common ownership" exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider;
(b) "Control" exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.
(2) OMAP allows costs applicable to services, facilities, and supplies furnished to the FQHC or RHC by a related party at the lower of cost, excluding profits and markups to the related party, or charge to the clinic. Such costs are allowable in accordance with 42 CFR 413.17, to the extent that they:
(a) Relate to Title XIX and Title XXI client care;
(b) Are reasonable, ordinary, and necessary; and
(c) Are not in excess of those costs incurred by a prudent cost-conscious buyer.
(3) The intent is to treat the costs incurred by the related party as if they were incurred by the FQHC/RHC itself.
(4) Clinics must disclose a related party who is enrolled as a provider with OMAP with a separate OMAP provider number.
(5) Documentation of costs to related parties shall be made available at the time of an audit or as requested by OMAP. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.
(6) OMAP will allow rental expense paid to related individuals or organizations for facilities or equipment to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of the FQHC and RHC Administrative Rules.
(7) If all of these conditions are not met, none of the costs of the related party transaction can be reported as reimbursable costs on the FQHC or RHC's cost statement report.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0280; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0610
Targeted Case Management (TCM)

(1) Targeted Case Management (TCM) services are provided and reimbursed through a separate program requiring enrollment as a TCM provider.
(2) Refer to OAR 410 Division 138, Targeted Case Management, for specific requirements.

(3) If an FQHC or RHC is participating in a TCM program, the clinic must notify OMAP in writing and must include a description of the TCM program. With the exception of maternity case management (MCM) services authorized by OAR 410-147-0200, costs for TCM services cannot be included in a clinic's cost statement and cannot be billed as an encounter under the FQHC or RHC per a clinic's encounter rate, or billed to a prepaid health plan (PHP).

(4) A client may only participate in a single TCM program. OMAP does not allow multiple TCM billings. This includes Maternity Case Management (MCM).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

410-147-0620
Medicare/Medical Assistance Program Claims

(1) If a client has both Medicare and Medicaid coverage under the Oregon Health Plan (OHP), coordinated by the Office of Medical Assistance Program (OMAP), providers must bill Medicare first.

(2) All claims submitted by Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) to OMAP for clients who have both Medicare and OMAP coverage must be billed on a CMS-1500 claim form or by 837P transmission. See also Billing for Medicare/Medicaid Clients in the FQHC and RHC Supplemental Information.

(3) If an out-of-state Medicare carrier or intermediary was billed, you must bill OMAP using a CMS-1500 claim form or 837P transmission, but only after that carrier has made payment determination.

(4) When billing on a CMS-1500 claim form or 837P transmission for a client with both Medicare and OMAP coverage:

(a) Bill all services provided to an OHP beneficiary using a procedure code listed in Table 147-0120-1, FQHC/RHC Encounter Codes;

(b) Bill the clinic's encounter rate; and

(c) Enter the total Medicare payment received in the "Amount Paid" field or use the appropriate Third Party Resources (TPR) explanation. Refer to CMS-1500 or 837P detailed billing instructions.

(5) Claims for Qualified Medicare Beneficiary (QMB)-only clients must be billed on CMS-1500 claim form or 837P transmission. Refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System. Specific billing information and instructions are located in the FQHC and RHC Supplemental Information billing guide:

(a) The total charged amount must equal the total Medicare allowed/covered charges, minus any reductions or contract adjustments. FQHCs and RHCs are not to bill their encounter rate for services provided to Qualified Medicare Beneficiary (QMB)-only clients;

(b) FQHC and RHCs must bill each service, treatment or item provided to a QMB-only beneficiary on the CMS-1500 claim form or 837P transmission identical to how Medicare was billed.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0040; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06

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Department of Human Services,
Director's Office
Chapter 407

Rule Caption: Medicare Part C and D Authorized Decision Makers.
Adm. Order No.: DHSD 4-2006
Filed with Sec. of State: 5-26-2006
Certified to be Effective: 5-26-06
Notice Publication Date: 5-1-06
Rules Adopted: 407-050-0000, 407-050-0005, 407-050-0010
Subject: Establishes the parties that are authorized to make Medicare Part C and D decisions for clients of the Department of Human Services. These rules currently exist as temporary rules in effect through 5/26/06.
Rules Coordinator: Jennifer Bittel—(503) 947-5250

407-050-0000
Purpose

These rules set forth parameters concerning who can make decisions and take action on behalf of individuals who are incapable of making their own Medicare Part D Decisions. The decisions and actions include choosing a Medicare Part D prescription drug plan or a Part C Medicare Advantage Plan and filing drug coverage exceptions and appeals, and pursuing grievances with Medicare Part C or D plan sponsors and the federal Centers for Medicare and Medicaid Services (CMS). These rules only pertain to those individuals who receive benefits or services, which are provided by, operated by, authorized or funded by Oregon Department of Human Services (Department). Those acting under the authority of this rule must do so with the express purpose of meeting the pharmaceutical and medical needs of the individual receiving the assistance.

Stat. Auth.: ORS 409.050, 410.070, 410.090, 411.116, 426.500 & 430.640
Stats. Implemented: ORS 409.010, 410.250, 410.280, 410.020, 411.060, 426.490 & 430.630
Hist.: DHSD 1-2005(Temp), f. & cert. ef. 11-28-05 thru 5-26-06; DHSD 4-2006, f. & cert. ef. 5-26-06

407-050-0005
Definitions

(1) "Authorized Representative" for purposes of these rules means one of the following, as determined in accordance with these rules:

(a) Closest Available Relative;

(b) Friend or Advocate;

(c) Department Case Manager/Eligibility Specialist or Department Social Worker or designee named by the Department office responsible for enrollment;

(d) Owner, operator, or employee of a Department licensed or certified residential service, nursing home, foster home, or a Brokerage funded by the Department to provide Developmental Disability Support Services.

(2) "Capable" means that a person has the ability to receive and evaluate information effectively or communicate decisions to such an extent that the person currently has the ability to make Medicare Part D Decisions.

(3) "Closest Available Relative" means a Capable person who is related by blood, marriage, or adoption or a Domestic Partner and is aware of the Part D-eligible Individual's medical and pharmaceutical needs. This person has a history of acting to the benefit of the Part D-eligible Individual's health and safety and is available to make the needed decisions. It does not refer to physical proximity.

(4) "Domestic Partner" means a person who attests to meet all the following criteria:

(a) Is responsible for the Part-D eligible Individual's welfare;

(b) Is the Part-D eligible Individual's sole domestic partner;

(c) Has jointly shared the same regular and permanent residence with the Part-D eligible Individual for at least six months; and,

(d) Is jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household.

(5) "Department" means Oregon Department of Human Services.

(6) "Department Case Manager/Eligibility Specialist" means an employee of the Department, the Department's designee, Community Developmental Disability Program, Community Mental Health Program or the local Area Agency on Aging that provides case management services or determines eligibility for Department services for the Part D-eligible Individual.

(7) "Enroll and Enrollment" means the act of enrolling a Part D-eligible Individual into a Medicare Part D Prescription Drug Plan (PDP) or Medicare Advantage Plan (MA or MA-PD) or changing plans.

(8) "Friend or Advocate" means a Capable person known to the Part D-eligible Individual, who has had an ongoing, consistent personal relationship with the Part D-eligible Individual, is aware of the medical and pharmaceutical needs and who is interested in the welfare of the individual and will advocate appropriately on behalf of the individual.

(9) "Incapable" means that the Part D-eligible Individual's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the ability to make Medicare Part D Decisions.

(10) "Individual Designee" means a Capable person appointed verbally, in writing or by any means of communication by the Part D-eligible Individual for the purpose of making enrollment or post-enrollment decisions on behalf of the Part D-eligible Individual.

(11) "Medicare Part D Decision" means a decision to enroll or disenroll in a Medicare Part C or D plan, or any post-enrollment decision, as those terms are used in these rules.

(12) "Medicare Part D Plan, Medicare Prescription Drug Plan, Medicare Part C Plan, Medicare Advantage Plan" all mean a program under contract with the federal Centers for Medicare and Medicaid Services (CMS) to provide prescription drug insurance to people enrolled in the Medicare program.

(13) "Part D-eligible Individual" means an individual who is eligible to receive Medicare Part C or D drug benefits and who also receives benefits or services, which are provided by, operated by, authorized or funded by the Department.

(14) "Personal Representative" means:

(a) A person appointed as a guardian under ORS 125.305, 419B.370, 419C.481, or 419C.555 with authority to make medical, health care or fiscal decisions.

(b) A person appointed as a Health Care Representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions.

(c) Attorney-in-fact authorized to make Medicare decisions.

(d) Any other entity authorized in state or federal law or by order of a court of competent jurisdiction.

(15) "Post-enrollment Actions/Decision" means determining whether and how to do any of the following within the Part C or D program:

(a) File a grievance;

(b) Submit a complaint to the quality improvement organization;

(c) Request and obtain a coverage determination, including exception requests and requests for expedited procedures;

(d) File and request an appeal and direct any part of the appeals process; and,

(e) Disenroll from a Medicare Part C or D Plan.

Stat. Auth.: ORS 409.050, 410.070, 410.090, 411.116, 426.500 & 430.640
Stats. Implemented: ORS 409.010, 410.250, 410.280, 410.020, 411.060, 426.490 & 430.630
Hist.: DHSD 1-2005(Temp), f. & cert. ef. 11-28-05 thru 5-26-06; DHSD 4-2006, f. & cert. ef. 5-26-06

407-050-0010
Authorized Decision Makers

(1) These rules only pertain to those Part D-eligible Individuals who receive benefits or services, which are provided by, operated by, authorized or funded by the Department. Those acting under the authority of this rule must do so with the express purpose of assisting the Part D-eligible Individual to obtain the Part C or D drug benefit that will appropriately meet their pharmaceutical needs and protect their health and safety.

(2) These rules only apply to those persons who can make decisions and take action on behalf of Part D-eligible Individuals for Medicare Part D Decisions.

(3) A Capable Part D-eligible Individual or their Individual Designee must be allowed to make all Medicare Part D Decisions.

(4) If the Part D-eligible Individual is incapable and has a Personal Representative, the Personal Representative must be allowed to make all Medicare Part D Decisions.

(5) If the Part D-eligible Individual is incapable and has an Individual Designee, the Individual Designee must be allowed to make Part D Decisions within the scope of their authority as a designee of the Part D-eligible Individual.

(6) If the Part D-eligible Individual is incapable and does not have an Individual Designee or Personal Representative, these rules authorize the first available person from the following list to be an Authorized Representative for the Part D-eligible Individual solely for the purpose of making Medicare Part D Decision, in order of priority:

(a) Closest Available Relative;

(b) Friend or Advocate;

(c) Department Case Manager/ Eligibility Specialist or Department Social Worker or designee named by the Department office responsible for enrollment;

(d) Owner, operator, or employee of a Department licensed or certified residential service, nursing home, foster home, or a Brokerage funded by the Department to provide Developmental Disability Support Services.

(7) The person acting under authority of OAR 407-050-0010(6)(c) or (d) must provide the Part D-eligible Individual a written copy of the enrollment or disenrollment decision that includes the name of the person making the decision and his or her relationship to the Part D-eligible Individual and a statement that if he or she does not agree with the decision, he or she may change the decision or request the assistance of a different person. The written notice must be retained in the individual's file and made available to the Part D-eligible Individual upon request. In addition to providing the written information, this information may also be provided to the Part D-eligible Individual orally or in a manner that will effectively communicate with the individual.

(8) Medicare Part D Decisions by a person acting under authority of subsection (6) of these rules must be clearly guided by the Part D-eligible Individual's expressed wishes or in the Part D-eligible Individual's best interest in the drug benefit that will appropriately meet their pharmaceutical needs.

(9) An individual may not act as a Authorized Representative under subsection (6) of these rules or Individual Designee under subsection (5) of these rules if the individual or any entity from which that individual receives remuneration:

(a) Receives monetary remuneration or any other compensation from a pharmacy or a Part C or D plan based on Part C or D plan enrollment or post-enrollment activities;

(b) Makes Part C or D decisions for the benefit of a facility, pharmacy, or a plan; or

(c) Is an agent of a Medicare Part C or D plan.

(10) Any individual may be disqualified as acting as an Authorized Representative under subsection (6) or as an Individual Designee under subsection (5) of these rules by the Part D-eligible Individual, a court or hearing process or determination by the Department that an individual is disqualified based upon a substantiated finding of abuse or neglect.

(11) Nothing in this rule implies or authorizes an individual to act on behalf of another individual as a Health Care Representative as defined in OAR 309-041-1500.

(12) These rules do not impair or supersede the existing laws relating to:

(a) The right of a person has to make his or her own decisions;

(b) Health Care Representatives;

(c) Protective proceedings; or

(d) Powers of Attorney.

(13) The intent of these rules is to encourage ongoing review of these Part D Decisions during regularly scheduled service planning. Nothing in these rules should be construed to limit regular review procedures that may include prescription drug needs of the Part D-eligible Individual and their coverage under a Medicare Part C or D plan.

(14) If a dispute exists over the decision of incapability, over whom should be the Authorized Representative or over a decision made by an Authorized Representative, the Part D-eligible Individual's Department Case Manager/Eligibility Specialist and service planning team, which must include the Authorized Representative, must review the Part D Decision and make modifications as necessary.

(15) If the dispute is not resolved by the Department Case Manager and service planning team, the dispute may be referred by any party to the Assistant Director of the Department's Seniors and People with Disabilities cluster or designee.

Stat. Auth.: ORS 409.050, 410.070, 410.090, 411.116, 426.500 & 430.640
Stats. Implemented: ORS 409.010, 410.250, 410.280, 410.020, 411.060, 426.490 & 430.630
Hist.: DHSD 1-2005(Temp), f. & cert. ef. 11-28-05 thru 5-26-06; DHSD 4-2006, f. & cert. ef. 5-26-06

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Rule Caption: Review of Abuse When Self-Defense is Asserted at State Hospitals/Department-Operated Residential Training Homes.
Adm. Order No.: DHSD 5-2006
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 5-1-06
Rules Adopted: 407-045-0000, 407-045-0010, 407-045-0020, 407-045-0030, 407-045-0040, 407-045-0050, 407-045-0060, 407-045-0070, 407-045-0080, 407-045-0090, 407-045-0100, 407-045-0110
Subject: The purpose of these rules is to outline procedures for employees to have notice and to request a review of a determination when a physical abuse investigation in a state hospital or Department-operated residential training home results in a "substantiated" determination and the person alleged to be responsible for the abuse indicates their conduct was in self-defense.
Rules Coordinator: Jennifer Bittel—(503) 947-5250

407-045-0000
Purpose

The purpose of these rules is to outline procedures for employees to have notice and to request a review of a determination when a physical abuse investigation in a state hospital or Department-operated residential training home results in a "substantiated" determination and the person alleged to be responsible for the abuse indicates their conduct was in self-defense. These rules outline a process to provide review, upon request, by the Human Services Abuse Review Committee (HSARC) of the Department of Human Services (Department). The HSARC makes a recommendation to the Director to change or keep the determination made in the investigation by the Office of Investigations and Training (OIT).

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0010
Definitions

(1) "Director" means Director of Oregon's Department of Human Services or their designee.

(2) "Department" means the Oregon Department of Human Services.

(3) "Human Services Abuse Review Committee (HSARC)" means a standing group of individuals appointed by the Director, none of whom were involved in the investigation that resulted in the specific OIT substantiated determination under review, and five of whom will be assigned for each state hospital and the Department-operated training homes.

(4) "Legal Finding" means a court finding, guilty plea or guilty verdict which identifies that the person inquiring about or requesting a review was responsible for the abuse or any other offense stemming from the employee's conduct which was the subject of the OIT substantiated determination.

(5) "Notice of OIT Substantiated Determination" means that OIT determined at the conclusion of an investigation of alleged abuse that there is reasonable cause to believe physical abuse occurred; and that there is reasonable cause to believe that a specific person or persons employed by the state hospital or residential training home were responsible for the abuse.

(6) "Notice of Waived Rights for Review" means a written notice that OIT staff will send to a person requesting a review, when OIT has documentation that a person refused to accept delivery of the notice of OIT substantiated determination or that the person accepted the delivery and did not request a review within 30 calendar days, or when there is a legal determination which indicates that the person accused was responsible for the subject abuse.

(7) "OIT" means the Office of Investigations and Training of the Department which performed the investigation of alleged abuse at the state hospitals or residential training home.

(8) "OIT Determination" is a finding that completes an OIT investigation. Determinations are defined in OAR 410-009-0060 as follows:

(a) "Substantiated" means that the evidence supports a conclusion that there is reasonable cause to believe that abuse occurred.

(b) "Not Substantiated" means that the evidence does not support a conclusion that there is reasonable cause to believe that abuse occurred.

(c) "Inconclusive" means that the available evidence does not support a final decision that there was reasonable cause to believe that abuse occurred or did not occur.

(d) OIT must make a finding of not substantiated if OIT finds that:

(A) The person was acting in self-defense in response to the use or imminent use of physical force.

(B) The amount of force used was reasonably necessary to protect the person from violence of assault; and

(C) The person used the least restrictive procedures necessary under the circumstances in accordance with an approved behavior management plan or other method of response approved by the Department.

(9) "Department approved behavior response" includes:

(a) "Oregon Intervention System" or "OIS" means a system of providing training to people who work with designated individuals with developmental disabilities, to provide elements of positive behavior support and non-aversive behavior intervention. The system uses principles of proactive support and describes approved physical intervention techniques that are used to maintain health and safety.

(b) "Professional Assault Crisis Training Program" or "Pro-Act" means a program designed to provide employees who work with individuals at state hospitals with a systematic approach to intervention during incidents of potential assault. The program is an approach that stresses intervention principles to enable staff to remain safe and minimize the risk of injury to all.

(c) Successor system to OIS or Pro-Act.

(10) "Person requesting review" or "Requestor" means an individual who is identified as the person accused of abuse in an OIT substantiated determination and who requests a review of the determination because the individual believes it was self-defense and not abuse and therefore that the determination is wrong.

(11) "Request for Review by HSARC" means a written request from a person requesting review. The specific requirements for a request for review are described in OAR 407-045-0070.

(12) "Residential Training Home" means State-operated comprehensive 24-hour residential programs licensed by the Department of Human Services under ORS 443.400(7) and (8).

(13) "Self-Defense" means the use of physical force upon another person in self-defense or to defend a third person.

(14) "State Hospital" means Oregon State Hospital and Blue Mountain Recovery Center (Eastern Oregon Psychiatric Center).

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0020
Department Employee – Application of Departmental Employee Policies

The Department will refer to Departmental employee policies for additional or different requirements for individuals identified as responsible for substantiated abuse who are employees of the Department.

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0030
Providing Notice of an OIT Substantiated Physical Abuse Determination after the Effective Date of these Rules when Self-Defense was Asserted

When OIT staff determine a person is responsible for substantiated abuse and that person asserted self-defense as an explanation of their conduct, after January 1, 2006, OIT will deliver a notice of substantiated determination along with a copy of the redacted report summary and conclusions to the person identified, in one of the following ways:

(1) By certified mail, restricted delivery, with a return receipt to the last known address; or

(2) By hand delivery; hand-delivered notice must be addressed to the individual, the original is to be signed and dated by the individual to whom it is addressed to acknowledge receipt, and signed by the person delivering the notice. OIT staff will place the document with original signature in the case record.

Stat. Auth: ORS 179.040, 409.010 & 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210 & 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0040
Information Included in the Notice of an OIT Physical Abuse Substantiated Determination when Self-Defense was Asserted

The notice of an OIT substantiated determination when self-defense is asserted will include all of the following.

(1) The case number assigned to the investigation that resulted in the OIT substantiated determination;

(2) The full name of the individual who has been identified as responsible for the abuse as it is recorded in the case record;

(3) A statement that the OIT determination was recorded as substantiated including a description of the abuse identified and a redacted summary and conclusions of the investigation report;

(4) A statement about the right of the individual to make a request for review of the substantiated determination;

(5) Instructions for making a request for review;

(6) A statement that the person waives the right to request a review if the request for review is not received by OIT within 30 calendar days from the date of receipt of the notice of OIT substantiated determination, as documented by the U.S. Postal Service;

(7) A statement that the HSARC will consider all relevant information including the OIT investigation and determination, and all information provided by the person requesting review in their request for review, and that the HSARC will not: re-interview the alleged victim, interview or meet with the person requesting a review, or others associated with the requestor, or others mentioned in the investigation, or conduct a further investigation of the allegation of abuse; and

(8) A statement that OIT will send the requestor notification of the Director's decision within 60 calendar days of receiving a written request for review.

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0050
OIT Responsibilities When a Person Inquires About a Review of an OIT Substantiated Physical Abuse Determination when Self-Defense was Asserted

OIT staff will take the following steps when a person inquires about a review of an OIT substantiated physical abuse determination.

(1) OIT staff will record the individual's name and address, and a telephone number when available.

(2) OIT staff will review the records to determine whether:

(a) A notice of an OIT substantiated determination was delivered to the person; or

(b) Whether the person refused delivery.

(3) If OIT staff determine that either the notice was delivered as evidenced by the returned receipt, or that the person refused the delivery as evidenced by the returned receipt, the staff may prepare and deliver a notice of waived rights for review.

(4) If OIT staff determine that the notice was not delivered as evidenced by the returned receipt, the staff will deliver a notice of OIT substantiated determination as outlined in OAR 407-045-0030 and 407-045-0060.

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0060
Making a Request for a Review of an OIT Substantiated Physical Abuse Determination when Self-Defense was Asserted

(1) A person who meets the criteria outlined in OAR 407-045-0050 may make a written request for review.

(2) A person requesting review will use information found on the notice of OIT substantiated determination to prepare a written request for review. The written request for review must be delivered to OIT within 30 calendar days of the receipt of the notice of OIT substantiated determination and must include the following items:

(a) Date the request for review is written;

(b) Case number (found on the notice of OIT substantiated determination);

(c) Full name of the person identified as responsible in the OIT substantiated determination;

(d) The reason the person is requesting the review and an explanation of why the person believes the OIT substantiated determination is wrong and they believe it was self-defense;

(e) The person's current name (if it has changed from name noted in (c) above);

(f) The person's current street address, city, state, zip code and telephone number; and

(g) The person's signature.

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0070
Determining When Legal Findings Limit or Preclude a Right to Request a Review

(1) When a criminal process is pending, a review is not allowed under this rule until it is determined that no further criminal investigation will occur.

(2) A legal criminal investigation or finding relevant to the substantiated physical abuse determination related to the incident where self-defense was asserted will preclude a person's right to a review.

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0080
OIT Responsibilities Related to Notice and Review

(1) If an individual asks to review the investigation report, ORS 179.505 (public record law), the Health Insurance Portability and Accountability Act (HIPAA) and OAR 410-009-0130, will govern inspection and copying.

(2) OIT staff will maintain records to demonstrate the following, when applicable:

(a) Whether OIT delivered a notice of OIT substantiated physical abuse determination when self-defense asserted;

(b) Whether or not the notice of OIT substantiated determination was received by the addressee, as evidence by a returned receipt documenting the notice was received, refused, or not received within the 15 calendar day time period as provided by the U.S. Postal Service;

(c) Date a request for review was received; and

(d) When a review was made, whether the notice of the HSARC's decision was received by the person accused or not, as evidenced by a returned receipt documenting the notice was received, refused, or not received within the 15 calendar day time period as provided by the U.S. Postal Service.

(3) The OIT Director or designee will maintain a comprehensive record of the reviews held of OIT substantiated physical abuse determinations when self-defense was asserted. The record will include but is not limited to the date, case number, HSARC's recommendation and the Director's decision.

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0090
HSARC Review of OIT Substantiated Physical Abuse Determinations when Self-Defense was Asserted

(1) The HSARC must conduct a review within 30 calendar days of OIT's receipt of a request for review of an OIT substantiated physical abuse determination where self-defense was asserted.

(2) If the request for review has been retained as per OAR 407-045-0070 and a criminal finding was not made that would preclude a review, the review must occur within 30 calendar days of OIT's receipt of documentation of the legal proceeding's outcome.

(3) The HSARC will operate as follows:

(a) The HSARC will consider all relevant information including the OIT investigation report and determination, and information provided by the person requesting review. The HSARC will not: re-interview the alleged victim, interview or meet with the person requesting a review, or others associated with the requestor, or others mentioned in the investigation, or conduct a further investigation of the allegation of abuse.

(b) The HSARC will have the authority to recommend changing or maintaining an OIT determination based upon their review;

(c) When reviewing an OIT substantiated physical abuse determination, the HSARC will determine whether there is or is not reasonable cause to believe that abuse occurred and will make a recommendation that the allegation is not substantiated if:

(A) The person was acting in self-defense in response to the use or imminent use of physical force;

(B) The amount of force used was reasonably necessary to protect the person from violence of assault; and

(C) the person used the least restrictive procedures necessary under the circumstances in accordance with an approved behavior management plan or other method of Department approved response by rule.

(d) The HSARC will make their recommendation to the Director of whether the OIT determination should be retained or changed by majority vote of the participating committee members.

(e) The HSARC shall prepare and deliver their written recommendation to the Director within 15 calendar days after conclusion of their review.

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0100
Providing the HSARC's Recommendation to the Director

The HSARC's recommendation will include the following items:

(1) Whether there is or is not reasonable cause to believe the person requesting the review was responsible for the abuse;

(2) The recommendation of the HSARC about whether the OIT substantiated physical abuse determination should be retained or changed to not substantiated; and

(3) A summary of the information upon which the recommendation was based.

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

407-045-0110
Director's Responsibilities Related to Decision and Notice

(1) After receipt of the HSARC recommendation, the Director must make a decision and send written notification of their final decision to OIT within 15 calendar days of their determination.

(2) The decision of the Director is the final agency action.

(3) The Director will deliver a copy of the decision to OIT, and the OIT Director or designee will place the request for review, and a copy of the HSARC's recommendation and Director's decision into the case file. No change will be made in the existing written case record.

(4) OIT will send the Director's decision by certified mail, restricted delivery, with a return receipt requested, to the person requesting review within 15 calendar days of the Director's final decision.

(5) OIT staff will notify the state hospital and residential training program operated by the Department of the decision within 15 calendar days of the Director's decision.

(6) OIT will notify anyone else who received the initial substantiated determination of the Director's decision when there is a change in the determination.

Stat. Auth: ORS 179.040, 409.010, 409.050
Stats. Implemented: ORS 179.390, 426.385, 427.031, 430.210, 430.735 - 430.768
Hist.: DHSD 5-2006, f. & c ert. ef. 6-1-06

Department of Human Services,
Public Health
Chapter 333

Rule Caption: Adopts rules relating to the WIC Farm Direct Nutrition Program.
Adm. Order No.: PH 10-2006
Filed with Sec. of State: 6-5-2006
Certified to be Effective: 6-5-06
Notice Publication Date: 5-1-06
Rules Adopted: 333-052-0030, 333-052-0040, 333-052-0050, 333-052-0060, 333-052-0065, 333-052-0070, 333-052-0075, 333-052-0080, 333-052-0090, 333-052-0100, 333-052-0110, 333-052-0120, 333-052-0130
Subject: The Department of Human Services (DHS) is permanently adopting Oregon Administrative Rules in order to administer the federal requirements for authorization and oversight of farmers and farmers' markets, operating within the special supplemental nutrition program for Women, Infants and Children (WIC) Farm Direct Nutrition Program.
Rules Coordinator: Christina Hartman—(971) 673-1291

333-052-0030
Program Overview

(1) The purpose of the WIC Farm Direct Nutrition Program (FDNP) is to:

(a) Provide locally grown, fresh, nutritious, unprepared fruits and vegetables to women, infants over five months of age, and children, who participate in the special supplemental nutrition program for women, infants, and children (WIC); and

(b) Expand the awareness and use of farmers' markets and farm stands where consumers can buy directly from the farmer.

(2) FDNP is administered by the Oregon Department of Human Services in partnership with the Oregon Department of Agriculture.

(3) Farmers' markets and farm stands are authorized to participate in the WIC FDNP in conjunction with the Senior FDNP, and both programs are collectively identified to the public as the Oregon Farm Direct Nutrition Program. The Senior FDNP is similarly administered and provides similar benefits to low-income seniors through a separate federal grant.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0040
Definitions

(1) "Agreement," means a written legal document binding the market or farmer and DHS to designated terms and conditions.

(2) "Authorized" or "authorization," means an eligible farmer or farmers' market has met the selection criteria and signed an agreement with DHS allowing participation in FDNP, and is not currently disqualified.

(3) "Check," means a negotiable financial instrument by which FDNP benefits are provided to participants.

(4) "CMP," means a civil money penalty.

(5) "DHS," means the Oregon Department of Human Services.

(6) "Disqualification," means the act of terminating the agreement of an authorized farmers' market, or farmer from the WIC FDNP for noncompliance with program requirements.

(7) "Eligible foods," means fresh, nutritious, unprepared, locally grown fruits and vegetables and culinary herbs for human consumption. Eligible foods may not be processed or prepared beyond their natural state except for usual harvesting and cleaning processes. For example, checks cannot be used for honey, maple syrup, cider, nuts, seeds, plants, eggs, meat, cheese and seafood.

(8) "Farmer," means a person who owns, leases, rents or sharecrops land to grow, cultivate or harvest crops on that land.

(9) "Farm Direct Nutrition Program" or "FDNP," means the Farmers' Market Nutrition Program administered by the United States Department of Agriculture, Food and Nutrition Services and implemented by the State of Oregon.

(10) "Farmers' Market," means a group of five or more farmers who assemble over the course of a year at a defined location for the purpose of selling their eligible produce directly to consumers.

(11) "Farm Stand," means a location at which a farmer sells produce directly to consumers.

(12) "Fine," means a monetary penalty imposed against the farmer for non-compliance of FDNP rules.

(13) "Locally grown," means grown in the state of Oregon or in the following counties of a contiguous state: California - Del Norte, Modoc, Siskiyou; Idaho - Adams, Canyon, Idaho, Owyhee, Payette, Washington; Nevada - Humboldt, Washoe; Washington - Asotin, Benton, Clark, Columbia, Cowlitz, Garfield, Klickitat, Pacific, Skamania, Wahkiakum, Walla Walla.

(14) "Local WIC agency," means the agency or clinic where a participant receives WIC services and FDNP checks.

(15) "Market," means a farmers' market that has a signed agreement with DHS to participate in the FDNP.

(16) "Market Coordinator," means an individual designated by the farmers' market manager (or market board members) responsible for overseeing the market's participation in the FDNP.

(17) "Participant Access" means the availability of other farmers within the county, geographic barriers to using other farmers, local agency recommendations based upon identified participants' needs, and the availability of public transportation and roads.

(18) "Trafficking," means the buying or exchanging of FDNP checks for cash, drugs, firearms or alcohol.

(19) "USDA" means the United States Department of Agriculture.

(20) "Validating," means stamping the FDNP check in the designated box with the farmer identification number using the stamp provided by DHS.

(21) "Violation," means an activity that is prohibited by OAR 333-052-0030 through 333-052-0090 and classified in 333-052-0080 through 333-052-0130.

(22) "WIC" or "WIC program" means the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) authorized by Section 17 of the Federal Child Nutrition Act of 1966, as amended, 42 U.S.C. §1786.

(23) "WIC participant" or "participant," means any pregnant, breast feeding, or postpartum woman, infant, or child who receives WIC benefits.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0050
Eligible Foods

(1) FDNP checks may be used to purchase only eligible foods.

(2) Ineligible items include, but are not limited to, baked goods, cheeses, cider, crafts, dairy products, dried fruits, dried herbs, dried vegetables, eggs, flowers, fruit juices, honey, jams, jellies, meats, nuts, plants of any kind, potted herbs, seafood, seeds, and syrups.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0060
Farmer Participation

(1) Only authorized farmers may accept FDNP checks in exchange for eligible foods.

(2) In order to be eligible for participation in the FDNP, a farmer applicant must:

(a) Grow, cultivate, or harvest fresh fruits, vegetables and cut herbs in Oregon or a bordering county in a contiguous state to sell to FDNP participants;

(b) Sell at an authorized Market or an authorized farm stand;

(c) Complete the farmer application and return it to the Oregon Department of Agriculture to verify eligibility;

(d) Agree to follow the terms and conditions of the farmer agreement; and

(e) Sign the FDNP agreement and return it to DHS for signature.

(3) Applications will be used to determine authorization for FDNP.

(4) DHS and the FDNP are not required to authorize all applicants.

(5) Any person who purchases all the produce they plan to sell is considered a distributor and is not allowed to participate in the FDNP.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0065
Farmer Agreements

(1) A farmer agreement must be signed by a representative who has legal authority to obligate the farmer.

(2) The farmer agreement must include a requirement that the farmer comply with OAR 333-052-0030 to 333-052-0130, as applicable to farmers.

(3) The farmer agreement will be valid for one season that is defined by DHS.

(4) Neither DHS nor the farmer is obligated to renew the agreement.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0070
Market Participation

(1) In order to be eligible for participation in the FDNP a Farmer's Market applicant must:

(a) Designate a person to be the FDNP market coordinator who will be on-site during operating hours;

(b) Have a minimum of five authorized farmers participating in the Market each year;

(c) Operate on a consistent basis over the course of the season; and

(d) Agree to comply with all terms and conditions specified in the FDNP agreement.

(2) DHS and the FDNP are not required to authorize all applicants.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0075
Farmers' Market Agreements

(1) A Farmers' Market agreement must be signed by a representative who has legal authority to obligate the Market.

(2) The agreement must include a requirement that the Market:

(a) Comply with OAR 333-052-0030 to 333-052-0130, as applicable to Markets;

(b) Furnish the necessary personnel and services to conduct market activities; and

(c) Do all things necessary for or incidental to the performance of the work set forth in the agreement.

(3) The market agreement will be valid for one season that is defined by DHS.

(4) Neither DHS nor the market has an obligation to renew an agreement.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0080
Farmer Participation Requirements, Violations and Sanctions

(1) An authorized farmer must:

(a) Comply with FDNP requirements and the terms and conditions of the farmer agreement;

(b) Accept training on FDNP requirements and ensure that all persons working in the Farmer's stall at the farmers' market or farm stand are trained;

(c) Accept FDNP checks:

(A) For eligible foods only; and

(B) Within the valid dates of the program.

(d) Prominently display the official FDNP sign provided by DHS on each day of operation when at authorized farmers' markets or authorized farm stands;

(e) Provide FDNP clients with the full amount of product for the value of each FDNP check;

(f) Not provide rain checks or credit in exchange for FDNP checks;

(g) Comply with all state or federal laws regarding non-discrimination, and applicable USDA instructions to ensure that no person will, on the grounds of race, color, national origin, age, sex or handicap, be excluded from participation, be denied benefits, or be otherwise subjected to discrimination, under the FDNP;

(h) Ensure that FDNP shoppers receive equitable treatment, including the availability of produce that is of the same quality and no greater price than sold to other shoppers;

(i) Assure that all FDNP checks are stamped with the Farmer's DHS-assigned identification number and properly endorsed before cashing or depositing at the Farmer's bank;

(j) Deposit or cash FDNP checks at the authorized farmer's bank by the date determined by DHS;

(k) Reimburse DHS for FDNP checks that are improperly transacted;

(l) Not charge sales tax on FDNP check purchases;

(m) Not seek restitution from WIC participants for a check not paid by DHS;

(n) Not give cash back for purchases that amount to less than the value of a check (providing change);

(o) Not use FDNP checks for any purpose other than deposit or cash at their financial institution; and

(p) Cooperate with staff from DHS or the Oregon Department of Agriculture in monitoring for compliance with program requirements and provide information that DHS or the Oregon Department of Agriculture may require.

(2) A Farmer is in violation of the FDNP if the farmer:

(a) Fails to:

(A) Comply with FDNP requirements and the terms and conditions of the farmer agreement;

(B) Accept training on FDNP requirements and ensure that all persons working in the Farmer's stall at the farmers' market or farm stand are trained;

(C) Prominently display the official FDNP sign provided by DHS on each day of operation when at authorized farmers' markets or authorized farm stands;

(D) Provide FDNP clients with the full amount of product for the value of each FDNP check;

(E) Comply with all state or federal laws regarding non-discrimination, and applicable USDA instructions to ensure that no person will, on the grounds of race, color, national origin, age, sex or handicap, be excluded from participation, be denied benefits, or be otherwise subjected to discrimination, under the FDNP;

(F) Ensure that FDNP shoppers receive equitable treatment, including the availability of produce that is of the same quality and no greater price than sold to other shoppers;

(G) Assure that all FDNP checks are stamped with the Farmer's DHS-assigned identification number and properly endorsed before cashing or depositing at the Farmer's bank;

(H) Deposit or cash FDNP checks at the authorized farmer's bank by the date determined by DHS;

(I) Reimburse DHS for FDNP checks that are improperly transacted;

(J) Cooperate with staff from DHS or the Oregon Department of Agriculture in monitoring for compliance with program requirements and provide information that DHS or the Oregon Department of Agriculture may require.

(b) Accepts FDNP checks:

(A) For ineligible foods; or

(B) For invalid dates.

(c) Provides rain checks or credit in exchange for FDNP checks;

(d) Charges sales tax on FDNP check purchases;

(e) Seeks restitution from WIC participants for a check not paid by DHS;

(f) Gives cash back for purchases that amount to less than the value of a check (providing change); and

(g) Uses FDNP checks for any purpose other than deposit or cash at their financial institution.

(3) Farmer Sanctions:

(a) DHS may issue a notification of non-compliance to an authorized farmer for an initial incident of:

(A) Accepting FDNP checks for ineligible foods;

(B) Failing to prominently display the official sign provided by DHS, each market day when at authorized farmers' markets or authorized farm stands;

(C) Failing to provide FDNP clients with the full amount of product for the value of each FDNP check;

(D) Failing to ensure that FDNP shoppers receive equitable treatment, including the availability of produce that is of the same quality and no greater price than sold to other shoppers;

(E) Failing to reimburse DHS for FDNP checks that are improperly transacted;

(F) Charging sales tax on FDNP check purchases;

(G) Seeking restitution from WIC participants for checks not paid by DHS;

(H) Giving cash back for purchases less than the value of the checks (providing change);

(I) Using FDNP checks for any purpose other than deposit or cash at the authorized farmer's financial institution; and

(J) Failing to cooperate with staff from DHS or the Oregon Department of Agriculture in monitoring for compliance with program requirements and failing to provide information that DHS or the Oregon Department of Agriculture may require.

(b) DHS may disqualify a farmer for four season months, which may cross from the year during which the violation occurred into the following year for an initial incident of providing rain checks or credit in exchange for FDNP checks.

(c) DHS may disqualify a farmer for four season months, which may cross from the year during which the violation occurred into the following year, for second or subsequent incidents of:

(A) Accepting FDNP checks for ineligible foods;

(B) Failing to prominently display the official sign provided by DHS, each market day when at authorized farmers' markets or authorized farm stands;

(C) Failing to provide FDNP clients with the full amount of product for the value of each FDNP check;

(D) Failing to ensure that FDNP shoppers receive equitable treatment, including the availability of produce that is of the same quality and no greater price than sold to other shoppers;

(E) Charging sales tax on FDNP check purchases;

(F) Seeking restitution from WIC participants for checks not paid by DHS;

(G) Using FDNP checks for any purpose other than deposit or cash at the authorized farmer's financial institution;

(H) Charging FDNP participants higher prices than other customers; and

(I) Giving cash back for purchases less than the value of the checks (providing change).

(d) DHS may not authorize farmers to accept FDNP checks the season following second or subsequent incidents of:

(A) Failing to reimburse DHS for FDNP checks that are improperly transacted; or

(B) Failing to cooperate with staff from DHS or the Oregon Department of Agriculture in monitoring for compliance with program requirements and failing to provide information required to be submitted by DHS or the Oregon Department of Agriculture.

(e) DHS may immediately disqualify a farmer from the FDNP program for the remainder of the current season and the entire following season for an initial incident of:

(A) Trafficking in FDNP checks (exchanging checks for cash, controlled substances, tobacco products, firearms or alcohol) in any amount; or

(B) A USDA substantiated violation of laws regarding non-discrimination, and applicable USDA instructions.

(f) Checks accepted outside the valid dates of the program will be rejected for payment;

(g) FDNP checks that are not stamped with the Farmer's DHS-assigned identification number will be returned to the farmer without payment. The farmer will have a single opportunity, per check, to stamp and redeposit any check that is returned for this reason;

(h) FDNP checks cashed outside the dates determined by DHS will not be reimbursed;

(i) FDNP checks redeemed by a farmer who has not been authorized will not be reimbursed;

(j) Farmers who do not comply with FDNP requirements are subject to sanctions, including fines, in addition to, or in lieu of, disqualification. Prior to disqualifying a farmer, DHS must consider whether the disqualification would result in inadequate FDNP participant access;

(k) DHS must give written notice to a farmer of an action proposed to be taken against a farmer, not less than fifteen days before the effective date of the action. The notice must state what action is being taken, the effective date of the action, and the procedure for requesting a hearing;

(l) A farmer that has been disqualified from the FDNP may reapply at the end of the disqualification period;

(m) DHS may accept a farmer's voluntary withdrawal from the program as an alternative to disqualification. If a farmer chooses to withdraw in lieu of disqualification, the farmer may not apply for participation until the following year;

(n) DHS will not reimburse farmers who have been disqualified or have withdrawn in lieu of disqualification;

(o) Fines must be paid to DHS within the time period specified in the Notice; and

(p) A farmer who commits fraud or abuse of the FDNP is subject to prosecution under applicable federal, state or local laws.

(4) Prior to disqualifying a farmer, DHS may determine if disqualification of the farmer would result in inadequate participant access. If DHS determines that disqualification of the farmer would result in inadequate participant access, DHS may impose a CMP in lieu of disqualification in the amount of 5% of the farmer's previous season WIC FDNP sales or $250.00, whichever is greater.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0090
Market Participation Requirements, Violations and Sanctions

(1) An authorized market must:

(a) Comply with FDNP requirements contained in 7 CFR 248, FDNP rules, and the terms and conditions of the market agreement;

(b) Coordinate authorized farmers to ensure that an authorized farmer is present at the market during all market hours of operation;

(c) Accept training on FDNP procedures and provide such training to market staff including volunteers and eligible farmers on behalf of DHS;

(d) Cooperate in DHS investigations of authorized farmers who:

(A) Redeem checks for ineligible foods;

(B) Charge FDNP customers higher prices than other customers;

(C) Accept checks outside the DHS determined market season;

(D) Issue change for food purchased with FDNP checks;

(E) May not meet the definitions of "eligible farmer" ; and

(F) Abuse any other Program procedures.

(e) Comply with all state or federal laws regarding non-discrimination, and applicable USDA instructions to ensure that no person will, on the grounds of race, color, national origin, age, sex or handicap, be excluded from participation, be denied benefits, or be otherwise subjected to discrimination, under the FDNP;

(f) Cooperate with staff from DHS or the Oregon Department of Agriculture in monitoring for compliance with program requirements and failing to provide information required to be submitted by DHS or the Oregon Department of Agriculture may require; and

(g) Respond to requests, implement corrective action, and comply with the terms in final orders as directed by DHS.

(2) A market is in violation of the FDNP if the market fails to:

(a) Coordinate authorized farmers to ensure that an authorized farmer is present at the market during all market hours of operation;

(b) Accept training on FDNP procedures and provide such training to market staff including volunteers and authorized farmers on behalf of DHS;

(c) Cooperate in DHS investigations of authorized farmers;

(d) Comply with all state or federal laws regarding non-discrimination, and applicable USDA instructions to ensure that no person will, on the grounds of race, color, national origin, age, sex or handicap, be excluded from participation, be denied benefits, or be otherwise subjected to discrimination, under the FDNP;

(e) Cooperate with staff from DHS or the Oregon Department of Agriculture in monitoring for compliance with program requirements and provide information that DHS or the Oregon Department of Agriculture may require; and

(f) Respond to requests, implement corrective action, and comply with the terms in final orders as directed by DHS.

(3) Market sanctions:

(a) DHS may issue a notice of non-compliance to an authorized market for an initial incident of failing to:

(A) Coordinate authorized farmers to ensure that an authorized farmer is present at the market during all market hours of operations;

(B) Accept training on FDNP procedures and provide such training to market staff including volunteers and authorized farmers on behalf of DHS;

(C) Cooperate in DHS investigations of authorized farmers;

(D) Cooperate with staff from DHS or the Oregon Department of Agriculture in monitoring for compliance with program requirements and provide information that DHS or the Oregon Department of Agriculture may require; and

(E) Respond to requests, implement corrective action, and comply with the terms in final orders as directed by DHS.

(b) A market may not be authorized the following year if, within the current season, there is a second or subsequent occurrence of failing to:

(A) Coordinate authorized farmers to ensure that an authorized farmer is present at the market during all market hours of operations;

(B) Accept training on FDNP procedures and provide such training to market staff including volunteers and eligible farmers on behalf of DHS;

(C) Cooperate in DHS investigations of authorized farmers;

(D) Cooperate with staff from DHS or the Oregon Department of Agriculture in monitoring for compliance with program requirements and failing to provide information required to be submitted by DHS or the Oregon Department of Agriculture; and

(E) Respond to requests, implement corrective action, and comply with the terms in final orders as directed by DHS.

(c) DHS may immediately disqualify a market from the FDNP program for the remainder of the current season and the entire following season for an initial incident of a USDA substantiated violation of laws regarding non-discrimination, and applicable USDA instructions;

(d) Markets who do not comply with FDNP requirements are subject to sanctions. Prior to disqualifying a market, DHS must consider whether the disqualification would result in inadequate FDNP participant access;

(e) DHS must give written notice to a market of an action proposed to be taken against a market, not less than fifteen days before the effective date of the action. The notice must state what action is being taken, the effective date of the action, and the procedure for requesting a hearing;

(f) A market that has been disqualified from the FDNP may reapply at the end of the disqualification period;

(g) DHS may accept a market's voluntary withdrawal from the program as an alternative to disqualification. If a market chooses to withdraw in lieu of disqualification, the market may not apply for participation until the following year; and

(h) A market that commits fraud or abuse of the FDNP is subject to prosecution under applicable federal, state or local laws.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0100
DHS Responsibilities

DHS must:

(1) Administer the Farmers' Market Nutrition Program in accordance with 7 CFR 248, and the Senior Farmers' Market Nutrition Program (under the collective name of Oregon FDNP).

(2) Distribute or facilitate distribution to WIC clients, FDNP Checks, redeemable in predetermined increments between specified dates during each year.

(3) Assure payment to farmers for only properly redeemed FDNP checks.

(4) Assure that annual training is provided to all authorized farmers.

(5) Assure that "Oregon Farm Direct Nutrition Checks Welcome Here" signs are provided to the farmer.

(6) Monitor farmers for compliance with FDNP laws and agreements, and if necessary, impose sanctions.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0110
Monitoring

(1) DHS must monitor farmers and markets for compliance with applicable laws and rules, including on-site investigation of randomly selected farmers and markets.

(2) DHS may conduct covert compliance buys on FDNP authorized farmers for compliance with DHS rules and regulations.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0120
Complaints

(1) Any person wishing to file a complaint against a WIC participant, authorized farmer, authorized market, the state WIC Program or local WIC Program may do so in the following manner:

(a) Write to or use the comment form, given to participating markets and local WIC agencies, and send the form to WIC Compliance Coordinator at 800 NE Oregon St., Suite 865, Portland, Oregon, 97232; or

(b) Call the state WIC office.

(2) A local WIC clinic or market manager may file a complaint on behalf of an individual who does not want to file a complaint independently.

(3) When DHS receives a complaint alleging discrimination on the basis of race, color, national origin, age, sex or disability DHS must automatically forward the complaint to USDA for investigation.

(4) Persons alleging discrimination on the basis of race, color, national origin, age, sex or disability may also write directly to USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD).

(5) DHS may refer complaints regarding farmers or markets to the Oregon Department of Agriculture for investigation.

(6) The identity of any person filing a complaint will be kept confidential except to the extent necessary to conduct any investigation, hearing or judicial proceeding regarding the complaint.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

333-052-0130
Appeals

(1) Markets and farmers are entitled to a hearing as provided by the Administrative Procedures Act (ORS Chapter 183) for a denial of participation, imposition of a sanction, or disqualification.

(2) Markets and farmers may not be entitled to a hearing under the Administrative Procedures Act to challenge:

(a) The validity or appropriateness of DHS' selection criteria for farmer or market participation;

(b) The validity or appropriateness of DHS' participant access determinations;

(c) The duration or expiration of a farmer or market agreement; or

(d) A DHS decision regarding a check payment or claims.

(3) DHS may, at its discretion, permit the market or farmer to continue participating in the program pending the outcome of an administrative hearing. The farmer may be required to repay funds for FDNP checks redeemed during the pendency of the hearing, depending on the hearing outcome.

(4) A request for a hearing must be in writing and must be received within 30 days from the date of the notice describing the proposed action.

(5) The request for hearing must include:

(a) The name and address of the farmer or market requesting the hearing;

(b) The name and address of the attorney representing the farmer or market, if any;

(c) The decision made or action taken by DHS against the farmer or market;

(d) The reason the farmer or market disagrees with the decision or action;

(e) Any special needs or requirements, such as, an interpreter or other special accommodations; and

(f) An attached copy of the notice from DHS.

(6) If a hearing is requested under subsection (1) of this rule, a final written decision must be made within sixty (60) days from the date the request for a hearing was received by the WIC Operations Manager. The time for issuing a decision may be extended upon agreement by the parties.

Stat. Auth.: ORS 409.600
Stats. Implemented: ORS 409.600
Hist.: PH 10-2006, f. & cert. ef. 6-5-06

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Department of Human Services,
Self-Sufficiency Programs
Chapter 461

Rule Caption: Changing OARs affecting public assistance, medical assistance or food stamp clients.
Adm. Order No.: SSP 8-2006
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 12-1-05
Rules Adopted: 461-135-1175
Rules Amended: 461-001-0010, 461-101-0010, 461-110-0750, 461-135-1100, 461-135-1120, 461-155-0235
Rules Repealed: 461-135-1130
Subject: OAR 461-001-0010 concerning Notices of Proposed Rulemaking and Rulemaking rules is being amended. Services covered by Chapter 461 will be following the department-wide rule on notices being adopted at OAR 407-001-0000 and 407-001-0005.

OAR 461-101-0010 is being amended and OAR 461-135-1175 is being adopted to include the Senior Farm Direct Nutrition Program (SFDNP), which has been operating as a pilot program since 2001, as part of chapter 461 of the Oregon Administrative Rules. SFDNP provides food vouchers for low-income seniors. These rules describe the scope of the program as well as its eligibility requirements and timeframes.

Rule 461-110-0750 is being amended to clarify that persons requesting benefits must meet all nonfinancial requirements, resource limits, and income limits to be included in the benefit group and to remove conditions for OHP-OPU clients regarding inclusion or exclusion from the benefit group.

Rule 461-135-1100 is being amended to include the requirement that premiums be paid in accordance with Rule 461-135-1120 as a condition of eligibility for the Oregon Health Plan (OHP) Standard program and to clarify that not all eligibility requirements are covered in this rule.

Rule 461-135-1120 is being amended to exempt — from the requirement to pay premiums and to cancel any unpaid premiums — clients in a need group: whose countable income assigned to the budget month at certification or recertification is 10% or less of the federal poverty level; formed when an OHP client leaves the filing group if the countable income assigned to the budget month from the current certification for the new need group(s) is 10% or less of the federal poverty level; or formed when two OHP households are combined if the countable income assigned to the budget month from the

current certification for the new need group is 10% or less of the federal poverty level. Rule 461-135-1120 is also being amended to indicate that a client who is required to pay premiums will not be disenrolled from OHP Standard during their certification period for past due premiums; indicate that all past due premiums must be paid before a filing group can establish a new certification period; remove the disqualification provision for clients who fail to pay required premiums on time; remove the ADA accommodation for late payment of premiums; and add language regarding the cancellation of arrearages.

Rule 461-135-1130 — which establishes criteria for disqualification from receiving OHP (Oregon Health Plan) benefits for failure to pay premiums on time — is being repealed. A client will no longer be subject to disqualification for failure to pay premiums on time in the OHP Standard program. Sections 3 and 4 of this rule address cancellation of arrearages and are being moved to OAR 461-135-1120.

Rule 461-155-0235 is being amended to eliminate premiums for some OHP (Oregon Health Plan) benefit groups.

Rules Coordinator: Annette Tesch—(503) 945-6067

461-001-0010
Notice of Rulemaking

See the current version of OAR 407-001-0000 and 407-001-0005 which apply to notices of rulemaking for rules in Chapter 461.

Stat. Auth.: ORS 183.341, 411.060 & 418.100
Stats. Implemented: ORS 183.341, 411.060 & 418.100
Hist.: AFS 37-1995, f. 11-28-95, cert. ef. 12-1-95; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 8-2006, f. & cert. ef. 6-1-06

461-101-0010
Program Acronyms and Overview

(1) Acronyms are used when referring to each program (except Assessment and Repatriate). There is an acronym for each umbrella program (for instance, ERDC) and acronyms for each subprogram (for instance, ERDC-SBG).

(2) When no program acronym appears in a rule in chapter 461 of these rules, the rule with no program acronym applies to all programs listed in this rule. If a rule does not apply to all programs, the rule uses program acronyms to identify the programs to which the rule applies.

(3) Wherever an umbrella acronym appears, that means the rule covers all the subprograms under that code (for instance, OSIP means OSIP-AB, OSIP-AD, and OSIP-OAA).

(4) ADC; Aid to Dependent Children. Financial aid to low-income families when children are deprived of parental support because of continued absence, death, incapacity, or unemployment. When used alone, ADC refers to all ADC programs. Use of the acronym, ADC, which stands for Aid to Dependent Children, and use of the phrase, Aid to Dependent Children, refer to the state's Temporary Assistance for Needy Families Program, and its acronym, TANF. The following codes are used for ADC subprograms:

(a) ADC-BAS; Aid to Dependent Children - Basic (includes eligibility based on continued absence, death, incapacity, or unemployment). ADC with deprivation based on unemployment is also denoted by ADC-BAS/UN.

(b) EA; Aid to Dependent Children - Emergency Assistance. Emergency cash to families without the resources to meet emergent needs.

(5) ADCM; Aid to Dependent Children Medical. Medical aid to low-income families when children are deprived of parental support, as for ADC. Use of the acronym ADCM, which stands for Aid to Dependent Children Medical, and use of the phrase Aid to Dependent Children Medical refer to EXT, MAA, MAF, and SAC programs. When used alone, ADCM refers to all ADC-related medical programs. The following codes are used for ADCM subprograms:

(a) ADCM-BAS; Aid to Dependent Children Medical — Basic.

(b) ADCM-EXT; Aid to Dependent Children Medical — Extended. ADCM-EXT provides extended medical benefits to families after their ADC benefits end.

(c) ADCM-SAC; Aid to Dependent Children Medical — Substitute or Adoptive Care. ADCM-SAC gives medical coverage to children in substitute or adoptive care.

(6) The Assessment Program is an up-front assessment and resource-search program for TANF applicant families. The intent of the program is to convey the message that TANF is primarily a self-sufficiency development program and to help individuals find employment or other alternatives before they become dependent on public assistance.

(7) BCCM; Breast and Cervical Cancer Medical program.

(8) CAWEM; Citizen/Alien — Waived Emergent Medical. Medicaid coverage of emergent medical needs for clients who are not eligible for other medical programs solely because they do not meet citizenship and alien status requirements.

(9) ERDC; Employment- or Education-Related Day Care. Helps low-income families pay the cost of child care. When used alone, ERDC refers to all ERDC programs. The following codes are used for ERDC subprograms:

(a) ERDC-BAS; ERDC — Basic. Child care for working families.

(b) ERDC-SBG; ERDC — Student Block Grant. Child care for students.

(10) EXT; Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the Assessment Program, MAA, or MAF due to an increase in their child support or earned income.

(11) FS; Food Stamps. Helps low-income households maintain proper nutrition by giving them the means to purchase food.

(12) GA; General Assistance. Cash assistance to low-income individuals with disabilities who do not have dependent children.

(13) GAM; General Assistance Medical. Medical assistance to clients who are eligible for the GA program but have not been found eligible for OSIPM benefits.

(14) HSP; Housing Stabilization Program. A program that helps low-income families obtain stable housing. The program is operated through the Housing and Community Services Department through community-based, service-provider agencies. The Department's rules for the program (OAR 461-135-1305 to 1335) were repealed July 1, 2001.

(15) JOBS; Job Opportunities and Basic Skills. An employment program for REF, REFM, and TANF clients. JOBS helps these clients attain self-sufficiency through training and employment. The program is part of Welfare Reform.

(16) JOBS Plus. Provides subsidized jobs rather than FS or TANF benefits. For TANF clients, JOBS Plus is a component of the JOBS Program; for FS clients and noncustodial parents of children receiving TANF, it is a separate employment program. Eligibility for TANF clients, FS clients, and noncustodial parents of children receiving TANF is determined by the Department. Eligibility for UI recipients is determined by the Oregon State Employment Department. When used alone, JOBS Plus includes only clients whose JOBS Plus program participation is through the Department of Human Services. JOBS Plus administered through the Oregon State Employment Department is known in chapter 461 of the Oregon Administrative Rules as Oregon Employment Department UI JOBS Plus. The following acronyms are used for specific categories:

(a) ADC-PLS; Clients eligible for JOBS Plus based on TANF.

(b) FS-PLS; Clients eligible for JOBS Plus based on FS.

(c) NCP-PLS; Noncustodial parents of children receiving TANF.

(17) LIS; Low-Income Subsidy. The Low-Income Subsidy program is a federal assistance program for Medicare clients who are eligible for extra help meeting their Medicare Part D prescription drug costs.

(18) MAA; Medical Assistance Assumed. The Medical Assistance Assumed program provides medical assistance to people who are eligible for the Assessment Program or ongoing TANF benefits.

(19) MAF; Medical Assistance to Families. The Medical Assistance to Families program provides medical assistance to people who are ineligible for MAA but are eligible for Medicaid using ADC program standards and methodologies that were in effect as of July 16, 1996.

(20) OFSET. The Oregon Food Stamp Employment Transition Program, which helps FS recipients find employment. This program is mandatory for some FS recipients.

(21) OHP; Oregon Health Plan. The Oregon Health Plan Program provides medical assistance to many low-income individuals and families. The program includes five categories of people who may qualify for benefits. The acronyms for these categories are:

(a) OHP-OPU; Adults. OHP coverage for adults who qualify under the 100 percent income standard. A person eligible under OHP-OPU is referred to as a health plan new/noncategorical (HPN) client.

(b) OHP-OPC; Children. OHP coverage for children who qualify under the 100 percent income standard.

(c) OHP-OP6; Children Under 6. OHP coverage for children under age 6 who qualify under the 133 percent income standard.

(d) OHP-OPP; Pregnant Females and their newborn children. OHP coverage for pregnant females who qualify under the 185 percent income standard and their newborn children.

(e) OHP-CHP; Persons Under 19. OHP coverage for persons under age 19 who qualify under the 185 percent income standard for medical assistance authorized by the Children's Health Insurance Program (CHIP) provision of the 1997 Balanced Budget Act.

(22) OSIP; Oregon Supplemental Income Program. Cash supplements and special need payments to persons who are blind, disabled, or 65 years of age or older. When used alone, OSIP refers to all OSIP programs. The following acronyms are used for OSIP subprograms:

(a) OSIP-AB; Oregon Supplemental Income Program — Aid to the Blind.

(b) OSIP-AD; Oregon Supplemental Income Program — Aid to the Disabled.

(c) OSIP-EPD; Oregon Supplemental Income Program — Employed Persons with Disabilities program. This program provides Medicaid coverage for employed persons with disabilities with adjusted income less than 250 percent of the Federal Poverty Level.

(d) OSIP-OAA; Oregon Supplemental Income Program — Old Age Assistance.

(23) OSIPM; Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals. When used alone, OSIPM refers to all OSIP-related medical programs. The following codes are used for OSIPM subprograms:

(a) OSIPM-AB; Oregon Supplemental Income Program Medical — Aid to the Blind.

(b) OSIPM-AD; Oregon Supplemental Income Program Medical — Aid to the Disabled.

(c) OSIPM-EPD; Oregon Supplemental Income Program Medical — Employed Persons with Disabilities program. This program provides Medicaid coverage for employed persons with disabilities with adjusted income less than 250 percent of the Federal Poverty Level.

(d) OSIPM-OAA; Oregon Supplemental Income Program Medical — Old Age Assistance.

(e) OSIPM-IC; Oregon Supplemental Income Program Medical — Independent Choices

(24) QMB; Qualified Medicare Beneficiaries. Additional medical coverage for Medicare recipients. When used alone, QMB refers to all QMB programs. The following codes are used for QMB subprograms:

(a) QMB-BAS; Qualified Medicare Beneficiaries — Basic. The basic QMB program.

(b) QMB-DW; Qualified Medicare Beneficiaries — Disabled Worker. Payment of the Medicare Part A premium for people under age 65 who have lost eligibility for Social Security disability benefits because they have become substantially gainfully employed.

(c) QMB-SMB; Qualified Medicare Beneficiaries — Special Medicare Beneficiary. Payment of all or a portion of the Medicare Part B premium only. There are no medical benefits available through QMB-SMB.

(25) REF; Refugee Assistance. Cash assistance to low-income refugee singles or married couples without children.

(26) REFM or REFM-BAS; Refugee Assistance Medical — Basic. Medical coverage for low-income refugees.

(27) The Repatriate Program helps Americans resettle in the United States if they have left a foreign land because of an emergency situation.

(28) SAC; Medical Coverage for Children in Substitute or Adoptive Care.

(29) Senior Prescription Drug Assistance Program; provides that people 65 years of age or older can purchase prescription drugs at the Medicaid price.

(30) SFDNP; Senior Farm Direct Nutrition Program. Food vouchers for low income seniors. Funded by a grant from the United States Department of Agriculture.

(31) TA-DVS; Temporary Assistance for Domestic Violence Survivors. Addresses the needs of clients threatened by domestic violence.

(32) TANF; Temporary Assistance for Needy Families. Cash assistance for families when children in those families are deprived of parental support because of continued absence, death, incapacity, or unemployment. Cash assistance used to be known as ADC.

Stat. Auth.: ORS 411.060, 411.816 & 414.342

Stats. Implemented: ORS 411.060, 411.816 & 414.342

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 12-1990, f. 3-30-90, cert. ef. 4-1-90; AFS 16-1990, f. 6-29-90, cert. ef. 7-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 35-1992, f. 12-31-92, cert. ef. 1-1-93; AFS 16-1993, f. & cert. ef. 9-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 17-1996, f. 4-29-96, cert. ef. 5-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; 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 17-1998, f. & cert. ef. 10-1-98; AFS 25-1998, f. 12-18-98, cert. ef. 1-1-99; AFS 1-1999(Temp), f. & cert. ef. 2-1-99 thru 7-31-99; AFS 7-1999, f. 4-27-99, cert. ef. 5-1-99; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 11-2001, f. 6-29-01, cert. ef. 7-1-01; AFS 17-2001(Temp), f. 8-31-01, cert. ef. 9-1-01 thru 9-30-01; AFS 22-2001, f. & cert. ef. 10-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 7-2003, f. & cert. ef. 4-1-03; 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 17-2004, f. & cert. ef. 7-1-04; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 8-2006, f. & cert. ef. 6-1-06

461-110-0750
Benefit Group

(1) Except as provided in section (2) of this rule, for people not assumed eligible (see OAR 461-135-0010), the benefit group consists of the people from the need group requesting benefits who:

(a) Meet all nonfinancial eligibility requirements;

(b) Have resources below the resource limit; and

(c) Have income below the Income Limits/Payment Standards.

(2) In the GA and GAM programs, the following persons are not in the benefit group:

(a) A person receiving or deemed to be receiving SSI or SSDI benefits.

(b) A person who meets the non-disability eligibility requirements under Title II of the Social Security Act.

(3) For people assumed eligible (see OAR 461-135-0010), the benefit group consists of the people who are in the benefit group of the program used to assume eligibility.

Stat. Auth.: ORS 411.060, 411.816 & 418.100

Stats. Implemented: ORS 411.060, 411.816 & 418.100

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; 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 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 8-2006, f. & cert. ef. 6-1-06

461-135-1100
Specific Requirements; OHP

In addition to eligibility requirements applicable to the OHP program in other rules in chapter 461 of the Oregon Administrative Rules, this rule sets out specific eligibility requirements for the OHP program.

(1) For purposes of this rule, the *term private major medical health insurance* refers to health insurance coverage that provides medical care for physician and hospital services, including major illnesses, with a limit of not less than $10,000 for each covered individual. This term does not include coverage under the Kaiser Child Health Program.

(2) To be eligible for OHP, a person cannot:

(a) Be receiving, or deemed to be receiving, SSI benefits;

(b) Be eligible for Medicare, except that this requirement does not apply to OHP-OPP;

(c) Be receiving Medicaid through another program; or

(d) Be enrolled in a health insurance plan subsidized by the Family Health Insurance Assistance program (FHIAP, see ORS 735.720 to 735.740).

(3) To be eligible for the OHP-OPU program, a person must be 19 years of age or older and must not be pregnant. A person eligible for OHP-OPU is referred to as a health plan new/noncategorical (HPN) client. In addition to all other OHP eligibility requirements, an HPN client:

(a) Must not be covered by private major medical health insurance and must not have been covered by private major medical health insurance during the six months preceding the effective date for starting medical benefits. The six-month waiting period is waived if:

(A) The person has a condition that, without treatment, would be life-threatening or would cause permanent loss of function or disability;

(B) The person's private health insurance premium was reimbursed under the provisions of OAR 461-135-0990;

(C) The person's private health insurance premium was subsidized through FHIAP and the client did not voluntarily end the insurance coverage; or

(D) A member of the person's filing group was a victim of domestic violence.

(b) Must meet the following eligibility requirements:

(A) The resource limit provided in OAR 461-160-0015.

(B) The higher education student requirements provided in OAR 461-135-1110.

(C) Payment of premiums determined in accordance with OAR 461-155-0235 and paid in accordance with OAR 461-135-1120.

(D) Selection of a medical, dental and mental health managed health care plan (MHCP) or primary care case manager (PCCM) if available, unless the HPN client is exempted by OAR 410-141-0060.

(E) The requirements in OAR 461-120-0345 related to obtaining medical coverage for members of the benefit group through the Family Health Insurance Assistance Program (FHIAP), if applicable.

(4) To be eligible for the OHP-OPC program, a person must be less than 19 years of age.

(5) To be eligible for the OHP-OP6 program, a child must be less than six years of age and not eligible for OHP-OPC.

(6) To be eligible for the OHP-OPP program, a person must be pregnant or must be a newborn assumed eligible under OAR 461-135-0010(4).

(7) To be eligible for the OHP-CHP program, a person must be under 19 years of age and must:

(a) Not be eligible for OHP-OPC, OHP-OPP or OHP-OP6;

(b) Meet the resource limit provided in OAR 461-160-0015;

(c) Meet budgeting requirements of OAR 461-160-0700;

(d) Select a medical, dental and mental health managed health care plan (MHCP) or primary care case manager (PCCM) if available, unless the client is exempted by OAR 410-141-0060; and

(e) Not be covered by private major medical health insurance or by any private major medical health insurance during the preceding six months. The six-month waiting period is waived if:

(A) The person has a condition that, without treatment, would be life-threatening or cause permanent loss of function or disability;

(B) The person's private health insurance premium was reimbursed under OAR 461-135-0990;

(C) The person's private health insurance premium was subsidized by FHIAP; or

(D) A member of the person's filing group was a victim of domestic violence.

(8) A child who becomes ineligible for OHP because of age while receiving in-patient medical services remains eligible until the end of the month in which he or she no longer receives those services if he or she is receiving in-patient medical services on the last day of the month in which the age requirement is no longer met.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
Hist.: AFS 2-1994, f. & cert. ef. 2-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 41-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 27-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 36-1996, f. 10-31-96, cert. ef. 11-1-96; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 8-2006, f. & cert. ef. 6-1-06

461-135-1120
Premium Requirement; OHP-OPU

In the OHP-OPU program, a monthly premium must be paid when the benefit group includes at least one non-exempt (HPN) client (see OAR 461-135-1100) as follows:

(1) The following HPNs are exempt from the premium requirement:

(a) Members of a federally recognized Indian tribe, band, or group.

(b) Eskimos, Aleuts, and other Alaska natives enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act.

(c) Persons eligible for benefits through an Indian Health Program.

(d) Clients who are eligible for the CAWEM program (see OAR 461-135-1070).

(e) Persons in need groups with countable income that is 10 percent or less of the federal poverty level in any of the following situations:

(A) Using income assigned to the budget month at certification or recertification;

(B) Using income assigned to the budget month from the current certification for the need group(s) formed when an HPN client leaves the filing group;

(C) Using income assigned to the budget month from the current certification when OHP cases are combined.

(2) The amount of the premium is determined in accordance with OAR 461-155-0235.

(3) All non-exempt clients in the benefit group are responsible for payment of premiums.

(4) Once the amount of the premium is established, the amount will not change during the certification period unless:

(a) An HPN client becomes pregnant.

(b) An HPN client becomes eligible for another program (for example, MAA or OSIPM).

(c) An HPN client leaves the filing group.

(d) OHP cases are combined during their certification periods.

(e) An HPN client's exemption status changes.

(f) An HPN client is no longer a member of the benefit group.

(5) For premiums billed on or after February 1, 2004, a premium is considered paid on time when the payment is received by the Oregon Health Plan billing office on or before the 20th of the month for which the premium was billed. The day the payment arrives in the office's post office box is the date it is received. A premium not paid on time is past due. A client will not be disenrolled during their certification period for past due premiums. All past due premiums for a filing group must be paid before a client can establish a new certification period.

(6) For any billed premium, the arrearage is cancelled if the applicant is otherwise eligible for OHP and:

(a) The arrearage was incurred while the client was exempt from the requirement to pay a premium; or

(b) The applicant is exempt from the requirement to pay premiums under subsection (1)(e) of this rule.

(7) Any premium arrearage over three years old is cancelled.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
Hist.: AFS 19-1997, f. & cert. ef. 10-1-97; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; Administrative correction 2-23-99; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 19-2003(Temp), f. & cert. ef. 7-1-03 thru 9-30-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 3-2004(Temp), f. & cert. ef. 2-19-04 thru 6-30-04; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 8-2006, f. & cert. ef. 6-1-06

461-135-1175
Senior Farm Direct Nutrition Program

(1) The Senior Farm Direct Nutrition Program (SFDNP) provides food vouchers for low income seniors.

(2) An individual age 60 or over is eligible for SFDNP if the individual meets all of the following eligibility criteria on April 1 of the calendar year in which benefits are sought:

(a) Has income at or below 135% of the Federal Poverty Level as described in OAR 461-155-0295.

(b) Receives Medicaid or Food Stamp benefits.

(c) Resides in their own home or rental property.

(3) This program is funded by a grant from the United States Department of Agriculture. The voucher amount will be determined on a year-to-year basis, based on the grant allocation received and the number of eligible seniors.

(4) The program begins June 1 each year and ends on October 31 each year.

(5) This benefit will not affect the benefits in any other program under this chapter of rules (see OAR 461-145-0190).

Stat. Auth.: ORS 409.050, 410.070, 411.060, 411.070
Stats. Implemented: ORS 410.070, 411.060, 411.070
Hist.: SSP 8-2006, f. & cert. ef. 6-1-06

461-155-0235
OHP Premium Standards

In the OHP program, the following steps are followed to determine the amount of the monthly premium for the filing group:

(1) The number of persons in the OHP need group is determined in accordance with OAR 461-110-0630.

(2) The financial group's countable income is determined in accordance with OAR 461-150-0055 and 461-160-0700.

(3) Based on the number in the need group and the countable income, the monthly premium for each non-exempt OHP-OPU client in the benefit group is determined from the following table: [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060 & 411.070
Hist.: AFS 35-1995, f. 11-28-95, cert. ef. 12-1-95; AFS 22-1996, f. 5-30-96, cert. ef. 6-1-96; AFS 5-1997, f. 4-30-97, cert. ef. 5-1-97; AFS 6-1998(Temp), f. 3-30-98, cert. ef. 4-1-98 thru 5-31-98; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 3-1999, f. 3-31-99, cert. ef. 4-1-99; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 6-2003(Temp), f. 2-26-03, cert. ef. 3-1-03 thru 6-30-03; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 5-2004(Temp), f. & cert. ef. 3-1-04 thru 3-31-04; SSP 8-2004, f. & cert. ef. 4-1-04; SSP 2-2005, f. & cert. ef. 2-18-05; SSP 1-2006, f. & cert. ef. 1-24-06; SSP 8-2006, f. & cert. ef. 6-1-06

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Rule Caption: Changing OARs affecting public assistance, medical assistance or food stamp clients.
Adm. Order No.: SSP 9-2006(Temp)
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 6-1-06 thru 9-30-06
Notice Publication Date:
Rules Amended: 461-115-0530, 461-170-0130, 461-180-0085
Subject: OAR 461-115-0530 is being amended to state that the certification period for the Children's Health Insurance Program (CHIP or OHP-CHP) is 12 months. The certification period is the period for which a client is certified eligible for the program. Previously, the certification period was set at 6 months.

OAR 461-170-0130 is being amended to state that when an Oregon Health Plan (OHP) client, who is required to report a change in circumstances, makes a timely report of change that could reduce or end medical benefits, the Department must review the filing group for eligibility for other medical programs prior to reducing or end-

ing medical benefits. If additional information is needed to act on the reported change by the OHP client, the benefit group remains eligible from the date the change was reported until the Department determines eligibility in accordance with application processing time frames.

OAR 461-180-0085 is being amended to state that when the Department initiates a redetermination of eligibility for the Oregon Health Plan (OHP), the filing group must be reviewed for eligibility for other medical programs prior to reducing or ending medical benefits. If additional information is needed to redetermine eligibility, the benefit group remains eligible from the date the review is initiated until the Department determines eligibility in accordance with application processing time frames.

Rules Coordinator: Annette Tesch—(503) 945-6067

461-115-0530

Certification Period; OHP

(1) The OHP certification period is the period for which a client is certified eligible for the program.

(2) For an OHP applicant (except OHP-CHP) not currently receiving BCCM, EXT, MAA, MAF, OHP, OSIPM, REFM, or SAC benefits, the initial OHP certification period begins on the effective date for starting medical benefits (described in OAR 461-180-0090) and includes the following six calendar months. All other OHP certification periods (except OHP-CHP) are for six months.

(3) For an OHP-CHP applicant not currently receiving BCCM, EXT, MAA, MAF, OHP, OSIPM, REFM, or SAC benefits, the initial OHP-CHP certification period begins on the effective date for starting medical benefits (described in OAR 461-180-0090) and includes the following twelve calendar months. All other OHP-CHP certification periods are for twelve months.

(4) A client's OHP benefits end before the end of the certification period if the client no longer meets the program eligibility requirements or the program ends.

(5) To establish a new certification period, an OHP benefit group must complete a redetermination of eligibility and be found eligible.

(6) When a person wishes to be added to an OHP benefit group already certified for OHP, the entire group must establish a new certification period. If, as a result of the new redetermination process, the new filing group is ineligible, the original benefit group remains eligible for the remainder of its certification period.

(7) If a member leaves an OHP benefit group, that individual and other members of the benefit group remain eligible for the remainder of the certification period.

(8) If a current OHP client moves into another current OHP filing group, that client and the members of that filing group who are OHP-eligible are combined into one benefit group if the client is required to be in the current household's OHP filing group. The certification period for the new benefit group ends the later of the date the current client's certification period or the filing group's period was set to end.

(9) A pregnant woman found eligible for the OHP-OPP program is not assigned a certification period — she is eligible for the period described in OAR 461-135-0010.

Stat. Auth.: ORS 409.050 & 411.060
Stats. Implemented: ORS 409.050, 411.060
Hist.: AFS 2-1994, f. & cert. ef. 2-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; AFS 22-2001, f. & cert. ef. 10-1-01; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 5-2003, f. 2-26-03, cert. ef. 3-1-03; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 6-2006, f. 3-31-06, cert. ef. 4-1-06; SSP 9-2006(Temp), f. & cert. ef. 6-1-06 thru 9-30-06

461-170-0130

Acting on Reported Changes; EXT, GAM, MAA, MAF, OSIPM, SAC

(1) When an EXT, GAM, MAA, MAF, OHP, OSIPM, or SAC client, who is required by this division of rules to report a change in circumstances, makes a timely report of a change that could reduce or end medical benefits, the Department must review the filing group for other medical program eligibility prior to reducing or ending medical benefits.

(2) If the Department needs additional information to act on the timely reported change, the benefit group remains eligible from the date the change was reported until the Department determines eligibility in accordance with the application processing time frames in OAR 461-115-0190.

Stat. Auth.: ORS 409.050 & 411.060
Stats. Implemented: ORS 409.050, 411.060
Hist.: SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 9-2006(Temp), f. & cert. ef. 6-1-06 thru 9-30-06

461-180-0085

Effective Dates; Redeterminations of EXT, GAM, MAA, MAF, OSIPM, SAC

In the EXT, GAM, MAA, MAF, OHP, OSIPM, and SAC programs, when the Department initiates a redetermination of eligibility, the Department must review the filing group for other medical program eligibility prior to reducing or ending medical benefits. If additional information is needed to redetermine eligibility, the benefit group remains eligible from the date the review is initiated until the Department determines eligibility in accordance with the application processing time frames in OAR 461-115-0190.

Stat. Auth.: ORS 409.050 & 411.060
Stats. Implemented: ORS 411.060
Hist.: SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 9-2006(Temp), f. & cert. ef. 6-1-06 thru 9-30-06

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

Rule Caption: Clarifying Definitions, Activities of Daily Living, and Service Assessment Policies, termination waivered service eligibility for TANF.

Adm. Order No.: SPD 19-2006

Filed with Sec. of State: 5-26-2006

Certified to be Effective: 6-1-06

Notice Publication Date: 5-1-06

Rules Adopted: 411-015-0006, 411-015-0008

Rules Amended: 411-015-0000, 411-015-0005, 411-015-0010, 411-015-0015, 411-015-0100

Subject: All rules are amended as appropriate to reflect language changes that are more person-centered. The standards for assessing assistance needs in Activities of Daily living have been removed from the Definitions rule OAR 411-015-0005 and established in a new rule for Activities of Daily Living. The criteria for assistance and full assistance in Activities of Daily Living, which underlies the service priority levels, has not changed. Another new rule was added to address standards for service assessment and re-assessments of new applicants and eligible individuals. In accordance with HB 3268, this rule gives individuals a voice in some of the logistics of assessments and requires SPD to send a notice of the need for a service re-assessment at least 14 days in advance of the re-assessment. Other changes were made to clarify and increase consistency in language and terms used across rules and to add references to relevant rules. These changes are necessary to assist staff to improve the consistency and quality of service assessments. Language allowing individuals on TANF to receive waivered services through SPD has been eliminated. Eligibility for individuals with natural supports who meet all of the individual's service needs has been clarified to be consistent with the program purpose specified in OAR 411-015-0000.

Rules Coordinator: Lisa Richards—(503) 945-6398

411-015-0000

Purpose

The purpose of establishing priorities for persons to be served is to assist the Department in addressing the following goals:

(1) To enable persons eligible for and receiving services to remain in the least restrictive and least costly setting consistent with their service needs; and

(2) To serve those persons who are the most functionally impaired and who have no or inadequate alternative service resources; and

(3) To assure access to services paid by the Department to eligible persons; and

(4) To assure that services paid by the Department, and the setting in which they are provided are safe and adequate; and

(5) To manage limited resources to enable the greatest possible number of persons to receive needed services through a priority system based on the Department's assessment of the individual's functional impairment and alternative service resources.

Stat. Auth.: ORS 410
Stats. Implemented: ORS 410.070
Hist.: SSD 3-1985, f. & ef. 4-1-85; SSD 5-1986, f. & ef. 4-14-86; SSD 9-1986, f. & ef. 7-1-86; SSD 12-1987, f. 12-31-87, cert. ef. 1-1-88; SSD 12-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 21-1991, f. 12-31-91, cert. ef. 1-1-92, Former (2)(a) - (l) Renumbered to 411-015-0005; Former (3) renumbered to 411-015-0010; Former (4) Renumbered to 411-015-0015;

SDSD 11-2002(Temp), f. 12-5-02, cert. ef. 12-6-02 thru 6-3-03; SPD 12-2003, f. 5-30-03, cert. ef. 6-4-03; SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06

411-015-0005
Definitions

(1) "All phases" means each part of an activity.

(2) "Alternative Service Resources" means other possible resources for the provision of services to meet the individual's needs. This includes, but is not limited to, natural supports (relatives, friends, significant others, roommates, neighbors or the community), Risk Intervention services, Older Americans Act programs, or other community supports. Alternative Service Resources are not paid by Medicaid.

(3) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet the specific service need of the eligible individual.

(4) "Area Agency on Aging (AAA)" means the Department of Human Services (DHS) designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors and possibly individuals with disabilities in a planning and service area. For purposes of these rules, the term Area Agency on Aging (AAA) is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 through 410.300.

(5) "Assistance Types" needed for activities of daily living and instrumental activities of daily living include, but are not limited to the following terms:

(a) "Cueing" means giving verbal or visual clues during the activity to help the individual complete activities without hands-on assistance.

(b) "Hands-on" means a provider physically performs all or parts of an activity because the individual is unable to do so.

(c) "Monitoring" means a provider must observe the individual to determine if intervention is needed.

(d) "Reassurance" means to offer encouragement and support.

(e) "Redirection" means to divert the individual to another more appropriate activity.

(f) "Set-up" means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.

(g) "Stand-by" means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

(h) "Support" means to enhance the environment to enable the individual to be as independent as possible.

(6) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living (ADL). This definition includes the use of service animals, general household items or furniture to assist the individual.

(7) "Behavioral Care plan" means a documented set of procedures, reviewed by the Department or AAA representative, which describes interventions for use by the provider to prevent, mitigate or respond to behavioral symptoms that negatively impact the health and safety of an individual or others in the home or care setting. The preferences of the individual should be included in developing the plan.

(8) "Business days and hours" means Monday through Friday and excludes Saturdays, Sundays and state or federal holidays. Hours are from 8:00 AM to 5:00 PM.

(9) "Care setting" means a Medicaid contracted facility at which the Medicaid eligible individual resides and receives services. Care settings are adult foster homes, residential care facilities, assisted living facilities, specialized living contracted residences and nursing facilities.

(10) "Case Manager" means an SPD/AAA employee who assesses the service needs of an applicant or eligible individual, determines eligibility and offers service choices to eligible individuals. The Case Manager authorizes and implements the service plan and monitors the services delivered.

(11) "Client Assessment and Planning System (CA/PS)" is a single entry data system used for completing a comprehensive and holistic assessment, surveying the individual's physical, mental, and social functioning, and identifying risk factors, individual choices and preferences, and the status of service needs. The CA/PS documents the level of need and calculates the individual's service priority level in accordance with OAR chapter 411, division 015 rules, calculates the service payment rates, and accommodates client participation in service planning.

(12) "Cost effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices consist of the available services on the published SPD rate schedule, the utilization of assistive devices or architectural modifications and alternative service resources. Less costly alternatives may include resources not paid for by the Department.

(13) "Department" means the Oregon Department of Human Services, (DHS), Seniors and People with Disabilities (SPD).

(14) "Extraordinary circumstances" means:

(a) The individual being assessed is working full time during business hours; or

(b) A family member, whose presence is requested by the individual being assessed, is traveling from outside the area and is available for only a limited period of time which does not include business days and hours.

(15) "Functional Impairment" means an individual's pattern of mental and physical limitations that restricts the individual's ability to perform activities of daily living and instrumental activities of daily living without the assistance of another person.

(16) "Home and Community Based Waivered Services" means services approved for Oregon by the Centers for Medicare and Medicaid Services for seniors and people with physical disabilities in accordance with Sections 1915 (c) and 1115 of Title XIX of the Social Security Act.

(17) "Independent" means the individual does not meet the definition of "Assist" or "Full Assist" when assessing an Activity of Daily Living as defined in OAR 411-015-0006 or, when assessing an Instrumental Activity of Daily Living as defined in OAR 411-015-0007.

(18) "Individual" means the person applying or eligible for services. "Client" is synonymous with individual.

(19) "Mental or Emotional Disorder" means a schizophrenic, mood, paranoid, panic or other anxiety disorder; somatoform, personality, dissociative, factitious, eating, sleeping, impulse control or adjustment disorder or other psychotic disorder, as defined in the Diagnostic and Statistical Manual, published in 1994 by the American Psychiatric Association.

(20) "Natural Supports" or "Natural Support system" means the resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Services provided by natural supports are resources not paid for by the Department. Exceptions are permitted in the Independent Choices Program defined in OAR chapter 411, division 036, at service re-assessments only.

(21) "Seniors and People with Disabilities (SPD)" means the part of the Department of Human Services responsible for the administration of programs to seniors and people with physical disabilities. Many of the services are provided to individuals through local Area Agency on Aging (AAA) and disability (AAAD) offices.

(22) "Service Priority Level (SPL)" means the order in which Department and AAA staff identifies individuals eligible for Nursing Facility or Home and Community Based Waivered Services programs, Spousal Pay Program and Oregon Project Independence. A lower service priority level number indicates greater or more severe functional impairment. The number is synonymous with the service priority level.

(23) "Substance abuse related disorders" means disorders related to the taking of a drug or toxin of abuse (including alcohol) and the side effects of medication. These disorders include substance dependency and substance abuse, alcohol dependency and alcohol abuse, substance induced disorders and alcohol induced disorders as defined in the Diagnostic and Statistical Manual, published in 1994 by the American Psychiatric Association. Substance abuse related disorders are not considered physical disabilities. Dementia or other long term physical or health impairments resulting from substance abuse may be considered physical disabilities.

(24) "Without supports" means lacking the assistance of another person, a care setting and its staff or an alternative service resource defined in OAR 411-015-0005.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.060, 410.070 & 414.065
Hist.: SSD 3-1985, f. & ef. 4-1-85; SSD 5-1986, f. & ef. 4-14-86; SSD 9-1986, f. & ef. 7-1-86; SSD 12-1987, f. 12-31-87, cert. ef. 1-1-88; SSD 12-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 21-1991, f. 12-31-91, cert. ef. 1-1-92, Renumbered from former 411-015-0000(2)(a) - (l); SDSD 11-2002(Temp), f. 12-5-02, cert. ef. 12-6-02 thru 6-3-03; SPD 12-2003, f. 5-30-03, cert. ef. 6-4-03; SPD 16-2003(Temp), f. & cert. ef. 10-27-03 thru 4-23-04; SPD 8-2004, f. & cert. ef. 4-27-04; SPD 19-2005, f. & cert. ef. 12-29-05; SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06

411-015-0006
Activities of Daily Living (ADL)

(1) "Activities of Daily Living (ADL)" means those personal functional activities required by an individual for continued well being which are essential for health and safety. For the purposes of these rules, ADLs consist of eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel and bladder management), and cognition/behavior.

(2) Evaluation of the individual's needs for assistance in Activities of Daily Living is based on:

(a) The individual's abilities rather than the services provided; and

(b) How the individual functioned during the thirty days prior to the assessment date, with consideration of how the person is likely to function in the thirty days following the assessment date; and

(c) Evidence of the actual or predicted need for assistance of another person within the assessment time frame and it can not be based on possible or preventative needs.

(3) "Independent" means the individual does not meet the definition of "Assist" or "Full Assist" for each Activity of Daily Living as defined in this rule.

(4) Bathing/Personal Hygiene. Bathing/Personal Hygiene is comprised of two components. To be considered Assist, the individual must require Assistance in Bathing or Full Assistance in Hygiene. To be considered Full Assist, the individual must require Full Assistance in Bathing:

(a) Bathing means the activities of bathing and washing hair and using assistive devices if needed. Bathing includes the act of getting in and out of the bathtub or shower:

(A) Assist: Even with assistive devices, the individual is unable to accomplish some tasks of bathing without the assistance of another person. This means hands-on assistance for part of the task, cueing during the activity or stand-by presence during the activity.

(B) Full Assist: Even with assistive devices, the individual is unable to accomplish any task of bathing without the assistance of another person. This means the individual needs hands-on assistance of another person through all phases of the activity, every time the activity is attempted.

(b) Personal Hygiene means the activities of shaving and caring for the mouth:

(A) Assist: Even with assistive devices, the individual is unable to accomplish some tasks of personal hygiene activities without the assistance of another person. This means hands-on assistance for part of the task, cueing during the activity or stand-by presence during the activity.

(B) Full Assist: Even with assistive devices, the individual is unable to accomplish personal hygiene activities, without the assistance of another person. This means the individual needs hands-on assistance of another person through all phases of the activity, every time the activity is attempted.

(5) Cognition/Behavior means functions of the brain of adaptation, awareness, judgment/decision-making, memory and orientation. Cognition/Behavior includes three components of behavioral symptoms: demands on others, danger to self or others and wandering:

(a) The individual's ability to manage each component of cognition/behavior is assessed by how the person would function without supports, meaning the assistance of another person, a care setting or an alternative service resource as defined in OAR 411-015-0005. Lack of medication or lack of medication management is not considered when evaluating cognition/behavior.

(b) The assessment time frame in OAR 411-015-0008 of thirty (30) days prior to the date of the assessment may be expanded when assessing cognition/behavior without supports. History or incidents in the past more than 30 days prior to the assessment date may be considered if they negatively impacted health and safety in the past and are also current concerns that need to be addressed.

(c) An individual under age 65 with cognition/behavior assistance or full assistance needs based on a mental or emotional disorder does not meet the criteria for service eligibility per OAR 411-015-0015.

(d) An individual must require assistance in at least three of the eight components of cognition/behaviors to meet the criteria for assist in cognition/behaviors. An individual must require full assistance in three of the eight components to meet the criteria for full assistance in cognition/behaviors.

(A) Adaptation is the ability to respond, cope and adjust to major life changes such as a change in living situation or a loss (such as health, close relationship, pet, divorce or a death):

(i) Assist: The individual requires reassurance from another person to cope with or adjust to change. Assistance involves multiple occurrences less than daily.

(ii) Full Assist: The individual requires constant emotional support and reassurance or is unable to adapt to change. These occurrences are ongoing and daily.

(B) Awareness means the ability to understand basic health and safety needs (such as the need for food, shelter and clothing):

(i) Assist: The individual requires assistance of another person to understand basic health and safety needs.

(ii) Full Assist: The individual does not have the ability to understand those needs and requires ongoing and daily intervention by another person.

(C) Judgment means decision-making. It is the ability to identify choices and understand the benefits, risks and consequences of those choices. Individuals who lack the ability to understand choices or the potential risks and consequences need assistance in decision-making. Judgment/Decision making does not include what others might deem a poor choice:

(i) Assist: At least weekly, the individual needs protection, monitoring and guidance from another person to make decisions.

(ii) Full Assist: The individual's decisions require daily intervention by another person.

(D) Memory means the ability to remember and appropriately use current information, impacting the health and safety of the individual:

(i) Assist: The individual has difficulty remembering and using current information and requires reminding from another person.

(ii) Full Assist: The individual cannot remember or use information and requires assistance beyond reminding.

(E) Orientation means the ability to accurately understand or recognize person or place or time to maintain health and safety:

(i) Assist: The individual is disoriented to person, or place or time and requires the assistance of another person. These occurrences are episodic during the week but less than daily.

(ii) Full Assist: The individual is disoriented daily to person, or place or time and requires the assistance of another person.

(F) Danger to Self or Others means behavioral symptoms, other than wandering, that are hazardous to the individual (including self-injury), or harmful or disruptive to those around the individual:

(i) Assist: At least monthly, the individual is disruptive or aggressive in a non-physical way, agitated, or sexually inappropriate and needs the assistance of another person. These behavioral symptoms are challenging but the individual can be verbally redirected.

(ii) Full Assist: The individual has had more than one episode of aggressive, disruptive, agitated, dangerous, or physically abusive or sexually aggressive behavioral symptoms directed at self or others. These behavioral symptoms are extreme, may be unpredictable, and necessitate intervention beyond verbal redirection, requiring an individualized behavioral care plan (as defined in OAR 411-015-0005) that all staff are trained to deliver.

(G) Demands on Others means behavioral symptoms, other than wandering, that negatively impact and affect living arrangements, providers or other residents:

(i) Assist: The individual's habits and emotional states limit the types of living arrangements and companions, but can be modified with individualized routines, changes to the environment (such as roommates or noise reduction) or general training for the provider that is not specific to the individual.

(ii) Full Assist: The individual's habits and emotional states can be modified only with a 24-hour specialized care setting or an individualized behavioral care plan (as defined in OAR 411-015-0005) that all staff are trained to deliver.

(H) Wandering means moving about aimlessly, or elopement, without relationship to needs or safety:

(i) Assist: The individual wanders within the home or facility, but does not jeopardize safety.

(ii) Full Assist: The individual wanders inside or out and jeopardizes safety.

(6) Dressing/Grooming: This is comprised of two elements. To be considered Assist, the individual must require Assistance in Dressing or Full Assistance in Grooming. To be considered Full Assist the individual must require Full Assistance in Dressing:

(a) Dressing means the activities of dressing and undressing:

(A) Assist: Even with assistive devices, the individual is unable to accomplish some tasks of dressing without the assistance of another person. This means hands-on assistance for part of the task, cueing during the activity, or stand-by presence during the activity.

(B) Full Assist: Even with assistive devices, the individual is unable to accomplish any tasks of dressing without the assistance of another person. This means the individual needs hands-on assistance of another person through all phases of the activity, every time the activity is attempted.

(b) Grooming means nail care and the activities of brushing and combing hair.

(A) Assist: Even with assistive devices, the individual is unable to accomplish some tasks of grooming without the assistance of another person. This means hands-on assistance for part of the task, cueing during the activity, or stand-by presence during the activity.

(B) Full Assist: Even with assistive devices, the individual is unable to perform any tasks of grooming without the assistance of another person. This means the individual needs the assistance of another person through all phases of the activity, every time the activity is attempted.

(7) Eating means the activity of feeding and eating and may include using assistive devices:

(a) Assist: When eating, the individual requires another person to be immediately available and within sight. Assistance requires hands-on feed-

ing, hands-on assistance with special utensils, cueing during the act of eating, or monitoring to prevent choking or aspiration. Assistance with eating is a daily need or can vary if an individual's medical condition fluctuates significantly during a one-month period.

(b) Full Assist: When eating, the individual always requires one-on-one assistance for direct feeding, constant cueing, or to prevent choking or aspiration. This includes nutritional IV or feeding tube set-up by another person. This means the individual needs the assistance of another person through all phases of the activity, every time the activity is attempted.

(8) Elimination: This is comprised of three components. To be considered Assist, the individual must require Assistance in at least one of the three components. To be considered Full Assist the individual must require Full Assist in any of the three components. Dialysis care needs are not assessed as part of elimination:

(a) Bladder means managing bladder care. This includes tasks such as catheter care, toileting schedule, monitoring for infection, ostomy care and changing incontinence supplies.

(A) Assist: Even with assistive devices or supplies, the individual is unable to accomplish some of the tasks of bladder care without the assistance from another person at least monthly.

(B) Full Assist: The individual is unable to manage any part of bladder or catheter care without the assistance of another person. This means the individual needs the assistance of another person through all phases of the activity, every time the activity is attempted.

(b) Bowel means managing bowel care. This includes tasks such as digital stimulation, toileting schedule, suppository insertion, ostomy care, enemas and changing incontinence supplies.

(A) Assist: Even with assistive devices the individual is unable to accomplish some tasks of bowel care without the assistance of another person at least monthly.

(B) Full Assist: The individual is unable to accomplish any part of bowel care without the assistance of another person. This means the individual needs the assistance of another person through all phases of the activity, every time the activity is attempted.

(c) Toileting means the activity of getting to and from, and on and off the toilet (including bedpan, commode or urinal), cleansing after elimination or adjusting clothing, cleaning and maintaining assistive devices, or cleaning the toileting area after elimination because of unsanitary conditions that would pose a health risk. This does not include routine bathroom cleaning.

(A) Assist: Even with assistive devices, the individual is unable to accomplish some tasks of toileting without the assistance of another person at least monthly.

(B) Full Assist: The individual is unable to accomplish any part of toileting without the assistance of another person. This means the individual needs the assistance of another person through all phases of the activity, every time the activity is attempted.

(9) Mobility: This is comprised of two components, Ambulation and Transfer. In the Mobility cluster only, assistance is categorized into three levels. To be considered Minimal Assist, the individual must require Minimal Assistance in Ambulation. To be considered Substantial Assist, the individual must require Substantial Assistance with Ambulation or an Assist with Transfer. To be considered Full Assist, the individual must require Full Assistance with Ambulation or Transfer:

(a) Mobility does not include the following activities: getting in and out of a motor vehicle, getting in or out of a bathtub/shower, moving on or off the toilet, or moving to and from the toilet.

(b) In mobility, for the purposes of this rule, inside the home or care setting means inside the entrance to the client's home or apartment unit or inside the care setting (as defined in OAR 411-015-0005). Courtyards, balconies, stairs or hallways exterior to the doorway of the home or apartment unit that is not within a care setting are not considered inside.

(c) A history of falls with an inability to rise without the assistance of another person or with negative physical health consequences may be considered in assessing ambulation or transfer if occurring within the assessment time frame, Falls previous to the assessment time frame or the need for prevention of falls alone, even if recommended by medical personnel, is not a sufficient qualifier for assistance in ambulation or transfer.

(d) Ambulation means the activity of moving around both inside within the home or care setting and outside, during the assessment time frame while using assistive devices, if needed. Ambulation does not include exercise or physical therapy:

(A) Minimal Assist: Even with assistive devices, if needed, the individual can get around inside his or her home or care setting without the assistance of another person. Outside of the individual's home or care setting, the individual requires the assistance of another person.

(B) Substantial Assist: Even with assistive devices, the individual is unable to ambulate without the assistance of another person inside his or her home or care setting. Even with assistive devices, this assistance may also be needed outside.

(C) Full Assist: Even with assistive devices, the individual is unable to ambulate without the assistance from another person. This means the individual needs the hands-on assistance of another person through all phases of the activity, every time the activity is attempted.

(e) Transfer means the activity of moving to or from a chair, bed or wheelchair using assistive devices, if needed. This assistance must be needed inside the individual's home or care setting:

(A) Assist: Even with assistive devices, the individual is unable to accomplish a transfer without the assistance of another person at least four days during a month.

(B) Full Assist: Even with assistive devices, the individual is unable to transfer and is dependent on one or more other persons to perform the transfer. This means the individual needs the assistance of another person through all phases of the activity, every time the activity is attempted.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06

411-015-0008
Assessments

(1) Assessment. The assessment process will identify the individual's ability to perform activities of daily living, instrumental activities of daily living (self-management tasks), and determine the individual's ability to address health and safety concerns and his or her preferences to meet needs. The case manager will conduct this assessment in accordance with standards of practices established by the Department.

(a) The case manager must assess the individual's abilities regardless of architectural modifications, assistive devices or services provided by care facilities, alternative service resources or other community providers.

(b) The time frame reference for evaluation is how the individual functioned during the thirty days prior to the assessment date, with consideration of how the person is likely to function in the thirty days following the assessment date:

(A) An individual must have demonstrated the need for the assistance of another person within the assessment time frame and expect the need to be on-going beyond the assessment time frame, in order to be eligible.

(B) The time frame for assessing the Cognition/Behavior Activity of Daily Living may be extended as noted in OAR 411-015-0006.

(c) The assessment will be conducted by a case manager or other qualified Department or Area Agency on Aging representative no less than annually, with a standardized assessment tool approved by Seniors and People with Disabilities.

(d) The initial assessment will be conducted face to face in the individual's home or care setting. Annual re-assessments will be conducted face to face in the individual's home or care setting unless there is a compelling reason to meet elsewhere and the individual requests an alternative location. Case Managers are required to visit the individual's home or care setting to complete the re-assessment and identify service plan needs, as well as safety and risk concerns.

(e) Effective July 1, 2006, individuals will be sent a notice of the need for re-assessment a minimum of fourteen (14) days in advance. Re-assessments based on a change in the individual's condition or needs are exempt from the 14-day advance notice requirement.

(f) The individual being assessed may request the presence of natural supports at any assessment.

(g) Assessment times will be scheduled within business days and hours unless extraordinary circumstances necessitate an alternate time. If an alternate time is necessary, the individual must request the after hours appointment and coordinate a mutually acceptable appointment time with the local Department or AAA office.

(2) Service Plan:

(a) The individual being assessed, others identified by the individual, and the case manager will consider the service options as well as assistive devices, architectural modifications, and other alternative service resources as defined in OAR 411-015-0005 to meet the service needs identified in the assessment process.

(b) The case manager has responsibility for determining eligibility for specific services, presenting alternatives to the individual, identifying risks and assessing the cost effectiveness of the plan. The case manager will monitor the plan and make adjustments as needed based on the service needs of the individual.

(c) The eligible individual, or their representative, has the responsibility to choose and assist in developing less costly service alternatives.

(d) The Service Plan payment will be considered full payment for the services rendered under Title XIX. Under no circumstances may any provider demand or receive additional payment for Title XIX-covered services from the eligible individual or any other source.

(3) The applicant or their representative has the responsibility to participate in and provide information necessary to complete assessments and re-assessments within the time frame requested by the Department. Failure to participate in or provide requested assessment or re-assessment information within the application time frame will result in a denial of service eligibility for Nursing Facility, Spousal Pay, Title XIX Home and Community Based waivered and Independent Choices Program services. The Department may allow additional time if there are circumstances beyond the control of the individual or the individual's representative which prevent timely participation or timely submission of information.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06

411-015-0010
Priority of Paid Services

To determine the service priority level, an individual must be found eligible, using the Department's standardized assessment tool, as meeting at least the requirements for Assist or Full Assist in activities of daily living as defined in OAR 411-015-0006, in the following order and as designated in OAR 411-015-0015.

(1) Requires Full Assistance in Mobility, Eating, Elimination, and Cognition.

(2) Requires Full Assistance in Mobility, Eating, and Cognition.

(3) Requires Full Assistance in Mobility, or Cognition, or Eating.

(4) Requires Full Assistance in Elimination.

(5) Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.

(6) Requires Substantial Assistance with Mobility and Assistance with Eating.

(7) Requires Substantial Assistance with Mobility and Assistance with Elimination.

(8) Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination.

(9) Requires Assistance with Eating and Elimination.

(10) Requires Substantial Assistance with Mobility.

(11) Requires Minimal Assistance with Mobility and Assistance with Elimination.

(12) Requires Minimal Assistance with Mobility and Assistance with Eating.

(13) Requires Assistance with Elimination.

(14) Requires Assistance with Eating.

(15) Requires Minimal Assistance with Mobility.

(16) Requires Full Assistance in Bathing or Dressing.

(17) Requires Assistance in Bathing or Dressing.

(18) Independent in the above levels but requires structured living for supervision for complex medical problems or a complex medication regimen.

Stat. Auth.: ORS 410
Stats. Implemented: ORS 410.070
Hist.: SSD 3-1985, f. & ef. 4-1-85; SSD 5-1986, f. & ef. 4-14-86; SSD 9-1986, f. & ef. 7-1-86; SSD 12-1987, f. 12-31-87, cert. ef. 1-1-88; SSD 12-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 21-1991, f. 12-31-91, cert. ef. 1-1-92, Renumbered from former 411-015-0000(3); SDSD 11-2002(Temp), f. 12-5-02, cert. ef. 12-6-02 thru 6-3-03; SPD 12-2003, f. 5-30-03, cert. ef. 6-4-03; SPD 16-2003(Temp), f. & cert. ef. 10-27-03 thru 4-23-04; SPD 8-2004, f. & cert. ef. 4-27-04; SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06

411-015-0015
Current Limitations

The Department has the authority to establish by Administrative Rule service eligibility within which to manage its limited resources. The Department is currently able to serve:

(1) Individuals determined eligible for OSIPM who are assessed as meeting at least one of the service priority levels (1) through (13) as defined in OAR 411-015-0010.

(2) Individuals eligible for Oregon Project Independence funded services if they meet at least one of the service priority levels (1) through (18) of OAR 411-015-0010.

(3) Individuals needing Risk Intervention Services in areas designated to provide such services. Individuals with the lowest service priority level number under OAR 411-015-0010 will be served first.

(4) The following persons:

(a) Individuals sixty-five years of age or older determined eligible for Developmental Disability services or having a primary diagnosis of a mental or emotional disorder are eligible for nursing facility and community based waivered services if they meet sections (1), (2), or (3) of this rule and are not in need of specialized mental health treatment services or other specialized Department residential program intervention as identified through the PASRR process defined in OAR 411-070-0043 or mental health assessment process.

(b) Individuals under sixty-five years of age determined eligible for developmental disability services or having a primary diagnosis of a mental or emotional disorder are not eligible for Department nursing facility services unless determined appropriate through the PASRR process defined in OAR 411-070-0043.

(c) Individuals under sixty-five years of age determined to be eligible for developmental disabilities services are not eligible for Title XIX Home and Community Based Waivered Services paid for under the Department's 1915C Waiver for seniors and people with physical disabilities.

(d) Individuals under sixty-five years of age who have a diagnosis of mental or emotional disorder or substance abuse related disorder are not eligible for Title XIX Home and Community Based Waivered Services paid for under the Department's 1915C Waiver for seniors and people with physical disabilities unless:

(A) They have a medical non-psychiatric diagnosis or physical disability; and

(B) Their need for services is based on their medical non-psychiatric diagnosis or physical disability; and

(C) They provide supporting documentation demonstrating that their need for services is based on the medical, non-psychiatric diagnosis or physical disability. The Department will authorize documentation sources through approved and published policy transmittals.

(5) Title XIX Home and Community Based Waivered Services paid for under the Department's 1915 (c) Waiver are not intended to replace the resources available to a client from their natural support system. Individuals whose service needs are met by their alternative service resources are not eligible for Title XIX Home and Community Based Waivered Services. Services may be authorized only when the alternative service resources are unavailable, insufficient or inadequate to meet the needs of the individual.

(6) Individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and 461-160-0620.

Stat. Auth.: ORS 410.060, 410.070 & 411
Stats. Implemented: ORS 410.070
Hist.: SSD 3-1985, f. & ef. 4-1-85; SSD 5-1986, f. & ef. 4-14-86; SSD 9-1986, f. & ef. 7-1-86; SSD 12-1987, f. 12-31-87, cert. ef. 1-1-88; SSD 12-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 21-1991, f. 12-31-91, cert. ef. 1-1-92, Renumbered from former 411-015-0000(4); SSD 1-1993, f. 3-19-93, cert. ef. 4-1-93; SDSD 11-2002(Temp), f. 12-5-02, cert. ef. 12-6-02 thru 6-3-03; SPD 1-2003(Temp), f. 1-7-03, cert. ef. 2-1-03 thru 6-3-03; SDP 3-2003(Temp), f. 2-14-03, cert. ef. 2-18-03 thru 6-3-03; SPD 5-2003(Temp), f. & cert. ef. 3-12-03 thru 6-3-03; SPD 6-2003(Temp), f. & cert. ef. 3-20-03 thru 6-3-03; SPD 12-2003, f. 5-30-03, cert. ef. 6-4-03; SPD 16-2003(Temp), f. & cert. ef. 10-27-03 thru 4-23-04; SPD 5-2004(Temp), f. & cert. ef. 3-23-04 thru 4-27-04; SPD 8-2004, f. & cert. ef. 4-27-04; SPD 20-2004(Temp), f. & cert. ef. 7-7-04; SPD 29-2004(Temp), f. & cert. ef. 8-6-04 thru 1-3-05; SPD 1-2005, f. & cert. ef. 1-4-05; SPD 8-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06

411-015-0100
Eligibility for Nursing Facility or Community-Based Waivered Services

(1) To be eligible for nursing facility services, Community-based waivered services for aged and physically disabled, Independent Choices, Spousal Pay, or the Program of All-inclusive Care for the Elderly (PACE), a person must:

(a) Be age 18 or older; and

(b) Be eligible for OSIPM; and

(c) Meet the functional impairment level within the service priority levels currently served by Seniors and People with Disabilities as outlined in OAR 411-015-0010 and the requirements in OAR 411-015-0015; or

(d) To be eligible to have services paid through the State Spousal Pay Program, the person must meet requirements as listed above in subsection (a), (b), & (c), and in addition, the requirements in OAR 411-030-0080.

(2) Individuals who are age 17 or younger and reside in a nursing facility are eligible for nursing facility services only. They are not eligible to receive Community-based waivered services, Spousal Pay or Independent Choices program services.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.060, 410.070 & 414.065
Hist.: SSD 7-1991(Temp), f. & cert. ef. 4-1-91; SSD 13-1991, f. 6-28-91, cert. ef. 7-1-91; SDSD 11-2002(Temp), f. 12-5-02, cert. ef. 12-6-02 thru 6-3-03; SPD 1-2003(Temp), f. 1-7-03, cert. ef. 2-1-03 thru 6-3-03; SPD 12-2003, f. 5-30-03, cert. ef. 6-4-03; SPD 17-2003(Temp), f. 10-31-03, cert. ef. 11-1-03 thru 4-28-04; SPD 8-2004, f. & cert. ef. 4-27-04; SPD 29-2004(Temp), f. & cert. ef. 8-6-04 thru 1-3-05; SPD 1-2005, f. & cert. ef. 1-4-05; SPD 19-2005, f. & cert. ef. 12-29-05; SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06

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Rule Caption: Revisions were made to rule definitions eligible living arrangements and authorization of service plan hours.
Adm. Order No.: SPD 20-2006
Filed with Sec. of State: 5-26-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 5-1-06

Rules Adopted: 411-030-0055
Rules Amended: 411-030-0020, 411-030-0033, 411-030-0040, 411-030-0050, 411-030-0070, 411-030-0080, 411-030-0090
Rules Repealed: 411-030-0055(T)
Subject: • Eligible living arrangements for receiving in-home services, including what is considered the client's home;
• Authorization and eligibility for service-plan hours, including exceptions to maximums;
"Live-in paid leave" as opposed to "respite" for Spousal Pay providers;
• Contract agencies do not provide live-in services;
• Service-related transportation includes trips to and from work for EPD eligible individuals;
• General Assistance eligibility and hardship shelter allowances were removed.
Rules Coordinator: Lisa Richards—(503) 945-6398

411-030-0020
Definitions

As used in these rules:

(1) "Activities of Daily Living (ADL)" means those personal, functional activities required by an individual for continued well-being, which are essential for health and safety. Activities consist of Eating, Dressing/Grooming, Bathing/Personal hygiene, Mobility (ambulation and transfer), Elimination (toileting, bowel and bladder management), and Cognition/Behavior as defined in OAR 411-015-0006.

(2) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet a specific service need of the eligible individual.

(3) "Area Agency on Aging (AAA)" means the Department of Human Services (DHS) designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors or people with disabilities in a planning and service area. For purposes of these rules, the term Area Agency on Aging (AAA) is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 through 410.300.

(4) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living (ADL). This definition includes the use of service animals, general household items or furniture to assist the individual.

(5) "Business days" means Monday through Friday and excludes Saturdays, Sundays and state or federal holidays.

(6) "Case Manager" means a Department or AAA employee who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The Case Manager authorizes and implements the Service Plan, and monitors the services delivered.

(7) "Client" or "client-employer" means the individual eligible for in-home support services.

(8) "Client-Employed Provider Program (CEP)" refers to the program wherein the provider is directly employed by the client and provides either hourly or live-in services. In some aspects of the employer-employee relationship, the Department of Human Services acts as an agent for the client-employer. These functions are clearly described in OAR 411-031-0040.

(9) "Contracted In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR 333-536-0000 through 333-536-0095 that provides hourly contracted in-home care to clients of the Department or Area Agency on Aging.

(10) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet a client's service needs. Those choices consist of the available services on the published SPD rate schedule, the utilization of assistive devices, natural supports, architectural modifications and alternative service resources (described in OAR 411-015-0005). Less costly alternatives may include resources not paid for by the Department.

(11) "Department" means the Department of Human Services, Seniors and People with Disabilities (SPD).

(12) "Exception" means an approval for a monthly payment or monthly rate granted to a specific client in their current residence (or in the proposed residence identified in the exception request) that exceeds the monthly rates on the SPD published rate schedule. The approval is based on the exceptional service needs of the client and is contingent upon meeting the requirements in OAR 411-027-0000 and 411-027-0050. The term "exception" is synonymous with "exceptional rate" or "exceptional payment."

(13) "Homecare Worker" means a provider, as described in OAR chapter 411, division 031, who is directly employed by the client and provides either hourly or live-in services to eligible clients. Homecare Workers also include providers in the Spousal Pay Program.

(14) "Hourly Services" means the in-home support services, including activities of daily living and self-management tasks, that are provided at regularly scheduled times.

(15) "In-home support services" means those activities of daily living and self-management tasks that assist an individual to stay in his or her own home.

(16) "Live-In Services" means those Client-Employed Provider Program services provided when a client requires ADL, self-management tasks, and twenty-four hour availability. Time spent by any live-in employee doing self-management and twenty-four hour availability are exempt from federal and state minimum wage and overtime requirements. To ensure continuity of care for the client, live-in Service Plans must include at least one HCW providing 24-hour availability for a minimum of five (5) days in a calendar week.

(17) "Natural Supports" or "Natural Support system" means the resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Services provided by natural supports are resources not paid for by the Department, except as allowed in the Independent Choices Program defined in Oregon Administrative Rules chapter 411, division 036.

(18) "Oregon Project Independence (OPI)" means the program of in-home support services defined in OAR chapter 411, division 032.

(19) "Provider" means the individual who actually renders the service.

(20) "Registered Nurse Plan of Care" means a document completed by an RN identifying the tasks which must be provided to meet the individual's assessed needs.

(21) "Respite", as used in OAR 411-030-0080, means securing a paid temporary replacement worker to perform the authorized duties normally performed by the Spousal Pay Program provider, in order to allow the Spousal Pay Program provider interim relief from providing care to the client.

(22) "Self-Management" or "Instrumental Activities of Daily Living (IADL)" means those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in self-management tasks are identified in OAR 411-015-0007.

(23) "Service Need" means the assistance an individual requires from another person for those functions or activities identified in OAR 411-015-0006 and 411-015-0007.

(24) "Twenty-Four Hour Availability" means the availability and responsibility of an employee to meet Activities of Daily Living and self-management needs of an eligible individual as required by that person over a twenty-four hour period. These services are provided by a live-in employee and are exempt from federal and state minimum wage and overtime requirements.

(25) "Waivered Services" means services provided through Oregon's Medicaid Home and Community-Based Services waiver under the authority of section 1915 (c) and through Oregon's Research and Demonstration program (Independent Choices Program) under the authority of section 1115 (c) of the Social Security Act, which allow the state to provide home and community-based services to eligible individuals in place of nursing facility care. Waivered services include in-home services, residential care facility services, assisted living facility services, adult foster care services, home-delivered meals (when provided in conjunction with in-home services), specialized living services, and adult day services.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070
Hist.: SSD 5-1983, f. 6-7-83, ef. 7-1-83; SSD 3-1985, f. & ef. 4-1-85; SSD 5-1987, f. & ef. 7-1-87; SSD 4-1993, f. 4-30-93, cert. ef. 6-1-93; SSD 6-1994, f. & cert. ef. 11-15-94; SPD 14-2003, f. & cert. ef. 7-31-03; SPD 15-2003 f. & cert. ef. 9-30-03; SPD 18-2003(Temp), f. & cert. ef. 12-11-03 thru 6-7-04; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 18-2005(Temp), f. 12-20-05, cert. ef. 12-21-05 thru 6-1-06; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06

411-030-0033
Program Scope

(1) In-Home Support Services are designed to provide essential supportive services that enable an individual to remain in his or her own home. The services range from assistance with household tasks to assistance with activities of daily living. The extent of the services may vary from a few hours per week to full-time. Live-in services may be an option depending on the program.

(2) In-home support services may be provided through the Home and Community-Based Services waivered In-Home Services Program, Independent Choices Program, the State-funded Spousal Pay Program, or Oregon Project Independence Program.

(3) Permissible In-Home Services Program Living Arrangements

(a) The following terms are used in this rule:

(A) "Informal arrangement" means a paid or unpaid arrangement for shelter or utility costs that does not include the elements of a "property manager's rental agreement" as defined in this rule.

(B) "Property manager's rental agreement" means a payment arrangement for shelter or utility costs with a property owner, property manager or landlord that includes all of the following elements:

(i) The name and contact information for the property manager, landlord, or leaser;

(ii) The period or term of the agreement and method for terminating the agreement;

(iii) The number of tenants or occupants;

(iv) The rental fee and any other charges (such as security deposits);

(v) The frequency of payments (such as monthly);

(vi) What costs are covered by the amount of rent charged (such as shelter, utilities or other expenses); and

(vii) The duties and responsibilities of the property manager and the tenant, such as:

(I) The person responsible for maintenance;

(II) If the property is furnished or unfurnished; and

(III) Advance notice requirements prior to an increase rent

(C) "Provider-owned dwelling" means a dwelling that is owned by the provider or his or her spouse when the provider is proposing to be paid through waivered services. The dwelling does not include the client's name on the property deed, mortgage or title. Such dwellings include, but are not limited to:

(i) Houses, apartments and condominiums;

(ii) A portion of a house such as basement or a garage even when remodeled to be used as a separate dwelling;

(iii) Trailers and mobile homes; or

(iv) Duplexes, unless the structure displays a separate address from the other residential unit and was originally built as a duplex.

(D) "Provider-rented dwelling" means a dwelling that is rented or leased by the provider or his or her spouse when the provider is proposing to be paid through waivered services. The dwelling does not include the name of the client on the property manager's rental agreement.

(b) A client residing in any of the following living arrangements will not be eligible for the Home and Community-Based Services waivered In-Home Services Program:

(A) The client resides in a provider-owned dwelling. Such a setting may meet the requirements for relative adult foster care or limited license adult foster care as described in OAR 411-050-0405.

(B) The client resides in a provider-rented dwelling through an informal arrangement.

(c) If the client's name is added to the property deed, mortgage, title, or property manager's rental agreement (as defined in paragraph (3)(a)(B) of this rule), the client may be considered for waivered in-home services.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070
Hist.: SSD 4-1993, f. 4-30-93, cert. ef. 6-1-93; SPD 14-2003, f. & cert. ef. 7-31-03; SPD 15-2003 f. & cert. ef. 9-30-03; SPD 18-2003(Temp), f. & cert. ef. 12-11-03 thru 6-7-04; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 18-2005(Temp), f. 12-20-05, cert. ef. 12-21-05 thru 6-1-06; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06

411-030-0040
Eligibility Criteria

(1) In-home support services may be provided to those individuals who meet the established priorities for service as described in OAR chapter 411, division 015 and have been assessed to be in need of a service provided in OAR chapter 411, division 030. Payments for in-home support services are not intended to replace the resources available to an individual from their natural support system. Payment by the Department can be considered or authorized only when such resources are not available, not sufficient, or cannot be developed to adequately meet the needs of the individual. An individual whose service needs are met by their natural supports will not be eligible for in-home support services. Service plans will be based upon the least costly means of providing adequate care.

(2) Individuals served under the Home and Community Based Services waivered In-Home Services Program must meet the established priorities for service as described in OAR chapter 411, division 015 and must:

(a) Be current recipients of OSIPM; and

(b) Reside in a living arrangement in which in-home support services may be provided as described in OAR 411-030-0033; and

(c) Be eighteen years of age or older

(3) To be eligible for the Home and Community-Based Services waivered In-Home Services Program, an individual must employ an enrolled Homecare Worker or Contracted In-Home Care Agency to provide those services authorized and paid by the Department.

(a) Initial eligibility for waivered in-home services does not begin until a Service Plan has been authorized. The Service Plan must identify the provider who will deliver the authorized services, and must include the date when the provision of services will begin and the maximum number of hours authorized.

(b) If, for any reason, the employment relationship between the client and provider is discontinued, an enrolled Homecare Worker or Contracted In-Home Care Agency must be employed within fourteen business days for the client to remain eligible for the program.

(c) An eligible individual who has been receiving waivered in-home services and temporarily enters a nursing facility or medical institution must employ an enrolled Homecare Worker or Contracted In-Home Care Agency within fourteen business days of discharge from the facility or institution.

(4) Separate eligibility for in-home support services exists for persons eligible for:

(a) Oregon Project Independence as defined in OAR chapter 411, division 032;

(b) Independent Choices as defined in OAR chapter 411, division 036; or

(c) Spousal Pay Program as defined in OAR 411-030-0080.

(5) Residents of licensed community-based care facilities, nursing facilities, prisons, hospitals and other institutions that provide assistance with activities of daily living are not eligible for in-home support services.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070
Hist.: SSD 3-1985, f. & ef. 4-1-85; SSD 4-1993, f. 4-30-93, cert. ef. 6-12-93, Renumbered from 411-030-0001; SPD 2-2003(Temp), f. 1-31-03, cert. ef. 2-1-03 thru 7-30-03; SPD 14-2003, f. & cert. ef. 7-31-03; SPD 15-2003 f. & cert. ef. 9-30-03; SPD 18-2003(Temp), f. & cert. ef. 12-11-03 thru 6-7-04; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 18-2005(Temp), f. 12-20-05, cert. ef. 12-21-05 thru 6-1-06; SPD 1-2006(Temp), f. & cert. ef. 1-13-06 thru 6-1-06; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06

411-030-0050
Case Management

(1) Assessment

(a) The assessment process will identify the individual's ability to perform activities of daily living, self-management tasks, and determine the individual's ability to address health and safety concerns. The case manager will conduct this assessment in accordance with standards of practices established by the Department in OAR 411-015-0008.

(b) The assessment will be conducted by a case manager or other qualified Department or Area Agency on Aging representative in the home of the eligible individual, no less than annually, with a standardized assessment tool approved by Seniors and People with Disabilities.

(2) Contract RN Assessment:

(a) Contract RN services are prior authorized by a Department or Area Agency on Aging case manager to provide:

(A) Nursing assessment and reassessment as appropriate;

(B) Medication review;

(C) Assignment of basic care tasks to a Homecare Worker; and

(D) Delegation of special tasks of nursing care to a Homecare Worker.

(b) Indicators of the need for RN assessment and monitoring include:

(A) Full assistance in cognition;

(B) Medical instability;

(C) Potential for skin breakdown or decubitus ulcer;

(D) Multiple health problems or frailty with a strong probability of deterioration; or

(E) Potential for increased self-care, but instruction and support for the individual are needed to reach goals.

(c) Maximum hours for each contracted RN service will be established by the Department.

(3) Service Plan:

(a) The client and case manager, with the assistance of other involved individuals, will consider in-home service options as well as assistive devices, architectural modifications, and other community-based care resources to meet the service needs identified in the assessment process.

(b) The case manager has responsibility for determining eligibility for specific services, presenting alternatives to the individual, identifying risks, and assessing the cost effectiveness of the plan. The case manager will monitor the plan and make adjustments as needed.

(c) The client, or their representative, has the responsibility to choose and assist in developing less costly service alternatives, including the Client-Employed Provider Program and Contracted In-Home Care Agency services.

(d) The Service Plan payment will be considered full payment for the services rendered under Title XIX. Under no circumstances is the employee to demand or receive additional payment for these Title XIX-covered services from the client-employer or any other source. Additional payment to Homecare Workers for the same services covered by Oregon's Title XIX Home and Community Based services Waiver or Spousal Pay Programs is prohibited.

(e) The Department will not authorize individuals applying for a hardship shelter allowance associated with employing a live-in provider on or after June 1, 2006.

(f) Individuals eligible for and authorized to receive a hardship shelter allowance before June 1, 2006 may continue to receive a hardship shelter allowance on or after June 1, 2006 at the rate established by the Department if one of the following conditions is met:

(A) The client will be forced to move from their current dwelling and his/her current average monthly rent or mortgage costs exceed current OSIP and OSIPM standards for a one-person need group as outlined in OAR 461-155-0250; or

(B) Service costs would significantly increase as a result of the client being unable to provide living quarters for a necessary live-in provider.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070
Hist.: SSD 5-1983, f. 6-7-83, ef. 7-1-83; SSD 3-1985, f. & ef. 4-1-85; SSD 12-1985(Temp), f. & ef. 9-19-85; SSD 16-1985, f. 12-31-85, ef. 1-1-86; SSD 4-1987(Temp), f. & ef. 7-1-87; SSD 1-1988, f. & cert. ef. 3-1-88; SSD 6-1988, f. & cert. ef. 7-1-88; SSD 9-1989, f. 6-30-89, cert. ef. 7-1-89; SSD 11-1989(Temp), f. & cert. ef. 9-1-89; SSD 18-1989, f. 12-29-89, cert. ef. 1-1-90; SSD 7-1990(Temp), f. & cert. ef. 3-1-90; SSD 16-1990, f. & cert. ef. 8-20-90; SSD 1-1992, f. & cert. ef. 2-21-92; SSD 4-1993, f. 4-30-93, cert. ef. 6-1-93, Renumbered from 411-030-0022; SPD 14-2003, f. & cert. ef. 7-31-03; SPD 15-2003 f. & cert. ef. 9-30-03; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 18-2005(Temp), f. 12-20-05, cert. ef. 12-21-05 thru 6-1-06; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06

411-030-0055
Service Plan-Related Transportation

(1) Service-related transportation (non-medical) may be prior-authorized for reasons related to an eligible individual's safety or health, in accordance with a plan of care. Such services will be offered through contracted transportation providers or by Homecare workers.

(2) Service-related transportation may be authorized to assist an eligible individual in getting to and from his or her place of employment when that individual is approved for the Employed Persons with Disabilities Program (OSIPM-EPD).

(3) Natural supports, volunteer transportation, and other transportation services available to the eligible individual will be considered a prior resource and must not be replaced with transportation paid by the Department.

(a) OMAP is a prior resource for medical transportation to a physician, hospital, clinic or other medical service provider. Medical transportation costs cannot be reimbursed through service-related transportation.

(b) The Department will not provide service-related transportation to obtain medical or non-medical items that can be delivered by a supplier or sent by mail order without cost to the eligible individual.

(4) Transportation must be prior authorized by the Case Manager and documented in the case record. Under no circumstances will any provider receive payment from the Department for more than the total number of hours, miles or rides authorized by the Department in the Service Plan.

(a) Contracted transportation providers will be reimbursed according to the terms of their contract with the Department. Service transportation services provided through contracted transportation providers must be authorized by the Case Manager based on an estimate of a total count of one way rides per month.

(b) Homecare Workers will be reimbursed according to the terms defined in their collective bargaining agreement when they use their own personal vehicle for service-related transportation. Any mileage reimbursement authorized to a Homecare Worker must be based on an estimate of the monthly maximum miles required to drive to and from the destination(s) authorized in the Service Plan. Transportation hours are authorized in accordance with OAR 411-030-0070.

(c) SPD/AAA will not authorize reimbursement for travel to or from the residence of the Homecare Worker. Transportation and mileage may only be authorized from the home of the eligible individual to the destination(s) authorized in the Service Plan and back to the eligible individual's home.

(5) The Department is not responsible for any vehicle damage or personal injury sustained while using a personal motor vehicle for service-related transportation.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070
Hist.: SPD 18-2005(Temp), f. 12-20-05, cert. ef. 12-21-05 thru 6-1-06; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06

411-030-0070
Maximum Hours of Service

(1) Levels of assistance for determining Service Plan hours:

(a) "Minimal Assistance" means the individual is able to perform the majority of an activity, but requires some assistance from another person.

(b) "Substantial Assistance" means the individual can perform only a small portion of the tasks that comprise the activity without assistance from another person.

(c) "Full Assistance" means the individual needs assistance from another person through all phases of the activity, every time the activity is attempted.

(2) Maximum Monthly Hours for Activities of Daily Living:

(a) The planning process will use the following limitations for time allotments for ADL tasks. Hours authorized are based on the service needs of the individual. Case Managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial or full).

(A) Eating: Minimal assistance — 5 hours; substantial assistance — 20 hours; full assistance — 30 hours;

(B) Dressing/Grooming: Minimal assistance — 5 hours; substantial assistance — 15 hours; full assistance — 20 hours;

(C) Bathing and Personal Hygiene: Minimal assistance — 10 hours; substantial assistance — 15 hours; full assistance — 25 hours;

(D) Mobility: Minimal assistance — 10 hours; substantial assistance — 15 hours; full assistance — 25 hours;

(E) Elimination (Toileting, Bowel and Bladder): Minimal assistance — 10 hours; substantial assistance — 20 hours; full assistance — 25 hours;

(F) Cognition/Behavior: Minimal assistance — 5 hours; substantial assistance — 10 hours; full assistance — 20 hours.

(b) Service plan hours for activities of daily living may only be authorized for an individual if the individual requires assistance (assist, minimal assist, substantial assist or full assist) from another person in that activity of daily living as determined by a service assessment applying the parameters in OAR 411-015-0006.

(c) For households with two or more eligible individuals, each person's ADL service needs are considered separately. In accordance with subsection (3)(c) of this rule, authorization of self-management hours will be limited for each additional individual in the home.

(d) Hours authorized for activities of daily living are paid at hourly rates established and published by the Department.

(3) Maximum Hours for Self-Management Tasks:

(a) The planning process will use the following limitations for time allotments for all services. Hours authorized are based on the service needs of the individual. Case Managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial or full).

(A) Medication and Oxygen Management: Minimal assistance — 2 hours; substantial assistance — 4 hours; full assistance — 6 hours;

(B) Transportation or Escort Assistance: Minimal assistance — 2 hours; substantial assistance — 3 hours; full assistance — 5 hours;

(C) Meal Preparation: Minimal assistance—Breakfast — 4 hours, lunch — 4 hours, supper — 8 hours; substantial assistance—breakfast — 8 hours, lunch — 8 hours, supper — 16 hours; full assistance—breakfast — 12 hours, lunch — 12 hours, supper — 24 hours;

(D) Shopping: Minimal assistance — 2 hours; substantial assistance — 4 hours; full assistance — 6 hours;

(E) Housecleaning: Minimal assistance — 5 hours; substantial assistance — 10 hours; full assistance — 20 hours.

(b) Rates paid will be established and published by the Department. When a live-in employee is present, these hours may be paid at less than minimum wage according to the Fair Labor Standards Act.

(c) When two or more individuals eligible for self-management task hours live in the same household, the assessed self-management need of each individual will be calculated. Payment will be made for the highest of the allotments and a total of four additional self-management hours per month for each additional individual to allow for the specific self-management needs of the other individuals.

(d) Service plan hours for self-management tasks may only be authorized for an individual if the individual requires assistance (assist, minimal assist, substantial assist or full assist) from another person in that self-management task as determined by a service assessment applying the parameters in OAR 411-015-0007.

(4) Twenty-Four Hour Availability:

(a) Payment for twenty-four hour availability will be authorized only when the client employs a live-in Homecare Worker and requires this availability due to the following:

(A) The individual requires assistance with activities of daily living or self-management tasks at unpredictable times throughout most twenty-four hour periods; and

(B) The individual requires minimal, substantial, or full assistance with Ambulation and requires assistance with Transfer (as defined in OAR 411-015-0006); or

(C) The individual requires full assistance in Transfer or Elimination (as defined in OAR 411-015-0006); or

(D) The individual requires full assist in at least three of the eight components of Cognition/Behavior (as defined in OAR 411-015-0006).

(b) The number of hours allowed per month will have the following maximums. Hours authorized are based on the service needs of the individual. Case Managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial or full).

(A) Minimal assistance — 60 hours. Minimal assistance hours may be authorized when an individual requires one of these assessed needs as defined in OAR 411-015-0006:

(i) Full Assist in Cognition; or

(ii) Full Assist in Toileting or Bowel or Bladder

(B) Substantial assistance — 110 hours. Substantial Assistance hours may be authorized when an individual requires these assessed needs as defined in OAR 411-015-0006:

(i) Assist in Transfer; and

(ii) Assist in Ambulation; and

(iii) Full Assist in Cognition; or

(iv) Full Assist in Toileting or Bowel or Bladder.

(C) Full assistance — 159 hours. Full assistance hours may be authorized when:

(i) The authorized provider cannot get at least 5 continuous hours of sleep in an eight hour period during a 24-hour work period; and

(ii) The eligible individual requires these assessed needs as defined in OAR 411-015-0006:

(I) Full Assist in Transfer; and

(II) Assist in Mobility; or

(III) Full Assist in Toileting or Bowel or Bladder; or

(IV) Full Assist in Cognition.

(c) Service Plans that include full-time live-in Homecare Workers will include a minimum of sixty (60) hours per month of 24-hour availability. When a live-in Homecare Worker is employed less than full time, the hours will be pro-rated. Full-time means the live-in Homecare Worker is providing services to the client-employer seven (7) days per week throughout a calendar month.

(d) Rates for this availability will be established and published by the Department and paid at less than minimum wage according to the Fair Labor Standards Act and ORS 653.020 (2).

(e) Twenty-four hour availability assumes the Homecare Worker will be available to address the service needs of an individual as they arise throughout a twenty-four hour period. A Homecare Worker who engages in employment outside the eligible individual's home or building during the work periods he or she is on duty as a Homecare Worker, is not considered available to meet the service needs of the individual.

(5) Under no circumstances will any provider receive payment from the Department for more than the total amount authorized by the Department on the Service Plan Authorization Form. All service payments must be prior-authorized by SPD or AAA.

(6) Authorized hours are subject to the availability of funds. Case managers must assess and utilize as appropriate, natural supports, cost-effective assistive devices, durable medical equipment, housing accommodations, and alternative service resources (as defined in OAR 411-015-0005) which could reduce the individual's reliance on paid in-home service hours.

(7) It is the intent of the Department to authorize paid in-home support services only to the extent necessary to supplement potential or existing resources within the individual's natural support system.

(8) Payment by the Department for waivered in-home services and Spousal Pay Program services can only be made for those tasks described in this rule as activities of daily living, self-management tasks and 24-hour availability. Services must be authorized to meet the needs of the eligible individual and cannot be provided to benefit the entire household.

(9) Exceptions to Maximum Hours of Service:

(a) To meet an extraordinary ADL service need that has been documented, the hours authorized for activities of daily living can exceed the full assistance hours (defined in section (2) of this rule) as long as the total number of ADL hours in the service plan does not exceed 145 hours per month.

(b) Monthly service payments that exceed 145 ADL hours per month may be approved by SPD central office when the exceptional payment criteria identified in OAR 411-027-0000 and 411-027-0050 are met.

(c) Monthly service plans that exceed 389 hours per month for a live-in Homecare Worker plan, or that exceed the equivalent monthly service payment for an hourly services plan, may be approved by SPD central office when the exceptional payment criteria identified in OAR 411-027-0000 and 411-027-0050 are met.

(d) As long as the total number of self-management task hours in the service plan does not exceed 85 hours per month and the service need is documented, the hours authorized for self-management tasks can exceed the hours for full assistance (as defined in section (3) of this rule) for the following tasks and circumstances:

(A) Housekeeping based on medical need (such as immune deficiency); or

(B) Short-term extraordinary housekeeping services necessary to reverse unsanitary conditions that would jeopardize the health of the individual; or

(C) Extraordinary self-management needs in medication management or service-related transportation.

(e) Monthly service plans that exceed 85 hours per month in self-management tasks may be approved by SPD central office when the individual meets the exceptional payment criteria identified in OAR 411-027-0000 and 411-027-0050.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 410.070 & 410.090

Stats. Implemented: ORS 410.010, 410.020 & 410.070

Hist.: SSD 4-1993, f. 4-30-93, cert. ef. 6-1-93; SSD 6-1994, f. & cert. ef. 11-15-94; SDSD 8-1999(Temp), f. & cert. ef. 10-15-99 thru 4-11-00; SDSD 3-2000, f. 4-11-00, cert. ef. 4-12-00; SPD 14-2003, f. & cert. ef. 7-31-03; SPD 15-2003 f. & cert. ef. 9-30-03; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 18-2005(Temp), f. 12-20-05, cert. ef. 12-21-05 thru 6-1-06; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06

411-030-0080
Spousal Pay Program

(1) Spousal Pay Program Eligibility: In-home services, provided by the spouse of an OSIPM client is compensable by the Department under ORS 411.803 only when the following conditions are met:

(a) The client requires full assistance in at least four of the six activities of daily living, as determined by the assessment, and would require nursing facility placement without in-home support services;

(b) The client has a medically diagnosed progressive debilitating condition which will limit additional activities of daily living, or has experienced a spinal cord injury or similar disability with permanent impairment of the ability to perform activities of daily living;

(c) The spouse demonstrates the capability and health to provide the services and actually provides the principal care for which payment has been authorized; and

(d) The client's service needs exceed in both extent and duration the usual and customary services rendered by one spouse to another.

(2) Establishment and maintenance of a centralized waiting list for eligible clients requesting services compensated through the Spousal Pay Program.

(a) The Department's Central Office staff will establish and maintain a list of eligible clients based on referrals from local offices.

(b) The Department has established funding to serve a biennial limit on the number of Spousal Pay clients in the program each month.

(c) When the biennial limit is reached, clients requesting services through the Spousal Pay Program, whose eligibility determination process has been finalized, will be placed on a waiting list. Names on the waiting list will be entered according to the date submitted by the local office.

(d) Prior to submission of name, applicants must have completed:

(A) The financial application process; and

(B) Had an assessment of service needs completed by the appropriate local office staff.

(e) As vacancies occur, eligible waiting list clients will be selected in order of submission, as defined in subsection (2)(c) of this rule.

(f) Clients on the waiting list may receive services through other appropriate Department programs for which they are eligible.

(3) Payments:

(a) All payments will be prior authorized by the Department or its designee.

(b) Payments will be based on the equivalent of one-half of the 24-hour availability and self-management task hours, plus the time required for specific documented activities of daily living.

(c) Payment of any respite care will be the responsibility of the spouse and not be paid by the Department. Eligible Spousal Pay Providers may receive live-in paid leave as described in OAR 411-031-0040.

(d) Payment to a spouse is not considered as a need item to establish initial eligibility or continuing eligibility for OSIPM.

(e) Under ORS 411.802, Homecare Workers who become the spouse of their employer will retain the same level of pay as described in OAR 411-030-0070 if their employer meets the spousal pay eligibility criteria as described in subsection (1)(a) of this rule.

Stat. Auth.: ORS 409.050, 410.070 & 410.090

Stats. Implemented: ORS 410.010, 410.020 & 410.070

Hist.: SSD 4-1984, f. 4-27-84, ef. 5-1-84; SSD 3-1985, f. & ef. 4-1-85; SSD 4-1993, f. 4-30-93, cert. ef. 6-1-93, Renumbered from 411-030-0027; SDSD 2-2000, f. 3-27-00, cert. ef. 4-1-00; SPD 2-2003(Temp), f. 1-31-03, cert. ef. 2-1-03 thru 7-30-03; SPD 14-2003, f. & cert. ef. 7-31-03; SPD 15-2003 f. & cert. ef. 9-30-03; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06

411-030-0090
Contracted In-Home Care Agency Services

Limitations in Scope and Duration: Contracted in-home care agency services will be used when the service proves to be the most cost efficient in meeting the needs of the eligible individual or necessary to meet interim or emergency service needs while more cost-effective solutions are sought and procured. In-Home Care Agencies must be licensed in accordance with OAR 333-536-0000 through 333-536-0095. Contracted In-Home Care Agency Services consist of minimal, substantial or full assistance with activities of daily living and self-management tasks and do not include live-in services. The specific services provided will be described in each contract's statement of work.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070
Hist.: SSD 4-1993, f. 4-30-93, cert. ef. 6-1-93; SPD 14-2003, f. & cert. ef. 7-31-03; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06

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

Rule Caption: Increase certification requirements for fire officials who review construction and fire protection systems plans.
Adm. Order No.: OSFM 8-2006
Filed with Sec. of State: 5-22-2006
Certified to be Effective: 5-22-06
Notice Publication Date: 5-1-06
Rules Amended: 837-039-0010, 837-039-0015, 837-039-0110
Subject: Fire officials who review plans shall successfully attain certification within eighteen months from the effective date of these rules. The Office of State Fire Marshal shall maintain a roster of ICC Fire Inspector II and ICC Fire Plans Examiner certified fire officials and provide this list to each building jurisdiction annually.
Rules Coordinator: Pat Carroll—(503) 373-1540, ext. 276

837-039-0010
Applications for Exempt Status

(1) Local governmental subdivisions seeking exempt status shall submit a written request to the State Fire Marshal that describes in detail the scope of the proposed exemption.

(2) The request shall include a detailed explanation of the fire prevention and investigation programs to be provided by the requesting jurisdiction and how the programs will be provided. Such programs will include but are not limited to:

(a) Fire code enforcement.
(b) Fire cause determination.
(c) Juvenile firesetter intervention.
(d) Fire and life safety education.

NOTE: Submitting a business plan demonstrating measurable goals and objectives in each of the categories is the method of explaining the proposed programs preferred by the State Fire Marshal. However, other formats may be used and will be considered where they adequately demonstrate what will be done and how it is accomplished.

(3) The request shall include an explanation of the Delegated Appeals Process to be employed and how it generally conforms to ORS 476.113 and 476.115.

(4) The request shall include an explanation of how the jurisdiction satisfies the qualifications specified in these rules.

(5) The request shall include such documentation and supportive materials as may be necessary to support the exemption request, including a copy of any locally adopted fire code and intergovernmental agreements.

(6) The State Fire Marshal will distribute copies of the request(s) to each of the review board members, requesting an advisory by them within 60 days of receiving the material as to the sufficiency of the application. Such advisories, both individually and collectively, shall not be binding on the State Fire Marshal but will be considered by the State Fire Marshal in deciding whether to grant the exemption.

(7) The State Fire Marshal will make a determination as to granting the exemption and notify the applicant accordingly within 30 days of receipt of the board's written advisory.

(8) Once granted, exempt status shall remain in effect:

(a) Unless terminated by the State Fire Marshal for cause pursuant to ORS 476.030(3) and OAR 837-039-0055; or

(b) Upon 90 days written termination notice to the State Fire Marshal at the discretion of the local jurisdiction; or

(c) Unless there is an unsatisfactory biennial review by the State Fire Marshal of the exempt authority's program and administration.

Stat. Auth.: ORS 476.030
Stats. Implemented: ORS 476.030(3)
Hist.: FM 3-1978, f. & ef. 6-16-78; FM 5-1978, f. & ef. 9-29-78; FM 2-1988, f. & cert. ef. 2-17-88; FM 5-1992, f. 6-15-92, cert. ef. 7-15-92; OSFM 9-2000, f. & cert. ef. 8-22-00; OSFM 8-2006 f. & cert. ef. 5-22-06

837-039-0015
Minimum Fire Code Requirements

(1) Under ORS 476.030 and 476.120, the State Fire Marshal is responsible for promulgating rules and regulations which establish minimum standards for the protection of life and property from the dangers of fire.

(2) To meet this responsibility and to promote uniformity, the State Fire Marshal shall assure that locally adopted fire codes in both exempt and non-exempt jurisdictions are consistent with minimum state fire code standards. Therefore, in adopting a fire code, local governmental subdivisions will:

(a) Adopt by reference the fire code promulgated by the State Fire Marshal; or

(b) Adopt a code that is consistent with state fire protection statutes and, is equal to or more stringent than, the fire code promulgated by the State Fire Marshal.

(3) Nothing in this Division requires a local governmental subdivision to adopt a fire code.

(4) Nothing in this Division shall prevent a local governmental subdivision from adopting a fire code which is more stringent than the State Fire Code, if such local fire code is otherwise lawful.

(5) When an authority having jurisdiction proposes a new local fire code, or proposes to amend an existing fire code, a draft copy of the proposed fire code or amendment shall be provided to the State Fire Marshal for a pre-adoption evaluation at the earliest date possible prior to final adoption and a final copy within 30 days after adoption.

(6) The State Fire Marshal shall cause the fire codes or amendments submitted under section (5) to be evaluated to assure conformity with state fire protection statutes and the minimum standards established by the State Fire Marshal to the extent possible within the time frame requested by the applicant.

(7) If the State Fire Marshal determines that a fire code submitted under section (5) of this rule conforms with minimum state standards, the State Fire Marshal shall issue a consistency finding at the earliest date possible.

(8) If the State Fire Marshal determines that a fire code or amendment submitted under section (5) of this rule does not meet minimum state standards, the State Fire Marshal shall:

(a) Notify the authority having jurisdiction of the proposed finding; and

(b) Give the authority having jurisdiction a reasonable time to amend or delete such inconsistencies.

(9) Whenever the State Fire Marshal issues a proposed inconsistency finding under section(8) of this rule, and the authority having jurisdiction disagrees with the proposed finding, the aggrieved party may within 20 days of receiving the inconsistency finding appeal and request a contested case hearing under ORS Chapter 183 and OAR 837-039-0055. Thereafter, the State Fire Marshal shall process the appeal within a reasonable time.

(10) If an appeal is not filed within 20 days of notification, and the authority having jurisdiction has failed to delete or amend the inconsistent fire code provision identified by the State Fire Marshal, a final inconsistency finding shall be issued.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 476.030
Stats. Implemented: ORS 476.030(3) & 476.120
Hist.: FM 3-1978, f. & ef. 6-16-78; FM 2-1988, f. & cert. ef. 2-17-88; FM 5-1992, f. 6-15-92, cert. ef. 7-15-92; OSFM 9-2000, f. & cert. ef. 8-22-00; OSFM 8-2006 f. & cert. ef. 5-22-06

837-039-0110
Certification and Training Requirements for Plan Review

(1) These rules establish standards for certification of fire officials who review plans for input to a building official for new construction, alterations, and specifications from a Fire Code approved by the State Fire Marshal.

(2) All fire officials who review plans for new construction, alterations, and specifications shall obtain an ICC Fire Inspector II and ICC Fire

Plans Examiner certification or equivalent certification approved by the State Fire Marshal.

(3) Fire Officials who review plans only for fire department access and fire protection water supplies shall successfully complete the State Fire Marshal's Fire and Life Safety Awareness courses on fire department access, water supply, and fire flow.

(4) All fire chiefs and every assistant to the state fire marshal meeting the definition under ORS 476.060 shall complete the state fire marshal's Fire and Life Safety Awareness course module 1, Scope of Authority and Assembly Group A Occupancies.

(5) Fire Officials who review plans for new construction, alterations, and specifications; or who review plans only for fire department access and fire protection water supplies; or fire chiefs and assistants to the state fire marshal meeting the definition under ORS 476.060, shall have eighteen months from the effective date of these rules to comply with the certification and training provisions of OAR 837-039-0110.

(6) The State Fire Marshal shall maintain a roster of ICC Fire Inspector II and ICC Fire Plans Examiner certified fire officials. A current list of ICC Fire Inspector II and ICC Fire Plans Examiners certified fire officials will be provided to each building jurisdiction annually. Certifications must be maintained to continue participation in the plan review process.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 479.165
Stats. Implemented: ORS 479.165
Hist.: FM 3-1994, f. & cert. ef. 3-1-94; OSFM 9-2000, f. & cert. ef. 8-22-00; OSFM 8-2006 f. & cert. ef. 5-22-06

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Rule Caption: Adopting amendments Mid-cycle to the 2004 Oregon Fire Code. Repeals unexpired Temporary Administrative Rules.
Adm. Order No.: OSFM 9-2006
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 6-12-06
Notice Publication Date: 2-1-06
Rules Adopted: 837-040-0020
Rules Amended: 837-040-0001, 837-040-0010, 837-040-0140
Rules Repealed: 837-040-0001(T), 837-040-0010(T), 837-040-0020(T), 837-040-0140(T)
Subject: These rules are necessary to define and clarify when sprinkler systems are required in parking garages, piers and wharves; to adopt the most recent standards for sprinkler installations in commercial and residential properties; to correlate various provisions within the code and to address certain fire, life-safety concerns related to exit door hardware. These rules will maintain correlation with the Oregon Structural Specialty Code. This permanent rule repeals the unexpired temporary rule.
Rules Coordinator: Pat Carroll—(503) 373-1540, ext. 276

837-040-0001
Scope

(1) The **International Fire Code** and the Oregon amendments represent a total scope of regulation.

(2) None of the individual chapters in the International Fire Code and Oregon amendments are stand alone requirements.

(3) The provisions of these chapters are not retroactive for existing facilities unless the chief determines that the condition presents a distinct hazard to life or property.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 476.030
Stats. Implemented: ORS 476.030
Hist.: FM 6-1992, f. 6-15-92, cert. ef. 7-15-92; OSFM 4-2004, f. 3-26-04, cert. ef. 10-1-04; OSFM 1-2006(Temp), f. 1-9-06 cert. ef. 2-1-06 thru 7-28-06; OSFM 9-2006, f. & cert. ef. 6-12-06

837-040-0010
Adoption of the International Fire Code

(1) The 2003 edition of the **International Fire Code** as promulgated by the International Code Council is hereby adopted as the Oregon Fire Code, 2004 edition, subject to the exclusions there from and amendments thereto as hereafter set forth in these regulations.

(2) The Oregon Fire Code is generally adopted every three years coinciding with the publication of a nationally recognized fire code.

[Publications: Publications referenced are available from the agency.]
Stat. Auth: ORS 476.030
Stats. Implemented: ORS 476.030
Hist.: FM 3-1986, f. & ef. 3-11-86; FM 5-1986 (corrects FM 3-1986), f. & ef. 4-30-86 & Renumbered from 837-040-0005, Sec. (3) Uniform Fire Code; FM 3-1989, f. 6-30-89, cert. ef. 7-1-89; FM 6-1990, f. & cert. ef. 9-13-90; F)M 6-1992, f. 6-15-92, cert. ef. 7-15-92; FM 2-1996, f. 1-22-96, cert. ef. 4-1-96; OSFM 1-1998, f. & cert. ef. 4-30-98; OSFM 3-1998, f. & cert. ef. 9-30-98; OSFM 4-1999, f. 12-29-99, cert. ef. 1-1-00; OSFM 3-2000, f. 4-1-00, cert. ef. 5-1-00; OSFM 13-2000, f. 10-3-00, cert. ef. 11-1-00; OSFM 9-2001, f. 10-3-01, cert. ef. 2-1-02; OSFM 4-2004, f. 3-26-04, cert. ef. 10-1-04; OSFM 8-2004(Temp), f. 12-29-04, cert. ef. 1-3-05 thru 6-30-05; OSFM 11-2005, f. & cert. ef. 6-27-05; OSFM 1-2006(Temp), f. 1-9-06 cert. ef. 2-1-06 thru 7-28-06; OSFM 9-2006, f. & cert. ef. 6-12-06

837-040-0020
Amendments to the Oregon Fire Code

(1) The Office of State Fire Marshal amends the Oregon Fire Code approximately midway between publications of the International Fire Code based on proposed code amendments submitted for consideration by interested persons.

(2) Any time between publications of the International Fire Code, The Office of State Fire Marshal may initiate and adopt code amendments to the Oregon Fire Code, as circumstance merits.

(3) Effective July 1, 2006, the following sections of the 2004 Oregon Fire Code are amended by the Office of State Fire Marshal as follows:

(a) Add to Section 202, the reference section for the definition of a Pier and Wharf.

(b) Delete the Oregon amendment in Section 304.3.1 and return to model code language.

(c) Add to Section 902.1, the definitions for Pier and Wharf.

(d) Amend Section 903.2.9 to require sprinklers in S-2 occupancies if the fire area exceeds 12,000 square feet or if the S-2 is an enclosed garage and located beneath other occupancy groups.

(e) Amend Section 903.2.10.4, sprinkler requirements for piers and wharves.

(f) Amend Section 1008.1.8.6 to require an approved sprinkler system or a smoke detection system but not both for delayed egress.

(g) Amend Section 1008.1.9 by changing the occupant load from 100 to 50.

(h) Adopt Section 3301.2 except for the words "and regulated in accordance with this section".

(i) Amend Chapter 45, NFPA 13, 13D and 13R standards to reference the 2002 edition.

(j) Amend Chapter 45, NFPA 58 standard to reference the 2004 edition.

(k) Add to Chapter 45 a reference to NFPA 307, 2006 edition.

(l) Delete the 70' diameter cul-de-sac and the 60' hammerhead figures in Appendix D, Table D103.1

[Publications: Publications referenced are available for review at the agency.]
Stat. Auth: ORS 476.030
Stats. Implemented: ORS 476.030
Hist.: OSFM 1-2006(Temp), f. 1-9-06 cert. ef. 2-1-06 thru 7-28-06; OSFM 9-2006, f. & cert. ef. 6-12-06

837-040-0140
Adoption of the Oregon Structural Specialty Code and Oregon Mechanical Specialty Code

The fire and life safety provisions of the 2004 edition of the **Oregon Structural Specialty Code** and the **2004 edition of the Oregon Mechanical Specialty Code** is hereby adopted as a standard for the purpose of evaluation of existing buildings.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 476.030
Stats. Implemented: ORS 476.030
Hist.: OSFM 1-1998, f. & cert. ef. 4-30-98; OSFM 9-2001, f. 10-3-01, cert. ef. 2-1-02; OSFM 4-2004, f. 3-26-04, cert. ef. 10-1-04; OSFM 1-2006(Temp), f. 1-9-06 cert. ef. 2-1-06 thru 7-28-06; OSFM 9-2006, f. & cert. ef. 6-12-06

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Rule Caption: Extend the term of state explosives magazine certifications to align with federal explosives magazine certifications.
Adm. Order No.: OSFM 10-2006(Temp)
Filed with Sec. of State: 6-15-2006
Certified to be Effective: 6-15-06 thru 12-12-06
Notice Publication Date:
Rules Amended: 837-012-1200, 837-012-1210, 837-012-1220, 837-012-1230, 837-012-1240, 837-012-1250, 837-012-1260, 837-012-1270, 837-012-1280, 837-012-1290, 837-012-1300, 837-012-1310, 837-012-1320, 837-012-1330, 837-012-1340, 837-012-1350, 837-012-1360, 837-012-1370, 837-012-1380, 837-012-1390, 837-012-1400, 837-012-1410, 837-012-1420
Subject: To extend the term of explosives certifications, as allowed by ORS 183.705. This rule change will extend the length of magazine certifications used by the Office of State Fire Marshal, to align with the Bureau of Alcohol, Tobacco, Firearms, and Explosives (BATFE) magazine certifications. Also included in these rule

changes are housekeeping items, such as italicizing defined words, rather than capitalizing them.

Rules Coordinator: Pat Carroll—(503) 373-1540, ext. 276

837-012-1200
Purpose and Scope

(1) The purpose of these rules is to establish standards, policies, and procedures for the possession, storage, and use of explosives for the protection and safety of the public, first responders, and individuals purchasing, possessing, storing, using, and transporting explosives.

(2) The scope of these rules applies to the implementation of ORS 480.200 through 480.290.

Stat. Auth.: ORS 476.030 & 480.280
Stats. Implemented: ORS 480.200 - 480.290
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 10-2006(Temp), f. & cert. ef.. 6-15-06 thru 12-12-06

837-012-1210
Definitions

For purposes of OAR 837-012-1200 through 837-012-1420 the following definitions apply:

(1) "Authorized Agent" as referenced in ORS 480.210 means an employee or representative of a manufacturer of explosives or dealer in explosives licensed by BATFE who possesses explosives for purposes of manufacturing or dealing. The term does not include an employee or representative who uses or possesses explosives for other purposes.

(2) "BATFE" means the Bureau of Alcohol, Tobacco, Firearms and Explosives.

(3) "Certificate of Possession" has the meaning provided in ORS 480.200(1).

(4) "Certificate of Registration" has the meaning provided in ORS 480.200(2).

(5) "Day Box" means:

(a) A structure or container used for the temporary transport or temporary keeping of explosives for present use.

(b) Is always attended and in line of sight vision of a holder of a certificate of possession.

(c) Complies with the construction requirements of NFPA 495, Explosive Materials Code, 2001 Edition, 8-6.3 (A) and (B).

(6) "Dealer" as referenced in ORS 480.210 means any person engaged in the business of distributing explosives at wholesale or retail.

(7) "Detonator" means any device containing an initiating or primary explosive that is used for initiating detonation, and not containing more than 10g of total explosive material per unit, excluding ignition or delay charges. The term includes, but is not limited to, electric detonators of the instantaneous and delay types, detonators for use with safety fuses, detonating cord delay connectors, and non-electric detonators of the instantaneous and delay types that consist of a detonating cord, a shock tube, or any other replacement for electric leg wires according to NFPA 495, Explosive Materials Code, 2001 Edition.

(8) "Expire" as referenced in ORS 480.239 and 480.244 means a renewal certificate of possession or renewal of certificate of registration has not been issued by the Office of State Fire Marshal on or before the expiration date of the current certificate.

(9) "Explosive" or "Explosives" has the meaning provided in ORS 480.200(3).

(10) "Facility" means a single building, structure, or container used or intended to be used for the storage of explosives. A day box is not a facility.

(11) "Fertilizer" means any substance, or any combination or mixture of substances, designed for use principally as a source of plant food, in inducing increased crop yields or plant growth, or producing any physical or chemical change in the soil and contains five percent or more of available nitrogen, phosphorus pentoxide (phosphoric acid) or potassium oxide (potash), singly, collectively or in combination, except hays, straws, peat and leaf mold, and unfortified animal manures according to ORS 633.310(5).

(12) "Formal Hearing" means a proceeding before a hearings officer conducted pursuant to the Administrative Procedures Act (APA), ORS chapter 183.

(13) "Individual" means a single human being.

(14) "Informal Conference" means a meeting between the party and the Office of State Fire Marshal, prior to a formal hearing, that may include a discussion about whether a basis exists for informal disposition of a contested case by stipulation, agreed settlement, consent order or other means.

(15) "Lapse" as referenced in ORS 480.239 and 480.244, has the meaning provided in subsection (8) of this rule.

(16) "Magazine" has the meaning provided in ORS 480.200(5). (Refer to OAR 837-012-1210(10) for a definition of facility).

(17) "Manufacturer" as referenced in ORS 480.210 means any person engaged in the business of manufacturing explosives for purposes of sale or distribution or for the person's own use.

(18) "May" means a regulation of conduct and implies probability or permission.

(19) "May Not" means a prohibition of conduct.

(20) "Must" means a mandatory requirement.

(21) "NFPA" means the National Fire Protection Association.

(22) "Owner" means a person with a vested ownership interest in the magazine. The term does not mean a renter, lessor, or sub-lessor of the magazine.

(23) "Person" means one or more individuals, legal representatives, partnerships, joint ventures, associations, corporations (whether or not organized for profit), business trusts, or any organized group of persons and includes the state, state agencies, counties, municipal corporations, school districts, and other public corporations.

(24) "Possession" means to own, to have physical possession of, or otherwise to exercise dominion or control over explosives.

(25) "Re-location" for purposes of ORS 480.244 and OAR 837-012-1360 means moving a magazine any distance.

(26) "Request for Hearing" means a written request for a formal hearing.

(27) "Small arms ammunition" has the meaning provided in ORS 480.200(6).

(28) "Small arms ammunition primers" has the meaning provided in ORS 480.200(7).

(29) "Store" means to deposit and place explosives in a magazine for safekeeping and future use.

[Publications: Publications referenced are available from the agency.]
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 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 10-2006(Temp), f. & cert. ef. .6-15-06 thru 12-12-06

837-012-1220
General

(1) A certificate of possession allows the holder of the certificate to engage in those activities including the purchase, possession, storage and transportation of explosives when those activities are otherwise in conformance with the requirements of these rules and any other applicable federal, state and local laws, rules and regulations.

(2) Holders of a certificate of possession must comply with the following:

(a) ORS 480.200 through 480.290.

(b) OAR 837-012-1200 through 837-012-1420.

(c) All applicable regulations in the Oregon Fire Code, 2004 Edition, and Oregon Structural Specialty Code, 2004 Edition.

(d) NFPA 495, Explosive Materials Code, 2001 Edition, as adopted in OAR 837-012-1340.

(e) All applicable federal, state and local laws, rules, and regulations governing explosives.

(3) Holders of a certificate of possession may purchase explosives only from those persons who have a BATFE license to sell explosives.

(4) Pursuant to ORS 480.210(1)(b), a BATFE dealer or manufacturer license authorizes the holder of such a license to possess explosives only when the possession is for purposes of a use or activity expressly authorized by the license, namely the business of manufacturing or dealing in explosives.

(5) Proof pursuant to ORS 480.210(3)(b) must be:

(a) A certified copy of a manufacturer or dealer license issued by the BATFE;

(b) A written certification signed by a person that holds the license referred to in subsection (a) that certifies under penalty of perjury that the person charged under ORS 480.210(1) is an employee or representative of the licensed person and is engaged in the business of manufacturing or dealing in explosives.

(6) Holders of a certificate of possession or a certificate of registration must notify the Office of State Fire Marshal in writing of a change in their address within two weeks of the date of the change.

(7) Holders of a certificate of registration must notify the Office of State Fire Marshal in writing of a change in ownership of a magazine within two weeks of the date of the change.

(8) Holders of an unexpired certificate of possession or certificate of registration may request a duplicate copy of their certificate by certifying in writing to the Office of State Fire Marshal that their certificate has been

lost, stolen or destroyed. Written requests must be signed and dated by the holder of the certificate.

[Publications: Publications referenced are available from the agency.]
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 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1230
Fees

(1) Fees must be payable to the Office of State Fire Marshal.

(2) Fees may be paid at, or mailed to, the Office of State Fire Marshal and must accompany the appropriate application.

(3) Payment may be made by personal check, business check, cashier's check or money order. If the fee is paid by a personal or business check, the application will be placed in a pending status until the check clears the bank.

(4) Fees are:

(a) $50 — Certificate of Possession

(b) $30 — Examination

(c) $125 — Initial two-year magazine registration with Office of State Fire Marshal inspection

(d) $187.50 — three-year magazine registration renewal with Office of State Fire Marshal inspection

(e) $250 — four-year magazine registration with Office of State Fire Marshal inspection

(f) $50 — Initial two-year magazine registration with acceptance of BATFE inspection

(g) $75 — three-year magazine registration renewal with acceptance of BATFE inspection

(h) $100 — four-year magazine registration renewal with acceptance of BATFE inspection

(5) Fees are non-refundable and non-transferable.

(6) Three- and four-year renewal fee authority is in accordance with ORS 183.705 and OAR 837-012-1330(2).

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; OSFM 14-2005, f. 10-21-05, cert. ef. 10-22-05; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1240
Applications

(1) Applications for the examination required under ORS 480.225(1)(j), a certificate of possession, and a certificate of registration must be on forms provided by the Office of State Fire Marshal.

(2) Applicants must complete the applications in full and pay the applicable fees before the Office of State Fire Marshal will process the applications.

(3) Pursuant to federal law, the Office of State Fire Marshal requires disclosure of the applicant's social security number on the applications. Any social security number disclosed on an application may be used for identification purposes only and remains confidential unless otherwise provided by law.

(4) Application for the examination required under ORS 480.225(1)(j):

(a) The application must be completed by the individual who will be taking the required examination.

(b) The application and fee must be received by the Office of State Fire Marshal a minimum of fourteen days before the applicant intends to complete the examination to allow time for:

(A) The fee payment to clear the bank.

(B) The Office of State Fire Marshal to notify the applicant of the acceptance of the application and fee payment.

(5) Application for a certificate of possession under ORS 480.210. Any individual who intends to possess explosives must:

(a) Complete the application.

(b) Submit a separate application and fee for each certificate of possession to be issued.

(c) Submit with their application a fingerprint card compatible with the processing requirements of the Oregon State Police Identification Services Division.

(6) Application for a certificate of registration of magazine under ORS 480.244. The owner of the magazine must:

(a) Complete the application.

(b) Submit a separate application for each magazine to be registered.

(c) Specify on their application which agency they select to inspect their magazine:

(A) The Office of State Fire Marshal

(B) The Bureau of Alcohol, Tobacco, Firearms and Explosives.

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 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1250
Eligibility for a Certificate of Possession

To be eligible for a certificate of possession, applicants must meet the requirements under ORS 480.225 and 480.230.

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 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1260
Certificate of Possession — Examination

(1) Upon receipt and processing of a completed application, the Office of State Fire Marshal will notify the applicant of the date, time and place for the examination.

(2) Applicants must provide valid photo identification at the time they appear to take the examination. Only photo identification issued by the Department of Motor Vehicles in the applicant's state of residency is accepted by the Office of State Fire Marshal.

(3) The examination is based upon, and examines the applicant's knowledge of:

(a) NFPA 495, Explosive Materials Code, 2001 Edition as adopted in OAR 837-012-1340

(b) ORS 480.200 through 480.290.

(4) The examination is open book.

(a) Applicants are responsible for providing their own copy of NFPA 495, Explosive Materials Code, 2001 Edition, to use during the examination.

(b) The Office of State Fire Marshal provides a copy of ORS 480.200 through 480.290 for use during the examination.

(5) To pass the examination, the applicant must answer correctly 80% or more of the examination questions.

(6) The Office of State Fire Marshal notifies applicants of the results of their examination using the address listed on the applicant's examination application.

(7) If an applicant fails to:

(a) arrive at the scheduled examination appointment, (b) complete the examination, or

(c) pass the examination, the applicant must submit a new application and fee pursuant to OAR 837-012-1230 and 837-012-1240 to the Office of State Fire Marshal.

(8) Passing examination scores are valid for two years from the date of the examination. If the examinee does not apply for and receive a certificate of possession within two years from the date of passing the examination, the examination score will be considered invalid and the applicant must re-take and pass the examination.

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 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1270
Certificate of Possession — Issuance

(1) Upon receipt of a properly completed application, application fee, and fingerprint card, the Office of State Fire Marshal will conduct an investigation to ensure the applicant meets the requirements of ORS 480.225 and 480.230.

(2) The investigation includes, but is not limited to:

(a) Electronic processing of fingerprint cards through the Law Enforcement Data System.

(b) Accessing records at Mental Health and Developmental Disability Services Division pursuant to ORS 480.225(1)(d).

(3) Upon its approval of an application, the Office of State Fire Marshal issues a certificate of possession to the applicant.

(4) The Office of State Fire Marshal assigns a unique number to each certificate of possession issued.

(5) The issuance of a certificate of possession does not in any way constitute an approval by the Office of State Fire Marshal of any explosives possessed under the certificate.

(6) The Office of State Fire Marshal mails the original certificate of possession to the applicant at the address listed on the application.

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 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1280
Certificate of Possession - Renewal

(1) A certificate of possession must be renewed every three years.

(2) The holder of the certificate of possession is not required to retake the examination required under ORS 480.225(1)(j) unless the current certificate expires or lapses.

(3) All other requirements for the issuance of a renewal of certificate of possession are the same as the issuance of the original certificate.

(4) Applications for the renewal of a certificate of possession may not be submitted to the Office of State Fire Marshal more than 90 days prior to the expiration date of the current certificate.

(5) Applications for the renewal of a certificate of possession should be received by the Office of State Fire Marshal at least 60 days prior to the expiration date of the current certificate. This allows the Office of State Fire Marshal adequate time to process the application prior to the expiration date of the current certificate.

(6) Applications not received by the Office of State Fire Marshal at least 60 days prior to the expiration date of the current may not certificate of possession could result in the expiration or lapse, of the current certificate.

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 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1290
Explosives Storage

(1) Explosives may be stored only in a magazine that has been issued a certificate of registration by the Office of State Fire Marshal.

(2) The storage of explosives must be in compliance with all applicable requirements of:

(a) NFPA 495, Explosive Materials Code, 2001 Edition as adopted in OAR 837-012-1340.

(b) Oregon Fire Code, 2004 Edition.

(c) Oregon Structural Specialty Code, 2004 Edition.

(d) All applicable federal, state and local laws, rules and regulations pertaining to explosives.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 476 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.: OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 1-2004, f. & cert. ef. 1-14-04; OSFM 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1300
Magazine Registration and Inspection

(1) Magazines not issued a certificate of registration may not be used for the storage of explosives.

(2) To be eligible for a certificate of registration, a magazine must comply with all requirements of:

(a) ORS 480.200 through 480.290.

(b) OAR 837-012-1200 through 837-012-1240.

(c) Oregon Fire Code, 2004 Edition.

(d) Oregon Structural Specialty Code, 2004 Edition.

(e) NFPA 495, Explosive Materials Code, 2001 Edition as adopted in OAR 837-012-1340

(f) All applicable federal, state and local laws, rules and regulations pertaining to explosives.

(3) Prior to the issuance of a certificate of registration, the magazine must be inspected for compliance with these rules.

(4) The inspection may be completed by:

(a) The Office of State Fire Marshal

(b) The BATFE pursuant to OAR 837-012-1320.

(5) A certificate of registration allows the holder of the certificate to store explosives in the registered magazine when otherwise in conformance with the requirements of these rules.

Stat. Auth.: ORS 476 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.: OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 1-2004, f. & cert. ef. 1-14-04; OSFM 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1310
State Fire Marshal Inspection of Magazines

(1) The State Fire Marshal may complete an inspection of a magazine prior to the issuance of a certificate of registration pursuant to OAR 837-012-1300(3) and (4).

(2) Upon receipt of information that a magazine is not in compliance with the requirements of these rules, the Office of State Fire Marshal may conduct an inspection of the magazine.

(3) If, upon its inspection, the Office of State Fire Marshal determines the magazine is not in compliance, the Office of State Fire Marshal may issue a notice of correction to the owner of the magazine.

(4) All notices of correction are on forms provided by the Office of State Fire Marshal.

(5) Notices of correction specify the deficiencies required to be corrected prior to the magazine being issued a certificate of registration.

(6) Notices of correction specify the date by which the deficiencies are to be corrected.

(7) A copy of each notice of correction is provided by the OSFM to the owner of the magazine by:

(a) Personal service;

(b) Service by certified mail

(c) Service by regular mail.

(8) After presenting a copy of the notice of correction to the owner of the magazine, the Office of State Fire Marshal retains all remaining copies of the notice until the re-inspection of the magazine is completed.

(9) At the end of the time allowed for correction of the deficiencies, as required by the notice of correction, the Office of State Fire Marshal may:

(a) Re-inspect the magazine to determine if the deficiencies specified in the notice of correction have been corrected.

(b) Complete the re-inspection section of the notice of correction.

(10) Upon re-inspection of the magazine, the Office of State Fire Marshal provides a copy of the completed notice of correction to the owner of the magazine pursuant to subsection (7) of this rule.

(11) Failure to correct the deficiencies noted in the notice of correction will result in the following, until such time as the deficiencies are corrected:

(a) The magazine will not be issued a certificate of registration.

(b) The magazine will not be issued a renewal certificate of registration.

(c) The certificate of registration for the magazine may be suspended or revoked.

Stat. Auth.: ORS 476 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.: OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1320
Certificate of Registration of Magazine — With Bureau of Alcohol, Tobacco, Firearms and Explosives Inspection

(1) The Office of State Fire Marshal may accept an inspection completed by BATFE in lieu of the Office of State Fire Marshal inspection.

(2) The decision to accept or not accept the BATFE inspection rests solely with the Office of State Fire Marshal.

(3) The Office of State Fire Marshal may consider, but is not limited to, the following criteria in deciding whether to accept a BATFE inspection:

(a) The inspection was completed not more than 180 days prior to the date of the application for a certificate of registration;

(b) A United States Post Office postmark date is used to determine the date of application.

(c) The inspection proves the magazine is in compliance with these rules.

(4)(d) If deficiencies are noted on the BATFE inspection, the Office of State Fire Marshal may decide to conduct its own inspection. Should the Office of State Fire Marshal decide to complete its own inspection, the applicant must submit additional payment of the following applicable fee prior to the Office of State Fire Marshal conducting its inspection:

(a) $75 for an initial two-year registration

(b) $137.50 for a three-year renewal

(c) $175 for a four-year renewal

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 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 15-2005(Temp), f. & cert. ef. 11-9-05 thru 5-7-06; OSFM 7-2006, f. & cert. ef. 5-5-06; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1330
Certificate of Registration of Magazine — Renewal

(1) All requirements for the issuance of a certificate of registration must be met before a certificate is renewed.

(2) Pursuant to ORS 183.705, certificates of registration may be renewed every two years, or up to four years, as determined by the Office of State Fire Marshal, in order to bring the Office of State Fire Marshal

magazine registration renewal dates in alignment with the BATFE renewal dates.

(3) Applications for the renewal of a certificate of registration may not be submitted to the Office of State Fire Marshal more than 120 days prior to the expiration date of the current certificate.

(4) Applications for the renewal of a certificate of registration should be received by the Office of State Fire Marshal at least 90 days prior to the expiration date of the current certificate. This allows the Office of State Fire Marshal adequate time to process the application, including inspection by the State Fire Marshal of the magazine, prior to the expiration date of the current certificate.

(5) Applications not received by the Office of State Fire Marshal at least 90 days prior to the expiration date of the current certificate of registration may result in the expiration or lapse, of the current certificate.

(6) If a current certificate of registration expires or lapses, explosives may not be stored in the magazine until the magazine is issued a renewal certificate of registration.

Stat. Auth.: ORS 476 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.: OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1340
Fire and Life Safety Standards

NFPA 495, Explosive Materials Code, 2001 Edition, is hereby adopted with the following exceptions:

(1) Chapter four is not adopted.

(2) Although NFPA 495, Explosive Materials Code, 2001 Edition, requires magazines to be opened and inspected at intervals of three days, the Office of State Fire Marshal requires magazines to be opened and inspected at intervals of seven days. (See NFPA 495, Explosive Materials Code, 2001 Edition, 8-7.2).

(3) NFPA standards regarding the transportation of explosives are hereby adopted for purposes of the examination required under ORS 480.225(1)(j).

[Publications: Publications referenced are available from the agency.]
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 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1350
Removal/Confiscation of Explosives

(1) Explosives may not be stored in a magazine, or possessed by an individual if:

(a) An application for a certification of registration, or certificate of possession, is denied.

(b) A certificate of registration, or certificate of possession, is suspended or revoked pursuant to ORS 480.244(9) or 480.270 or these rules.

(c) A certificate of registration, or certificate of possession, expires or lapses.

(2) The Office of State Fire Marshal may confiscate explosives possessed or stored in violation of ORS 480.200 to 480.290 or these rules.

(3) Any confiscation of explosives by the Office of State Fire Marshal are carried out pursuant to a warrant.

(4) Upon finding a violation, the Office of State Fire Marshal may order that any explosives be:

(a) transferred to a magazine that has been issued a certificate of registration by the Office of State Fire Marshal

(b) returned to the supplier of the explosives

(c) disposed of in any manner the Office of State Fire Marshal sees fit, including destruction of the explosives.

Stat. Auth.: ORS 476.030 & 480.280
Stats. Implemented: ORS 480.239
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 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1360
Magazine Re-location — Reporting

(1) Re-location of any magazine required to be registered under ORS 480.244 must be reported to the Office of State Fire Marshal within 24 hours of its relocation.

(2) The owner or the individual with either:

(a) physical possession; or

(b) control of the magazine is the individual responsible for reporting the relocation of the magazine.

(3) The toll free reporting number for reporting relocation of magazines is 1-877-459-9366.

(4) A report of relocation of the magazine must include the following information:

(a) Certificate of registration number issued to the magazine.

(b) New location of the magazine including the street address, city, and state.

(c) The name and phone number of the individual reporting the relocation of the magazine.

(d) The name of the fire department having jurisdiction, if known.

(3) There is no fee for reporting the relocation of a magazine.

Stat. Auth.: ORS 476 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.: OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1370
Record Keeping Requirements for Explosives

(1) Holders of a certificate of possession must maintain a record of the type and quantity of all explosives possessed.

(2) The Office of State Fire Marshal may inspect the records required to be maintained under ORS 480.235(5) and subsection (1) of this rule:

(a) At the time of the magazine inspection by the Office of State Fire Marshal; or

(b) Upon demand by the Office of State Fire Marshal.

Stat. Auth.: ORS 476 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.: OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1380
Hazardous Materials Reporting

Persons possessing 10 pounds or more of explosives, as classified by the United States Department of Transportation, must annually complete the Hazardous Substance Survey pursuant to ORS 453.307 to 453.372 and OAR chapter 837, division 85.

Stat. Auth.: ORS 453, 476, 478 & 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 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1390
Denial, Suspension or Revocation

(1) The Office of State Fire Marshal may deny, suspend or revoke a certificate of possession if:

(a) An individual who has applied for, or has been issued, a certificate of possession is ineligible for the certificate under ORS 480.225 or 480.230; or

(b) The individual who has been issued a certificate of possession has been convicted of a violation under ORS 480.990(6).

(2) If an individual to whom a certificate of possession was issued is found to be ineligible for the certificate under ORS 480.225 or 480.230, the Office of State Fire Marshal may revoke the certificate.

(a) An individual is ineligible for a certificate of possession if, before or after being issued a certificate, the individual fails to comply with ORS 480.225 or 480.230.

(b) An individual is ineligible for a certificate of possession under ORS 480.225(1)(l) if the individual fails to possess, use, store or transport explosives in accordance with these rules and all other applicable federal, state or local laws, rules or regulations.

(3) If an individual to whom a certificate of possession was issued has been convicted of a violation under ORS 480.990(6), the Office of State Fire Marshal may consider the following guidelines:

(a) If the individual has been convicted of one violation, the Office of State Fire Marshal may deny, suspend or revoke the certificate of possession for up to one year.

(b) If the individual has been convicted of two violations, the Office of State Fire Marshal may deny, suspend or revoke the certificate of possession for up to two years.

(c) If the individual has been convicted of three or more violations, the Office of State Fire Marshal may deny, suspend or revoke the certificate of possession for up to three years.

(4) The Office of State Fire Marshal may deny, suspend or revoke a certificate of registration if:

(a) The magazine registered, or to be registered, is ineligible for registration under ORS 480.200 to 480.290 or these rules; or

(b) For failure to comply with any provision of ORS 480.200 to 480.290 or these rules.

(5) If a magazine that has been issued a certificate of registration is found to be ineligible, the Office of State Fire Marshal may revoke the certificate.

(6) A magazine is ineligible for a certificate of registration if, before or after the magazine is registered, the magazine does not comply with ORS 480.244 or these rules.

(7) Suspension or revocation of a certificate of possession or a certificate of registration may include suspension or revocation of the current certificate and the right to apply for a renewal certificate.

(8) The period for denial, suspension or revocation of a certificate of possession or certificate of registration may not exceed three years, unless otherwise provided by law. In determining the appropriate sanction, the Office of State Fire Marshal may consider the following criteria:

(a) The severity of the violation or violations and the impact on public safety.

(b) The number of similar or related violations.

(c) Whether the violation or violations were willful or intentional.

(d) The prior history of sanctions imposed by the Office of State Fire Marshal against the individual or person.

(e) Other circumstances determined by the Office of State Fire Marshal to be applicable to the particular violation.

(9) Any notice of denial, suspension or revocation issued by the Office of State Fire Marshal is mailed by certified mail to the most recent address on file with the Office of State Fire Marshal pursuant to OAR 837-012-1220(6).

Stat. Auth.: ORS 476, 478 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.: OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1400
Contested Cases

(1) A person may request a formal hearing regarding the suspension, revocation, or denial of a certificate of registration or a certificate of possession by the Office of State Fire Marshal.

(2) A request for hearing must be timely filed.

(3) A request for hearing is timely filed when the request is postmarked or received by the Office of State Fire Marshal within 20 days from the date of service of the notice of suspension, revocation, or denial, unless a 60-day deadline applies pursuant to ORS 183.435.

(4) If a request for hearing is not timely filed under section (3) of this rule, the person waives the right to a contested case under ORS chapter 183.

(5) A person may write to or call the Office of State Fire Marshal to informally discuss the notice of suspension, revocation, or denial; however, an informal communication may not extend the deadline established in subsection (3) of this rule.

(6) A contested case may include:

(a) An informal conference; or

(b) A formal hearing.

(7) Contested cases are conducted pursuant to the provisions of ORS chapter 183 and the rules adopted thereto.

Stat. Auth.: ORS 183, 476, 478 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.:OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1410
Informal Conference

(1) The Office of State Fire Marshal may provide an opportunity for an informal conference.

(2) A request for an informal conference may be made verbally or in writing; and:

(a) Be made or addressed to the Office of State Fire Marshal; and

(b) Clearly state the issue or issues to be discussed.

(3) If the Office of State Fire Marshal and the party agrees, an informal conference may be held by telephone.

(4) After an informal conference, the Office of State Fire Marshal may amend, withdraw, or reduce the suspension, revocation or denial in accordance with ORS chapter 183 and the rules adopted thereto.

Stat. Auth.: ORS 183, 476, 478 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.: OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

837-012-1420
Formal Hearing

(1) A person may file a written request for hearing before or after an informal conference, at any time before the deadline established in OAR 837-012-1400(3).

(2) The Office of State Fire Marshal has the responsibility to arrange for a hearings officer to conduct the formal hearing.

(3) The Office of State Fire Marshal has the responsibility to set the date, time, and location for the formal hearing.

Stat. Auth.: ORS 183, 476, 478 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.:OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 10-2005, f. 5-24-05, cert. ef. 6-7-05; OSFM 10-2006(Temp), f. & cert. ef. 6-15-06 thru 12-12-06

Department of Public Safety Standards and Training
Chapter 259

Rule Caption: Revises standards relating to Student Conduct.
Adm. Order No.: DPSST 8-2006(Temp)
Filed with Sec. of State: 6-9-2006
Certified to be Effective: 6-9-06 thru 12-1-06
Notice Publication Date:
Rules Amended: 259-012-0005, 259-012-0010, 259-012-0015, 259-012-0035
Subject: Revises rules relating to student conduct at Public Safety Academy and establishes secure weapons procedures.
Rules Coordinator: Bonnie Salle—(503) 378-2431

259-012-0005
Attendance

(1) The Oregon Public Safety Academy is open to all eligible personnel upon application from their employing agencies. All persons attending the courses may live in the dormitories provided, or, with the permission of their department, they may commute to classes. Reasonable fees may be charged to cover operating costs of the Academy for those attending courses that are not mandatory, and for persons not defined as corrections, parole and probation, emergency medical dispatchers, telecommunicators or police officers under ORS 181.610. Additionally, fees may be charged to an agency under the Act if they do not adhere to minimum standards as defined in OAR 259-008-0010. Application for Training (BPSST Form F-5) must be used to apply for Mandated courses. Other courses presented at the Oregon Public Safety Academy may be announced through mailed course announcements with response required prior to established deadlines.

(2) Students must obtain permission from their employing agency before attending any optional classes offered at the Academy.

(3) Admission to the Oregon Public Safety Academy may be denied to any person who does not meet the minimum employment standards established by OAR 259-008-0010.

(4) Selection criteria for Academy training courses sponsored by the Department will be as follows:

(a) Mandated Basic Training:

(A) For mandated basic training, first priority for acceptance will be granted to public safety personnel identified under the mandatory provisions of ORS 181.610, 181.640, 181.644, 181.652, 181.653, and 181.665.

(B) Second priority will be granted to persons from public or private safety agencies who are not identified under the mandatory provisions of ORS 181.610, 181.640, 181.644, 181.652, 181.653, and 181.665.

(C) Third priority will be granted to persons from other public or non-public agencies or organizations. These decisions will be made after reviewing course content, candidates' job assignments, and following established Department policy.

(b) Supervisory and Middle Management Training:

(A) First priority for acceptance into the mandated supervisory and middle management courses will be granted to public safety personnel identified under the mandatory provisions of ORS 181.610, 181.640, 181.644, 181.652, 181.653, and 181.665. These persons must be designated as supervisors or middle managers by the assigning officials.

(B) Second priority will be granted to designated supervisors or middle managers from other public or private safety agencies.

(C) Third priority will be granted to persons from agencies which come under the mandatory provisions of ORS 181.610, 181.640, 181.644, 181.652, 181.653, and 181.665 and are not designated as supervisors or middle managers.

(D) Fourth priority will be granted to persons from other public or private safety agencies who are not designated as supervisors or middle managers.

(E) Fifth priority will be granted to persons from other public or non-public agencies or organizations. These decisions will be made after reviewing candidates' job assignments and following established Department policy.

(c) Executive Level Training:

(A) First priority for acceptance into executive level courses will be granted to command officers identified under the mandatory provisions of ORS 181.610, 181.640, 181.644, 181.652, 181.653, and 181.665.

(B) Second priority will be granted to command officers from other public or private safety agencies.

(C) Third priority will be granted to persons identified under the mandatory provisions of ORS 181.610, 181.640, 181.644, 181.652, 181.653, and 181.665 and are not command officers.

(D) Fourth priority will be granted to persons from other public or private safety agencies who are not command officers.

(E) Fifth priority will be granted to persons from other public or non-public agencies or organizations. These decisions will be made after reviewing candidates' job assignments and following established Department policy.

(d) Advanced and Specialized Training:

(A) First priority for acceptance into advanced and specialized courses will be granted to public safety personnel identified under the mandatory provisions of ORS 181.610, 181.640, 181.644, 181.652, 181.653, and 181.665, except as noted in paragraph (D) of this subsection.

(B) Second priority will be granted to persons from other public or private safety agencies.

(C) Third priority will be granted to persons from other public or non-public agencies or organizations. These decisions will be made after reviewing candidates' job assignments and following established Department policy.

(D) Acceptance criteria for certain specialized courses will vary from these listed priorities due to the specific nature of the courses, or special entrance criteria established by the Department or a co-sponsoring organization or agency.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 181.640
Stats. Implemented: ORS 181.640
Hist.: PS 1-1983, f. & ef. 12-15-83; PS 1-1985, f. & ef. 4-24-85; PS 1-1990, f. & cert. ef. 2-7-90; PS 2-1995, f. & cert. ef. 9-27-95; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; DPSST 8-2006(Temp), f. & cert. ef. 6-9-06 thru 12-1-06

259-012-0010
Standards of Conduct

(1) All students must report to the Academy at the time designated in the course announcement or the Department's letter accepting their attendance to a specific course, unless prior arrangements have been made with Academy staff.

(2) All students must adhere to the Department's rules and regulations governing student conduct. The student rules and regulations will be made available to:

(a) All students during initial orientation; and

(b) The public through electronic transmission or internet access.

(3) In addition to these rules, all persons attending classes at the Academy shall be held accountable to the provisions of the Criminal Justice Code of Ethics or equivalent discipline specific Code of Ethics and the current Student Rules and Regulations.

Stat. Auth.: ORS 181.640
Stats. Implemented: ORS 181.640
Hist.: PS 1-1983, f. & ef. 12-15-83; PS 1-1985, f. & ef. 4-24-85; PS 1-1990, f. & cert. ef. 2-7-90; PS 2-1995, f. & cert. ef. 9-27-95; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 6-2001, f. & cert. ef. 8-22-01; DPSST 8-2006(Temp), f. & cert. ef. 6-9-06 thru 12-1-06

259-012-0015
Weapons

(1) Immediately upon arrival at the Academy, all basic students will secure all weapons in their assigned gun lockers. This shall include firearms, ammunition and chemical agents such as oleocapsicum sprays. Possession of any weapon by a basic student is prohibited except when authorized for training purposes or by Academy training staff.

(2) Any person residing at the Academy or attending specialized or advanced courses is also prohibited from possessing weapons, including firearms and chemical agents, in the dormitory sleeping areas.

Stat. Auth.: ORS 181.640
Stats. Implemented: ORS 181.640
Hist.: PS 1-1983, f. & ef. 12-15-83; PS 1-1985, f. & ef. 4-24-85; PS 1-1990, f. & cert. ef. 2-7-90; PS 2-1995, f. & cert. ef. 9-27-95; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; DPSST 8-2006(Temp), f. & cert. ef. 6-9-06 thru 12-1-06

259-012-0035
Penalties

(1) A person attending any course as a student or other participant, or a person residing at the Academy for any purpose, is subject to the rules which have been promulgated by the Department. The rules will be posted in a prominent location at the Academy. All persons attending the Academy will be expected to be knowledgeable of and to conform their conduct to the standards set forth in the rules.

(2) Failure to comply with the rules may result in the person being dismissed from the Academy, suspended from participating in Academy activities, or any other disciplinary action deemed appropriate. A student dismissed from the Academy or suspended from Academy participation for conduct or behavior in violation of the rules may not be given training credit or credit for completion of the course in which that student was enrolled. Any decision to withhold credit will be subject to Department approval.

(3) Any alleged violation of these rules, wherein a formal written report is made, shall be communicated to the student's department administrator by the DPSST staff. All disciplinary actions shall be made in accordance with the Oregon Public Safety Academy Student Rules and Regulations.

(4) Dismissal, suspension, or other disciplinary action may be ordered by the Director, or any DPSST staff delegated that authority.

(a) In addition to the procedures for due process outlined in the Student Rules and Regulations, if a student is to be dismissed the student may request a meeting with the Director and present written evidence.

(A) If the Director, or designee, agrees with the dismissal, the student's agency may appeal within 30 days of the dismissal to the Board. The appeal must be in writing and state the agency's case against the dismissal.

(5) Any person subject to sanctions for violation of these rules can request a hearing in accordance with OAR 259-005-0015.

Stat. Auth.: ORS 181.640
Stats. Implemented: ORS 181.640
Hist.: PS 1-1983, f. & ef. 12-15-83; PS 1-1985, f. & ef. 4-24-85; PS 1-1990, f. & cert. ef. 2-7-90; PS 2-1995, f. & cert. ef. 9-27-95; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; DPSST 4-2004, f. & cert. ef. 4-23-04; DPSST 8-2006(Temp), f. & cert. ef. 6-9-06 thru 12-1-06

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Department of Transportation
Chapter 731

Rule Caption: Public contracting rules affecting procurement of goods and services, public improvement and public works.
Adm. Order No.: DOT 5-2006(Temp)
Filed with Sec. of State: 5-25-2006
Certified to be Effective: 5-25-06 thru 11-20-06
Notice Publication Date:
Rules Amended: 731-146-0010, 731-147-0010, 731-148-0010, 731-149-0010
Subject: These rules are amended to reflect changes made to the Department of Justice (DOJ) Model Rules, effective January 1, 2006, affecting state and local contracting agencies.
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 January 1, 2006), 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.

(3) This rule applies retroactively to January 1, 2006.

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; DOT 5-2006(Temp), f. & cert. ef. 5-25-06 thru 11-20-06

731-147-0010
Application

(1) The Oregon Department of Transportation adopts OAR 137-047-0000 through 137-047-0810 (effective January 1, 2006) 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.

(2) This rule applies retroactively to January 1, 2006.

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; DOT 5-2006(Temp), f. & cert. ef. 5-25-06 thru 11-20-06

731-148-0010
Application

(1) The Oregon Department of Transportation adopts OAR 137-048-0100 through 137-048-0320 (effective January 1, 2006), the Department of Justice Model Rules, Consultant Selection: Architectural, Engineering, Land Surveying, and Related Services Contracts including the additional provisions provided in these rules.

(2) This rule applies retroactively to January 1, 2006.

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; DOT 5-2006(Temp), f. & cert. ef. 5-25-06 thru 11-20-06

731-149-0010
Application

(1) The Oregon Department of Transportation adopts OAR 137-049-0100 through 137-049-0910 (effective January 1, 2006), 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.

(2) The Public Improvements Contracts as well as the Public Contracts for ordinary construction Services that are not Public Improvements shall also comply with OAR 731-007-0335.

(3) This rule applies retroactively to January 1, 2006.

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; DOT 5-2006(Temp), f. & cert. ef. 5-25-06 thru 11-20-06

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

Rule Caption: Adopts and Amends Rules Regarding the Regulation of Vehicle Dismantlers; Repeals Rules No Longer Needed.
Adm. Order No.: DMV 4-2006
Filed with Sec. of State: 5-25-2006
Certified to be Effective: 5-25-06
Notice Publication Date: 2-1-06
Rules Adopted: 735-024-0077, 735-152-0025, 735-152-0031, 735-152-0034, 735-152-0037, 735-152-0045, 735-152-0060, 735-152-0070, 735-152-0080, 735-152-0090
Rules Amended: 735-001-0040, 735-020-0010, 735-020-0070, 735-022-0000, 735-024-0015, 735-024-0030, 735-024-0070, 735-024-0075, 735-024-0080, 735-024-0120, 735-024-0130, 735-024-0170, 735-028-0010, 735-028-0090, 735-028-0110, 735-032-0020, 735-150-0005, 735-150-0010, 735-152-0000, 735-152-0005, 735-152-0010, 735-152-0020, 735-152-0040, 735-152-0050
Rules Repealed: 735-046-0080, 735-152-0030, 735-001-0040(T), 735-020-0010(T), 735-020-0070(T), 735-022-0000(T), 735-024-0015(T), 735-024-0030(T), 735-024-0070(T), 735-024-0075(T), 735-024-0077(T), 735-024-0080(T), 735-024-0120(T), 735-024-0130(T), 735-024-0170(T), 735-028-0010(T), 735-028-0090(T), 735-028-0110(T), 735-032-0020(T), 735-150-0005(T), 735-150-0010(T), 735-152-0000(T), 735-152-0005(T), 735-152-0010(T), 735-152-0020(T), 735-152-0025(T), 735-152-0031(T), 735-152-0034(T), 735-152-0037(T), 735-152-0040(T), 735-152-0045(T), 735-152-0050(T), 735-152-0060(T), 735-152-0070(T), 735-152-0080(T), 735-152-0090(T)
Subject: Chapter 654, Oregon Laws 2005 (HB 2429), relating to motor vehicle dismantlers (formerly vehicle wreckers), creates new business requirements, new definitions and grants DMV additional regulatory authority to impose sanctions and civil penalties against vehicle dismantlers found in violation of applicable laws and rules. The rulemaking clarifies dismantler business requirements including record keeping and requirements for reporting business activities to DMV. The rules also establish new violations, sanctions and civil penalties that DMV may assess dismantlers found in violation of applicable laws and DMV rules. Finally, the term “vehicle wrecker” is replaced with “dismantler” in all DMV rules. OAR 735-152-0030 is repealed because it has been incorporated into the OAR 735-152-0050.

Chapter 514, Oregon Laws 2005 (HB 2507), requires vehicle air bags containing sodium azide to be removed from a subject vehicle before it is wrecked or dismantled. It also requires sodium azide air bags be deployed within seven days of removal unless properly stored by a vehicle dealer, automobile repair facility or a certified dismantler. These rules establish violations and civil penalties that DMV may assess dismantlers found in violation of applicable laws and DMV rules regarding sodium azide air bags.

Chapter 738, Oregon Laws 2005 (HB 3121), authorizes city or county authorities to dispose of a vehicle that is located on private property upon request of a person who is both the owner of the property and in legal possession of the vehicle, provided that the vehicle has an appraised value of $500 or less. OAR 735-024-0077 designates the form of notice that must be submitted to DMV by an authority requested to dispose of an abandoned vehicle appraised at a value of $500 or less and abandoned on private property under the provisions of Chapter 738, Oregon Laws 2005 (HB 3121).

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

OAR 735-046-0080 (Oregon Trail Registration Plate Series) is repealed because the statutory authority for the rule no longer exists.

DMV filed temporary rules to become effective January 1, 2006, because there was not sufficient time to complete the permanent rulemaking process to coincide with effective date of the legislation. OAR 735-046-0080 (Oregon Trail Registration Plate Series) was temporarily suspended because the statutory authority for the rule no longer exists. These permanent rules replace the temporary rules.
Rules Coordinator: Brenda Trump—(503) 945-5278

735-001-0040
DMV Representation at Contested Case Hearings

This rule authorizes an agency officer or employee to represent DMV at a contested case hearing as described in this rule. Except for a hearing described under ORS 183.430(2), the Attorney General has granted authority to DMV to appoint officers or employees to represent DMV at contested case hearings regarding:

(1) Suspension, revocation and cancellation of driving privileges, except an implied consent suspension;

(2) Non-issuance of driver licenses and identification cards;

(3) Suspension, revocation, cancellation, probation and denial of certificates;

(4) Suspension, revocation, cancellation and denial of dismantler certificates;

(5) Suspension, revocation, denial and refusal to issue or renew a towing company certificate;

(6) Revocation and denial of a vehicle transporter certificate; and

(7) Civil penalties assessed under the authority of ORS 822.009 and OAR chapter 735, division 150.

Stat. Auth.: ORS 183.415, 183.450, 184.616, 814.619, 802.010
Stats. Implemented: ORS 183.450
Hist.: MV 16-1988, f. & cert. ef. 5-18-88; MV 3-1991, f. & cert. ef. 5-16-91, Renumbered from 735-070-0100; MV 9-1992, f. & cert. ef. 8-17-92; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-020-0010
Perfection of Security Interest; Primary Ownership Document

(1) This rule specifies the documents DMV will consider primary ownership documents for the purposes of perfecting a security interest in a vehicle.

(2) Except as provided in section (3) of this rule, a primary ownership document is:

(a) A manufacturer’s certificate of origin (MCO) or equivalent document as described in OAR 735-022-0030 through 735-022-0060. This subsection applies to:

(A) A vehicle or camper built by a manufacturer that has never been titled or registered; and

(B) A vehicle or camper built, assembled, or reconstructed using a component kit that has never been titled or registered. The MCO may only be considered a primary ownership document for the vehicle parts contained in the kit.

(b) A current certificate of title or salvage title issued for a vehicle or camper; or

(c) A Certificate to Obtain Title for a Vehicle (U.S. Government Form SF 97), for a vehicle or camper previously owned by the U.S. Government and where interest is being transferred.

(3) Notwithstanding section (2) of this rule, DMV may, at its discretion, consider other documents to be primary ownership documents when:

(a) DMV is satisfied that the original Oregon title has been lost or destroyed, and that there has been a change in interest;

(b) Interest has been transferred by operation of law under Oregon law, or through court action in a court having jurisdiction over persons or

property located in Oregon, and the primary ownership documents described in section (2) of this rule are not available;

(c) The security interest is in a vehicle or camper not manufactured for sale in the U.S., and that is not currently registered or titled in the U.S.;

(d) The security interest is in a vehicle or camper last titled or registered outside the U.S.; or

(e) DMV is satisfied that a primary ownership document described in section (2) of this rule was never issued, is not obtainable, or has been surrendered to another jurisdiction.

(4) Documents DMV may determine are primary ownership documents under section (3) of this rule include but are not limited to:

(a) A court judgment or decree from a court having jurisdiction over persons or property located in Oregon that awards ownership of a vehicle or camper as a matter of law;

(b) A sheriff's bill of sale;

(c) A certificate of possessory lien foreclosure as described in OAR 735-020-0012;

(d) A completed and signed Inheritance Affidavit (DMV Form 735-516) vesting the interest of a deceased owner in the person designated by all the heirs as the owner of the vehicle or camper;

(e) A completed and signed Certificate of Ownership of an Assembled Light Trailer or Heavy Trailer (DMV Form 735-6644) for a trailer built by someone other than a manufacturer;

(f) A completed and signed Application for Replacement Title (DMV Form 735-515) or Application for Replacement Salvage Title (DMV Form 735-230) where:

(A) The application is accompanied by an Application for Title and Registration (DMV Form 735-226) that includes a release of interest from anyone listed on the original title that will not be listed on the new title; and

(B) Any change in interest is of a type not subject to odometer disclosure requirements under ORS 803.102 and OAR 735-028-0000 through 735-028-0100;

(g) A completed and signed Certification of Ownership Facts (DMV Form 735-550);

(h) An Ownership document issued by the U.S. Armed Forces for a vehicle or camper owned by a member of the U.S. Armed Forces;

(i) A salvage title, salvage bill of sale, or dismantler (wrecker) bill of sale on a vehicle or camper whose title has been surrendered to a jurisdiction; or

(j) For a vehicle or camper described under subsections (3)(c) and (d) of this rule:

(A) A certificate for export purposes issued by a foreign jurisdiction; or

(B) A vehicle or camper registration if the vehicle has been registered but is not currently titled.

(5) When the application for notation of a security interest is for a vehicle or camper that is initially being titled as assembled, reconstructed, or a vehicle replica, the primary ownership document must be specific to the frame or unibody.

(6) When the application for notation of a security interest is for a vehicle or camper manufactured in more than one stage, the primary ownership document(s) must cover each stage of manufacture.

(7) DMV may invalidate a primary ownership document as evidence of ownership if it determines:

(a) The document is fraudulent or contains false information; or

(b) The document does not show the most current ownership interest in the vehicle or camper.

(8) If, after a title has been issued, it is determined that the evidence of ownership is invalid under section (7) of this rule, DMV may cancel the vehicle title. Before a title is cancelled, DMV will send a notice of the proposed cancellation to the vehicle owner or lessee, security interest holder(s) and lessor (if applicable), as listed in DMV records. A cancellation becomes effective 10 days after the date the notice is deposited with the postal service, unless a hearing is requested within that 10-day period. If a timely hearing is requested, the cancellation will be contingent on the outcome of the hearing.

(9) A title cancellation under section (8) of this rule automatically invalidates the security interest(s) noted on that title. A new application for notation for perfection of security interest and valid evidence of ownership must be submitted to DMV before security interest in a vehicle can be perfected pursuant to ORS 803.097.

(10) DMV will not invalidate a primary ownership document as evidence of ownership based solely on missing title requirements (e.g., missing odometer information, and fees).

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 184.616, 184.619, 801.402, 802.010 & 803.097
Stats. Implemented: ORS 801.402 & 803.097
Hist.: MV 2-1988, f. & cert. ef. 1-7-88; Administrative Renumbering 3-1988, Renumbered from 735-110-0510; MV 18-1988, f. & cert. ef. 6-1-88; MV 9-1993, f. 10-22-93, cert. ef. 11-4-93; DMV 10-2002, f. & cert. ef. 6-24-02; DMV 11-2005, f. 4-25-05, cert. ef. 5-1-05; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-020-0070
Junk Titles

(1) Pursuant to ORS 803.045, DMV will not issue an Oregon title or salvage title for a vehicle that has been issued a junk title, junk certificate, or similar ownership document, or junk or similar brand or notation that includes a word, term, brand or notation including but not limited to the following:

(a) Destroyed;

(b) Dismantled or Dismantler only;

(c) Hulk;

(d) Junk;

(e) Non-rebuildable;

(f) Non-repairable;

(g) Parts only;

(h) Scrap; or

(i) Wreck or Wrecker only.

(2) A designation as described in section (1) of this rule is based strictly on a determination made by another jurisdiction, as reflected on the current title or other ownership document issued by that jurisdiction.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 803.045
Stat. Implemented: ORS 803.045
Hist.: DMV 31-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; DMV 7-2004, f. & cert. ef. 5-24-04; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-022-0000
Standards Establishing Evidence of Ownership to a Vehicle

(1) To ensure compliance with applicable statutes, the following standards are established as satisfactory evidence of ownership of a motor vehicle. Evidence includes:

(a) A manufacturer's certificate of origin (MCO) as defined in OAR 735-022-0030.

(b) A Title or bill of sale from the owner(s) of record. "Owner of record" means the person(s) listed as vehicle owner in DMV records.

(c) A bill of sale or sales contract issued by an insurance company, motor vehicle dismantler (wrecker) if the title has been surrendered to DMV or is not available.

(d) A legal disposition: sheriff's bill of sale, or a court order of award.

(e) Estate settlement papers.

(f) Acquisition of vehicle through property rights (vehicle is on property at time the property was purchased).

(g) A bill of sale to the frame, unibody or engine.

(2) Before DMV issues title to a vehicle, evidence of ownership as described under section (1) of this rule must be submitted to DMV.

(3) When DMV receives an application for title for a motorcycle or moped that does not have a vehicle identification number (VIN), DMV will assign a VIN to the frame of the vehicle. The assigned VIN will be recorded in the DMV record for the vehicle.

(4) DMV will not attach an assigned VIN to the frame of a motorcycle or moped if either qualifies for registration as an antique or special interest vehicle and DMV is satisfied that the vehicle was originally manufactured without a VIN.

(5) In addition to meeting all other requirements of this rule, a manufactured trailer must have a bill of sale for the axle or trailer frame before DMV will issue a title.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.045, 803.050 & 821.060
Stats. Implemented: ORS 803.045 & 803.050
Hist.: MV 7-1980, f. & ef. 5-27-80; Administrative Renumbering 3-1988, Renumbered from 735-071-0071; MV 3-1993, f. & cert. ef. 4-16-93; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-024-0015
Definitions; Title Brands

As used in this rule through 735-024-0025, the following definitions apply:

(1) "Brand", "branded title", or "title brand" means a notation, indicator, symbol or phrase that is or has been printed, stamped or otherwise affixed to a certificate of title to indicate the history, condition, or circumstances of a vehicle. A title brand does not necessarily indicate the extent to which a vehicle may have been damaged, whether a vehicle has been repaired or to what degree a damaged vehicle has been repaired.

(2) "Assembled vehicle" as defined in ORS 801.130 and these rules means a vehicle:

(a) With a body that does not resemble any particular year model or make of vehicle;

(b) That is not a vehicle rebuilt by a manufacturer;

(c) That is not a vehicle built in a factory where the year model and make are assigned at the factory; and

(d) That is not an antique vehicle, a vehicle of special interest, a reconstructed vehicle or a replica.

(3) The following title brands defined under this section are adopted pursuant to ORS 803.015 and indicate a determination of a vehicle's condition made by another jurisdiction, or in the case of "glider kit" or "replica vehicle" a determination made by Oregon DMV:

(a) "Branded" means:

(A) A listing of two or more brands on an out-of-state title or similar document; or

(B) A brand not specifically defined or identified under this rule.

(b) "Flood damaged," "flood," or a word of similar import means a brand to indicate that a vehicle has been submerged in water to the point that the vehicle sustained damage;

(c) "Glider kit" or a word of similar import means a brand to indicate:

(A) A kit consisting of a new truck cab or cab and hood assembly, including a front axle assembly and frame rails, with or without an engine, transmission and rear axle, manufactured and sold with a manufacturer's statement of origin, has been used to replace damaged or worn components of an existing heavy truck or tractor; or

(B) A heavy truck or tractor was assembled using a kit consisting of all new component parts, including engine, transmission and rear axle, manufactured and sold with a manufacturer's statement of origin, and assembled by a person other than the manufacturer of the components.

(C) For purposes of this subsection, "heavy truck or tractor" means truck or tractor with a gross vehicle weight rating of more than 16,000 pounds.

(d) "Lemon," "lemon-defective," "lemon-law buy-back," "returned to manufacturer" or a word of similar import means a brand to indicate a vehicle was returned to the manufacturer because of a defect or condition that could not be corrected and that substantially impaired the safety, market value, or the use, or intended use, of the vehicle.

(e) "Previous damage" means a title brand issued by DMV prior to August 20, 2004, to indicate that DMV had received information from another jurisdiction that a vehicle was damage, destroyed, wrecked or salvaged, or words of similar import. The term "previous damaged" does not apply to vehicles issued a junk title or similar ownership document by another jurisdiction as described under OAR 735-020-0070;

(f) "Reconstructed vehicle," or "reconstructed" as defined in ORS 801.405 and these rules, means either:

(A) A vehicle that:

(i) Has a body that resembles and primarily is a particular year model or make of vehicle;

(ii) Is not a vehicle rebuilt by a manufacturer;

(iii) Is not a vehicle built in a factory where the year model and make are assigned at the factory; and

(iv) Is not a replica; or

(B) A motor truck that has been rebuilt using a component kit if the manufacturer of the kit assigns a vehicle identification number and provides a manufacturer's certificate of origin for the kit.

(g) "Totaled vehicle" or "totaled" as defined in ORS 801.527 and these rules means a vehicle that:

(A) Is declared a total loss by an insurer that is obligated to cover the loss or that the insurer takes possession of or title to.

(B) Is stolen, if it is not recovered within 30 days of the date that it is stolen and if the loss is not covered by an insurer.

(C) Has sustained damage that is not covered by an insurer and the estimated cost to repair the vehicle is equal to at least 80 percent of the retail market value of the vehicle before it was damaged. For purposes of this subsection, "retail market value" shall be as reflected in publications relied upon by financial institutions doing business in this state, including but not limited to the Title and Registration Textbook of the National Automobile Dealers Association (N.A.D.A. Guide), The Automobile Red Book or The Kelley Blue Book .

(h) "Replica" as defined in ORS 801.425 and these rules, means a vehicle with a body built to resemble and be a reproduction of another vehicle of a given year and given manufacturer;

(4) "DMV" means the Driver and Motor Vehicle Services Division of the Oregon Department of Transportation;

(5) "Oregon Certificate of Title" or "Oregon title" means a certificate of title, as that term is defined in ORS 801.185, issued by DMV.

(6) "Oregon Salvage Title Certificate" means a written document issued by DMV under the provisions of ORS 803.140 and 819.016 as evidence of vehicle ownership. An Oregon Salvage Title Certificate is not an Oregon Certificate of Title.

(7) "Salvage title," "salvage certificate" and "dismantler (wrecker) bill of sale" means a document issued by another jurisdiction to indicate the vehicle has been damaged, wrecked or salvaged or words of similar import. "Salvage title" does not refer to an Oregon salvage title certificate as defined by ORS 801.454 and this rule, unless the Oregon salvage title certificate reflects a brand that indicates the vehicle was damaged in another jurisdiction, before being titled in Oregon.

(8) "Word(s) of similar import" means any word, term, indicator, symbol or phrase that means the same or has the same effect as the terms described under OAR 735-020-0070 (junk titles) and defined under section (2) of this rule.

(9) For purposes of this rule, OAR chapter 735, division 024, division 152, ORS chapters 819 and 822, "Auto Recycler" has the same meaning as "dismantler" as defined under OAR 735-152-0000 and means a person issued a dismantler certificate under ORS 822.110.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.012, 803.015, 803.140, 819.016 & 821.060
Stats. Implemented: ORS 803.015 & 803.420
Hist.: DMV 18-2004, f. & cert. ef. 8-20-04; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-024-0030
Definitions Relating to Vehicles and Documents for Vehicles that Have Been Damaged, Altered, or Rebuilt

The following definitions and application of terms apply to OAR 735-024-0030 through 735-024-0170:

(1) "Accepting Vehicles as Salvage Material" as used in ORS 819.040, means to receive or purchase a vehicle that has already been wrecked, dismantled, or disassembled.

(2) "Assembled Vehicle" as defined in ORS 801.130 and these rules, means a vehicle:

(a) With a body that does not resemble any particular year model or make of vehicle;

(b) That is not a vehicle rebuilt by a manufacturer;

(c) That is not a vehicle built in a factory where the year model and make are assigned at the factory; and

(d) That is not an antique vehicle, a vehicle of special interest, a reconstructed vehicle or a replica.

(3) "Brand," "branded title" or "title brand" means a notation, indicator, symbol or phrase that is or has been printed, stamped or otherwise affixed to a certificate of title to indicate the history, condition, or circumstances of a vehicle. A title brand does not necessarily indicate the extent to which a vehicle may have been damaged, whether a vehicle has been repaired or to what degree a damaged vehicle has been repaired.

(4) "Certificate of Title" or "title" is defined in ORS 801.185. A title:

(a) May be issued by Oregon or some other jurisdiction;

(b) When issued by Oregon, is issued under ORS 803.045 or as is provided in 821.060;

(c) Except where designated, does not include a "salvage title certificate," "salvage title" or "salvage certificate";

(d) Is not issued to vehicles that:

(A) Are dismantled, disassembled, or substantially altered;

(B) Are otherwise in a condition that would require the title to be surrendered to the DMV for cancellation; or

(C) Have been issued a junk title, junk certificate or similar ownership document or brand as described in OAR 735-020-0070.

(e) Follows the frame or unibody of the vehicle for which the title was originally issued.

(5) "Dismantle" and "Disassemble" are defined in OAR 735-024-0050.

(6) "Frame" or "Unibody" refer to the major component(s) of a vehicle that form the support structure, undercarriage or lower structure of the vehicle, excluding such things as wheels or suspension. "Frame" does not include the body of the vehicle.

(7) "Insurer" as used in ORS 801.527 and 819.014 and in these rules, means a person engaged in the business of entering into policies of insurance. The term does not include persons who are self-insured.

(8) "Primary Ownership Document" is defined in ORS 801.402 and OAR 735-020-0010.

(9) "Proof of Compliance" means a document issued by DMV as evidence that:

(a) The title or primary ownership document was surrendered to DMV in accordance with ORS 819.010, 819.012 or 819.014; and

(b) The title or primary ownership document was marked, or DMV received other documentation that satisfied DMV that the vehicle was wrecked, dismantled, disassembled or totaled.

(10) "Reconstructed Vehicle," or "reconstructed" as defined in ORS 801.405 and these rules, means either:

(a) A vehicle that:

(A) Has a body that resembles and primarily is a particular year model or make of vehicle;

(B) Is not a vehicle rebuilt by a manufacturer;

(C) Is not a vehicle built in a factory where the year model and make are assigned at the factory; and

(D) Is not a replica; or

(b) A motor truck that has been rebuilt using a component kit if the manufacturer of the kit assigns a vehicle identification number and provides a manufacturer's certificate of origin for the kit.

(11) "Replica" as defined in ORS 801.425 and these rules, means a vehicle with a body built to resemble and be a reproduction of another vehicle of a given year and given manufacturer.

(12) "Salvage Title Certificate," "Oregon Salvage Title Certificate" or "salvage title" as defined in ORS 801.454 and this rule means a written document issued by DMV under the provisions of ORS 803.140 and 819.016 as evidence of vehicle ownership. Unless designated otherwise, an Oregon Salvage Title Certificate is not a certificate of title.

(13) "Salvage title," "salvage certificate," and "dismantler (wrecker) bill of sale" means a document issued for a vehicle to indicate the vehicle has been damaged, wrecked or salvaged or words of similar import. "Salvage title" does not refer to an Oregon salvage title certificate as defined by ORS 801.454 and this rule, unless the Oregon salvage title certificate reflects a brand that indicates the vehicle was damaged in another jurisdiction, before being titled in Oregon.

(14) "Substantially Alter the Form" is defined in OAR 735-024-0050.

(15) "Totaled vehicle" and "totaled" as defined in ORS 801.527 and these rules means:

(a) A vehicle that is declared a total loss by an insurer that is obligated to cover the loss or that the insurer takes possession of or title to;

(b) A vehicle that is stolen, if it is not recovered within 30 days of the date that it is stolen and if the loss is not covered by an insurer; or

(c) A vehicle that has sustained damage that is not covered by an insurer and that is such that the estimated cost to repair the vehicle is equal to at least 80 percent of the retail market value of the vehicle prior to the damage. For purposes of this subsection, "retail market value" is determined utilizing publications used by financial institutions doing business in Oregon.

(16) "Wreck" is defined in OAR 735-024-0050.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.012, 803.015, 803.0140, 819.016 & 821.060
Stats. Implemented: ORS 803.015 & 803.420
Hist.: MV 32-1991, f. 12-30-91, cert. ef. 1-1-92; DMV 18-2004, f. & cert. ef. 8-20-04; DMV 11-2005, f. 4-25-05, cert. ef. 5-1-05; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-024-0070
Vehicles that Are Wrecked, Dismantled, Disassembled, or Substantially Altered in Form — Responsibility of Parties

(1) The types of vehicles that are subject to the provisions of ORS 819.010 (e.g., wrecked, dismantled, substantially altered) include:

(a) Vehicles of the type that, when operated over the highways of this state, are required to be registered and titled;

(b) Class I or III all-terrain vehicles;

(c) Snowmobiles; and

(d) Any other vehicle that has been issued a title by DMV; or by another jurisdiction.

(2) ORS 819.010 and any related rules apply if the activity described in ORS 819.010 and OAR 735-024-0050 is performed in this state, and the vehicle is of a type covered in section (1) of this rule. This applies to vehicles titled in Oregon, those titled in another jurisdiction, and any vehicle not subject to title requirements.

(3) A person who dismantles, disassembles, wrecks or substantially alters the form of a vehicle, must comply with the provisions of ORS 819.010 and apply for an Oregon salvage title except as provided in ORS 819.016 and OAR 735-024-0130.

(4) Primary ownership documents for vehicles described in section (1) of this rule may be surrendered to DMV, in lieu of the certificate of title where a title does not exist, or where ownership is being transferred by operation of law and the title is not available.

(5) The Oregon title certificate, foreign title certificate, or primary ownership document must be surrendered to DMV together with the application for salvage title, if a salvage title is required.

(6) The Oregon title must be surrendered to DMV along with a written statement that indicates the vehicle was dismantled, disassembled, wrecked or substantially altered, if a salvage title is not required. The statement must be submitted on a DMV Form 735-6017, "Notice of Vehicle to be Dismantled/Proof of Compliance, "if submitted by someone other than a dismantler issued a certificate under ORS 822.110.

(7) Except as provided in section (11) of this rule, registration cards and registration plates that are required to be surrendered, may be submitted with the title or primary ownership document, or submitted separately to DMV, along with information as to why they are being surrendered.

(8) Vehicles that are subject to this rule may not be repaired, rebuilt, transferred, or the frame or unibody used for repairing or constructing another vehicle, until a salvage title is applied for and issued, consistent with ORS 819.016 and 819.018.

(9) If a salvage title is not required, DMV may issue proof of compliance upon request, if:

(a) The title or primary ownership document is surrendered to DMV;

(b) DMV is provided with documentation that indicates the vehicle has been wrecked, dismantled or disassembled; and

(c) DMV is satisfied that a salvage title is not required.

(10) The act of wrecking, dismantling, disassembling or substantially altering a vehicle will not by itself cause a vehicle to be considered a totaled vehicle. Such a vehicle:

(a) Is subject to the requirements under ORS 819.010 and DMV rules; and

(b) Is not considered totaled, and is not subject to requirements that apply to totaled vehicles unless the vehicle was determined to be totaled before the vehicle was dismantled, disassembled, wrecked or substantially altered.

(11) Notwithstanding section (7) of this rule, a dismantler must destroy the registration card issued to and registration plates attached to a motor vehicle acquired by the dismantler. Registration cards and registration plates must be destroyed to the extent that they can never be used again. For purposes of this section, "acquired" means to take physical possession of a motor vehicle together with possession of the vehicle's ownership record.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.140 & 819.012 - 819.018
Stats. Implemented: ORS 819.010 - 819.040
Hist.: MV 32-1991, f. 12-30-91, cert. ef. 1-1-92; DMV 11-2005, f. 4-25-05, cert. ef. 5-1-05; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-024-0075
Notification of Disposal of Abandoned Vehicle Appraised at $500 or Less

(1) This rule designates the form of notice that must be submitted to the Driver and Motor Vehicle Services Division of the Department of Transportation (DMV) for the disposal of an abandoned vehicle appraised at a value of $500 or less under the provisions of ORS 819.215.

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

(a) "An authority" means a law enforcement or government agency authorized to remove an abandoned vehicle as described in ORS 819.140;

(b) "Dismantler" means a person who is the holder of a valid dismantler certificate issued under ORS 822.110; and

(c) "Tower" means the towing business that tows a vehicle at the request of an authority.

(3) A completed signed Abandoned Vehicle Certificate (DMV Form 271) must be submitted to DMV when an appropriate authority (i.e., a law enforcement agency or government entity), or tower determines to dispose of an abandoned vehicle.

(4) DMV will not accept an Abandoned Vehicle Certificate:

(a) That does not contain the make, plate number, registration state, vehicle identification number, appraised value, name of the dismantler to whom the vehicle will be disposed, and the certification, including the name, address and authorized signature of the authority or tower disposing of the vehicle;

(b) Shows an appraised value of more than $500; or

(c) That has a form revision date before December 1998.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 819.215
Stat. Implemented: ORS 819.215
Hist.: DMV 12-2005, f. 5-19-05, cert. ef. 6-1-05; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-024-0077
Notification of Request to Dispose of a Vehicle Appraised at $500 or Less Abandoned on Private Property

(1) This rule designates the form of notice that must be submitted to DMV by an authority requested by a person to dispose of an abandoned vehicle appraised at a value of $500 or less and abandoned on private property under the provisions of ORS 819.280.

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

(a) "An authority" means a law enforcement or government agency authorized to dispose of an abandoned vehicle as described in ORS 819.140(1)(b) or (c).

(b) "Appraiser" means a person who is the holder of a valid vehicle appraiser certificate issued under ORS 819.230.

(c) "Dismantler" means a person who is the holder of a valid dismantler certificate issued under ORS 822.110.

(3) A completed and signed Abandoned Vehicle Certificate - Vehicle Abandoned on Private Property (DMV Form 272) must be submitted to

DMV by an authority when the authority chooses to dispose of an abandoned vehicle as described under section (1) of this rule.

(4) An Abandoned Vehicle Certificate — Vehicle Abandoned on Private Property form must include:

(a) The name and address of the authority disposing of the vehicle;

(b) The name and address of the person requesting the disposal;

(c) The vehicle identification number;

(d) The registration plate number, if the registration plates are on the vehicle;

(e) The appraised value of the vehicle; and

(f) The appraiser's certificate number and signature.

(5) DMV will not accept an Abandoned Vehicle Certificate — Vehicle Abandoned on Private Property if the form:

(a) Does not contain all of the information listed in section (4) of this rule;

(b) Shows an appraised value of more than $500; or

(c) Shows a form revision date before January 2006.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 819.215 & 819.280
Stat. Implemented: ORS 819.215 & 819.280
Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-024-0080
Abandoned Vehicles Sold Under ORS 819.220

(1) This rule defines terms and establishes procedures for the sale of abandoned vehicles under ORS 819.220. As used in this rule:

(a) "Authority" means an agency authorized under ORS 819.140 to take custody of and dispose of abandoned vehicles.

(b) "Dismantler" means a person issued a certificate under ORS 822.110.

(c) "Purchaser" means a person to whom the authority sold a vehicle under the provisions of ORS 819.220 but does not include a dismantler.

(2) In addition to complying with other applicable provisions of ORS 819.220, an authority must provide to the purchaser or dismantler a certificate of sale and a Notice of Vehicle to be Dismantled/Proof of Compliance (DMV Form 735-6017).

(3) The purchaser must:

(a) Submit a Form 735-6017 to notify DMV if the purchaser intends to wreck, dismantle, disassemble or substantially alter the form of the vehicle as required under ORS 819.010; and

(b) Submit another copy of the Form 735-6017 to DMV along with the title or primary ownership document (e.g., sheriff's certificate of sale), within 30 days of when the vehicle has been wrecked, dismantled, disassembled or substantially altered, if the vehicle is exempt from salvage title requirements under ORS 819.016 or OAR 735-024-0130.

(4) Dismantlers who purchase vehicles under ORS 819.220, must comply with the provisions of ORS 819.010 as it applies to dismantlers, and any other provisions of law or rule that apply to dismantlers.

(5) Except as otherwise provided in ORS 819.016 and OAR 735-024-0130, a purchaser must apply to DMV for a salvage title.

(6) Even if other provisions of this rule apply, a purchaser who purchased a vehicle under ORS 819.220 before January 1, 1992, is not required to apply for salvage title unless:

(a) The vehicle is repaired. If the vehicle is repaired, the applicant may apply for a salvage title or a branded certificate of title showing the vehicle as assembled, reconstructed or a replica, whichever applies;

(b) The vehicle is wrecked, dismantled, disassembled or substantially altered in form; or

(c) Ownership of the frame or unibody of the vehicle is transferred.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 819.110, 819.140, & 819.220
Stats. Implemented: ORS 819.220
Hist.: MV 32-1991, f. 12-30-91, cert. ef. 1-1-92; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-024-0120
Totaled Vehicles — Persons Who Receive or Purchase

(1) Except as otherwise provided by law, a person who receives or purchases a totaled vehicle is required under ORS 819.012 to surrender the title for the vehicle within 30 days of the purchase or receipt of the vehicle. As used in that statute and this rule:

(a) A primary ownership document may be surrendered when a title does not exist or in the case of a transfer by operation of law, is not available;

(b) The requirement that the title or primary ownership document be surrendered does not apply when:

(A) The title or primary ownership document has already been surrendered to the DMV with information indicating the vehicle was totaled; or

(B) A salvage title has already been issued for the vehicle. This section does not exempt persons from applying for salvage title in their name, if required to do so under OAR 735-024-0170.

(2) Persons who receive or purchase a totaled vehicle, and except as provided in section (1) of this rule, must within 30 days of receipt or purchase, surrender the title or primary ownership document to DMV, and do one of the following:

(a) Apply for salvage title as required under OAR 735-024-0130 and as provided under OAR 735-024-0140;

(b) Apply for a certificate of title identifying the vehicle as totaled and assembled or reconstructed or vehicle replica;

(c) If a salvage title is not required, and the vehicle is not eligible for or a certificate of title is not being applied for, surrender the certificate of title or primary ownership document, together with assignments of interest or other evidence that the person(s) shown on the current title no longer hold an interest, and a written statement that indicates:

(A) The name and address of the person submitting the title;

(B) That the vehicle was totaled; and

(C) Why the vehicle is exempt from having to be issued a salvage title.

(3) Subsection (2)(c) of this rule only applies to situations where a salvage title is not required because the person does not intend to:

(a) Rebuild or repair the vehicle; or

(b) Use the frame or unibody in repairing or constructing another vehicle.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 819.014
Stats. Implemented: ORS 819.010 - 819.040
Hist.: MV 32-1991, f. 12-30-91, cert. ef. 1-1-92; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-024-0130
Salvage Title — Vehicles Subject and When/Who Required to Apply

(1) An Oregon salvage title is an ownership document that is used to assign interest and to make an odometer disclosure on a vehicle, from the time that the certificate of title is required to be surrendered to DMV until:

(a) The vehicle is repaired, rebuilt or is issued a certificate of title; or

(b) It is determined that:

(A) The vehicle will not be rebuilt or repaired; and

(B) The frame or unibody of the vehicle will not be used to repair or construct another vehicle.

(2) Vehicle types subject to the issuance of salvage titles, include any vehicle:

(a) Of the type required to be titled or registered in this state, if operated over the highways;

(b) Snowmobiles required to be titled and registered by DMV; and

(c) Any other vehicle that has been issued a certificate of title by DMV, or some other jurisdiction.

(3) An application for a salvage title is required on a subject vehicle that is:

(a) Wrecked, dismantled, disassembled, or where the form of the vehicle is substantially altered, as covered in ORS 819.010 and OAR 735-024-0050;

(b) Determined to be a totaled vehicle, and the title is required to be surrendered to DMV under ORS 819.012 or 819.014; or

(c) An abandoned vehicle that is sold under the provisions of ORS 819.220.

(4) When a salvage title is required, application must be made:

(a) For a vehicle that is declared a total loss by an insurer that is obligated to cover the loss, or that the insurer takes possession of or title to:

(A) The insurer must apply for the salvage title if the insurer obtains the title as provided under ORS 819.014, unless a salvage title has already been issued; or

(B) The owner must apply for the salvage title if the vehicle owner does not surrender the title to the insurer.

(b) By the owner for a vehicle that is totaled due to damage when the loss is not covered by an insurer;

(c) By any person who purchases an abandoned vehicle sold under ORS 819.220; or

(d) By any person who receives or purchases a vehicle subject to salvage title requirements unless:

(A) A salvage title or similar document has already been issued by Oregon or some other jurisdiction, and the person is not required to apply for salvage title in his or her name under OAR 735-024-0170; or

(B) A totaled vehicle that was purchased before January 1, 1992, and is not subject until the vehicle, frame or unibody is transferred, or the vehicle is wrecked, dismantled, disassembled, or substantially altered in form.

(5) The term "receive" as used in section (4) of this rule and ORS 819.012, does not apply to auctions or other parties who as an agent of

another, take possession or control of a vehicle, but who do not actually acquire an interest in the vehicle or vehicle salvage. This section does not:

(a) Relieve insurers or persons who are actually transferring interest in the vehicle or vehicle salvage, from the responsibility to apply for and provide any purchaser with a salvage title, as required under ORS 819.012 through 819.018 and this rule; or

(b) Prevent parties from entering into agreements to allow agents to apply for and provide salvage titles to any purchaser on behalf of another.

(6) An odometer disclosure is required when application is made for the issuance or transfer of a salvage title for motor vehicles, except those exempt from disclosure requirements under OAR 735-028-0010.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.140 & 819.012 - 819.018
Stats. Implemented: ORS 803.140, 819.010 - 819.040 & 49 CFR Part 580
Hist.: MV 32-1991, f. 12-30-91, cert. ef. 1-1-92; DMV 11-2005, f. 4-25-05, cert. ef. 5-1-05; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-024-0170
Salvage Title — Assignment, Transfer, Requirements for Surrender

(1) The owner of a vehicle issued a salvage title, must keep the title until:

(a) The frame or unibody are no longer subject to salvage requirements described in OAR 735-024-0130; or

(b) The vehicle is transferred to a new owner.

(2) If the vehicle is wrecked, dismantled, disassembled, or substantially altered in form, and the parts are transferred separately:

(a) The salvage title must remain with the frame or unibody, if it is still subject to salvage title requirements or is sold to someone in another jurisdiction;

(b) The salvage title must be surrendered to DMV if the frame or unibody is no longer subject to salvage title requirements and has not been sold to someone in another jurisdiction. In this case, the salvage title must be surrendered to DMV within 30 days of when the vehicle, including the frame or unibody, is no longer subject to salvage title requirements.

(3) The provisions of this rule relating to forms used for assigning interest and making odometer disclosures only apply to a vehicle or frame or unibody remaining in this state. Other states may require assignments and disclosures to be made on the salvage title or on secure assignment forms that may be submitted with the salvage title.

(4) A dealer, dismantler, or insurer is not required to apply for salvage title in their name if ownership of a vehicle or frame or unibody has been issued or is transferred to a dealer or dismantler who holds a certificate issued under ORS 822.020 or 822.110, or to an insurer. This section does not prohibit a dealer, dismantler or insurer from applying for a salvage title in their name:

(a) Except as provided in subsection (4)(b) of this rule, any assignment of interest to the insurer, dealer or dismantler must be made on:

(A) The current salvage title; or

(B) If all of the assignment spaces on the salvage title are filled up, a separate assignment must accompany and remain with the salvage title. If ownership of the vehicle is transferred at a later time, any assignment(s) not recorded on the title must be provided with the salvage title to the transferee at time of transfer.

(b) The assignment may be made on the replacement title application or on documents supporting the application for replacement title, if the salvage title is lost, mutilated or destroyed, and where allowed under OAR 735-024-0150, the replacement salvage title is to be issued in a name other than the current owner of record.

(5) If ownership of a vehicle or frame or unibody for which a salvage title has been issued is transferred to anyone other than a dealer or dismantler who holds a certificate issued under ORS 822.020 or 822.110, or an insurer, that person is required to apply for salvage title in his or her name. In this case:

(a) Assignments of interest may be made as provided in section (4) of this rule;

(b) Odometer disclosures may be made on the application for salvage title or as otherwise provided in OAR 735-028-0000; and

(c) The person must apply for salvage title as described in OAR 735-024-0140, or if the salvage title is lost, destroyed or mutilated, as provided in OAR 735-024-0150.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.140, 819.016
Stats. Implemented: ORS 803.140
Hist.: MV 32-1991, f. 12-30-91, cert. ef. 1-1-92; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-028-0010
Vehicles Exempt from Odometer Disclosure Requirements

(1) In addition to the exemptions described under ORS 803.102, the following vehicles are exempt from odometer disclosure requirements:

(a) A new vehicle that is transferred before it is sold to a retail customer. For example, the transfer of a new vehicle between vehicle dealers.

(b) Snowmobiles.

(c) Class I all-terrain vehicles.

(d) A vehicle that has been reported stolen and has not been recovered.

(e) A vehicle originally manufactured without an odometer.

(f) A vehicle covered by a salvage title, if:

(A) The odometer has been destroyed, removed or is unreadable; or

(B) The frame or unibody is transferred separately from the odometer.

(g) A vehicle that has been wrecked, dismantled, disassembled or substantially altered and:

(A) The provisions of ORS 819.010 have been complied with and DMV has issued proof of compliance under ORS 819.030; and

(B) The vehicle is acquired by a vehicle dismantler as defined under OAR 735-152-0000

(h) A vehicle that is ten years old or older. January 1 of the vehicle model year is used as the starting point in calculating the age of a vehicle. For purposes of this subsection, the model year is the year assigned by the manufacturer for a manufactured vehicle, or the model year listed on the vehicle title for an assembled, reconstructed or a replica vehicle. For example, a 1996 model vehicle is considered 10 years old on January 1, 2006.

(2) DMV may require an applicant to submit additional information to verify the model year of a vehicle.

Stat. Auth.: ORS 184.616, 803.045 & 803.102
Stats. Implemented: ORS 803.045 & 803.102
Hist.: MV 23-1985, f. 12-31-85, ef. 1-1-86; MV 29-1987, f. & ef. 10-1-87; Administrative Renumbering 3-1988, Renumbered from 735-110-0410; MV 51-1989, f. & cert. ef. 12-1-89; MV 12-1991, f. 9-18-91, cert. ef. 9-29-91; MV 8-1992, f. 6-30-92, cert. ef. 7-1-92; DMV 1-1997, f. & cert. ef. 1-17-97; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-028-0090
Odometer Disclosure a Requirement for Issuance of Title, Exceptions

(1) DMV will not issue title to a vehicle subject to odometer requirements until an odometer disclosure that meets the requirements of this division is submitted to DMV

(2) Except as otherwise provided in this rule, if there has been more than one transfer since the last title or other primary ownership document was issued (e.g., the owner sold the vehicle to a dealer who sold it to another person) the following odometer disclosures are required:

(a) Between the owner (seller) in whose name the last title or other primary ownership document was issued and the first buyer; and

(b) Between the person who last transferred the vehicle and the current applicant for title.

(3) If a vehicle is transferred through multiple parties (e.g., a vehicle sold from dealer to dealer), only the first and last disclosure must be submitted to DMV as provided in section (2) of this rule. However, this does not exempt the in-between owners from requirements to obtain, provide, and in some cases, maintain records on odometer disclosures, as otherwise required by DMV rules, federal law or federal rules.

(4) DMV may accept an odometer disclosure from the buyer, rather than the seller, or accept a transfer where only one of the two disclosures required under section (2) of this rule is provided, in the following situations:

(a) The most recent buyer does not receive the required disclosure(s) from the seller or the disclosure is subsequently lost or destroyed, and the seller is not available or refuses to provide the required disclosure(s);

(b) Interest is transferred by operation of law and the person who transferred interest did not have possession of or reasonable access to the vehicle, such as a transfer ordered by a court;

(c) DMV is satisfied a disclosure(s) required under section (2) of this rule is otherwise not available;

(d) The owner shown on an out-of-state title does not make a disclosure. This exception does not apply if the owner on an out-of-state title sells the vehicle directly to an Oregon business required to keep records of odometer disclosures, identified in section (6) of this rule;

(e) The owner shown on an Oregon title sells the vehicle to an out-of-state dealer and does not make a disclosure, and the vehicle is subsequently transferred to an Oregon buyer.

(5) When accepting a disclosure from the buyer or accepting a transfer where only one of the two disclosures required under section (2) of this rule is received, DMV may require additional evidence or information as to why a disclosure from the seller or person required to provide the disclosure has not been provided:

(a) When a transfer occurs between private parties or businesses not required by federal rule or law to maintain odometer disclosure records, in lieu of evidence, DMV:

(A) May accept a certification from the buyer that includes a statement that a disclosure from the seller is not available; or

(B) If one of the two disclosures required under section (2) of this rule is provided, DMV may accept the transfer without requiring an additional disclosure or certification.

(b) When a vehicle is sold by or through a business required by federal rule to maintain odometer disclosure records, in addition to the certification described in subsection (5)(a) of this rule, DMV may require any or all of the following:

(A) Evidence that the buyer attempted to get the required disclosure from the seller, or evidence that the seller no longer is in business;

(B) A statement, certification or other evidence from the seller stating why the seller is unable to provide the required disclosure information; or

(C) A certified copy of the disclosure from the seller's records, if the original disclosure is not available.

(c) When a transfer occurs by operation of law:

(A) DMV will accept a certification from the buyer as provided in subsection (5)(a) of this rule, without requiring further information or evidence as to the availability of a disclosure from the person who transferred the interest, if the transfer is of the type where the person who is transferring interest would in many cases not have possession of, or reasonable access to, the vehicle (e.g., transfer by court order or bankruptcy trustee);

(B) DMV may require the information described in subsection (5)(b) of this rule, if the transfer is of a type where the person who is transferring interest would in most cases have possession of or reasonable access to the vehicle (e.g., possessory lien sale or sheriff's sale).

(6) Businesses required to maintain odometer disclosure records under federal rule or law include:

(a) Auction companies, which as used in this rule, includes any person who takes possession (whether through consignment or bailment, or through any other arrangement) of a motor vehicle owned by another person for purposes of selling such motor vehicle at an auction;

(b) Dealers, which for the purpose of odometer disclosures under this rule and under federal odometer provisions, includes:

(A) Any person who meets the definition of "dealer" as defined in OAR 735-150-0010, regardless of whether the person holds a business certificate issued under ORS Chapter 822; and

(B) Any person who meets the definition of "dealer" in federal rules and laws (i.e., has sold five or more motor vehicles in the past 12 months to purchasers who in good faith purchase such vehicles for purposes other than resale). For the purpose of this rule, DMV considers any Oregon dismantler or dealer who holds a certificate issued under ORS Chapter 822 to meet this definition.

(c) Distributors, which as used in this rule, means any person who has sold five or more vehicles in the past 12 months for resale; and

(d) Lessors, which as used in this rule, means any person or agent for any person who has leased five or more motor vehicles in the past 12 months.

(7) In addition to any information or documents required under section (5) of this rule, and except as otherwise provided in this rule, disclosures accepted from buyers must contain at least the following:

(a) The odometer reading, excluding tenths of a mile or kilometer;

(b) Vehicle information sufficient for DMV to identify the vehicle;

(c) A certification as to whether, to the best of the person's knowledge, the odometer reading reflects the actual mileage, is in excess of the designed mechanical odometer limit, or does not reflect the actual mileage;

(d) The printed name and written signature of the buyer; and

(e) The buyer's address.

(8) DMV may accept a disclosure on a form other than required under OAR 735-028-0020 through 735-028-0090:

(a) Examples of situations where DMV may accept alternative forms include:

(A) A disclosure required to be on a title that is in the possession of, and is being retained by DMV;

(B) DMV accepting a disclosure as provided under section (5)of this rule; or

(C) A disclosure made on a secure power of attorney that has not been transferred to a state issued disclosure form.

(b) DMV will not accept a disclosure on an alternative form when:

(A) A dealer signs a disclosure as both seller and buyer and does not use a secure power of attorney form; or

(B) A dealer uses a secure power of attorney form to make a disclosure when the title was not lost or in the possession of a lienholder.

(9) DMV may accept an odometer disclosure that does not contain all the information required by rule, if the documents received by DMV contain all of the following:

(a) The odometer reading;

(b) A certification as to whether, to the best of the person's knowledge, the odometer reading reflects the actual mileage, mileage in excess of the designed mechanical limit of the odometer, or does not reflect the actual mileage;

(c) Vehicle information sufficient for DMV to identify the vehicle; and

(d) The signature of the person making the disclosure.

(10) DMV may accept a secure power of attorney that does not contain all the information required by rule, if the documents received by DMV contain all of the following:

(a) The odometer reading;

(b) A certification as to whether, to the best of the person's knowledge, the odometer reading reflects the actual mileage, mileage in excess of the designed mechanical limit of the odometer, or does not reflect the actual mileage;

(c) Vehicle information sufficient for DMV to identify the vehicle;

(d) The signature of the person granting power of attorney; and

(e) The signature of the named attorney.

(11) DMV may retain a separate power of attorney filing and fee under OAR 735-028-0080(9) that does not contain all the required information.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 802.200, 803.015, 803.045, 803.050, 803.065, 803.092, 803.094, 803.097, 803.102, 803.120, 803.122, 803.124, 803.126, 803.140, 803.207, 803.370, 803.475, 805.120, 815.405, 821.060 & 821.080
Stats. Implemented: ORS 803.120, 815.425 & 49 CFR Part 580
Hist.: MV 8-1992, f. 6-30-92, cert. ef. 7-1-92; MV 18-1992, f. 12-21-92, cert. ef. 1-1-93; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-028-0110
Control of Secure Forms — Definitions, Distribution and Fees

The following apply to DMV secure power of attorney and secure odometer disclosure/reassignment forms:

(1) As used in OAR 735-028-0110 through 735-028-0150:

(a) "Vendor" means a person authorized by DMV to print and sell secure forms to DMV and forms distributors;

(b) "Forms distributor" or "distributor" means a person authorized by DMV to distribute secure forms to end users;

(c) "End user" means a person that buys or sells vehicles or provides lending services for vehicles on a regular basis.

(d) "Application for approval" or "application" means a DMV application to become a forms distributor;

(e) "Authorized" means an applicant that has been approved by DMV to distribute secure forms.

(2) Secure forms may be distributed to end users by DMV or a forms distributor defined under section (1) of this rule.

(3) DMV will calculate the form fees charged to end users by adding DMV's cost of the forms and the cost of shipping and handling.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 802.200, 803.015, 803.045, 803.050, 803.065, 803.092, 803.094, 803.097, 803.102, 803.120, 803.122, 803.124, 803.126, 803.140, 803.207, 803.370, 803.475, 805.120, 815.405, 821.060 & 821.080
Stats. Implemented: ORS 803.124 & 49 CFR Part 580
Hist.: MV 18-1992, f. 12-21-92, cert. ef. 1-1-93; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-032-0020
Plates Considered Void

(1) Registration plates that are surrendered to DMV are considered void and may not be used to register or operate a vehicle again. This does not apply to plates surrendered to DMV in error and that have not already been destroyed.

(2) When a dismantler issued a certificate under ORS 822.110 acquires a wrecked vehicle with Oregon registration plates the plates are considered void and may not be used to register or operate a vehicle again. For purposes of this rule, "acquires" means physical possession of a motor vehicle together with possession of the vehicle's ownership record.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.210, 803.380, 819.010 - 819.030 & 822.100 - 822.145
Stats. Implemented: ORS 809.080 & 809.110
Hist.: MV 29-1986, f. 12-31-86, ef. 1-1-87; Administrative Renumbering 3-1988, Renumbered from 735-100-0320; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-150-0005
Oregon Dealer Advisory Committee

(1) The Oregon Dealer Advisory Committee is established pursuant to ORS 802.370.

(2) The committee's membership will consist of the following individuals:

(a) Two individuals who represent franchise dealers of new vehicles;

(b) Two individuals who represent dealers of used vehicles;

(c) Two individuals who represent Oregon dismantlers;

(d) Two individuals who represent the interests of the general public;

(e) One individual who represents recreational vehicle dealers;

(f) One individual who represents vehicle dealership office management interests;

(g) One individual who represents auto auctions;

(h) One individual who represents Oregon towing businesses.

(i) In addition to the committee membership described under subsections (a) through (h) of this section, membership may also include one realtor who is a certified vehicle dealer and one individual, whose term of appointment and interest of representation will be determined by the DMV Administrator.

(3) DMV must annually designate one member listed in section (2) of this rule as chair of the committee.

(4) Members' terms of appointment will be three (3) years. However, members serve at the pleasure of the DMV Administrator. A member may be replaced upon missing two (2) consecutive meetings without good cause. The initial date of expiration of terms will be staggered in a manner determined by DMV.

(5) DMV will seek the recommendation of a trade or professional association generally recognized to represent a membership category before appointing a committee member, however, DMV is not bound by the association's recommendation.

(6) DMV must consult with the committee before:

(a) Adopting administrative rules under ORS 822.035;

(b) Taking disciplinary action against a dealer under ORS 822.050 to revoke, suspend or place a dealer on probation;

(c) Levying a civil penalty against a dealer under ORS 822.009(1); or

(d) Taking disciplinary action against an Oregon dismantler under OAR 735-152-0050 to revoke, suspend or place a dismantler on probation.

(7) DMV, at its discretion, may consult with the committee or committee member by mail, telephone, or other electronic means, or at a meeting of the committee. However, DMV is not bound by a committee recommendation. DMV must provide members seven (7) days from the date of a mailing to respond to proposed actions, unless DMV determines continued operation of a business jeopardizes public health or safety.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 822.035

Stats. Implemented: ORS 802.370

Hist.: MV 19-1992, f. 12-23-92, cert. ef. 1-1-93; DMV 6-1994, f. & cert. ef. 7-21-94; DMV 20-2004, f. & cert. ef. 8-20-04; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-150-0010
Definitions

As used in this division and ORS Chapter 822:

(1) "Additional (or supplemental) place of business" or "additional (or supplemental) location" means a location, other than one exempted under OAR 735-150-0020, that is more than 500 feet from any other business location of the dealer that is operated under the same name as the main business location.

(2) "Advertise" means to offer a vehicle for sale or to communicate to the public that a person is acting as a vehicle dealer, by any oral, written, or graphic means including, but not limited to, handbills, the Internet, newspapers, signs, television, billboards, radio, and telephone directories.

(3) "Agent" means any dealer possessing a current valid vehicle dealer certificate issued under ORS 822.020, who accepts applications and fees for the titling and the registration of vehicles sold by the dealer and who performs such other duties related to the titling and registration of vehicles as DMV authorizes under the rules set forth in Division 150.

(4) "Broker" has the same meaning as "motor vehicle broker" as defined in ORS 822.047(1).

(5) "Brokerage services" has the same meaning as defined in ORS 822.047(1).

(6) "Business day" means Monday through Saturday and does not include Sundays or State of Oregon and Federal legal holidays.

(7) "Buyer," "purchaser" and "lessee" have the same meaning as "owner" as defined in ORS 801.375.

(8) "Cancellation" has the same meaning as "revocation" as defined in section (24) of this rule.

(9) "Certified dealer" means a dealer who holds a valid dealer certificate issued under ORS Chapter 822.

(10) "Circumstances beyond the dealer's control," as used in ORS 822.045(3)(b) and OAR 735-150-0050(5) means:

(a) That the dealer could not get the title from any state and the prior security interest holder was paid in full by the dealer; and

(b) The delay was a result of the security interest holder failing to release title; or

(c) DMV may consider the follow mitigating circumstances, if those circumstances result in the physical destruction of, or inaccessibility to vehicle records necessary to prove compliance with ORS 822.045(1) and OAR 735-150-0050(5):

(A) The direct result of clearly-established fraud or other criminal activity against the vehicle dealer, as determined in a criminal or civil action in a court of law or independently corroborated by a report of a law enforcement agency or insurer or the sworn testimony or affidavit of an accountant or the person who actually engaged in the criminal activity. This mitigating circumstance does not apply if the dealer is the perpetrator of the wrongdoing described in this paragraph; or

(B) The direct result of fire, flood or other calamitous event, resulting in physical destruction of, or inaccessibility to vehicle records to prove compliance with ORS 822.045(1) and OAR 735-150-0050(5).

(11) "Closure" means a vehicle dealership that no longer has legal authority to conduct dealer-related activity. For example, a dealer's certificate issued under ORS 822.020 is expired, cancelled, suspended or revoked.

(12) "Clearly marked" means the notice and dealer contact information required under ORS 822.040(4)(b) and OAR 735-150-0033 is conspicuously posted on the window of each display vehicle, is in plain view of the public and is legible at a distance of six feet or more.

(13) "Date of sale," or use of similar terms to indicate the day that the sale occurred, means the date that the purchaser takes possession of the vehicle. This does not apply to vehicles purchased by a dealer at wholesale auction. With respect to auto auctions and for purposes of consignor payment under ORS 822.060(1)(d), "date of sale" means, the date upon which the consigning party delivers the necessary title documents to the purchasing dealer.

(14) "Dealer" means a person who engages in any of the activities described in ORS 822.005, except those persons exempted by ORS 822.015.

(15) "Dealership," "place of business" or "business location" means a location within the State of Oregon where activities specified in ORS 822.005 take place.

(16) "Designated dealer" means a certified dealer who has been authorized to act as an agent of DMV under OAR 735-150-0040.

(17) "DMV" means the Driver and Motor Vehicle Services Division of the Oregon Department of Transportation.

(18) "DMV Administrator" means the administrator of the Driver and Motor Vehicles Services Division of the Oregon Department of Transportation.

(19) "Employee" means a person over whom a dealer exercises the type of control typically associated with an employer, including but not limited to:

(a) Determining the frequency, method and amount of compensation;

(b) Determining whether the person's work is continuous or intermittent;

(c) Determining the hours or frequency of a person's work; or

(d) Retaining the ability to terminate the relationship.

(20) "Good faith effort" as used in ORS 822.045(3) means action satisfactory to DMV that a vehicle dealer complied with the requirements set forth in OAR 735-150-0050(1) and (2).

(a) DMV will determine that the dealer's efforts are in good faith if written documentation is provided that verifies:

(A) Action(s) was taken by the dealer within ten (10) days of sale to resolve problems with providing transfer of ownership; and

(B) The dealer provided complete and timely information to the customer concerning any problems encountered and actions being taken to resolve them.

(b) DMV will not accept a good faith effort by a dealer if, before the sale of the vehicle, the dealer knows or reasonably should know that title transfer could not be completed within 30 days.

(21) "Location," "main business location" or "main dealership" means a location identified and listed as the dealer's main business location on the most current application for vehicle dealer certificate.

(22) "Normal business hours" means all times during which a dealer engages in any of the activities described in ORS 822.005, except as exempted by ORS 822.015.

(23) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation or any other legal or commercial entity.

(24) "Permanent revocation" means to permanently revoke a vehicle dealer certificate and the right to apply for a vehicle dealer certificate.

(25) "Probation" means a period of time specified by DMV during which a vehicle dealer may continue to operate, but only under the terms or conditions established by DMV.

(26) "Principal" means an owner, partner, corporate officer or other person who controls or manages the business organization or the employees or agents of the business organization.

(27) "Purchaser" has the same meaning as buyer or a lessee.

(28) "Rebuilder" means a person engaged in conducting a "vehicle rebuilding business" as specified in ORS 822.070.

(29) "Revocation" means to void and terminate a vehicle dealer certificate. Unless permanently revoked, DMV will specify the period of time before the person subject to the revocation may apply for a new vehicle dealer certificate.

(30) "Sanction" means an action taken against a vehicle dealer by DMV in cases of non-compliance, fraud, misuse or abuse of privileges granted by a vehicle dealer certificate pursuant to a violation of the Oregon Vehicle Code or any rule adopted by DMV relating to vehicle dealers or the operation of a vehicle dealership.

(31) "Suspension" means a period of time specified by DMV during which a vehicle dealer is prohibited from:

(a) Buying, selling, trading, exchanging any vehicle or providing brokerage services. This includes, but is not limited to, providing information about price, quality, availability, payment terms, or any other information specific to the sale of a vehicle; and

(b) Acting as DMV's agent.

(32) "Violation" means any violation by a person or vehicle dealer of the Oregon Vehicle Code or any rules adopted by DMV in accordance with ORS 822.009(1) & (2).

(33) "Warning" means a documented oral warning to the principal of a dealership or a written correction notice issued to the principal or an employee of the dealership.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 822.035
Stats. Implemented: ORS 822.005 - 822.080
Hist.: MV 7-1987, f. & ef. 7-13-87; MV 39-1989, f. & cert. ef. 10-3-89; MV 8-1991, f. & cert. ef. 7-19-91; MV 22-1991, f. 9-27-91, cert. ef. 9-29-91; MV 19-1992, f. 12-23-92, cert. ef. 1-1-93; DMV 6-1994, f. & cert. ef. 7-21-94; DMV 2-1996, f. & cert. ef. 4-18-96; DMV 17-2002, f. & cert. ef. 9-20-02; DMV 20-2004, f. & cert. ef. 8-20-04; DMV 11-2005, f. 4-25-05, cert. ef. 5-1-05; DMV 24-2005, f. 11-18-05, cert. ef. 1-1-06; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0000
Definitions

As used in this division the following definitions apply:

(1) "Acquires," "acquired " or "acquisition" means physical possession of a motor vehicle together with possession of the vehicle's ownership record.

(2) "Certificate of sale" has the same meaning as defined in ORS 801.183.

(3) "Date of sale" means the date that a purchaser takes possession of a major component purchased from a dismantler.

(4) "Destroy" has the same meaning as defined in ORS 822.133.

(5) "Dismantler" has the same meaning as defined in ORS 801.236.

(6) "Dismantle" means one or more parts are removed from a motor vehicle acquired by a dismantler.

(7) "Dispose" or "disposed of" means a motor vehicle acquired by a dismantler is transferred to another person or is dismantled or destroyed.

(8) "DMV" means the Driver and Motor Vehicle Services Division of the Oregon Department of Transportation.

(9) "Employee" means a person over whom a dismantler exercises the type of control typically associated with an employer, including:

(a) Determining the frequency, method and amount of compensation;

(b) Determining whether the person's work is continuous or intermittent;

(c) Determining the hours or frequency of a person's work; or

(d) Retaining the ability to terminate the relationship.

(10) "Major component part" has the same meaning as defined in ORS 822.137.

(11) "Ownership record" means a Primary Ownership record as defined in ORS 801.402 and includes those documents described in OAR 735-020-0010 or an abandoned vehicle certificate under OAR 735-024-0077.

(12) "Permanent revocation" means to permanently revoke a dismantler certificate and the right to apply for a dismantler certificate. A person subject to permanent revocation of a dismantler certificate is ineligible to apply for a new dismantler certificate.

(13) "Person" means an individual, partnership, corporation, association, or any other business organization if the context in which the term is used could also include these organizational forms.

(14) "Principal" means any owner, partner, corporate officer or other person who controls or manages the business organization or the employees or agents of the business organization.

(15) "Probation" means a period of time specified by DMV that a dismantler may continue to operate, but only under terms or conditions established by DMV.

(16) "Salvage Pool" means a person providing a storage service for salvage vehicles, and who either displays the vehicles for resale or solicits bids for the sale of salvage vehicles for other owners. This definition also applies to insurance companies who store and display salvage vehicles for sale. Salvage pools are considered dismantlers and must comply with all applicable requirements of ORS 822.100 through 822.150 and DMV rules pertaining to dismantlers.

(17) "Salvage Vehicle" means a vehicle which has sustained damages sufficient to require it to be rebuilt or disassembled for parts. This definition does not apply to: Campers, boats, canopies, mopeds, travel trailers, motorcycles, snowmobiles or Class I or III all-terrain vehicles or vehicles whose unloaded weight exceeds 8,000 pounds.

(18) "Sanction" means an action taken by DMV against a dismantler certificate for non-compliance with Oregon law or any applicable DMV rule.

(19) "Suspension" means the temporary withdrawal of the authority to act as a dismantler.

(20) "Revocation" means to void and terminate a dismantler certificate. Unless permanently revoked, DMV will specify the period of time before the person subject to the revocation may apply for a new dismantler certificate.

(21) "Vehicle Business" includes vehicle dealers as defined in OAR 735-150-0010(14), dismantlers, towing businesses, vehicle transporters, salvage pools and repair shops.

(22) "Violation" means any violation of Oregon law or a DMV rule applicable to a dismantler issued a certificate or any person engaged in dismantling activities.

(23) "Warning" means a documented warning or correction notice issued to a principal or employee of a dismantler business.

(24) "Wrecked vehicle" has the same meaning as defined in ORS 822.133.

(25) "Written report" means DMV Form 270, Vehicle Dismantler's Notice and the original ownership record for the vehicle.

Stat. Auth.: ORS 184.616, 184.619, 801.133, 801.236, 802.010, 822.100 – 822.150
Stats. Implemented: ORS 822.125 & 822.100 – 822.150
Hist.: MV 7-1987, f. & ef. 7-13-87; MV 10-1991, f. & cert. ef. 8-20-91; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0005
Dismantler Application

(1) In addition to the requirements for an application for a dismantler certificate under ORS 822.110, or a renewal under ORS 822.125, an applicant for a dismantler certificate must submit the following to the DMV Business Regulation Section:

(a) A completed and signed Application for Dismantler Certificate (DMV Form 735-373) that includes:

(A) A certification that the dismantler's business complies with the building, enclosure or barrier requirements under ORS 822.135(1) and OAR 734-040-0030;

(B) A state-issued picture identification (a copy of driver license or identification card) for each principal; and

(C) If the applicant is a corporation, firm or partnership, the Oregon business registry number assigned by the Secretary of State, Corporation Division.

(b) All applicable fees; and

(c) A completed and signed DMV statement of compliance for surety bond or letter of credit.

(2) In addition to the requirements of section (1) of this rule, the applicant must submit a completed and signed Application for Supplemental Dismantler Certificate (DMV Form 735-373A) for each additional business location other than the dismantler's primary business location.

(3) If a dismantler changes the business location or business name on the dismantler's certificate, the dismantler must submit a completed and signed Application to Correct Dismantler Certificate (DMV Form 735-373B) and obtain a corrected dismantler certificate before business can be conducted at the new location or under the new business name.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 822.100 – 822.150
Stats. Implemented: ORS 822.100 – 822.150
Hist.: DMV 4-1996, f. & cert. ef. 7-26-96; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0010
Investigation of Dismantler Applications

(1) DMV may investigate applications for an original or renewal of a dismantler certificate to determine whether the information contained in the application is accurate and complete, and will do so whenever DMV has reason to believe the application is not accurate.

(2) DMV will investigate each application for an original or renewal of a dismantler certificate to determine if any of the principals of the applicant are or have been financially or operationally involved with any other vehicle business whose certificate or right to apply for a certificate is or has been on probation, suspended, canceled or revoked.

(3) DMV may investigate any principal of the applicant to determine whether the principal:

(a) Has been convicted of a violation of any provision of ORS Chapter 822 within the five years preceding the date of the application;

(b) Has been convicted in any jurisdiction outside of the state of Oregon of any violation of that jurisdiction's statutes relating to vehicle businesses, vehicle registration, title transfers or stolen vehicles within the five years preceding the date of the application; or

(c) Is currently subject to any type of administrative action relating to vehicle businesses, vehicle registration, title transfers or stolen vehicles in a jurisdiction outside of the state of Oregon.

Stat. Auth.: ORS 802.010, 822.115, 822.125, 822.130 & Ch. 654, OL 2005
Stats. Implemented: ORS 822.115 - 822.125, Ch. 654, OL 2005
Hist.: MV 10-1991, f. & cert. ef. 8-20-91; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0020
Refusal to Issue and Probationary Status of Dismantler Certificate

(1) DMV will not issue an original or renewal of a dismantler certificate to any applicant when it determines the application is incomplete or information contained in the application is false.

(2) DMV will not issue an original or renewal of a dismantler certificate to any applicant when it determines a principal of the applicant is financially or operationally involved with any vehicle business whose certificate or right to apply for a certificate is currently suspended, canceled or revoked.

(3) DMV may issue an original or renewal of a dismantler certificate on a probationary basis if a principal of the applicant is financially or operationally involved with another vehicle business whose certificate or right to apply for a certificate is currently on probation.

(4) DMV will not issue an original or renewal of a dismantler certificate to any applicant when it determines a principal of the applicant:

(a) Has been convicted of a violation of any provision of ORS Chapter 822 within the five years preceding the date of the application;

(b) Has been convicted in any jurisdiction outside of the state of Oregon of any violation of that jurisdiction's statutes relating to vehicle businesses, vehicle registration, title transfers or stolen vehicles within the five years preceding the date of the application; or

(c) Is currently affected by any type of administrative sanction or penalty that prohibits the principal from conducting a vehicle business and relates to vehicle businesses, vehicle registration, title transfers or stolen vehicles in a jurisdiction outside of the state of Oregon.

(5) DMV will not issue an original or renewal of a dismantler certificate until such time as it is satisfied the applicant meets all requirements for issuance of a certificate found in ORS Chapter 822 and OAR 735, division 152.

(6) DMV will retain the fees paid with an application to cover processing costs when it refuses to issue a certificate.

(7) An applicant who has been refused issuance of a dismantler certificate is entitled to a contested case hearing as provided in the Oregon Administrative Procedures Act under ORS 183.413 to 183.500.

(8) The refused applicant's request for a hearing must be submitted in writing and received by DMV, within 60 days of the date of the refusal. A hearing request received in a timely manner will not result in issuance of a certificate, pending the outcome of the hearing. In case of a refusal to renew, the dismantler may continue to operate under the old certificate in accordance with ORS 183.430(1), pending the outcome of the hearing, except when DMV finds that such continued operation would constitute a serious danger to the public health or safety and extends the hearing request period to 90 days in accordance with ORS 183.430(2).

(9) When a dismantler or principal of the dismantler business fails to file a timely request for hearing, the charges shall be considered to have been admitted, the dismantler or principal shall be deemed in default as to those charges, DMV's file shall constitute the record of the case, and the order of refusal shall become final.

Stat. Auth.: ORS 184.616, 184.619, 802.010 822.100 – 822.150
Stats. Implemented: ORS 822.100 – 822.150
Hist.: MV 10-1991, f. & cert. ef. 8-20-91; DMV 23-2004, f. & cert. ef. 11-17-04; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0025
Dismantler Business Location Regulations

(1) Each dismantler business location must:

(a) Comply with the building, enclosure or barrier requirements under ORS 822.135(1) and OAR 734-040-0030;

(b) Provide a means for the public to contact the dismantler or an employee of the dismantler at all times during the dismantler's normal business hours;

(c) Display an exterior sign, permanently affixed to the land or a building, that identifies the dismantler business by the name printed on the dismantler certificate, with letters clearly visible to the major avenue of traffic; and

(d) Display, in a publicly accessible and conspicuous manner, the dismantler certificate.

(2) A dismantler must have a certificate or supplemental certificate on display for each location where the dismantler displays vehicles and component parts. A dismantler who uses a supplemental place of business must have a supplemental certificate from DMV before business can be conducted at the supplemental location.

(3) As required by ORS 822.133(2), if the dismantler takes possession of a wrecked vehicle without an ownership record or salvage title, the vehicle may remain on the business premises if it is:

(a) Confined to an area of the business location that is clearly off-limits to customers for purposes of buying or selling a vehicle or component part; or

(b) Tagged with a "not for sale" notice that is clearly and conspicuously posted on the vehicle in plain view of customers and legible at a distance of 20 feet or more.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 822.100 – 822.150
Stats. Implemented: ORS 822.100 – 822.150
Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0031
Dismantler Records

(1) As required by ORS 822.135, 822.137 and this rule, motor vehicle dismantlers must maintain records on each motor vehicle or major component part acquired and taken into the inventory of the dismantler's business. Records must be retained at the dismantler's business location for a period of three years from the date of acquisition. Records must include the following:

(a) For a motor vehicle:

(A) If last titled in Oregon, the Oregon title number, or if the title is not available a copy of the vehicle ownership document;

(B) If last titled in another jurisdiction, a copy of the out-of-state title or ownership document;

(C) If available, the registration plate number and the name of the jurisdiction where the vehicle was last registered;

(D) The year, make and model;

(E) The vehicle identification number;

(F) The date the vehicle was acquired as defined under OAR 735-152-0000(1);

(G) The vehicle, stock or yard number assigned to the vehicle by the dismantler; and

(H) Any other information required by DMV.

(b) A description of a major component part that identifies the part, including:

(A) The physical characteristics of the part;

(B) The stock or yard number assigned to the part by the dismantler;

(C) The vehicle identification number of the motor vehicle from which the part came; and

(D) Any other information required by DMV.

(2) Dismantler records subject to this rule must be maintained in a manner that allows for timely retrieval of any record requested by DMV or a police officer for inspection. The dismantler may maintain original records or an exact copy of the original records in hard copy, on film, or electronically. If first approved by DMV, an exact copy of the dismantler's original records may be stored in some other manner. DMV or a police officer may require that any record printed or completed in a language other than English be accompanied by a copy translated into English.

(3) DMV may inspect dismantler records including books, contracts, documents, letters and records of any type, including electronic and paper records, of any certified dismantler when DMV is investigating a potential violation of Oregon Vehicle Code or DMV rule.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 822.100 – 822.150
Stats. Implemented: ORS 822.100 – 822.150
Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0034
Report that Vehicle is Dismantled or Destroyed

(1) This rule designates the form of the written report required under ORS 822.133(2)(e).

(2) A dismantler must submit a completed and signed written report to DMV within 30 days of the date that a dismantler destroys or dismantles a motor vehicle acquired by the dismantler.

(3) The written report must include:

(a) A completed and signed Vehicle Dismantler's Notice (DMV Form 270); and

(b) The original ownership record for the vehicle.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 822.100 – 822.150
Stats. Implemented: ORS 822.100 – 822.150
Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0037
Late Renewal of Dismantler Certificate

(1) An application to renew a dismantler certificate will not be considered late if the dismantler submits an application for renewal:

(a) Within 15 days of the date that the previous certificate expired, and the application is submitted with a surety bond in effect during that 15-day period; or

(b) No later than 45 days after the previous certificate expired, and the application is submitted with a surety bond in effect during that 45-day period. A dismantler who submits an application for renewal under this subsection will be assessed a late fee of $100 in addition to the renewal fee.

(2) A dismantler who continues business operations 45 days after their certificate has expired is in violation of ORS 822.005 and is subject to civil penalties under OAR 735-152-0060.

(3) DMV may waive or reduce a penalty described under this rule if the dismantler provides DMV with written documentation that shows that mitigating circumstances prevented the dismantler from renewing their certificate on time. Mitigating circumstances DMV may consider include:

(a) The dismantler took action to renew the license on a date reasonably calculated to complete the process in a timely manner; and

(b) The delay in renewal was due to circumstances beyond the dismantler's ability to control.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 822.100 – 822.150
Stats. Implemented: ORS 822.100 – 822.150
Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0040
Dismantler Violations Subject to Sanction

A dismantler is subject to OAR 735-152-0050 if the dismantler:

(1) Commits the offense of improperly conducting a motor vehicle dismantling business for any of the reasons set forth in ORS 822.135.

(2) Allows a person who is not an employee of the dismantler to imply or represent an affiliation with the dismantler business in order to engage in any activity that would subject that person to dismantler certification and regulatory requirements.

(3) Fails to allow DMV to conduct an inspection.

(4) Fails to apply for a salvage title if required under ORS 819.016.

(5) Is issued notice that the dismantler's bond under ORS 822.120 is canceled.

(6) Fails to pay any civil penalty imposed under ORS 822.133 and 822.137.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 822.100 – 822.150
Stats. Implemented: ORS 822.100 – 822.150
Hist.: MV 10-1991, f. & cert. ef. 8-20-91; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0045
Civil Penalty Consideration; Certified Dismantlers

(1) A dismantler who violates the provisions of ORS 822.133 and 822.137 and any rule adopted by DMV relating to these provisions may incur, in addition to any other penalty or sanction provided by law, a civil penalty in an amount of not more than $1,000 for each violation.

(2) DMV will assess a penalty amount determined by DMV to be appropriate for the particular violation. In determining an appropriate penalty amount, DMV may use the schedule set forth in OAR 735-152-0060 as a guideline and may consider the following:

(a) The severity of the violation or its impact on the public;

(b) The number of similar or related violations;

(c) Whether a violation was willful or intentional;

(d) The prior history of all civil penalties and sanctions imposed by DMV against the dismantler or principals of the dismantler business;

(e) The number of violations compared to the volume of transactions at the dismantler business; or

(f) Other circumstances determined by DMV to be applicable to the particular violation.

(3) Upon review of the criteria listed in section (2) of this rule, and prior to the issuance of a final order, DMV may reassess a civil penalty amount and agree to a civil penalty amount other than that assessed in the Notice of Imposition of Civil Penalty. After review of the criteria listed in section (2) of this rule DMV may:

(a) Cancel, refuse to renew, or refuse to issue a certificate to any person who fails to pay a civil penalty assessed by DMV; or

(b) Waive the imposition of a civil penalty, or modify the amount, and request that a dismantler attend specialized training, as determined by DMV.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 822.100 – 822.150
Stats. Implemented: ORS 183.430, 822.100 – 822.150
Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0050
Sanctions

(1) DMV may impose sanctions when it determines a dismantler has violated provisions of the Motor Vehicle Code or rules promulgated by DMV relating to the operation of a dismantler business.

(2) Sanctions may be imposed against either or both of the following:

(a) A dismantler's certificate;

(b) An owner, partner, corporate officer or other principal of the dismantler business.

(3) Factors DMV may consider when imposing a sanction include:

(a) The severity of the violation or its impact on the public;

(b) The number of similar or related violations;

(c) Whether the violations were willful or intentional; and

(d) Previous sanctions, civil penalties and warnings issued or imposed against the dismantler or principals of the dismantler business.

(4) DMV shall determine the sanction to impose when it determines violations have occurred or are occurring. These may include one or more of the following:

(a) Verbal or written warnings, including correction notices.

(b) A revocation of the dismantler certificate and the right to apply for a dismantler certificate for up to three years.

(c) Permanent revocation of the dismantler certificate and the right to apply for a dismantler certificate.

(d) Revocation of the right of a principal of a dismantler business to apply for a dismantler certificate or another vehicle related business, including a vehicle related business with a different business name.

(e) Permanent revocation of the right of a principal of a dismantler business to apply for a dismantler certificate or another vehicle related business, including a vehicle related business with a different business name.

(f) Cancellation of the dismantler certificate if it is determined the applicant or a principal of the business is ineligible for a dismantler certificate.

(g) Immediate suspension or cancellation as provided in ORS 822.145(2) upon receipt of a notice the dismantler's bond under ORS 822.120 is canceled.

(h) Immediate suspension or cancellation for failure to pay a civil penalty imposed under ORS 822.133 and 822.137 and OAR 735-152-0045.

(5) A dismantler or principal whose business certificate or privileges are suspended, canceled or revoked is entitled to a contested case hearing as provided in the Oregon Administrative Procedures Act under ORS 183.413 to 183.500.

(6) Except as provided in section (7) of this rule, a dismantler's request for a hearing shall be submitted in writing to and received by DMV within 20 days of the date of the notice of the revocation or cancellation. A hearing request received in a timely manner shall result in a withdrawal of the revocation or cancellation pending the outcome of the hearing.

(7) In the instance of an immediate suspension or cancellation as provided by subsection (4)(g) or (h) of this rule, a dismantler's request for a hearing shall be submitted in writing to and received by DMV within 90 days of the date the notice is issued. A hearing request received in a timely manner shall not result in a withdrawal of the suspension or cancellation pending the outcome of the hearing.

(8) In order for a request for hearing to be timely, the request must be postmarked or received by DMV within the time periods established in sections (6) and (7) of this rule. If the request for hearing is not timely received, the person waives their right to a hearing, except as provided in OAR 137-003-0528. The time periods will be computed as set forth in OAR 137-003-0520(8).

(9) When a timely request for a hearing is not received, the dismantler or principal will have defaulted, waived the right to a hearing and DMV's file will then constitute the record of the case.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 184.616, 184.619, 802.010, 822.100 – 822.150
Stats. Implemented: ORS 822.100 – 822.150
Hist.: MV 10-1991, f. & cert. ef. 8-20-91; DMV 23-2004, f. & cert. ef. 11-17-04; DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0060
Civil Penalty Matrix for Certified Dismantlers

DMV may impose a civil penalty against a motor vehicle dismantler for any violation described under ORS 822.100 through 822.150 and DMV rules. DMV adopts this civil penalty matrix to determine civil penalty

amounts that may be imposed against dismantlers for specific violations. DMV may modify a civil penalty assessed against a dismantler under the provisions of OAR 735-152-0045. Under this rule, an offense is a “second or subsequent offense” if a dismantler committed the same offense within three years of the offence under consideration.

(1) Fraudulently obtaining a dismantler certificate by submission of an application under OAR 735-152-0005 containing a false statement or omission of a material fact: $1,000, for the first and subsequent violation(s).

(2) Failure to notify DMV of any change in the information provided to DMV in the application submitted under OAR 735-152-0005 within 30 days of the change:

(a) For the first violation: warning;

(b) For the second violation: $250;

(c) For the third violation: $500;

(d) For the fourth and subsequent violation(s): $1,000.

(3) Failure to comply with any provision of ORS 822.137(2)(f) or OAR 735-152-0031 concerning dismantler motor vehicle records:

(a) For the first violation: warning;

(b) For the second violation: $250;

(c) For the third violation: $500.

(d) For the fourth and subsequent violation(s): $1,000.

(4) Failure to comply with any provision of ORS 822.137(2)(f) or OAR 735-152-0031 concerning dismantler major component part records:

(a) For the first violation: warning;

(b) For the second violation: $250;

(c) For the third violation: $500.

(d) For the fourth and subsequent violation(s): $1,000.

(5) Failure to comply with ORS 822.133(2)(b), concerning removing parts or destroying a motor vehicle prior to obtaining an ownership record for the vehicle:

(a) For the first violation: $500.

(b) For the second and subsequent violation(s): $1,000.

(6) Failure to comply with ORS 822.133(2)(a), by acquiring a motor vehicle or major component part without first obtaining a certificate of sale and, if applicable, a certificate of title:

(a) For the first violation: warning;

(b) For the second violation: $250;

(c) For the third violation: $500.

(d) For the fourth and subsequent violation(s): $1,000.

(7) Failure to comply with ORS 822.133(2)(a) and OAR 735-152-0025(3) concerning physically separating or visually labeling a wrecked vehicle:

(a) For the first violation: $250;

(b) For the second violation: $500.

(c) For the third and subsequent violation(s): $1,000.

(8) Failure to comply with ORS 822.137(2)(b), regarding the possession, sale or otherwise disposing of a motor vehicle or any part of a motor vehicle knowing that the vehicle or part has been stolen: $1,000 for the first violation and subsequent violation(s).

(9) Failure to comply with ORS 822.137(2)(c), regarding selling, buying, receiving, concealing, possessing or disposing of a motor vehicle or any part of a motor vehicle having a missing, defaced, intentionally altered or covered vehicle identification number, unless directed to do so by a law enforcement official: $1,000 for the first violation and subsequent violation(s).

(10) Failure to comply with ORS 822.137(2)(d) by committing a forgery in the second degree, as defined in ORS 165.007, or misstating a material fact relating to a certificate of title, registration or other document related to a motor vehicle that has been reassembled from parts of other motor vehicles: $1,000 for the first violation and subsequent violation(s).

(11) Failure to comply with ORS 822.137(2)(e) by fraudulently creating or modifying a dismantler certificate: $1,000 for the first violation and subsequent violation(s).

(12) Failure to comply with ORS 822.137(2)(h) concerning a dishonest act or omission during the sale of a motor vehicle or major component part that, as determined by DMV, causes a loss to the purchaser: $1,000 for the first violation and subsequent violation(s).

(13) Failure to comply with ORS 822.137(2)(i) concerning being convicted of a crime involving false statements or dishonesty that directly relates to the business of the dismantler or suffers any civil judgment imposed for conduct involving fraud, misrepresentation or conversion: $1,000 for the first violation and subsequent violation(s).

(14) Failure to comply with ORS 822.133(2)(e) and OAR 735-152-0034 concerning furnishing DMV with a written report, in a form established by DMV by rule, after a wrecked vehicle is dismantled or destroyed:

(a) For the first violation: warning;

(b) For the second violation: $250;

(c) For the third violation: $500;

(d) For the fourth and subsequent violation(s): $1,000.

(15) Failure to comply with ORS 822.133(2)(c) concerning failure to demolish the registration plates of a wrecked vehicle at the time the ownership record is received:

(a) For the first violation: warning;

(b) For the second violation: $250;

(c) For the third violation: $500;

(d) For the fourth and subsequent violation(s): $1,000.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 822.115, 822.125, 822.130, 822.135 Ch. 514, 654, OL 2005
Stats. Implemented: ORS 183.430, 822.115 - 822.135 & Ch. 514, 654, OL 2005
Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0070
Civil Penalty Considerations; Acting as a Dismantler Without a Certificate

Any person not issued a dismantler certificate under ORS 822.110, who violates the Oregon Vehicle Code or any DMV rule relating to the dismantling of motor vehicles, will incur, in addition to any other penalty provided by law, a civil penalty not to exceed $5,000 for each vehicle:

(1) DMV will assess penalties in accordance with the schedule set forth in OAR 735-152-0080.

(2) The Business Regulation Section of DMV may evaluate the amount of a civil penalty assessed in individual cases and may agree to payment of an amount other than originally assessed. In making such an evaluation, the Business Regulation Section may consider:

(a) The severity of the violation or its impact on the public;

(b) The number of similar or related violations;

(c) Whether the violations were willful or intentional; and

(d) Any other consideration DMV deems appropriate.

(3) DMV will refuse to issue a certificate under ORS 822.110 or to renew a certificate under ORS 822.110 to any person who fails to pay a civil penalty.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 822.100 – 822.150
Stats. Implemented: ORS 183.430 & 822.100 – 822.150
Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0080
Schedule of Violation Penalties, Unlicensed Dismantler

(1) In addition to any other penalty provided by law, the following civil penalty schedule applies to persons acting as a dismantler without a current dismantler certificate, including a dismantler who sells a vehicle while the dismantler’s certificate is expired, suspended, cancelled, or revoked.

(2) This schedule does not apply to a person or dismantler exempt from dismantler certification requirements pursuant to ORS 822.105.

(3) Civil penalties under this schedule are assessed as follows:

(a) For the first offense: $2,500 per vehicle;

(b) For the second and subsequent offenses: $5,000 per vehicle.

(4) DMV may reduce a civil penalty assessed under subsection (3)(a) of this rule if:

(a) The person or dismantler applies for and is issued a dismantler certificate under ORS 822.110 or a certificate renewal under ORS 822.125, within 30 days of the date of notice of imposition of civil penalty for acting as dismantler without a certificate; or

(b) A hearing is requested and held in accordance with ORS Chapter 183, and within 30 days of issuance of a final order upholding the penalty, the person files with DMV a completed dismantler application that meets Oregon requirements for licensure.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 822.100 – 822.150
Stats. Implemented: ORS 183.430 & 822.100 – 822.150
Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

735-152-0090
Contested Case Hearings and Disposition

(1) The Business Regulation Section of DMV may, in accordance with ORS 183.415(5), make an informal disposition of any contested case prior to the conclusion of any hearing, resulting from a sanction or civil penalty assessed under OAR chapter 735, division 152. This disposition may include a stipulation, agreed settlement, consent order or default order.

(2) An informal disposition by stipulation, agreed settlement or consent order must be in writing, signed by any party to the contested case and incorporated into the final order.

(3) The administrative law judge presiding at a contested case hearing may not adjust the amount of a civil penalty imposed by DMV under OAR 735-152-0045 or 735-152-0070.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 822.100 – 822.150
Stats. Implemented: ORS 183.430 & 822.100 – 822.150

Hist.: DMV 32-2005(Temp), f. 12-14-05, cert. ef. 1-1-06 thru 6-29-06; DMV 4-2006, f. & cert. ef. 5-25-06

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Rule Caption: Regarding refunds, fleet and tow business registration and requirements for tow business certificates.
Adm. Order No.: DMV 5-2006
Filed with Sec. of State: 5-25-2006
Certified to be Effective: 5-25-06
Notice Publication Date: 3-1-06
Rules Adopted: 735-001-0100
Rules Amended: 735-042-0010, 735-042-0020, 735-154-0010
Rules Repealed: 735-154-0020, 735-154-0030
Subject: ORS 293.445 authorizes state agencies to establish by rule the minimum dollar amount that an agency will refund when the agency receives money not legally due to the agency. OAR 735-001-0100 establishes that any amount over $5 will automatically be refunded by DMV when it determines the money is not legally due to the Division. The rule will supersede DMV's current practice of refunding amounts over $2. OAR 735-042-0010, 735-042-0020 and 735-154-0010 are amended to remove or correct references to prorated refunds for fleet vehicle registration and tow vehicle business certificates. DMV lacks authority to issue refunds of these registration types. OAR 735-154-0020 and 735-154-0030 are repealed because amended OAR 735-154-0010 makes the rules unnecessary. Finally, other non-substantive changes are made to clarify and simplify rule language.
Rules Coordinator: Brenda Trump—(503) 945-5278

735-001-0100
Refunds

DMV will issue a refund of moneys received in excess of the amount legally due:

(1) If DMV determines a person has made an overpayment of more than $5; or

(2) Upon written request from a person who made an overpayment, or the person's legal representative, if the request is submitted to DMV within three years of the date that DMV received the overpayment.

Stat. Auth.: ORS 184.616, 184.619, 293.445, 802.010, 802.110
Stats. Implemented: ORS 293.445, 802.110
Hist.: DMV 5-2006, f. & cert. ef. 5-25-06

735-042-0010
Fleet Operator Responsibilities

(1) Fleet registration plates shall be surrendered to the Driver and Motor Vehicle Services Division of the Department of Transportation (DMV) within 30 days of the date:

(a) A vehicle becomes ineligible for fleet registration; or

(b) A vehicle is withdrawn from a fleet.

(2) The fleet operator may certify that a plate has been lost or destroyed instead of surrendering a plate under section (1) of this rule.

(3) The fleet operator is responsible for registration fees until a vehicle is ineligible or withdrawn from the fleet and:

(a) The registration plate is received by DMV; or

(b) DMV receives a certification that the registration plate is lost or destroyed.

(4) When a new fleet qualifies for this program, the fleet operator shall:

(a) Turn in the plates currently on the vehicles to DMV; or

(b) Destroy the plates and provide DMV with a certification listing the plates that were destroyed.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.415, 803.420 & 805.120
Stats. Implemented: ORS 805.120
Hist.: MV 7-1986, f. & ef. 4-16-86; Administrative Renumbering 3-1988, Renumbered from 735-100-0810; MV 47-1989, f. & cert. ef. 11-16-89; DMV 5-2006, f. & cert. ef. 5-25-06

735-042-0020
Application for and Issuance of Fleet Registration

(1) An applicant for fleet vehicle registration must submit the following to DMV for each fleet vehicle to be registered:

(a) A completed and signed DMV application list for fleet vehicle registration and applicable fees;

(b) The name and address of the fleet operator, the billing address and the name and phone number for the person in charge of fleet registration;

(c) If applicable, the current registration plate number, registration expiration date, vehicle identification number (VIN) and title number;

(d) If the applicant requests to have the entire fleet's registration expire at the same time, the requested month of expiration;

(e) A service fee of $2 for each vehicle registered or added to an existing fleet and a $1 fee for each registration renewal; and

(f) Any other requirements for vehicle registration including applicable fees, proof of insurance and proof of emissions compliance.

(2) Registration expiration dates for fleet vehicles will be recorded on DMV records. Expiration dates are not included on registration plates or registration cards.

(3) DMV will assign a unique registration account number to each vehicle fleet registered in Oregon.

(4) Fleet plates are issued with a "PF" prefix, and may not be transferred to another vehicle.

(5) Except as provided in OAR 735-042-0030, fleet vehicles eligible for quarterly registration will be registered on an annual basis. Vehicles subject to biennial registration will be registered for a two-year period.

(6) Approximately 60 days before the registration on a fleet vehicle is due to expire, DMV will provide a billing list for each vehicle that needs its registration renewed to the person in charge of fleet registration. Renewal will be issued upon return receipt of a completed signed billing list that includes applicable fees, proof of insurance and proof of emissions compliance, if required.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 803.415, 803.420 & 805.120
Stats. Implemented: ORS 805.120
Hist.: MV 7-1986, f. & ef. 4-16-86; Administrative Renumbering 3-1988, Renumbered from 735-100-0820; MV 22-1988, f. 6-29-88. cert. ef. 7-1-88; MV 47-1989, f. & cert. ef. 11-16-89; MV 57-1989, f. 12-29-89, cert. ef. 1-1-90; DMV 5-2006, f. & cert. ef. 5-25-06

735-154-0010
Requirements for Towing Business Certificate

(1) In addition to meeting the requirements for an application for a towing business certificate under ORS 822.200 to 822.215 or a renewal under ORS 822.210, an applicant for a towing vehicle certificate must submit the following to the DMV for each tow vehicle:

(a) A completed and signed Application for Tow or Recovery Vehicle Business Certificate (DMV Form 735-387);

(b) An application for title and registration, if titling and registering a vehicle;

(c) An application for registration, if only registering a vehicle; and

(d) All applicable fees.

(2) At the time that a tow or recovery vehicle is transferred or no longer operates as a tow or recovery vehicle, the towing business certificate, plates and stickers issued to the vehicle must be surrendered to DMV.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 822.205 & 822.215
Stats. Implemented: ORS 822.205
Hist.: MV 14-1981, f. 10-30-81, ef. 11-1-81; MV 15-1982, f. & ef. 9-23-82; Administrative Renumbering 3-1988, Renumbered from 735-071-0105; MV 21-1991, f. & cert. ef. 9-18-91; DMV 5-2006, f. & cert. ef. 5-25-06

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Rule Caption: DMV's review criteria for non-mandatory reports focused on affect of condition or impairment on driving.
Adm. Order No.: DMV 6-2006
Filed with Sec. of State: 5-25-2006
Certified to be Effective: 5-25-06
Notice Publication Date: 4-1-06
Rules Adopted: 735-074-0212, 735-076-0002, 735-076-0015, 735-076-0035, 735-076-0052
Rules Amended: 735-074-0050, 735-074-0060, 735-074-0080, 735-074-0110, 735-074-0120, 735-074-0140, 735-074-0180, 735-074-0200, 735-074-0210, 735-076-0000, 735-076-0005, 735-076-0010, 735-076-0020, 735-076-0050
Rules Repealed: 735-074-0150, 735-076-0030, 735-076-0040
Rules Ren. & Amend: 735-074-0160 to 735-076-0007, 735-074-0170 to 735-076-0018
Subject: OAR Chapter 735, Division 74 previously established the medical certification program and addressed both the mandatory and non-mandatory reporting of drivers who have medical conditions or impairments that may affect the person's ability to safely operate a motor vehicle upon the highways. The bulk of the division was devoted to the specific requirements of the mandatory reporting program. DMV renamed the Medical Certification Program to the At-Risk Driver Program. The At-Risk Driver Program addresses both the mandatory and non-mandatory report of drivers with medical conditions or impairments that may affect the person's ability to drive

safely. The mandatory reports are covered in Chapter 735, Division 74.

The At-Risk Driver Program also addresses those drivers reported to DMV for unsafe driving behavior who are required to reestablish eligibility by re-examination. These reports are considered to be non-mandatory reports. OAR Chapter 735, Division 76 established the driver re-examination program that addressed drivers reported to DMV for unsafe driving behaviors. The rules contained in this division became obsolete. DMV no longer has a separate driver re-examination program. Re-examination (testing) is now just one of the ways in which a person might be required to re-establish eligibility as a result of a report of medical conditions, medical impairments or unsafe driving behaviors. To clarify and simplify the program, DMV has now included all non-mandatory reports of an at-risk driver in Chapter 735, Division 76. DMV also amended these rules to clearly outline new procedures used in reviewing and acting upon non-mandatory reports. The changes made to the non-mandatory program were made to be consistent with the mandatory program, so that all drivers, no matter how reported to DMV would follow similar processes. Each report is considered using established criteria to determine the best action for that report. This action might include requiring additional medical information, asking the State Health Office for a Certificate of Eligibility or requiring the person to demonstrate the ability to drive safely by testing.

OAR 735-074-0212 and 735-076-0052 have been adopted to allow DMV to issue a restricted applicant permit to an at-risk driver whose driving privileges have been canceled and denied further testing specifically for the purposes of allowing the person to take driving lessons.

Rules Coordinator: Brenda Trump—(503) 945-5278

735-074-0050
Policy and Objective

(1) It is the policy of DMV to promote safety for all persons who travel or otherwise use the public highways of this state.

(2) The underlying policy of the Department's rules on medically at-risk drivers is to preserve the independence, dignity, and self-esteem that result from providing one's own mobility, so long as it is possible to do so without risk to oneself or to others.

(3) It is therefore an objective of these rules to establish a program for the mandatory reporting to DMV of those drivers who have functional and cognitive impairments that may affect the person's driving ability.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 807.710
Stat. Implemented: ORS 807.710
Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-074-0060
Purpose

(1) DMV recognizes that some persons have, or may develop, cognitive or functional impairments that affect driving ability. DMV acknowledges that the purpose of Division 74 rules is to prevent injury or death by establishing requirements for the mandatory reporting by physicians and health care providers of those persons with severe and uncontrollable cognitive or functional impairments affecting a person's ability to safely operate a motor vehicle.

(2) Division 74 rules designate:

(a) Those physicians and health care providers required to report and the cognitive or functional impairments that must be reported to DMV under ORS 807.710;

(b) The procedures for making a mandatory report to DMV; and

(c) The procedures followed by DMV when it receives a report.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 807.710
Stat. Implemented: ORS 807.710
Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-074-0080
Definitions

(1) "DMV" means the Driver and Motor Vehicle Services Division of the Oregon Department of Transportation.

(2) A "health care provider" is a person licensed, certified or otherwise authorized or permitted by law to administer health care in the State of Oregon. For purposes of these rules, the term health care provider is limited to: a chiropractic physician, naturopathic physician, nurse practitioner, occupational therapist, physical therapist, optometrist, physician assistant and podiatric physician or surgeon.

(3) "Immediate suspension or cancellation" means the suspension or cancellation of driving privileges or the right to apply for driving privileges before the person is given an opportunity for a hearing to contest the suspension or cancellation.

(4) "Mandatory reporting or a mandatory report" is a report of severe and uncontrollable cognitive or functional impairments, submitted by a physician or designated health care provider as mandated under ORS 807.710 and these rules. DMV also has a non-mandatory reporting program that can be used by anyone, including physicians and health care providers, that reports medical issues or driving behaviors that may affect the person's ability to safely operate a motor vehicle. The non-mandatory reporting program is outlined in OAR chapter 735, division 76.

(5) A "medical report form" is the form provided to a person or designated by DMV to be used to obtain medical information for determining if the person is eligible or qualified for driving privileges.

(6) A "physician" is a doctor of medicine or osteopathy licensed to practice medicine in the state of Oregon by the Board of Medical Examiners.

(7) A "primary care provider" is a physician or health care provider who is responsible for supervising, coordinating and providing a person's initial and ongoing health care. A primary care provider initiates referrals for health care outside of his or her scope of practice, consultations and specialist care to assure continuity of a person's medically appropriate health care.

(8) "Primary and secondary driving controls" mean the steering wheel, gas pedal, brake, clutch (if applicable), turn signal controls, headlight controls, windshield wiper controls, defrost control and horn of a motor vehicle.

(9) "Recertification" or "recertify" is the process for requiring the person to reestablish eligibility at periodic intervals by submitting updated medical or vision information and possibly proving that the mental or physical condition or impairment does not affect their ability to safely operate a motor vehicle by passing DMV tests, obtaining a Certificate of Eligibility, or both.

(10) "Severe" means that the impairment substantially limits a person's ability to perform activities of daily living, including driving, because it is not controlled or compensated for by medication, therapy, surgery or adaptive devices. Severe does not include a temporary impairment for which the person is being treated by a physician or health care provider and which is not expected to last more than six months.

(11) The "State Health Office" is the Public Health Office of the Oregon Department of Human Services.

(12) The "State Health Officer" is a physician appointed as the Public Health Officer who is responsible for the medical and paramedical aspects of the health programs within the Oregon Department of Human Services or his/her designee.

(13) "Uncontrollable" means the impairment cannot be controlled or compensated for by medication, therapy, surgery, or adaptive devices.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 807.710
Stat. Implemented: ORS 807.710
Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 14-2005, f. & cert. ef. 5-19-05; DMV 6-2006, f. & cert. ef. 5-25-06

735-074-0110
Severe and Uncontrollable Impairments that must be Reported to DMV

As required by OAR 735-074-0090, a physician or health care provider must submit a report, as described in OAR 735-074-0120, to DMV when providing health care services to a person, 14 years of age or older, and who has one or more of the following cognitive or functional impairments which is severe and uncontrollable:

(1) Functional impairments include sensory impairments affecting peripheral sensation of extremities, including but not limited to: tingling and numbness and loss of position sense in extremities affecting the ability to feel, grasp, manipulate or release objects or use foot controls effectively.

(2) Functional impairments include motor impairments affecting the following areas:

(a) Strength, including but not limited to:

(A) The inability to consistently maintain a firm grip on objects;

(B) The inability to apply consistent pressure to objects with legs and feet;

(C) Weakness or paralysis of muscles affecting the ability to maintain sitting balance; or

(D) Weakness or paralysis in extremities affecting the ability to feel, grasp, manipulate or release objects or use foot controls effectively.

(b) Flexibility, including but not limited to: rigidity or limited range of mobility in neck, torso, arms, legs or joints.

(c) Motor planning and coordination, including but not limited to:

(A) Difficulty and slowness in initiating movement;

(B) Vertigo, dizziness, loss of balance or other motor planning conditions;

(C) Involuntary muscle movements; or

(D) Loss of muscle control.

(3) Cognitive impairments affecting the following areas:

(a) Attention, including but not limited to:

(A) Decreased awareness;

(B) Reduction in the ability to efficiently switch attention between multiple objects; or

(C) Reduced processing speed.

(b) Judgment and problem solving, including but not limited to:

(A) Reduced processing speed;

(B) An inability to understand a cause and effect relationship; or

(C) A deficit in decision making ability.

(c) Reaction time, including but not limited to a delayed reaction time.

(d) Planning and sequencing, including but not limited to:

(A) A deficit in the ability to anticipate or react to changes in the environment; or

(B) Problems with sequencing activities.

(e) Impulsivity, including but not limited to:

(A) Lack of emotional control; or

(B) Lack of decision making skills.

(f) Visuospatial, including but not limited to problems determining spatial relationships.

(g) Memory, including but not limited to:

(A) Problems with confusion or memory loss; or

(B) A decreased working memory capacity.

(h) Loss of consciousness or control.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 807.710
Stat. Implemented: ORS 807.710
Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-074-0120
The Mandatory Report to DMV

(1) To report a functional or cognitive impairment as required by OAR 735-074-0110, the reporting physician or health care provider must complete and submit to DMV, a Mandatory Impairment Referral, DMV Form 7230.

(2) To report visual acuity or field of vision not meeting DMV standards as required by OAR 735-074-0100, the reporting physician or health care provider must complete and submit to DMV, a Mandatory Impairment Referral, DMV Form 7230.

(3) The form must contain the following information:

(a) The name, address, date of birth, sex, and Oregon driver license or identification card number (if known) of the person being reported;

(b) The functional or cognitive impairment(s) being reported, as described in OAR 735-074-0100 or 735-074-0110;

(c) A description of how the person reported is affected by the impairment;

(d) Any underlying medical diagnosis or condition that may be applicable;

(e) If applicable, the date of the person's last episode of loss of consciousness or control, date of cerebrovascular accident (CVA), cardiac event or alcohol/drug/inhalant use or relapse;

(f) If applicable, medication prescribed that may interfere with safe driving behaviors or medication prescribed to treat the impairment(s) reported; and

(g) The name, address, phone number, license or certification number and signature of the reporting physician or health care provider.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 184.616, 184.619, 802.010 & 807.710
Stat. Implemented: ORS 807.710
Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-074-0140
DMV Response to Mandatory Report — Suspension, Opportunity to Re-Test, Reinstatement

(1) DMV will review a report received under OAR 735-074-0120 to determine if sufficient information has been provided. If the report does not contain the information required by OAR 735-074-0120 it may be returned to the reporting physician or health care provider for completion. If the report does not meet the requirements of a mandatory report, but if the report is of a possible mental or physical condition or impairment that indicates the person is no longer qualified to hold a driver license, driver permit or endorsement or may no longer be able to drive safely, DMV will review the report under the non-mandatory program described in OAR chapter 735, division 76 to determine what action, if any, is appropriate. If DMV is unable to determine from the report whether the person is able to safely operate a motor vehicle, the report will be submitted to the State Health Office for review.

(2) Using the standards set forth in OAR 735-074-0130, or upon recommendation of the State Health Officer, DMV will suspend driving privileges or the right to apply for driving privileges under ORS 809.419(3), if it is determined from the report submitted under OAR 735-074-0120 that the person has a mental or physical condition or impairment that affects the person's ability to safely operate a motor vehicle upon the highways. Driving privileges or the right to apply for driving privileges will be immediately suspended if DMV has reason to believe the person may endanger people or property if not immediately suspended.

(3) If DMV receives a report that indicates that a person's vision does not meet the vision standards set forth in OAR 735-062-0050, DMV will immediately suspend the person's driving privileges or right to apply for driving privileges under ORS 809.419(3). To be eligible for reinstatement of driving privileges the person must: submit proof from a licensed optometrist or physician who specializes in the diagnosis and treatment of eye diseases that the person's vision, with or without corrective lenses, meets the vision standards set forth in OAR 735-062-0050, and pass a knowledge and drive test. Proof that vision meets DMV standards is only valid for six months from the date DMV receives the Certificate of Vision form and the person must pass the knowledge and drive test within this time period for reinstatement of driving privileges.

(4) A person whose driving privileges and right to apply for driving privileges are suspended because of a functional impairment may request to be tested by DMV to demonstrate that notwithstanding the impairment, the person is qualified to safely operate a motor vehicle. If the request is granted, DMV will administer a vision screening under OAR 735-062-0050, a knowledge test under OAR 735-062-0040 and a DMV drive test under OAR 735-062-0070. DMV will deny the request if it has reason to believe the person is unable to safely operate a motor vehicle during a drive test. If the request is denied, DMV may give the person tests if the person:

(a) Obtains a Certificate of Eligibility from the State Health Officer;

(b) Submits proof of successful completion of a driver rehabilitation program conducted by a rehabilitation specialist;

(c) Submits proof of successful completion of a driver training course conducted by an ODOT certified commercial driver training school; or

(d) Submits proof that the person's motor vehicle is equipped with an appropriate adaptive device(s), such as hand controls, and provides documentation that the person knows how to use and has practiced with the adaptive devices(s).

(5) A person whose driving privileges and right to apply for driving privileges are suspended because of a cognitive impairment or a cognitive impairment in conjunction with a functional impairment reported under OAR 735-074-0110 may request to be tested by DMV to demonstrate that notwithstanding the disorder or the impairment, the person is qualified to safely operate a motor vehicle. Before DMV will grant the request to be tested, the person must obtain a Certificate of Eligibility from the State Health Officer. If the Certificate of Eligibility is obtained, the person must pass a vision screening under OAR 735-062-0050, a knowledge test under OAR 735-062-0040 and a DMV drive test under OAR 735-062-0070.

(6) The following apply to a request for testing under sections (4) and (5) of this rule:

(a) The request must be made by contacting DMV headquarters; and

(b) For a cognitive impairment or a cognitive impairment in conjunction with a functional impairment, testing must be completed within six months of the date of the DMV receives the Certificate of Eligibility from the State Health Officer.

(7) DMV may issue a no-fee identification card if a person whose driving privileges are suspended pursuant to this rule, voluntarily surrenders his or her valid driver license or driver permit.

(8) DMV will notify the reporting physician or health care provider if the person's driving privileges are reinstated.

(9) If the person reinstates his or her driving privileges, DMV may require the person to provide periodic medical information based on the recommendation of the State Health Officer or obtain periodic vision exams based on the recommendation of the person's vision specialist. DMV may send the Medical Impairment Referral and case file to the State Health Officer for review on those with functional impairments who are reinstated for determination of whether the person should be medically recertified at a later date. The State Health Officer will include a determination if medical re-certification is needed on cognitive impairments at the time a determination on testing is made. If periodic medical information is required, DMV will send the person a Medical Impairment Recertification form and require the person to obtain information from his or her physician, nurse practitioner or physician assistant and return that to DMV within 30 days of the date on the requirement letter. If a periodic vision exam must be obtained, DMV will send the person a Certificate of Vision form which

must be completed by the person's vision specialist and returned to DMV within 30 days of the date on the requirement letter.

(10) A person may be required to successfully complete DMV testing or may have driving privileges suspended based on information contained in the Medical Impairment Recertification form or periodic vision information report submitted under section (9) of this rule.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.340, 807.710 & 809.419

Stat. Implemented: ORS 807.340 & 807.710

Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 1-2005, f. & cert. ef. 1-20-05; DMV 6-2006, f. & cert. ef. 5-25-06

735-074-0180

When a Suspension or Cancellation of Driving Privilege Occurs

(1) DMV may issue an immediate suspension of driving privileges in the following situations:

(a) As set forth in OAR 735-074-0140, if DMV has reason to believe from the information provided in a mandatory report submitted under 735-074-0120 that the person may endanger people or property if not immediately suspended;

(b) The State Health Officer, upon review of medical information on a driver, recommends an immediate suspension;

(c) Information contained in a required Medical Impairment Recertification form submitted as required under OAR 735-074-0140 indicates that the person has a mental or physical condition that makes it unsafe for the person to operate a motor vehicle and DMV has reason to believe the person may endanger people or property if not immediately suspended; or

(d) Information contained in a required Certificate of Vision form submitted as required under OAR 735-074-0140 indicates the person's vision does not meet minimum vision standards under OAR 735-062-0050 and DMV has reason to believe the person may endanger people or property if not immediately suspended.

(2) DMV will immediately cancel a person's driving privileges if DMV has reason to believe that the person may endanger people or property if not immediately canceled. If DMV has reason to believe a person is unable to safely operate a motor vehicle and may endanger people or property, DMV may immediately cancel driving privileges pursuant to ORS 807.350 and OAR 735-070-0010, 735-070-0020 and 735-074-0220.

(3) DMV may cancel driving privileges pursuant to ORS 807.350 and OAR 735-070-0010, 735-070-0020 and 735-074-0220 if:

(a) The person's vision does not meet the minimum vision standards set forth in OAR 735-062-0050;

(b) DMV determines the person no longer meets the qualifications for a driver license, driver permit or endorsement because of a physical or mental condition or impairment that affects the person's ability to safely operate a motor vehicle upon the highway or a problem condition involving alcohol, inhalants or controlled substances; or

(c) The person is denied a drive test by DMV or the State Health Officer because of a physical or mental condition or impairment that affects the person's ability to safely operate a motor vehicle upon the highway.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.340, 807.350 & 809.419

Stat. Implemented: ORS 807.350 & 809.410

Hist.: MV 19-1987, f. 9-21-87, ef. 9-27-87; Administrative Renumbering 3-1988, Renumbered from 735-031-0410; MV 14-1993, f. 10-22-93, cert. ef. 11-4-93; DMV 14-2002, f. 8-14-02 cert. ef. 9-1-02; DMV 24-2002, f. 12-13-02 cert. ef. 1-1-03; DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; Renumbered from 735-074-0020; DMV 1-2005, f. & cert. ef. 1-20-05; DMV 14-2005, f. & cert. ef. 5-19-05; DMV 6-2006, f. & cert. ef. 5-25-06

735-074-0200

Testing Process

(1) The driver must test in the driver's current license class, unless the driver voluntarily chooses to test for a lower class of license.

(2) Before DMV may conduct a drive test, the person must successfully complete all other required tests.

(3) The waiting periods between knowledge or drive tests are listed in OAR 735-062-0040 and 735-062-0070, respectively.

(4) As set forth in OAR 735-062-0073, DMV may refuse to conduct or continue a drive test if a DMV employee reasonably believes that the person is likely to endanger persons or property while being tested. Further testing may be denied and driving privileges cancelled if DMV determines the person is likely to endanger persons or property during subsequent testing.

Stat. Auth.: ORS 184.616, 184.619, 802.010 &807.340

Stat. Implemented: ORS 807.070 & 807.340

Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-074-0210

Restricted Licenses

(1) DMV may issue a restricted license to a person who passes the required tests when DMV determines a restriction on the license is necessary to insure the safe operation of a motor vehicle by the person. These restrictions may include but are not limited to the following:

(a) Daylight driving only;

(b) Driving only on a certain, restricted route;

(c) Driving only during certain hours of the day; or

(d) Driving only with certain vehicle equipment or adaptive devices.

(2) A person whose driving privileges or right to apply for driving privileges are suspended under Division 74 rules, who is otherwise eligible for driving privileges, may obtain a 60-day restricted license for the express purpose of taking driving lessons, if DMV determines that with driving lessons the person may learn to safely operate a motor vehicle. The person must provide sufficient information to show that there is a reasonable likelihood that driving lessons will improve the person's ability to safely operate a motor vehicle. Such information may include, but is not limited to, medical information, information from a rehabilitation specialist that the person may benefit from lessons to learn to use an adaptive device or technique or an affidavit from a person with information showing that with driving lessons the applicant is likely to learn to safely operate a motor vehicle. The suspension will be rescinded for the 60-day period the restricted license is valid. Driving lessons must be provided by a commercial driving instructor, a rehabilitation specialist or other licensed driver approved by DMV as an instructor. The restricted license will only allow the person to drive with an instructor during instruction. No other driving, under any circumstances, will be allowed by the restricted license. The person must pass a DMV vision screening or submit a Certificate of Vision showing that the person's vision does meet DMV standards and pass a DMV knowledge test before DMV will issue a restricted license to take lessons. To be eligible for a DMV drive test, the person must provide a report from the driving instructor that the person has demonstrated the physical, mental and social driving skills necessary to safely operate a motor vehicle. A restricted license issued under this section shall include a notification that at the end of the 60-day period the suspension will be reinstated without further notice if the person has not successfully passed a driving test given by a DMV employee.

(3) If, at the end of the 60-day restricted license period under section (2) of this rule, the person has not successfully completed a driving test given by a DMV employee, DMV will reinstate the suspension of the person's driving privileges and right to apply for driving privileges. When a suspension is reinstated under this section, DMV is not required to provide the person with further notice or an opportunity for a contested case hearing.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.120

Stat. Implemented: ORS 807.120

Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-074-0212

Restricted Applicant Temporary Permit

(1) If a person's driving privileges are cancelled under the At-Risk Program, and the driver is denied further testing under OAR 735-062-0073, the person may apply for a 60-day restricted applicant temporary permit for the express purpose of taking driving lessons if DMV determines that with driving lessons the person may learn to safely operate a motor vehicle.

(2) The applicant for a permit must provide sufficient information to show that there is a reasonable likelihood that driving lessons will improve the person's ability to safely operate a motor vehicle. Such information may include, but is not limited to:

(a) Medical information;

(b) Information from a rehabilitation specialist that the person may benefit from lessons to learn to use an adaptive device or technique; or

(c) An affidavit from a person(s) with information to show that with driving lessons the applicant is likely to learn to safely operate a motor vehicle.

(3) Driving lessons must be provided by a certified commercial driving instructor, rehabilitation specialist or other licensed driver approved by DMV as an instructor.

(4) The permit restriction only allows the person to drive with an instructor during driving lessons and at no other time.

(5) To be eligible for a restricted permit the person must:

(a) Apply for driving privileges;

(b) Pass a DMV vision screening or submit a Certificate of Vision showing that the person's vision meets DMV standards; and

(c) Pass a DMV knowledge test.

(6) To be eligible for a DMV drive test, the person must provide a report from the driving instructor that the person has demonstrated the physical, mental and social driving skills necessary to safely operate a motor vehicle.

(7) A restricted permit issued under this rule will include a notification that at the end of the 60-day period the permit expires and the person no longer has driving privileges until he or she has successfully passed a DMV driving test and is eligible for driving privileges.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.120, 807.310, 807.340
Stats. Implemented: ORS 807.120, 807.310, 807.340
Hist.: DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0000
Policy, Objective and Purpose of the At-Risk Program – Non-Mandatory Reporting

(1) It is the policy of DMV to promote safety for all persons who travel or otherwise use the public highways of this state.

(2) The underlying policy of the Department's rules on at-risk drivers is to preserve the independence, dignity, and self-esteem that result from providing one's own mobility, so long as it is possible to do so without risk to oneself or to others.

(3) It is therefore an objective of these rules to establish a program for the non-mandatory reporting to DMV of those drivers who have a mental or physical condition or impairment that may affect driving ability, or drivers who have demonstrated unsafe or dangerous driving behaviors.

(4) DMV may receive information that indicates a person may no longer be qualified to hold a driver license, driver permit or endorsement or may no longer be able to drive safely. This information may come from many sources, including a physician or health care provider, a family member, friend or neighbor, a report from a police officer or a court, a DMV representative or a self-report on a driver license issuance, renewal or replacement application. Some of these reports may describe a possible mental or physical condition or impairment, a vision problem, or a possible problem condition involving alcohol, inhalants or controlled substances that indicates the person is no longer qualified to hold a driver license, driver permit or endorsement. Other reports may only describe unsafe or dangerous driving behavior that indicates the person is not able to drive safely. These rules provide procedures for the review of non-mandatory reports, the obtaining of required information necessary to determine if a driver remains qualified for driving privileges and the taking of necessary action when a determination is made that the driver is no longer qualified for driving privileges.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.340 & 809.419
Stats. Implemented: ORS 807.340
Hist.: MV 19-1987, f. 9-21-87, ef. 9-27-87; Administrative Renumbering 3-1988, Renumbered from 735-031-0440; DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0002
Definitions

(1) "Certificate of Eligibility" is the form provided to DMV by the State Health Officer establishing that the person's mental or physical condition or impairment does not affect the person's ability to safely operate a motor vehicle.

(2) "DMV" means the Driver and Motor Vehicle Services Division of the Oregon Department of Transportation.

(3) "Health care provider" is a person licensed, certified or otherwise authorized or permitted by law to administer health care in the State of Oregon. For purposes of these rules, the term health care provider is limited to: a chiropractic physician, naturopathic physician, nurse practitioner, occupational therapist, physical therapist, optometrist, physician assistant and podiatric physician or surgeon.

(4) "Immediate suspension" means the suspension of driving privileges or the right to apply for driving privileges before the person is given an opportunity for a hearing to contest the suspension.

(5) A "medical report form" is the form provided to a person or designated by DMV to be used to obtain medical information for determining if the person is eligible or qualified for driving privileges.

(6) "Non-mandatory reporting or a non-mandatory report" is a voluntary report to DMV of either a medical condition or impairment that may affect a driver's ability to safely operate a motor vehicle, or a report of actual driving behavior that may indicate the person is no longer able to safely operate a motor vehicle. A non-mandatory report does not include a report that must be filed by a physician or health care provider as required under OAR chapter 735, division 74 of a severe and uncontrollable impairment that affects a person's ability to safely operate a motor vehicle.

(7) A "physician" is a doctor of medicine or osteopathy licensed to practice medicine in the state of Oregon by the Board of Medical Examiners.

(8) "Problem condition involving alcohol, inhalants or controlled substances" has the meaning set forth in ORS 813.040.

(9) "Recertification" or "recertify" is the process for requiring the person to reestablish eligibility for driving privileges at periodic intervals by submitting a medical report form, or by submitting a Certificate of Vision form (DMV form 24) or passing a DMV vision screening. The process may also include DMV tests, a Certificate of Eligibility, or both, if determined necessary by DMV.

(10) The "State Health Officer" is a physician appointed as the Public Health Officer who is responsible for medical and paramedical aspects of the health programs within the Oregon Department of Human Services or his/her designee.

(11) "Tests" are examinations under ORS 807.070 that establish a person's eligibility for driving privileges. Tests include a DMV vision screening, a knowledge test and a drive test.

(12) "Unsafe or dangerous driving behavior" means a driver is unable to perform basic driving tasks in a safe and competent manner. Examples include, but are not limited to, the following:

(a) The driver is prevented from causing an accident by an evasive maneuver by another driver(s);

(b) The driver impedes traffic or fails to yield the right of way, such as: driving too slowly; driving in more than one lane of traffic; turning from the wrong lane; or turning into the wrong lane; and

(c) Failure to obey or difficulty obeying a traffic control device, such as: running a red light or stop sign; stopping beyond the designated stop line at a traffic light or stop sign; failing to stop for a pedestrian in a marked crosswalk; or driving the wrong way on a one-way street.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.340 & 809.419
Stats. Implemented: ORS 807.340
Hist.: DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0005
Reporting Requirements

(1) In order for DMV to process a non-mandatory report that indicates a person may no longer be qualified for driving privileges or may no longer be able to safely operate a motor vehicle, it must contain:

(a) The name of the person making the report, including a signature;

(b) The name and date of birth of the person being reported or a description of the person sufficient for DMV to identify the reported person from its records; and

(c) Sufficient information to give DMV reason to believe the person may no longer be qualified to hold a driver license, driver permit, or endorsement or may no longer be able to drive safely. For purposes of this rule, sufficient information includes but is not limited to:

(A) A physician or health care provider report of a physical or mental condition or impairment that is not reportable as required under OAR chapter 735 division 74 and includes a description of how the person's ability to drive safely may be affected;

(B) A report of a physical or mental condition or impairment, and a description of how the person's ability to safely operate a motor vehicle is affected; or a description of unsafe or dangerous driving behavior;

(C) A report by a police officer, physician or health care provider where a physical or mental condition or impairment is stated as a cause or possible cause of a crash or unsafe or dangerous driving behavior;

(D) A self-report on a driver's license/permit issuance, renewal or replacement application of a vision problem affecting driving and failure to pass a DMV administered vision screening;

(E) A self-report on a driver's license/permit issuance, renewal or replacement application of a mental or physical condition or impairment affecting the person's ability to drive safely;

(F) A self-report on a driver's license/permit issuance, renewal or replacement application of a problem condition involving alcohol, inhalants or controlled substances affecting the person's ability to drive safely; or

(G) A report of unsafe or dangerous driving behavior and DMV has reason to believe the driving behavior is likely to recur or similar driving behavior has previously been reported to DMV.

(2) All written documentation voluntarily submitted under this rule, including the name of the person submitting the documentation, will be kept confidential and not released to any person unless:

(a) DMV determines the documentation, or any portion thereof, must be released pursuant to the Public Records Law, ORS 192.410 to 192.505, or the Attorney General or a court orders disclosure in accordance with the Public Records Law; or

(b) The documentation is determined by DMV to be necessary evidence in an administrative proceeding involving the suspension or cancellation of the person's driving privileges or right to apply for driving privileges.

(3) Before taking action, DMV may request more information from the person making the report if DMV has reason to believe the information provided is inaccurate or inadequate.

Stat. Auth: ORS 184.616, 184.619, 802.010, 807.340 & 809.419
Stat. Implemented: ORS 807.340
Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0007

DMV Response to Non-Mandatory Report

DMV will review a non-mandatory report meeting the requirements under OAR 735-076-0005 to determine the appropriate action to take, which may include any or all of the following:

(1) No action if the report does not give DMV reason to believe the person being reported is no longer qualified to hold a driver license, driver permit, or endorsement or is no longer able to drive safely. This includes a report from a physician or health care provider indicating the condition or impairment is not likely to recur or does not affect the person' ability to drive safely, or a report of driving behavior that reports a single incident with no indication of a mental or physical condition or impairment affecting the person's ability to safely drive.

(2) The person may be required to reestablish eligibility by taking a test under ORS 807.070 when the report is one or more of the following:

(a) A report of a mental or physical condition or impairment that may affect the person's ability to safely operate a motor vehicle, not including a loss of consciousness or control or a problem condition involving alcohol, inhalants or controlled substances.

(b) A report of unsafe or dangerous driving behavior only.

(3) The person will be required to provide a medical report form or Certificate of Vision form when the report is of the following:

(a) The person's vision may not meet the vision standards set forth in OAR 735-060-0050;

(b) A self-report on a license/permit issuance, renewal or replacement application of a mental or physical condition or impairment that affects the person's ability to drive safely; and the condition or impairment is one that causes the loss of consciousness or control;

(c) A self-report on a license/permit issuance, renewal or replacement application of a problem condition involving alcohol, inhalants or controlled substances that affects the person's ability to drive safely; or

(d) A report of a condition or impairment that involves the loss of consciousness or control, or a possible problem condition involving alcohol, inhalants or controlled substances, and DMV has reason to believe from the report that the person may no longer be qualified for driving privileges or may no longer be able to safely operate a motor vehicle.

(4) The person may be required to obtain a Certificate of Eligibility from the State Health Officer under ORS 807.090 when the report indicates one or more of the following:

(a) A loss of consciousness or control is a cause or possible cause of a crash or of unsafe or dangerous driving behavior.

(b) Evidence of continued episodes of loss of consciousness or control despite current treatment.

(c) Evidence of a problem condition involving alcohol, inhalants or controlled substances.

(5) An immediate suspension of the person's driving privileges, under ORS 809.419(3)(c) when the report provides DMV reason to believe that the person may endanger people or property if not immediately suspended. To regain driving privileges the person will be required to reestablish eligibility for driving privileges which may include taking tests under ORS 807.070, submitting a medical report form or Certificate of Vision, or obtaining a Certificate of Eligibility under ORS 807.090.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.340 & 809.419

Stat. Implemented: ORS 807.340

Hist.: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 14-2005, f. & cert. ef. 5-19-05; Renumbered from 735-074-0160, DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0010

The Testing Process

(1) If DMV determines a person must reestablish eligibility by taking tests as described in OAR 735-076-0007(2), DMV will send a requirement letter to the driver requiring the driver to reestablish the person's eligibility by successfully completing tests.

(2) The driver must successfully complete the tests within 60 days of the date of the requirement letter. DMV may grant an extension, not to exceed 120 additional days, if:

(a) The person is seriously ill or injured and a physician requests an extension in writing; or

(b) The person is temporarily out of state and a written request is received from the person.

(3) The driver must test in the driver's current license class, unless the driver voluntarily chooses to test for a lower class of license.

(4) Before DMV will conduct a drive test, the person must successfully complete all other required tests.

(5) If the person is unable to pass the DMV vision screening, DMV will require the person to have a vision specialist complete a Certificate of Vision form. DMV will only provide a knowledge or drive test if the completed Certificate of Vision form indicates that the person's vision meets DMV's standards as set forth in OAR 735-062-0050.

(6) The waiting periods between knowledge or drive tests are listed in OAR 735-062-0040 and 735-062-0070, respectively.

(7) As set forth in OAR 735-062-0073, DMV may refuse to continue a drive test if a DMV employee reasonably believes that the person is likely to endanger persons or property while being tested, and further testing may be denied and driving privileges cancelled if DMV determines the person is likely to endanger persons or property during subsequent testing.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.340, 809.419

Stats. Implemented: ORS 807.070, 807.340

Hist.: MV 19-1987, f. 9-21-87, ef. 9-27-87; Administrative Renumbering 3-1988, Renumbered from 735-031-0450; DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0015

The Process When a Medical Report Form or Certificate of Vision is Required

(1) When DMV determines medical information or a Certificate of Vision form is necessary to determine the person's continuing eligibility for driving privilege, as described in OAR 735-076-0007(3), DMV will send a letter to the driver requiring the driver to submit the completed medical report form or Certificate of Vision form provided by DMV. The medical report form must be completed by the driver and by the driver's physician, nurse practitioner or physician assistant. The Certificate of Vision must be completed by the driver's vision specialist.

(2) The driver must submit the completed medical report form or Certificate of Vision form within 30 days of the date of the requirement letter. DMV may grant an extension, not to exceed 120 additional days, if:

(a) The person is seriously ill or injured and a physician requests an extension in writing;

(b) The person is temporarily out of state and a written request is received from the person; or

(c) The person can show that an appointment was requested in a timely manner, but the earliest appointment available exceeded the 30 days.

(3) Sections (1) and (2) of this rule apply when the person must provide a medical report form or Certificate of Vision from to recertify eligibility for driving privileges.

Stat. Auth: ORS 184.616, 184.619, 802.010, 807.340 & 809.419

Stat. Implemented: ORS 807.340

Hist.: DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0018

The Process when a Certificate of Eligibility is Required

(1) When DMV determines a Certificate of Eligibility is necessary to determine a person's continuing eligibility for driving privilege, as described in OAR 735-076-0007(4), DMV will require the person to submit a medical report form or Certificate of Vision form as set forth in OAR 735-076-0015.

(2) When received, DMV will send the medical report form or Certificate of Vision form and any other relevant reports or information in DMV's At-Risk Program file to the State Health Officer for review. The State Health Officer may either issue or deny a Certificate of Eligibility.

(3) A person issued a Certificate of Eligibility may be required to also pass tests as set forth in OAR 735-076-0010, if DMV has reason to believe that notwithstanding the Certificate, the person may not be able to safely operate a motor vehicle. The person will also be required to pass a driving test if the Certificate of Eligibility requires that the person's motor vehicle be equipped with an appropriate adaptive device(s), such as hand controls, and before a driving test is given, the person must provide documentation that he or she knows how to use and has practiced with the adaptive device(s).

(4) A person who is denied a Certificate of Eligibility must complete the requirements set forth by the State Health Officer in the denial, if any, before DMV will again submit information as set forth in subsection (2) of this rule to the State Health Officer for issuance of a Certificate of Eligibility.

Stat. Auth: ORS 184.616, ORS 184.619, 802.010, 807.340 & 809.419

Stat. Implemented: ORS 807.090 and 807.340

Hist.: MV 19-1987, f. 9-21-87, ef. 9-27-87; Administrative Renumbering 3-1988, Renumbered from 735-031-0405; MV 37-1989, f. & cert. ef. 10-3-89; MV 14-1993, f. 10-22-93, cert. ef. 11-4-93; DMV 14-2002, f. 8-14-02 cert. ef. 9-1-02; DMV 24-2002, f. 12-13-02 cert. ef. 1-1-03: DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; Renumbered from 735-074-0010; DMV 1-2005, f. & cert. ef. 1-20-05; DMV 14-2005, f. & cert. ef. 5-19-05; DMV 14-2005, f. & cert. ef. 5-19-05; Renumbered from 735-074-0170, DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0020

Suspension or Cancellation of Driving Privileges

(1) DMV may issue an immediate suspension of driving privileges in the following situations:

(a) If DMV determines from a non-mandatory report that the person has a mental or physical condition that makes it unsafe for the person to operate a motor vehicle upon the highways and DMV has reason to believe the person may endanger people or property if not immediately suspended;

(b) If based upon information included in a police accident report or other law enforcement report, DMV has reason to believe that a person may endanger people or property if not immediately suspended due a mental or physical condition that makes it unsafe for the person to operate a motor vehicle upon the highways;

(c) The State Health Officer, upon review of medical information on a driver, recommends an immediate suspension;

(d) Information contained in a required Medical Impairment Recertification form submitted as required under OAR 735-076-0035 indicates that the person has a mental or physical condition that makes it unsafe for the person to operate a motor vehicle and DMV has reason to believe the person may endanger people or property if not immediately suspended; or

(e) Information contained in a required Certificate of Vision form indicates the person's vision does not meet minimum vision standards under OAR 735-062-0050 and DMV has reason to believe the person may endanger people or property if not immediately suspended.

(2) DMV will suspend driving privileges or the right to apply for driving privileges as follows:

(a) Under ORS 809.419(1) if the person fails to successfully complete the required tests within 60 days of the date of the requirement letter, or within the time period granted if an extension is granted under OAR 735-076-0010(2);

(b) Under ORS 809.419(2), for failure to obtain a medical clearance, if the medical report form is not completed by the person and the person's physician, nurse practitioner, or physician assistant, submitted to and received by DMV within 30 days of the date on the letter sent from DMV, unless DMV has granted an extension under OAR 735-076-0015;

(c) Under ORS 809.419(2), for failure to obtain a medical clearance, if the person fails to submit a Medical Impairment Recertification form as required under OAR 735-076-0035, unless an extension is granted by DMV;

(d) Under ORS 809.419(2), for failure to obtain a medical clearance, if the person fails to submit a Certificate of Vision form when the person is required to obtain a periodic vision exam under OAR 735-076-0035, unless an extension is granted by DMV;

(e) Under ORS 809.419(3), as incompetent to drive because of a mental or physical condition or impairment that makes it unsafe for the person operate a motor vehicle, because the State Health Officer does not issue a Certificate of Eligibility to a person required to obtain the certificate under ORS 807.090, and the person has valid driving privileges;

(f) Under ORS 809.419(3), as incompetent to drive because of a mental or physical condition or impairment that makes it unsafe for the person to operate a motor vehicle, when a person voluntarily surrenders a license to DMV based upon the person's recognition that the person is no longer competent to drive and the person has failed to take or pass required examinations.

(3) DMV may cancel driving privileges pursuant to ORS 807.350 and OAR 735-070-0010, 735-070-0020 and 735-074-0220 if:

(a) The person's vision does not meet the minimum vision standards set forth in OAR 735-062-0050; or

(b) DMV determines the person no longer meets the qualifications for a driver license, driver permit or endorsement because of a physical or mental condition or impairment that affects the person's ability to safely operate a motor vehicle upon the highway or a problem condition involving alcohol, inhalants or controlled substances.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.340 & 809.419
Stats. Implemented: ORS 807.340 & 809.419
Hist.: MV 19-1987, f. 9-21-87, ef. 9-27-87; Administrative Renumbering 3-1988, Renumbered from 735-031-0460; MV 17-1992, f. 12-16-92, cert. ef. 1-1-93; DMV 16-2001, f. & cert. ef. 9-21-01; DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0035
Recertification

(1) If the person retains his or her driving privileges, or regains his or her driving privileges after a suspension, recertification may be required when:

(a) The person's reported condition or impairment is progressive or unpredictable;

(b) Recommended by the physician or health care provider when completing a medical report form; or

(c) Recommended by the State Health Officer.

(2) The time period for recertification will be based on the recommendation of the State Health Officer or the person's physician, nurse practitioner or physician assistant, or on the recommendation of the person's vision specialist.

(3) If medical recertification is required, DMV will send the person a Medical Impairment Recertification form which must be completed by his or her physician, nurse practitioner, or physician assistant and returned to DMV.

(4) If vision recertification is required, DMV will send the person a Certificate of Vision form which must be completed by the person's vision specialist and returned to DMV.

(5) The person must submit the completed Medical Impairment Recertification form or Vision form within 30 days of the date of the requirement letter. DMV may grant an extension, not to exceed 120 additional days, if:

(a) The person is seriously ill or injured and a physician requests an extension in writing;

(b) The person is temporarily out of state and a written request is received from the person; or

(c) The person can show that an appointment was requested in a timely manner, but the earliest appointment available exceeded the 30 days.

Stat. Auth: ORS 184.616, 184.619, 802.010, 807.340 & 809.419
Stat. Implemented: ORS 807.340
Hist.: DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0050
Restricted License

(1) DMV may issue a restricted license to a person who passes the required tests when DMV determines a restriction on the license is necessary to insure the safe operation of a motor vehicle by the person. These restrictions may include but are not limited to the following:

(a) Daylight driving only;

(b) Driving only on a certain, restricted route;

(c) Driving only during certain hours of the day; or

(d) Driving only with certain vehicle equipment or adaptive devices.

(2) A person whose driving privileges or right to apply for driving privileges are suspended under Division 76 rules, who is otherwise eligible for driving privileges, may obtain a 60-day restricted license for the express purpose of taking driving lessons, if DMV determines that with driving lessons the person may learn to safely operate a motor vehicle. The person must provide sufficient information to show that there is a reasonable likelihood that driving lessons will improve the person's ability to safely operate a motor vehicle. Such information may include, but is not limited to, medical information, information from a rehabilitation specialist that the person may benefit from lessons to learn to use an adaptive device or technique or an affidavit from a person(s) with information showing that with driving lessons the applicant is likely to learn to safely operate a motor vehicle. The suspension will be rescinded for the 60-day period the restricted license is valid. Driving lessons must be provided by a commercial driving instructor, a rehabilitation specialist or other licensed driver approved by DMV as an instructor. The restricted license will only allow the person to drive with an instructor during instruction. No other driving, under any circumstances, will be allowed by the restricted license. The person must pass a DMV vision screening or submit a Certificate of Vision showing that the person's vision does meet DMV standards and pass a DMV knowledge test before DMV will issue a restricted license to take lessons. To be eligible for a DMV drive test, the person must provide a report from the driving instructor that the person has demonstrated the physical, mental and social driving skills necessary to safely operate a motor vehicle. A restricted license issued under this section shall include a notification that at the end of the 60-day period the suspension will be reinstated without further notice if the person has not successfully passed a driving test given by a DMV employee.

(3) If, at the end of the 60-day restricted license period under section (2) of this rule, the person has not successfully completed a driving test given by a DMV employee, DMV will reinstate the suspension of the person's driving privileges and right to apply for driving privileges. When a suspension is reinstated under this section, DMV is not required to provide the person with further notice or an opportunity for a contested case hearing.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.120, 807.340 & 809.419
Stats. Implemented: ORS 807.120, 807.340
Hist.: MV 19-1987, f. 9-21-87, ef. 9-27-87; Administrative Renumbering 3-1988, Renumbered from 735-031-0490; DMV 8-2003, f. 5-14-03, cert. ef. 6-1-03; DMV 6-2006, f. & cert. ef. 5-25-06

735-076-0052
Restricted Applicant Temporary Permit

(1) If a person's driving privileges are cancelled under the At-Risk Program, and the driver is denied further testing under OAR 735-062-0073, the person may apply for a 60-day restricted applicant temporary permit for the express purpose of taking driving lessons if DMV determines that with driving lessons the person may learn to safely operate a motor vehicle.

(2) The applicant for a permit must provide sufficient information to show that there is a reasonable likelihood that driving lessons will improve

the person's ability to safely operate a motor vehicle. Such information may include, but is not limited to:

(a) Medical information;

(b) Information from a rehabilitation specialist that the person may benefit from lessons to learn to use an adaptive device or technique; or

(c) An affidavit from a person(s) with information to show that with driving lessons the applicant is likely to learn to safely operate a motor vehicle.

(3) Driving lessons must be provided by a certified commercial driving instructor, rehabilitation specialist or other licensed driver approved by DMV as an instructor.

(4) The permit restriction only allows the person to drive with an instructor during driving lessons and at no other time.

(5) To be eligible for a restricted permit the person must:

(a) Apply for driving privileges;

(b) Pass a DMV vision screening or submit a Certificate of Vision showing that the person's vision meets DMV standards; and

(c) Pass a DMV knowledge test.

(6) To be eligible for a DMV drive test, the person must provide a report from the driving instructor that the person has demonstrated the physical, mental and social driving skills necessary to safely operate a motor vehicle.

(7) A restricted permit issued under this rule will include a notification that at the end of the 60-day period the permit expires and the person no longer has driving privileges until he or she has successfully passed a DMV driving test and is eligible for driving privileges.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.120, 807.310, 807.340
Stats. Implemented: ORS 807.120, 807.310, 807.340
Hist.: DMV 6-2006, f. & cert. ef. 5-25-06

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Department of Transportation, Highway Division Chapter 734

Rule Caption: Allow summertime and weekend movement of overwidth loads east of the Cascade Range.
Adm. Order No.: HWD 3-2006
Filed with Sec. of State: 5-24-2006
Certified to be Effective: 5-24-06
Notice Publication Date: 4-1-06
Rules Amended: 734-082-0021
Subject: A petition was received from the Oregon Wheat Growers League (OWGL) asking for an amendment to this rule, which prohibited movement of loads over 8'6" wide during daylight hours Saturday after noon and Sundays from Memorial Day to Labor Day. OWGL stated that the rule posed an economic hardship to its members by restricting flexibility needed to timely obtain harvest equipment. Many wheat farmers lease combines to harvest their crop, and it is essential that the movement of the combines from out-of-state locations to an Oregon staging yard is not restricted. This amendment limits the prohibition to operations west of the Cascade Range.
Rules Coordinator: Brenda Trump—(503) 945-5278

734-082-0021
Days of Travel and Peak Traffic Hour Restrictions

(1) When operating on interstate highways and other highways approved by the Chief Engineer, movement from one-half hour after sunset to one-half hour before sunrise is allowed if:

(a) Width is not in excess of 12 feet on interstate highways or 10 feet on all other approved highways; and

(b) The outermost extremities are illuminated by lamps or markers as described by the requirements of ORS Chapter 816.

(2) Movement of a vehicle or combination of vehicles exceeding eight feet six inches in width is not allowed:

(a) From one-half hour after sunset to one-half hour before sunrise except as allowed in section (1) of this rule;

(b) During any hours on holidays as defined in OAR 734-082-0005(13);

(c) After 2 p.m. on the last business day preceding the observed holiday through one-half hour before sunrise of the first business day following the observed holiday, except operations conducted in accordance with section (1) of this rule may recommence at 12:01 a.m. on the first business day following the observed holiday;

(d) From noon on the Wednesday preceding Thanksgiving Day until one-half hour before sunrise on Monday following Thanksgiving Day, except operations conducted in accordance with section (1) of this rule may recommence at 12:01 a.m. on the Monday following Thanksgiving Day; or

(e) During daylight hours west of the summit of the Cascade mountain range Saturday after noon and Sundays from Memorial Day to Labor Day.

(3) In addition to the restrictions in section (2) of this rule, if width exceeds 12 feet:

(a) Movement is prohibited in the urban areas of Portland, Salem, Eugene, Grants Pass and Medford, on non-interstate highways, between the hours of 7 a.m. to 9 a.m. and 4 p.m. to 6 p.m.; and

(b) Movement on Interstate 5 between the Oregon-Washington border and its junction with OR 217, and Interstate 5 between Exit #24 and #33 near Medford is prohibited between the hours of 7 a.m. to 9 a.m. and 4 p.m. to 6 p.m.

(4) In addition to the restrictions in sections (1), (2) and (3) of this rule, if width exceeds 14 feet:

(a) Movement is prohibited in urban areas of Portland, Salem, Eugene, Grants Pass and Medford, on all highways, between the hours of 7 a.m. to 9 a.m., 11 a.m. to 1 p.m. and 4 p.m. to 6 p.m.;

(b) Movement is prohibited outside the Portland urban area between the hours of 7 a.m. to 9 a.m. and 4 p.m. to 6 p.m. Monday through Friday on the following highways:

(A) Interstate 5, between milepost 278 and the Oregon-Washington border;

(B) Interstate 84, between milepost 15 and the junction of Interstate 5 at mile post 0;

(C) Interstate 205; and

(D) US Highway 26 (Sunset Highway), between milepost 64 east to Portland.

(c) Movement is prohibited during daylight hours Saturday after noon and Sundays from Memorial Day to Labor Day.

(5) The Chief Engineer may impose or alter time of travel restrictions. These may be necessary to prevent conflict with highway construction or repair projects, or to cope with local or seasonal traffic conditions.

Stat. Auth.: ORS 184.616 & 184.619
Stats. Implemented: ORS 818.220 & 818.225
Hist.: HWY 17-1990, f. & cert. ef. 12-28-90; HWY 2-1992, f. & cert. ef. 2-18-92; HWY 11-1992, f. & cert. ef. 9-16-92; HWY 5-1997, f. & cert. ef. 5-9-97; TO 7-1998, f. & cert. ef. 8-20-98; TO 3-2000, f. & cert. ef. 2-11-00; TO 8-2002, f. & cert. ef. 10-14-02; HWD 3-2006, f. & cert. ef. 5-24-06

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Rule Caption: Adoption of the May 2006 Oregon Temporary Traffic Control Handbook.
Adm. Order No.: HWD 4-2006
Filed with Sec. of State: 5-26-2006
Certified to be Effective: 5-26-06
Notice Publication Date: 4-1-06
Rules Amended: 734-020-0005
Rules Repealed: 734-020-0005(T)
Subject: This rule adopts the Manual on Uniform Traffic Control Devices (MUTCD), the Oregon Suppliments to the MUTCD and the Oregon Temporary Traffic Control Handbook (OTTCH) to establish uniform standards for traffic control. The amendment adopts the Oregon Temporary Traffic Control Handbook dated May 2006 as a standard for temporary traffic control on public roads in Oregon for operations of three days or less, in accordance with ORS 810.200. OAR 734-020-0005 was amended in 2005 to adopt the OTTCH dated July 2005. Subsequently, a need for some corrections and clarifications was identified and Errata no. 1 was adopted by temporary rule effective December 14, 2005. This permanent rule replaces the temporary rule.
Rules Coordinator: Brenda Trump—(503) 945-5278

734-020-0005
Manual on Uniform Traffic Control Devices

(1) In accordance with ORS 810.200, the **2003 Edition of the Manual on Uniform Traffic Control Devices** with Revision no. 1 Incorporated, dated November 2004 (U.S. Department of Transportation, Federal Highway Administration) is hereby adopted by reference as the manual and specifications of uniform standards for traffic control devices for use upon highways within this state.

(2) The **Oregon Supplement to the Manual on Uniform Traffic Control Devices dated July 2005** is hereby adopted by reference as a register of deviations to the **2003 Edition of the Manual on Uniform Traffic Control Devices**.

(3) The **Oregon Temporary Traffic Control Handbook dated May 2006** is hereby adopted by reference as a standard for temporary traffic control for operations of three days or less.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 184.616, 184.619 & 810.200
Stats. Implemented: ORS 810.200
Hist.: HC 1270, f. & ef. 1-18-72; HC 1277, f. & ef. 3-3-72; 1 OTC 80, f. & ef. 12-27-76; 1 OTC 7-1978, f. & ef. 4-27-78; 1 OTC 15-1979(Temp), f. & ef. 7-18-79; 1 OTC 25-1979, f. & ef. 10-30-79; 1 OTC 16-1980, f. & ef. 9-18-80; 1 OTC 22-1980, f. & ef. 11-26-80; 1 OTC 23-1980, f. & ef. 11-26-80; 2HD 9-1983(Temp), f. & ef. 4-20-83; 2HD 16-1983, f. & ef. 9-23-83; 2HD 9-1984(Temp), f. & ef. 10-4-84; 2HD 1-1985, f. & ef. 3-29-85; 2HD 3-1985, f. & ef. 9-13-85; 2HD 1-1986, f. & ef. 2-14-86; 2HD 6-1986(Temp), f. & ef. 7-29-86; HWY 1-1987, f. & ef. 1-9-87; HWY 2-1988(Temp), f. & cert. ef. 5-27-88; HWY 7-1988, f. & cert. ef. 12-2-88; HWY 2-1990(Temp), f. & cert. ef. 2-1-90; HWY 10-1990, f. & cert. ef. 6-29-90; TO 3-2002, f. & cert. ef. 4-15-02; HWD 6-2005, f. & cert. ef. 7-22-05; HWD 10-2005(Temp), f. & cert. ef. 12-14-05 thru 6-11-06; HWD 4-2006, f. & cert. ef. 5-26-06

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Department of Veterans' Affairs
Chapter 274

Rule Caption: Monthly Assistance Amount Payable from the Covered Care Program.
Adm. Order No.: DVA 5-2006
Filed with Sec. of State: 5-30-2006
Certified to be Effective: 5-30-06
Notice Publication Date: 5-30-06
Rules Amended: 274-040-0030
Rules Repealed: 274-040-0030(T)
Subject: This rule amends 274-040-0030 and supersedes the Temporary Rule filed on March 31-2006 and effective upon filing through September 25, 2006.

The maximum monthly amount of financial assistance payable from the Covered Care Program account for the care received by an Oregon Veterans' Home (OVH) resident is being deleted to provide the Oregon Department of Veterans' Affairs (ODVA) more flexibility in determining the amount of the Program's financial assistance to OVH residents.

Housekeeping changes are a result of the passage of ORS 406.005 in the 2005 Legislature which establishes the Department of Veterans' Affairs. Text is being amended to replace "Director" with "Department."
Rules Coordinator: Herbert D. Riley—(503) 373-2055

274-040-0030
Covered Care

(1) It is the expressed policy of the Department of Veterans' Affairs (Department) to make the Oregon Veterans' Home (OVH) financially available to current or potential OVH resident by means of the Department's Covered Care Program described more fully below.

(2) Within the fund established by the Department pursuant to ORS 406.050, an account is designated for donations to be used by the Department consistent with this Covered Care Program. Funds held within this account will be used by the Department exclusively for the purpose of assisting OVH residents whose income, Medicare benefits, Medicaid benefits, and any other assets, as determined by the Department, are insufficient to meet the financial requirements necessary for the cost of OVH care.

(3) When determining to whom Covered Care Program assistance will be made available, the Department may take into consideration various factors, including but not limited to:

(a) The amount of funds in the Covered Care Program account available for this purpose;

(b) The anticipated future deposits into the Covered Care Program account;

(c) The amount of any present commitments from the Covered Care Program account;

(d) All available sources of revenue or income to a particular resident, including but not limited to:

(A) United States Department of Veterans Affairs (USDVA) payments;

(B) Social Security benefits;

(C) Other pensions;

(D) Millennium Bill benefits;

(E) Medicare benefits;

(F) Medicaid benefits;

(G) Annuities;

(H) Savings; and

(I) Investments.

(e) The amount of funds available to a particular or potential resident from members of his/her family, or others who are willing to provide financial assistance and agree to be legally obligated to meet such financial obligations of the resident;

(f) Whether or not the available Covered Care Program assistance will satisfy the entire gap in necessary funding for OVH care on behalf of the resident or potential resident;

(g) Whether or not the intended beneficiary of the Covered Care Program assistance is a current OVH resident.

(4) The payment of Covered Care Program assistance on behalf of any OVH resident is subject to the sole discretion of the Department. The Department may refuse, terminate, or suspend Covered Care Program assistance to any OVH resident at any time without notice. The Department shall be under no obligation to provide Covered Care Program assistance to any OVH resident or to solicit funds to meet the financial needs of the OVH resident, his/her family, or others.

(5) When determining to terminate or suspend Covered Care Program assistance to any current recipient, the Department may take into consideration various factors, including by not limited to:

(a) Any reported change in the financial status of the recipient or other OVH care payment provider;

(b) Any misrepresentation or omission of material facts in the application for the Covered Care Program assistance or otherwise;

(c) The behavior of the recipient while in the OVH;

(d) The feasibility of appropriate care for the recipient at the OVH;

(e) The availability of funds in the Covered Care Program account.

(6) If all of the funding of an OVH resident, or potential resident, cannot be met with allowable assistance from the Covered Care Program, no amounts will be committed by the Department or paid from the Covered Care Program account.

(7) Applications for assistance from the Covered Care Program account shall be made in such manner and detail, and on such forms, as the Department shall determine.

(8) Applications generally will be prioritized for consideration based on the date of completed receipt by the Department. The Department may, however, consider applications in such other order and at such other times as deemed reasonable.

Stat. Auth.: ORS 406.050, 408.360, 408.365 & 408.368
Stats. Implemented: ORS 408.365 & 408.368
Hist.: DVA 4-2002(Temp), f. & cert. ef. 4-5-02 thru 10-2-02; DVA 7-2002, f. & cert. ef. 9-24-02; DVA 10-2002(Temp), f. 12-27-02, cert. ef. 1-1-03 thru 6-27-03; DVA 9-2003(Temp), f. & cert. ef. 8-21-03 thru 2-17-03; DVA 12-2003(Temp), f. & cert. ef. 10-1-03 thru 2-17-04; DVA 14-2003(Temp), f. & cert. ef. 11-14-03 thru 2-14-04; DVA 15-2003, f. & cert. ef. 12-31-03; DVA 3-2006(Temp), f. & cert. ef. 3-31-06 thru 9-25-06; DVA 5-2006, f. & cert. ef. 5-30-06

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Economic and Community Development Department
Chapter 123

Rule Caption: Amends the recipient of the application to be the "County" in lieu of the Department in regards to the existing property definition.
Adm. Order No.: EDD 3-2006(Temp)
Filed with Sec. of State: 5-26-2006
Certified to be Effective: 5-26-06 thru 11-22-06
Notice Publication Date:
Rules Amended: 123-023-1100
Subject: This amendment clarifies the definition of existing property that is owned or leased by the Applicant (regardless of location) prior to the County's receipt of the Application.
Rules Coordinator: Paulina Bernard—(503) 986-0036

123-023-1100
Definitions

As used in this division of administrative rules, unless the context clearly indicates otherwise:

(1) **Applicant** means a business firm, including but not limited to a publicly or privately held corporation, for which the governing body of the County has officially requested approval for the Exemption, and that submits an Application to the Department.

(2) **Application** means the form, prescribed by the Department, and all supplemental attachments, exhibits and so forth that the Applicant completes or furnishes for the Strategic Investment Program.

(3) **Approved Project** means an investment or investments in taxable property that:

(a) The Applicant owns or leases;

(b) Is authorized to receive Exemption by determination of the Finance Committee;

(c) Conforms with the project definition established with the Finance Committee's determination; and

(d) Complies with all requirements and conditions set forth in the Application or its approval, as well as applicable laws, administrative rules and local agreements.

(4) **Commission** means the State of Oregon Economic and Community Development Commission appointed under ORS 285A.040.

(5) **County** means the Oregon county in which the Approved Project is located, except when the location is inside the reservation of a federally recognized Oregon Indian tribe, in which case "County" refers to the tribe/tribal.

(6) **Department** means the State of Oregon Economic and Community Development Department created under ORS 285A.070.

(7) **Exemption** means that property of an Approved Project is subject to taxation and assessment under ORS 307.123.

(8) **Existing Property** means property:

(a) Comprising any part of a another Approved Project, unless the property was never actually subject to Exemption; or

(b) Owned or leased by the Applicant (regardless of location) prior to the County's receipt of the Application.

(9) Finance Committee means the Finance Committee for the Commission as described in OAR 123-001-0520.

(10) **Urban Project** means an Approved Project located entirely outside a "rural area," as defined under ORS 285C.600, and hence, at least partially inside the urban growth boundary, as acknowledged and in effect on December 1, 2002, for:

(a) The Portland metropolitan region; or

(b) Any city, for which the most recently available population figure at the time of Application equals or exceeds 30,000.

Stat. Auth.: ORS 285A.075(5) & 285A.110(1)
Stats. Implemented: ORS 285C.600 - 285C.620 & 307.123
Hist.: EDD 7-1999, f. & cert. ef. 9-30-99; EDD 10-2004, f. & cert. ef. 5-24-04, Renumbered from 123-023-0351; EDD 3-2006(Temp), f.& cert. ef. 5-26-06 thru 11-22-06

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Employment Department, Child Care Division Chapter 414

Rule Caption: Amending rules in OAR 414-350, pursuant to the passage of HB 2999, increasing children in care from 12 to 16.
Adm. Order No.: CCD 3-2006
Filed with Sec. of State: 6-13-2006
Certified to be Effective: 6-13-06
Notice Publication Date: 5-1-06
Rules Amended: 414-350-0000, 414-350-0010, 414-350-0020, 414-350-0030, 414-350-0050, 414-350-0100, 414-350-0120, 414-350-0140, 414-350-0160, 414-350-0170, 414-350-0220, 414-350-0235, 414-350-0250
Subject: OAR 414-350-0000 to 0250 is being amended pursuant to the passage of HB 2999, increasing the number of children a certified family child care home provider can provide care from 12 to 16.
Rules Coordinator: Lynn M. Nelson—(503) 947-1724

414-350-0000
Applicability of Rules

(1) OAR 414-350-0000 through 414-350-0400 set forth the Child Care Division's requirements for the inspection and certification of certified family child care homes subject to Oregon laws governing child care facilities (ORS 657A.030, 657A.250 through 657A.310, 657A.350 through 657A.460, and 657A.990) that:

(a) Care for no more than 16 children; and

(b) Are located in a building constructed as a single-family dwelling.

(2) The following child care facilities are specifically excluded by law and are not required to comply with these rules:

(a) A registered family child care home;

(b) A facility that is primarily educational and provides care for less than four hours per day to children 36 months old or older but not yet attending kindergarten;

(c) Care provided in the home of the child; or

(d) Care provided on an occasional basis by a person, sponsor, or organization not ordinarily engaged in providing child care.

(3) If any court of law finds that any clause, phrase, or provision of these rules is unconstitutional or invalid for any reason whatsoever, this finding shall not affect the validity of the remaining portion of these rules.

(4) For purposes of these rules, the determination of compliance or noncompliance shall be made by CCD.

(5) Providers have a right to review any action or decision affecting them. The CCD grievance procedures are available upon request to all applicants for child care certification or operators of certified family child care homes.

(6) These rules apply only during the hours the provider is conducting the certified family child care business.

Stat. Auth.: ORS 657A
Stats. Implemented: ORS 657A.260 & 657A.280
Hist.: CSD 21-1988, f. & cert. ef. 9-29-88; CSD 10-1990, f. & cert. ef. 4-23-90; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0700; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0010
Definitions

The following words and terms, when used in OAR 414-350-0000 through 414-350-0400, have the following meanings:

(1) "Activity Area" means the area of the home that is available, during all the hours of operation, for the children's activities. This area excludes the food preparation area of the kitchen, bathrooms, storage areas, and those parts of rooms occupied by heating stoves, furniture and stationary equipment not used by children.

(2) "Attendance" means children actually present in the home at any given time.

(3) "Capacity" means the total number of children allowed in the certified family child care home at any one time, based on the available square footage, the ages of the children to be served and the total number of staff.

(4) "Caregiver" means any person, including the provider, who cares for the children in the certified family child care home and works directly with the children, providing care, supervision and guidance.

(5) "Certification" means the certification that is issued by CCD to a certified family child care home pursuant to ORS 657A.280.

(6) "Certified Family Child Care Home" or "Home" means: a child care facility located in a building constructed as a single family dwelling that has certification to care for a maximum of 16 children at any one time.

(7) "Child Care" means the care, supervision, and guidance on a regular basis of a child, unaccompanied by a parent, guardian, or custodian, during a part of the 24 hours of the day, with or without compensation. Child care does not include the care provided:

(a) In the home of the child;

(b) By the child's parent or guardian, or person acting in loco parentis;

(c) By a person related to the child by blood or marriage within the fourth degree as determined by civil law;

(d) On an occasional basis by a person, sponsor, or organization not ordinarily engaged in providing child care;

(e) By providers of medical services; or

(f) By a person who is a member of the child's extended family, as determined by the division on a case-by-case basis.

(8) "Child Care Child" means any child six weeks of age or older and under 13 years of age, or a child with special needs under the age of 18 who requires a level of care over and above the norm for his/her age, and for whom the provider has supervisory responsibility in the temporary absence of the parent.

(9) "CCD" means the Child Care Division of the Employment Department or the Administrator or staff of the Division.

(10) "Child Care Facility" means any facility that provides child care to children, including a child care center, certified family child care home, and registered family child care home. It includes those known under a descriptive name, such as nursery school, preschool, kindergarten, child play school, before and after school care, or child development center, except those excluded under ORS 657A.250. This term applies to the total child care operation. It includes the physical setting, equipment, staff, provider, program, and care of children.

(11) "Criminal History Registry" means CCD's Registry of individuals who have been approved to work in a child care facility in Oregon pursuant to ORS 657A.030 and OAR 414-061-0000 through 414-061-0120.

(12) "Enrollment" means all children registered to attend the certified family child care home.

(13) "Guidance and Discipline" means the on-going process of helping children develop self control and assume responsibility for their own acts.

(14) "Infant" means a child who is at least 6 weeks of age but is not yet walking alone.

(15) "Night Care" means care given to children who sleep at the home for all or part of the night.

(16) "Occasional" means infrequently or sporadically, including but not limited to care that is provided during summer or other holiday breaks

when children are not attending school, but not to exceed 70 calendar days in a year.

(17) "Operator" means the person responsible for the overall operation of the home and who has the authority to perform the duties necessary to meet certification requirements. In a certified family child care home, the operator is the provider.

(18) "Owner" means the person who holds the certified family child care business as property and has a major financial stake in the operation of the home.

(19) "Parent" means parent(s), custodian(s), or guardian(s) exercising physical care and legal custody of the child.

(20) "Potentially hazardous food" means any food or beverage containing milk or milk products, eggs, meat, fish, shellfish, poultry, cooked rice, beans or pasta, and all other previously cooked foods, including leftovers.

(21) "Pre-school Age Child" means a child 36 months of age to eligible to be enrolled in the first grade and, during the months of summer vacation from school, eligible to be enrolled in the first grade in the next school year.

(22) "Professional Development Registry" means the voluntary registry at the Oregon Center for Career Development in Childhood Care and Education at Portland State University that documents the training, education and experience of individuals who work in childhood care and education.

(23) "Program" means all activities and care provided for the children during their hours of attendance at the certified family child care home.

(24) "Provider" means the person in the certified family child care home who is responsible for the children in care, is the children's primary caregiver, and in whose name the certification is issued. In a certified family child care home, the provider is the operator.

(25) "Qualifying Teaching Experience" means 1,500 hours, gained in at least three-hour blocks, within a 36-month period, with a group of children in an on-going group setting. Such a setting includes a kindergarten, preschool, child care center, certified or registered family child care home, Head Start program, or equivalent. Qualifying teaching experience must be documented. Time spent in a college practicum or practice teaching is considered qualifying teaching experience. The following does not constitute qualifying teaching experience: leader of a scout troop; Sunday school teacher; and coaching.

(26) "Sanitizing" means using a bactericidal treatment that provides enough heat or concentration of chemicals for enough time to reduce the bacterial count, including disease-producing organisms, to a safe level on utensils, equipment, and toys.

(27) "School-Age Child" means a child eligible to be enrolled in the first grade or above and, during the months of summer vacation from school, a child eligible to be enrolled in the first grade or above in the next school year.

(28) "Serious complaint" means a complaint filed against a certified child care home by a person who has alleged that:

(a) Children are in imminent danger;

(b) There are more children in care than allowed by certified capacity;

(c) Corporal punishment is being used;

(d) Children are not being supervised;

(e) Multiple or serious fire, health or safety hazards are present in the home;

(f) Extreme unsanitary conditions are present in the home; or

(g) Adults are in the home who are not enrolled in the Criminal History Registry.

(29) "Special Needs Child" means a child under the age of 18 who requires a level of care over and above the norm for his/her age due to a physical, developmental, behavioral, mental or medical disability.

(30) "Substitute Caregiver" means a person who acts as the children's primary caregiver in the certified family child care home in the temporary absence of the provider.

(31) "Supervision" means the act of caring for a child or group of children. This includes awareness of and responsibility for the ongoing activity of each child. It requires a caregiver to be within sight and/or sound of the children, knowledge of children's needs, and accountability for children's care and well-being. Supervision also requires that staff be near and have ready access to children in order to intervene when needed.

(32) "Toddler" means a child who is able to walk alone but is under 36 months of age. "Younger toddler" means a child who is able to walk alone but is under 24 months of age; "older toddler" means a child who is at least 24 months of age but under 36 months of age.

(33) "Useable Exit" means an unobstructed door or window through which caregivers and children can evacuate the home in case of a fire or emergency. Doors must be able to be opened from the inside without a key, and window openings must be at least 20 inches wide and 22 inches in height, with a net clear opening of 5 square feet and a sill no more than 48 inches above the floor.

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CSD 2-1989, f. & cert. ef. 1-25-89; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0705; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 5-1999(Temp), f. 10-21-99, cert. ef. 10-23-99 thru 1-1-00; CCD 10-1999, f. 12-29-99, cert. ef. 1-1-00; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2003, f. 12-23-03, cert. ef. 12-28-03; CCD 7-2003, f. 12-23-03, cert. ef. 12-28-03; CCD 3-2004, f. 7-30-04 cert. ef 8-1-04; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0020
Application for a Child Care Certificate

(1) No person, unless exempted by Oregon laws governing child care facilities, shall operate a certified family child care home without a valid certification issued by the Child Care Division (CCD).

(2) Application for certification shall be made on forms provided by CCD.

(3) A completed application is required:

(a) For the initial certification;

(b) For the annual renewal of certification; and

(c) Whenever there is a change of provider or location.

(4) The applicant shall complete and submit an application to CCD at least:

(a) 45 days before the planned opening date of the certified family child care home; and

(b) For renewal of certification, 30 days prior to the expiration of the certificate.

(A) The expiration date of the current certification, the current certification, unless officially revoked, remains in force until CCD has acted on the application for renewal and has given notice of the action taken.

(B) If an application for renewal and payment of the required fee is not received by CCD at least 30 days prior to the expiration date of the current certification, the certification will expire as of the date stated on the certificate and child care must cease at the facility, unless the renewal is completed before the expiration date.

(5) An application for certification shall be accompanied by a non-refundable filing fee.

(a) For the initial application, a change of provider, the reopening of a facility after a lapse in certification, or a change of location, the fee is $25 plus $2 for each certified space (e.g., the fee for a certified family child care home certified to care for 12 children is $24 + $25 = $49).

(b) For a renewal application, the fee is $2 for each certified space.

(6) An application for certification must be completed by the applicant and approved by CCD within 12 months of submission or the application will be denied. If an application is denied, an applicant will be required to submit a new application for certification.

(7) The applicant shall submit with the initial application or when the home is being remodeled a drawing showing the dimensions of all rooms to be used (length and width), the planned use of each room, the location of required exits, the placement of the kitchen and bathrooms, and the location of plumbing fixtures.

(8) The applicant shall provide verification to CCD that the home meets all applicable building codes and zoning requirements that apply to certified family child care homes:

(a) Before the initial certification is issued; and

(b) Whenever the home is remodeled.

(9) The home shall be approved by a environmental health specialist registered under ORS Chapter 700 or an authorized representative of the Department of Human Services before a certification is issued by CCD.

(10) The home may be inspected by the local fire jurisdiction when local ordinances require a fire life safety survey as part of a business license or when CCD determines there is a need to do so.

(11) If the provider applies to care for more than 12 children, the provider must complete a fire life safety self evaluation. CCD staff and the provider will review the self evaluation. If fire safety concerns are identified, CCD staff may consult with the fire marshal and after consultation, may request that the fire marshal complete a fire life safety inspection.

(12) Upon receipt of a completed application, a representative of CCD shall evaluate the home and all aspects of the proposed operation to determine if certification requirements (OAR 414-350-0000 through 414-350-0400) are met.

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260, 657A.270, 657A.280 & 657A.310
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CSD 2-1989, f. & cert. ef. 1-25-89; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0710; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 2-1995(Temp), f. 12-28-95, cert. ef. 1-1-96; CCD 2-1996, f. 3-19-96, cert. ef. 4-1-96; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 8-2003, f. 12-23-03, cert. ef.

12-28-03; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0030
Issuance of a Child Care Certificate

(1) A certification shall be issued by CCD when it has been determined the home is in compliance with OAR 414-350-0000 through 414-350-0400. There are two types of certification. These are:

(a) A regular certification which, except as provided in OAR 414-350-0020(4)(b)(A), is valid for no more than one year; and

(b) A temporary certification. A certified family child care home may not operate under a temporary certification for more than 180 days in any 12-month period. A temporary certification is issued when:

(A) The home is in compliance with most requirements;

(B) There are no deficiencies identified by CCD that are hazardous to children; and

(C) The provider demonstrates an effort to be in full compliance.

(2) Certification is not transferable to any other location or to another organization or individual.

(3) A certification is granted in the name of the operator/provider. An operator/provider is limited to one certification at one address.

(4) An owner can have multiple sites under the following conditions:

(a) If the owner is the provider/operator in one of the homes, the owner can have two certified family child care homes; or

(b) If the owner does not directly care for any children, the owner can have more than two certified family child care homes.

(c) If the owner is the provider/operator in a home certified for more than 12 children, the owner may be the provider for only that certified family child care home. The provider may be the owner of other facilities. See OAR 414-350-0100 (5).

(5) Any changes in the conditions of certification shall be requested in writing to CCD and approved by CCD before the condition(s) of the current certification may be changed. Changes include, but are not limited to, facility capacity, age range of children, or hours of operation.

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260, 657A.280, 657A.300 & 657A.310
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0715; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0050
General Requirements

(1) The following items shall be posted in the certified family child care home where they may be viewed by parents:

(a) The child care certification document;

(b) Notification of a communicable disease outbreak at the home;

(c) The evacuation plan; and

(d) A notice that the following items are available for parents to review:

(A) The guidance/discipline policy;

(B) The current week's menus, with substitutions recorded;

(C) The description of the general routine;

(D) Information on how to report a complaint to CCD regarding certification requirements; and

(E) The most recent CCD and sanitation inspection reports and fire life safety self evaluation (or fire marshal inspection report if completed).

(2) The provider shall ensure that a copy of these administrative rules is available in the certified family child care home to all parents and staff.

(3) Caregivers shall report suspected child abuse or neglect immediately, as required by the Child Abuse Reporting Law (ORS 419B.005 through 419B.050) to the Department of Human Services or to a law enforcement agency. By statute, this requirement applies 24 hours per day.

(4) The certified family child care home shall comply with state and federal laws related to child safety systems and seat belts in vehicles, bicycle safety, civil rights laws, and the Americans With Disabilities Act (ADA).

(5) Representatives of all agencies involved in certification shall have immediate access to all parts of the home whenever the provider is conducting the child care business:

(a) CCD staff shall have the right to enter and inspect the home, including access to all caregivers, records of children enrolled in the home, and all records and reports related to the child care operation regarding compliance with these rules; and

(b) Representatives of the Department of Human Services and the State Fire Marshal have the right to enter and inspect the home when an inspection has been requested by CCD.

(6) Custodial parents of all children enrolled shall have access to the home during the hours their child(ren) are in care.

(7) The provider shall develop the following information in writing and shall make it available to CCD, to staff, and to parent(s) at the time of enrollment:

(a) Guidance and discipline policy;

(b) Information on transportation, when provided by the provider or other caregiver; and

(c) The plan for handling emergencies and/or evacuations, including, but not limited to, fire, acute illness of a child or staff, natural disasters, power outages, and situations which do not allow reentry to the home after evacuation.

(8) The provider shall comply with the Department of Human Services' administrative rules relating to:

(a) Immunization of children (OAR 333-019-0021 through 333-019-0090);

(b) Reporting communicable diseases (OAR 333-019-0215 through 333-019-0415); and

(c) Child care restrictable diseases (OAR 333-019-0010).

(9) The provider shall report to CCD:

(a) An accident at the home resulting in the death of a child, within 48 hours after the occurrence; and

(b) Injuries to a child at the certified family child care home which require attention from a licensed health care professional, such as a physician, EMT or nurse, within 7 days after the occurrence.

(10) Documentation of meals and snacks provided by the certified family child care home shall be made available to CCD upon request, if the home does not participate in the USDA Child and Adult Care Food Program. Documentation is limited to the three weeks prior to the request.

(11) The provider is responsible for compliance with these requirements (OAR 414-350-0000 through 414-350-0400).

(12) Parental request or permission to waive any of the rules for certified family child care homes does not give the provider permission to do so.

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260, 657A.280, 657A.290, 657A.300, 657A.390 & 657A.400
Hist.: CSD 21-1988, f. & cert. ef. 9-29-88; CSD 10-1990, f. & cert. ef. 4-23-90; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0720; CSD 9-1994, f. & cert. ef. 5-23-94; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0100
The Provider

(1) The provider shall be:

(a) At least 18 years of age if the facility is certified for 12 children; or at least 21 years of age if the facility is certified for more than 12 children; and

(b) Responsible for the operation of the certified family child care home, including those duties ordinarily considered to be administrative. These include, but are not limited to, financial management, maintaining records, maintenance of the building and grounds, meal planning and preparation, compliance with certification requirements, communication with CCD, and correcting deficiencies.

(2) The provider shall have:

(a) At least one year of qualifying teaching experience, as specified in OAR 414-350-0010(25), in the care of a group of children in an ongoing group setting such as a kindergarten, preschool, child care center, certified family child care home, registered family child care home, or Head Start program; or prior to applying to be certified for up to 16 children, completed one year of successful operation as a certified family child care facility for 12 children if the qualifying teaching experience is based on registered family child care; or

(b) Completion of 20 credits (semester system) or 30 credits (quarter system) of training in a college or university in early childhood education or child development; or

(c) Documentation of attaining at least level eight in the Oregon Registry.

(3) The provider shall provide evidence of the following training prior to being certified:

(a) A current certification in infant and child first aid and cardiopulmonary resuscitation;

(b) A current food handler certification pursuant to ORS 624.570; and

(c) Completion of two hours of training on child abuse and neglect issues.

(4) Prior to a facility providing care to more than two children under 24 months of age, the provider shall have at least 30 clock hours of training specific to infant and toddler care. The provider of facilities certified on October 15, 2002, who are providing care for more than two children under 24 months of age must have documentation of 30 hours of prior training in

infant and toddler care or a plan, approved by CCD, that shows how the training will be attained.

(5) The provider/operator shall be on-site at least half of the hours of operation that are reflected on the certification. If the facility is certified for more than 12 children, the provider shall be on site at least 2/3 of the hours of operation that are reflected on the certification. The hours shall be calculated on a weekly basis, except for planned vacations and emergency absences.

(6) The provider shall have no other employment, either in or out of the home, during the hours the provider is directly caring for children.

(7) The provider, or a substitute caregiver, shall be present during all the hours the certified family child care business is conducted.

(8) A caregiver substituting for the provider shall:

(a) Be at least 18 years old;

(b) Have current certification in infant and child first aid and cardiopulmonary resuscitation (CPR);

(c) Have current food handler certification pursuant to ORS 624.570, if the substitute will be preparing or serving food;

(d) Be familiar with the provider's policies and procedures and with these requirements (OAR 414-350-0000 through 414-350-0400;

(e) Be authorized and able to correct a deficiency that might be an immediate threat to children; and

(f) Have on file documentation of an orientation and training in these administrative rules and the functions and duties of a provider.

(g) Meet the qualifications in (a)-(f), have completed child abuse and neglect training, and have worked in the facility at least 60 hours when substituting for the provider in a facility certified to care for more than 12 children.

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260, 657A.280 & 657A.290
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0732; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0120
Caregiver/Child Ratios and Supervision

(1) The number of caregivers and group size shall be determined by the number and ages of the children in attendance.

(a) All children in the home, including the provider's or other caregivers' own children, shall be counted in determining the caregiver/child ratio and group size.

(b) All children visiting the home on a regular basis will count in capacity. Children attending with a parent do not count as enrolled as long as the parent remains with and is responsible for non-enrolled children.

(c) The required caregiver/child ratios shall be met at all times.

(2) Children shall at all times have the full attention of and be supervised by the required number of caregivers.

(a) Children shall be within sight and/or sound of a caregiver at all times.

(b) A caregiver shall be near enough to children to respond when needed. Children out of direct visual contact shall be monitored regularly and frequently and must be in approved activity areas.

(c) Children may not be on a floor level of the home unless a caregiver is on the same floor level, except as specified in OAR 414-305-0120(2)(d).

(d) When bathroom facilities are not on the same floor level, a written plan for adequate supervision of both bathroom and child care areas shall be developed and implemented.

(3) The number of caregivers is determined by the age and number of the youngest child(ren) in the group. If the provider is certified to care for more than 12 children and plans to care for more than 8 infants and/or toddlers, the provider must develop a plan showing how infants and toddlers will be limited to a group size of not more than eight. The plan must be approved by CCD.

(a) If all children are in the same age group, the following table determines the staff/child ratio. [Table not included. See ED. NOTE.]

(b) If children in care include any infants and/or toddlers, the following table determines the staff/child ratio. [Table not included. See ED. NOTE.]

(c) If children in care include a mix of only preschool and school aged children, the following table determines the staff/child ratio. [Table not included. See ED. NOTE.]

(d) Even though staff/child ratios are specified in (a) and (b) above, a certified family child care provider may care for 10 children ages 6 weeks to school-age if:

(A) No more than 6 children are pre-school age or younger, including the provider's own children and any staff children;

(B) Of the 6, only 2 children are under 24 months of age; and

(C) Four of the children are school-age.

(4) The maximum number of children allowed in a certified family child care home at any one time is 16.

(5) If the home is certified to care for more than 12 children and the age blend is such that group separation is required:

(a) Groups may be joined for: meals, naps, outdoor play, and limited quiet activities such as a video or circle time.

(b) Provider must develop a plan that shows how the groups will be separated without requiring remodeling of the home. The plan must be approved by CCD.

(6) If the facility provides care to more than two children under 24 months of age, the provider shall meet the requirements specified in OAR 414-350-0100(4).

(7) Prior to a facility providing care to more than four children under 24 months of age, at least one caregiver other than the provider shall meet the requirements specified in OAR 414-350-0100(4). In addition, the provider shall have an extra 20 clock hours of training specific to infant and toddler care above and beyond the original requirements. If the facility is certified to care for more than 12 children, there must be someone who meets the training requirements of OAR 414-350-100(4) on site at all times that five or more children under 24 months of age are in care.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260 & 657A.290
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CSD 7-1989, f. & cert. ef. 3-17-89; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0736; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0140
Indoor Area

(1) The indoor area used for child care shall meet the following requirements:

(a) If the provider is certified to care for 12 children or fewer, there shall be a minimum of 35 square feet of indoor activity area, as defined by OAR 414-350-0010(1), per child. If the provider is certified to care for more than 12 children, there shall be a minimum of 35 square feet of indoor activity area per child for 12 or fewer children, and 50 square feet of indoor activity area available per child for each of the additional four children. This space, considered in determining capacity of the home, shall be available for use by children at all times. The following shall not be counted as part of the 35 square feet per child requirement: heating units, storage areas; large permanent equipment; any space not useable by children.

(b) There shall be a designated area for children under 24 months of age that is developmentally appropriate and safe.

(c) If the facility is certified to care for more than 12 children, the provider must develop a written plan showing that the space accessible to the children meets their safety needs, there is adequate supervision and there is adequate availability of toileting and hand washing for the children in care. CCD must approve the plan.

(d) Activity areas shall be adequately lighted and ventilated. Room temperature shall be at least 68 degrees F. (20 degrees C.) and not so warm as to be dangerous or unhealthy to children in care.

(2) Indoor fixtures and equipment shall meet the following requirements:

(a) There shall be at least one flush toilet and one hand washing sink with mixing faucets available to the children at all times. If the facility is certified to care for more than 12 children, the provider must have a second flush toilet somewhere in the facility if: there are more than 15 children in care or if there are more than 12 toddlers in care. Homes with certification in effect on September 15, 2002, shall comply with the requirement for mixing faucets when bathroom facilities are remodeled.

(b) Easily cleanable steps or blocks shall be provided so that children can use the toilets and sinks without adult assistance.

(c) If bathroom facilities are not on the same floor level as the activity areas, the provider must comply with OAR 414-350-0120(2)(d).

(d) Telephone service shall be available in the home at all times when children are in care.

(e) Telephone numbers for fire, emergency medical care, and poison control, as well as the facility address, shall be posted on or near the telephone. Portable telephones must have emergency numbers and the facility address on the phone.

(f) There must be a system in place to ensure that parents can have contact with the provider and staff when children are in care.

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260, 657A.280 & 657A.290
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0742; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0160
Sanitation

(1) Water Supply:

(a) The home's water supply shall be continuous in quantity and from a water supply system approved by the Department of Human Services.

(b) If drinking water is from a private source, the provider shall provide evidence of bacterial and chemical analysis which establish safety of the water;

(c) The tests shall be conducted by the local health department, the Department of Human Services, or an approved commercial laboratory;

(d) The bacterial analysis shall be done quarterly;

(e) The chemical analysis shall be done only once for a well and yearly for other water sources;

(f) The provider shall have drinking water available to children that is supplied in a safe and sanitary manner. If drinking water is obtained from bathroom sinks or sinks used for handwashing after changing a diaper, the sink must be sanitized after each handwashing.

(2) Hand Washing:

(a) Caregivers and children shall wash their hands with soap and warm running water after nose wiping, after using the toilet, and before and after eating;

(b) Caregivers shall wash their hands with soap and warm running water before and after changing a diaper, before and after feeding a child or handling food, and after assisting a child with toileting and nose wiping;

(c) Infants' and children's hands shall be washed with soap and warm running water after diaper changing;

(d) Staff shall immediately and thoroughly wash their hands after handling animals or cleaning cages;

(e) Commercial products labeled "hand sanitizers" shall not replace hand washing. If hand sanitizers are present in the home, they shall be kept under child-proof lock and shall not be used by children;

(f) When hand washing is not possible, e.g., on field trips or the neighborhood park, moist towelettes shall be used.

(3) Maintenance:

(a) The building, toys, equipment, and furniture shall be maintained in a clean, sanitary, and hazard-free condition:

(A) Kitchen and bathrooms shall be cleaned when soiled and at least daily;

(B) Floors, walls, ceilings, and fixtures of all rooms shall be kept clean and in good repair;

(C) All kitchen counters, shelves, tables, refrigeration equipment, sinks, drain boards, cutting boards, and other equipment or utensils used for food preparation shall be kept clean and in good repair;

(D) All food storage areas shall be kept clean and free of food particles, dust, dirt and other materials;

(E) Cloths, both single use and multiple use, used for wiping food spills on utensils and food-contact surfaces shall be kept clean and used for no other purpose. Cloths that are reused shall be stored in a sanitizing solution between uses.

(F) The isolation area shall be thoroughly cleaned after use and all bedding laundered after each use;

(G) A diaper-changing table shall:

(i) Have a surface that is non-absorbent and easily cleaned;

(ii) Be cleaned and sanitized after each use;

(iii) Not be used for any purposes other than diapering, including food or drink preparation or storage, dish washing, storage of food service utensils, arts and crafts supplies or products, etc.; and

(iv) Comply with the requirements for diaper changing area specified in OAR 414-350-0235(2)(b).

(H) Bathtubs, showers, sinks, bathinettes, or other receptacles used for bathing children shall be cleaned and sanitized after each use.

(I) Bedding shall be cleaned when soiled, with change of occupant, or at least once a week.

(b) Tableware, kitchenware (pots, pans and equipment), and food-contact surfaces of equipment shall be washed, rinsed, sanitized, and air-dried after each use. The cleaning and sanitizing of tableware and kitchenware shall be accomplished by using:

(A) A dishwasher that is operated according to the manufacturer's instructions; or

(B) A three-step manual process as follows:

(i) Washing in the first compartment;

(ii) Rinsing in a second compartment; and

(iii) Immersion in a third compartment or large dishpan or tub for at least two minutes in a sanitizing solution containing at least 2 teaspoons of household chlorine bleach in each gallon of warm water.

(c) A sink used for diapering or bathing activities shall not be used for any part of food or drink preparation or dish washing.

(d) Soap, paper towels dispensed in a sanitary manner, and mixing faucets with hot and cold running water shall be provided at each hand washing sink.

(e) The home and grounds shall be kept clean and free of litter or rubbish and unused or inoperable equipment, utensils, and vehicles.

(f) All garbage, solid waste, and refuse shall be disposed of at least once a week.

(A) All garbage shall be kept in watertight, non-absorbent, and easily washable containers with close-fitting lids;

(B) All garbage storage areas and garbage containers shall be kept clean; and

(C) All garbage storage shall be inaccessible to children.

(4) Insect and Rodent Control:

(a) The home shall be in such condition as to prevent the infestation of rodents and insects.

(b) Doors and windows which are opened for ventilation shall be equipped with fine-meshed screens.

(c) Automatic insecticide dispensers, vaporizers, or fumigants shall not be used.

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260, 657A.280, 657A.290, 657A.400 & 657A.420
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CSD 10-1990, f. & cert. ef. 4-23-90; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0746; CSD 10-1994, f. & cert. ef. 5-23-94; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0170
Home Safety

(1) All floor levels used by children for play and napping shall have two usable exits to ground level.

(2) All rooms used by children for play and napping shall have two usable exits.

(3) Obstructions, including furniture, storage of supplies, or any other items shall not be placed in a manner that blocks usable exits.

(4) There shall be at least one 2-A-10 BC-rated fire extinguisher on each floor of the home. Fire extinguishers shall be easily accessible, kept out of the reach of children, and located along the path of emergency exiting.

(5) Smoke alarms shall be:

(a) Installed on each floor level of the home and in any area where children nap; and

(b) Maintained in operating order.

(6) Candles or other open flame decorative devices are prohibited, except for the brief use of celebratory candles.

(7) Matches and lighters shall be kept in locked storage when not in use.

(8) A portable light source, to be used in emergencies, shall be:

(a) Available in all activity areas used by children;

(b) In working condition; and

(c) Stored in an easily accessible place.

(9) Items of potential danger (e.g., cleaning supplies and equipment, paints, poisonous and toxic materials, plastic bags, aerosols, detergents) shall be:

(a) Kept in the original container or labeled;

(b) Stored under child-proof lock; and

(c) Kept away from food service supplies.

(10) The provider shall protect children from safety hazards, including but not limited to:

(a) A rigid screen or guard shall be installed to prevent children from falling into a fireplace or against a heater or wood stove;

(b) A movable barrier, such as mesh-type gate, shall be placed at the top and/or bottom of all stairways accessible to infants and toddlers. Gates and enclosures should have the Juvenile Products Manufacturers Assn. (JPMA) certification seal to ensure safety;

(c) Child-proof latches shall be installed on all cupboards, closets, and drawers that contain hazardous objects and may be accessible to preschool-age and younger children;

(d) Firearms, ammunition, and other potentially hazardous equipment, such as darts, other projectiles, power tools, and knives shall be kept under lock:

(A) Firearms, pellet or BB guns must be unloaded and kept in areas not used by child care children; and

(B) Ammunition shall be stored separately from firearms;

(e) Hot water heaters shall be equipped with a safety release valve and an overflow pipe that directs water to the floor or to another approved location;

(f) Unused appliances, such as old refrigerators or freezers, that present a risk for entrapment, shall be secured so as to prevent entry by children;

(g) Clear glass panels in doors shall be clearly marked at child level;

(h) All exposed electrical outlets in rooms used by preschool or younger children shall have hard-to-remove protective caps or safety devises when not in use;

(i) Extension cords shall not be used as permanent wiring. All appliance cords will be in good condition and multiple connectors for cords will not be used. A grounded power strip outlet with built-in over-current protection may be used;

(j) Floors shall be free of splinters, large unsealed cracks, sliding rugs, and other hazards;

(k) Devices which generate heat and are hot from recent use shall be inaccessible to children; and

(l) After painting or laying carpet, the certified home must be aired out completely for at least 24 hours with good ventilation before children are allowed to return.

(11) The provider shall have written evidence that any wood stove in the home has been inspected and approved for use by the local building official.

(12) All wood stove and fireplace flues shall be cleaned as needed or, at a minimum, once a year. A written record of cleaning shall be maintained on site.

(13) The use of unvented, fuel-fired space heaters is prohibited.

(14) Flammable and combustible liquids, such as paint thinner and gasoline, shall be stored in the original container or a safety container and, if over one gallon, kept in an unattached storage building.

(15) All caregivers and children shall practice at least one aspect of the emergency plan, as described in OAR 414-350-0050(7)(c), once per month.

(a) Evacuating the home shall be practiced at least eight times per year. If the facility is certified to care for more than 12 children and more than 4 children regularly in care are under 24 months of age, evacuating the home shall be practiced monthly.

(b) The provider shall maintain a written record showing the date, time of day, participants, and type of emergency of each emergency plan practice session.

(16) Other hazards observed in the certification process must be corrected.

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260, 657A.280, 657A.290 & 657A.420
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CSD 2-1989, f. & cert. ef. 1-25-89; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0748; CSD 10-1994, f. & cert. ef. 5-23-94; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0220
General Requirements

(1) There shall be activities for children according to their ages, interests, and abilities. If the provider is certified to care for more than 12 children the provider shall have a written program of activities for each age group.

(2) A description of the general routine, covering all hours of operation, shall be in writing and shall provide:

(a) Regularity of such activities as eating, napping, and toileting with flexibility to respond to the needs of individual children;

(b) A balance of active and quiet activities;

(c) Individual and group activities;

(d) Daily indoor and outdoor activities in which children use both large and small muscles;

(e) Periods of outdoor play each day when weather permits; and

(f) Opportunities for a free choice of activities by children.

(3) The provider and other caregivers shall use the written description of the general routine as a guide, allowing flexibility to respond to the needs of individual children and/or groups of children and to appropriate variations in daily activities.

(4) No child may view television or videos or play computer or electronic games for more than two hours per day.

(5) Infant and toddler program of activities. The following apply to infant and toddlers in care at the certified home.

(a) Infants shall be allowed to form and follow their own patterns of sleeping and waking periods.

(b) Children shall be given opportunities during each day to move freely by creeping and crawling in a safe, clean, warm, and uncluttered area.

(c) Throughout the day, each child shall receive physical contact and individual attention (e.g., being held, rocked, talked to, sung to, and taken on walks inside and outside the home).

(d) Routines relating to activities such as bedtime, feeding, diapering, and toileting shall be used as opportunities for language development, building the child's self-esteem, and other learning experiences.

(e) Children shall be encouraged to play with a variety of safe toys and objects.

(f) Children shall be given appropriate opportunities to use the five senses through sensory play.

(g) Infants shall be put to sleep on their backs.

(h) Immediate attention shall be given to the emotional and physical needs of the children. No child shall be routinely left in a crib except for sleep or rest.

(i) Caregivers shall encourage the development of self-help skills (dressing, toileting, washing, eating) as children are ready.

(j) In addition, toddlers shall be given opportunities to participate in:

(A) A variety of activities encouraging creative expression through the arts; and

(B) Running, climbing, and other vigorous physical activities.

(6) Preschool-age program of activities. In addition to the daily routine specified in OAR 414-350-0220(2), preschool-age children shall have opportunities, on a daily basis, to choose from a variety of activities and experiences, which shall include:

(a) Creative expression through the arts;

(b) Dramatic play;

(c) Gross (large) motor development;

(d) Fine (small) motor development;

(e) Music and movement;

(f) Opportunities to listen and speak;

(g) Concept development;

(h) Appropriate sensory play; and

(i) A supervised nap or rest period. Children who do not sleep after 20-45 minutes of quiet time must be provided with an alternative quiet activity. The activity may be in the same room where children are sleeping if it is not distracting to sleeping children.

(7) School-age program of activities. In addition to the daily routine specified in OAR 414-350-0220(2), school age children shall have opportunities to choose from a variety of activities, including:

(a) Individual or group projects and activities, including homework; and

(b) Rest or relaxation.

(8) A home providing swimming or other water activities to children shall meet all of the requirements set forth in OAR 414-350-0380.

(9) Spa pools on the grounds of the certified family child care home shall be enclosed by a barrier at least 48 inches high, with a lockable gate or door, and have a lockable pool cover. The enclosure and cover shall be locked whenever the child care business is being conducted.

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260, 657A.280 & 657A.290
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0770; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0235
Infant and Toddler Furniture and Equipment

(1) Each infant shall have a crib, portable crib, or playpen with a clean, non-absorbent mattress that meets the following requirements:

(a) Each crib shall be of sturdy construction with vertical slats no more than 2 3/8" apart;

(b) Locks and latches on the dropside of the crib shall be safe and secure from accidental release or release by the infant inside the crib;

(c) Each mattress shall fit snugly; and

(d) Sleeping arrangements shall be appropriate to the cultural background of the infant, with individual bedding appropriate to the season.

(2) If infants and toddlers are in care there shall be:

(a) A bathtub, bathinette, plastic basin, or similar size shallow sink available for bathing children; and

(b) A diaper-changing area. The area shall be located so that handwashing can occur immediately after diapering without contact with other surfaces or other children.

(c) If the provider is certified to care for more than 12 children and more than 8 infants and toddlers are regularly in care, there must be a second diaper-changing area available.

(3) The diaper-changing table or area shall comply with the requirements specified in OAR 414-350-0160(3)(a)(G).

(4) If high chairs are used, they shall have:

(a) A broad base to prevent tipping;

(b) A latch to keep a child from raising the tray; and

(c) Straps to prevent a child from sliding out.

(5) Cribs, portable cribs, playpens, and high chairs must meet US Consumer Product Safety Commission or equivalent standards.

(6) Car seats are to be used for transportation purposes only. Children who arrive at the home asleep in a car seat may remain in the car seat until they awake.

(7) The use of baby equipment shall not substitute for providing a variety of stimulating experiences.

(8) The use of infant walkers is prohibited.

(9) The use of potty chairs must be approved by the environmental health specialist and/or by CCD.

Stat. Auth.: ORS 657A
Stats. Implemented: ORS 657A.260 & 657A.280
Hist.: CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 8-2003, f. 12-23-03, cert. ef. 12-28-03; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

414-350-0250
Transportation

When transportation is provided by or arranged for by the certified family child care home, the following requirements must be met.

(1) Drivers shall be at least 18 years of age and hold a current driver's license.

(2) The vehicle shall be:

(a) In compliance with all applicable state and local motor vehicle laws, and

(b) Maintained in a safe operating condition.

(3) If transportation is provided between the certified family child care home and the child's school or other destination, the provider shall have in writing an acknowledgment from the parent(s) that they are aware of the time of day their child is to be picked up and/or delivered by the provider. If the pick-up schedule results in children being unsupervised at school or other location, the provider shall notify parents of this fact.

(4) When transporting children:

(a) The emergency information for each child who is being transported shall be in the vehicle.

(b) Children shall be transported only in sections of vehicles designed for and equipped to carry passengers.

(c) A seat that fully supports the passenger shall be provided for each child.

(d) The number of children transported shall not exceed the number of seat belts or child safety systems available in the vehicle.

(e) All children shall be transported in accordance with ORS 811.210. The child safety system and safety belts shall comply with ORS 815.055 and the standards adopted by the Oregon Department of Transportation. A child under four years of age and weighing 40 pounds or less shall be in an approved child safety system. A child between the ages of 4 and 6 years AND children who weigh between 40 and 60 pounds, regardless of age, must use a booster seat.

(f) Staff/child ratios, as specified in OAR 414-350-0120, shall be maintained in vehicles, as well as in the certified family child care home, when one caregiver is transporting children.

(g) Infants, toddlers, and preschool age children shall leave the vehicle on the same side of the street as the building they will enter.

(h) Drivers delivering children to their homes shall not depart until the child has been received by an authorized person.

(i) No child shall be left unattended inside or outside a vehicle.

(j) If firearms and ammunition are stored in a vehicle, they must be stored as specified in OAR 414-350-0170(10)(d).

Stat. Auth.: ORS 657A.260
Stats. Implemented: ORS 657A.260, 657A.280 & 657A.290
Hist.: CSD 12-1988, f. 6-29-88, cert. ef. 7-1-88; CCD 1-1994, f. & cert. ef. 1-12-94; Renumbered from 412-010-0776; CSD 11-1994, f. & cert. ef. 5-23-94; CCD 1-1995, f. 10-30-95, cert. ef. 11-1-95; CCD 3-2002, f. 10-14-02, cert. ef. 10-15-02; CCD 6-2005(Temp), f. 12-29-05, cert. ef. 1-1-06 thru 6-29-06; CCD 3-2006, f. & cert. ef. 6-13-06

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Office of Private Health Partnerships
Chapter 442

Rule Caption: Clarifying FHIAP requirements and implementing SB 303 (2005), HB 2062 (2005) and HB 2064 (2005).
Adm. Order No.: IPGB 2-2006
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 5-1-06
Rules Adopted: 442-005-0000, 442-005-0010, 442-005-0020, 442-005-0030, 442-005-0040, 442-005-0050, 442-005-0060, 442-005-0070, 442-005-0080, 442-005-0090, 442-005-0100, 442-005-0110, 442-005-0120, 442-005-0130, 442-005-0140, 442-005-0150, 442-005-0160, 442-005-0170, 442-005-0180, 442-005-0190, 442-005-0200, 442-005-0210, 442-005-0220, 442-005-0230, 442-005-0240, 442-005-0250, 442-005-0260, 442-005-0270, 442-005-0275, 442-005-0280, 442-005-0290, 442-005-0300, 442-005-0310, 442-005-0320, 442-005-0330, 442-005-0340, 442-005-0350
Rules Repealed: 442-004-0000, 442-004-0010, 442-004-0020, 442-004-0030, 442-004-0040, 442-004-0050, 442-004-0060, 442-004-0070, 442-004-0080, 442-004-0085, 442-004-0090, 442-004-0100, 442-004-0110, 442-004-0115, 442-004-0117, 442-004-0120, 442-004-0130, 442-004-0140, 442-004-0150, 442-004-0160, 442-004-0170
Subject: OPHP is repealing Division 4 and adopting Division 5 in an effort to clarify the intent of the rules. The new rules will streamline the application and determination process for the Family Health Insurance Assistance Program (FHIAP). In early 2005 FHIAP conducted a Business Process Improvement study. Many of the rule changes are a direct result of the report that was generated from that study.

Other changes being implemented include: no longer counting 529 College Savings Plans as an asset; no longer allowing group applicants to enroll into an individual plan before they can access a group plan; no longer including some educational income as family income; and adding rules relating to enrollment and payment processing. With the passage of SB 303, the Insurance Pool Governing Board's name is changing to the Office of Private Health Partnerships effective January 1, 2006. The name change is reflected in the new rules. The rules will also implement House Bill 2064 (2005), which changes the definition of family by allowing FHIAP to consider elderly relatives and adult disabled children as family members.
Rules Coordinator: Cindy Bowman—(503) 378-4674

442-005-0000
Purpose and Statutory Authority

(1) OAR 442-005-0000 to 442-005-0350 are adopted to carry out the purpose of ORS 735.720 to 735.740, establishing within the Office of Private Health Partnerships a Family Health Insurance Assistance Program for Oregon residents who earn up to 185 percent of the federal poverty level.

(2) OAR 442-005-0000 to 442-005-0350 are adopted pursuant to the general authority of the Office of Private Health Partnerships under ORS 735.734 and the specific authority in ORS 735.720 to 735.740.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0010
Definitions

(1) "Alien Status Requirement." A qualified non-citizen meets the alien status requirement for FHIAP if the individual is one of the following:

(a) A person who was admitted as a qualified non-citizen on or before August 22, 1996.

(b) A person who entered the U.S. on or after August 22, 1996 and it has been five years since he or she became a qualified non-citizen.

(c) A person who has obtained their qualified non-citizen status less than five years ago, but entered the U.S. prior to August 22, 1996. The non-citizen must show that he or she has been living in the U.S. continuously for five years from a date prior to August 22, 1996 to the date the non-citizen obtained their qualified status and did not leave during that five year period. If the non-citizen cannot establish the five-year continuous residence before he or she obtained their qualified status, the person is not considered to have entered the U.S. prior to August 22, 1996.

(d) Regardless when they were admitted, a person with one of the following designated statuses:

(A) A person who is admitted as a refugee under section 207 of the INA;

(B) A person who is granted asylum under section 208 of the INA;

(C) A person whose deportation is being withheld under section 243 (h) of the INA;

(D) A Cuban or Haitian entrant who is either a public interest or humanitarian parolee;

(E) A person who was granted immigration status according to the Foreign Operations Export Financing and Related Program Appropriation Act of 1988;

(F) A person who is a victim of a severe form of trafficking.

(e) Regardless of when they were admitted, a qualified non-citizen who is:

(A) A veteran of the U.S. Armed Forces, who was honorably discharged not on account of alien status and who fulfills the minimum active-duty service requirement; or

(B) On active duty in the U.S. Armed Forces (other than active duty for training).

(C) The spouse or unmarried dependent child of the veteran or person on active duty described in (e) (A) and (B).

(f) An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1359) apply; or

(g) A member of an Indian tribe (as described in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e)).

(h) Any legal non-citizen who was approved for a FHIAP subsidy prior to November 1, 2004.

(2) "Appeal" means the opportunity for an applicant to request and receive administrative review by Office staff of a decision made or action taken by the Third Party Administrator (TPA) or state office regarding program eligibility, subsidy level, termination, re-enrollment, overpayments, misrepresentation, or any other decision adverse to the applicant (ref. 442-005-0320).

(3) "Applicant" means a person who has initially applied or a member who is applying for continuation of FHIAP subsidy payments, but who has not yet been determined to be eligible to receive such subsidy or continued subsidy. "Applicant" also includes dependents as defined in OAR 442-005-0010(7).

(4) "Benchmark" means an identified minimum level of health insurance benefits qualifying for subsidy eligibility. The benchmark is established by the Office in consultation with the Health Insurance Reform Advisory Committee and is submitted to and approved by the federal government.

(5) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services that authorizes the transaction of health insurance. Carrier also includes the Oregon Medical Insurance Pool established under ORS 735.610.

(6) "Certified carrier" means a carrier that has been certified by the Office to participate in FHIAP. Certified carrier also includes the Oregon Medical Insurance Pool established under ORS 735.610.

(7) "Citizen" for the purposes of FHIAP means a native or naturalized member of the United States who can show proof of identity and citizenship as required in the Deficit Reduction Act (DRA) of 2005 (Pub. L. No. 109-171).

(8) "Dependent" for the purposes of FHIAP may include:

(a) An applicant's spouse, but not when deemed separated pursuant to OAR 442-005-0050(4) or 442-005-0070(5)(c).

(b) All of the applicant's and applicant's spouse's unmarried children, step children,-legally adopted children or children placed under the legal guardianship of the applicant or applicant's spouse who are under the age of 23 and reside with the applicant, and all dependent children of a dependent child.

(c) An unborn child of any applicant or applicant's dependent as verified by written correspondence from a licensed medical practitioner.

(d) An elderly relative or an adult disabled child, regardless of age, who lives in the home of the applicant, may be included as a dependent.

(A) For the purpose of FHIAP administration as it relates to ORS 735.720(3)(b), dependent elderly relative means any person 55 and older.

(B) For the purpose of FHIAP administration as it relates to ORS 735.720(3)(b) adult disabled child means:

(i) A child of the applicant of applicant's spouse who is unmarried, a step child, a legally adopted child, or a child placed under the legal guardianship of the applicant of applicant's spouse who is over the age of 18 and resides with the applicant; and

(ii) A child who is disabled with a physical or mental impairment that:

(I) Is likely to continue without substantial improvement for no less than 12 months or to result in death; and

(II) Prevents performance of substantially all the ordinary duties of occupations in which a person not having the physical or mental impairment is capable of engaging, having due regard to the training, experience and circumstances of the individual with the physical or mental impairment.

(9) "Federal poverty level" means the poverty income guidelines as defined by the United States Department of Health and Human Services. These guidelines will be adopted by FHIAP no later than May 1 each year.

(10) "FHIAP" means the Family Health Insurance Assistance Program established by ORS 735.720 to 735.740.

(11) "Group" means insurance offered through an employer or an association.

(12) "Health insurance producer" means a person who holds a current, valid license pursuant to ORS 774.052 to 774.089 as an insurance producer, where such producer is authorized to transact health insurance.

(13) "Incarcerated" means a person living in a correctional facility, such as:

(a) Individuals who are legally confined to a correctional facility such as jail, prison, penitentiary, or juvenile detention center; or

(b) Individuals temporarily released from a correctional facility to perform court-imposed community service work; or

(c) Individuals on leave of less than 30 days from a correctional facility; or

(d) Individuals released from a correctional facility for the sole purpose of obtaining medical care.

(14) "Income" includes, but is not limited to, earned and unearned gross income received by adults and unearned income received by children. Income includes bartering, or working in exchange for goods and services, discounts on goods and services, working in exchange for rent, and payments made for personal living expenses from business funds.

(a) For purposes of determining average monthly income, an applicant may deduct child or spousal support payments made by the applicant for a child or spouse that FHIAP does not consider a dependent. No deduction is allowed for support that is owed but not paid and collected through an offset against the applicant's state income tax refund.

(b) Income does not include educational grants or scholarships.

(15) "Investments and savings" include, but are not limited to: cash, checking accounts, savings accounts, time certificates, stocks, bonds, non-retirement qualified annuities, other securities easily converted to cash, and the tax-assessed value, as indicated by the county assessor, of any real property. Any of the above investments and savings that are owned by or in which a beneficial interest is held by the applicant or any member of the applicant's family will be considered investments and savings of the applicant.

(a) "Investments and savings" does not include one piece of real property maintained by the applicant or the applicant's family as a primary residence. If the applicant or applicant's family maintain multiple residences or own real property as residential rentals, those properties (other than one single primary residence) are included within the definition of "investments and savings."

(b) "Investments and savings" excludes 529 Educational Savings Plans and qualified retirement accounts, including but not limited to IRAs and 401(k) plans.

(16) "Medicaid," see OHP.

(17) "Medicare" means coverage under either parts A or B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et. seq., as amended.

(18) "Member" means a person approved for FHIAP and enrolled in a health insurance plan using the subsidy.

(19) "Misrepresentation" means making an inaccurate or deliberately false statement of material fact, by word, action, or omission.

(20) "OHP" means the Oregon Health Plan Medicaid program and all programs that include medical assistance provided under 42 U.S.C. section 396a (section 1902 of the Social Security Act).

(21) "Overpayment" means any subsidy payment made that exceeds the amount a member is eligible for, and has been received by, or on behalf of, that member, as well as any civil penalty assessed by the Office.

(22) "Qualified non-citizen" for the purposes of FHIAP. A person is a "qualified non-citizen" if he or she is any of the following:

(a) A non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 1101 et seq).

(b) A refugee who is admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157).

(c) A non-citizen who is granted asylum under section 208 of the INA (8 U.S.C. 1158).

(d) A non-citizen whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1523(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 251(b)(3) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996)).

(e) A non-citizen who is paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year.

(f) A non-citizen who is granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as in effect prior to April 1, 1980.

(g) A non-citizen who is a "Cuban and Haitian entrant" (as defined in section 501(3) of the Refugee Education Assistance Act of 1980).

(h) A battered spouse or dependent child who meets the requirements of 8 U.S.C. 1641(c) and is in the United States on a conditional resident status, as determined by the United States Immigration and Naturalization Service.

(i) American Indians born in Canada to whom the provision of section 289 of the INA (8 U.S.C. 1359) apply.

(j) Members of an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e)).

(k) A veteran of the U.S. Armed Forces who was honorably discharged for reasons other than alien status and who fulfilled the minimum active-duty requirements described in 38 U.S.C. ¶ 5303A(d).

(l) A member of the U.S. Armed Forces on active duty (other than active duty for training).

(m) The spouse or dependent child of a person described in either (k) or (l) above.

(n) A legal non-citizen approved for FHIAP subsidy prior to November 1, 2004.

(23) “Reapplication” means the periodic review and determination of a member’s continued eligibility or subsidy level.

(24) “Reservation list” means a list of potential applicants for FHIAP, entered onto a register maintained by the TPA or state office as authorized by ORS 735.724.

(25) “Resident” means a citizen or qualified non-citizen who resides in Oregon or a full-time college student who is a citizen or qualified non-citizen and has a parent who lives in Oregon.

(26) “Self-employment” means gross receipts received from a business owned, in whole or in part, by a FHIAP applicant or dependent if the gross receipts are reported on an Internal Revenue Servcie (IRS) Schedule C or 1099. Self employed income also includes income received for providing adult foster care if the recipient of the care lives in the applicant’s home. Self-employment does not include income received from a partnership, S-corporation, C-corporation, or adult foster care if the care is not provided in the caregiver’s home. Self-employment does not include income received from a Limited Liability Company except in the following situations:

(a) If an applicant or their dependent have income from a Limited Liability Company and file an IRS schedule C for said income, that income will be treated as self-employment and subject to business deductions.

(b) If an applicant or their dependent have income from a Limited Liability Company and file an IRS schedule F or J for said income, that income will be treated as Farming, Fishing or Ranching and subject to business deductions.

(27) “Support” means any court-ordered monetary payment for a child or former spouse or domestic partner whom FHIAP does not count in the applicant’s family.

(28) “Voluntary payroll deduction” means an amount the employee has authorized the employer to deduct from the employee’s income to pay expenses not required by law.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0020
Reservation Lists

(1) To manage enrollment and ensure that funds are available to cover subsidy payments for those enrolled, two reservation lists will be established and maintained for FHIAP. One list will be for prospective applicants who have or will have access to group health benefit coverage. One list will be for prospective applicants who do not have access to group health benefit coverage.

(2) The Office will establish procedures to manage the reservation lists with the goal of equal distribution of funds between the group health benefit market and the individual health benefit market. This may require FHIAP to release applications from one reservation list ahead of the other.

(3) An applicant may obtain an individual or group application by first getting on the reservation list; or may access a group application via FHIAP’s website; or from an employer or insurance producer.

(4) Prospective applicants will be added to the appropriate reservation list or assigned a reservation number in order of the date FHIAP receives a completed reservation request either in writing or over the telephone. A completed application form may be deemed a reservation request if no prior request was made.

(5) Each request will be assigned a reservation number, which will also function as confirmation of placement on the appropriate reservation list.

(6) Prospective applicants on the reservation list will be notified of their right to apply for FHIAP, as program funds are available.

(7) When enrollment in FHIAP reaches the maximum that funding will allow, additional enrollment may occur as current members terminate or if additional program funding becomes available.

(8) A prospective applicant has 75 calendar days from the date the Office mails the application form, or notifies the prospective applicant that they may apply for a FHIAP subsidy, to return a completed application form to the Office. If the Office does not receive a completed application form postmarked within 60 calendar days from the date it mails the application form, or notifies the applicant, the Office will mail a notice to the prospective applicant reminding them to complete and submit the application form.

(9) If a prospective applicant does not return an application form within 75 calendar days from the original date of mailing or notification, the Office will remove the prospective applicant’s name from the reservation list.

(10) A prospective applicant may enroll in a health benefit plan while on the reservation list as long as they have met the six-month period of uninsurance requirement or exceptions to the period of uninsurance requirement prior to enrolling in the plan.

(11) FHIAP applicants may add new dependents to an existing insurance plan or their FHIAP application without adding them to the reservation list first.

(12) Members who have terminated from FHIAP cannot re-enroll in the program without first being placed on the appropriate reservation list unless they have a family member who is still enrolled in FHIAP.

Stat. Auth.: ORS 735.734, 735.722(2) & 735.728(2)
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0030
Application Process

(1) An application form developed by the Office, and any documentation required on the form, will be used to determine eligibility and subsidy level.

(2) The Office will establish procedures for the application process with the goal of more equally distributing funds between the group health benefit market and the individual health benefit market. This may require the Office to release applications from one reservation list ahead of the other.

(3) The application process is the only time when applicants may submit information proving their program eligibility. Information not submitted during this process will not be accepted for purposes of audit, appeal or contested case hearing except as provided in OARs 442-005-0310, 442-005-0320, 442-005-0330 and 442-005-0340.

(4) As program funds are available, prospective applicants on a reservation list are notified in writing of their eligibility to apply for FHIAP. An application form is included with the notice.

(5) Once the completed application is received, FHIAP will take action on it. Action may be approval, denial or a request for further information from the applicant.

(6) FHIAP may screen applications for FHIAP for potential eligibility for OHP. If FHIAP discovers that such potential eligibility exists, FHIAP will advise the applicant in writing of this possibility.

(7) Documents that verify required information requested on the application must be provided with the application if FHIAP is not able to verify the information electronically. Required documentation includes but is not limited to:

(a) A copy of a current Oregon identification or other proof of Oregon residency for all adult applicants;

(b) For non-United States citizens, a copy of documentation from INS showing their status and when they arrived in the United States.

(c) Documents verifying all adult applicant's and spouse's earned and unearned income and children's unearned income for the three months prior to the month in which the application is signed. Documentation may include, but is not limited to, pay stubs, award letters, support printouts and unemployment benefit stubs or printouts;

(d) A completed Self-Employment Income Worksheet and documents verifying income from self-employment for the six months prior to the signature date on the application, if applicable. Documentation may include, but is not limited to, business ledgers, profit and loss statements and bank statements;

(e) A completed Farming, Ranching and Fishing Income Worksheet and documents verifying income from farming, fishing and ranching for the 12 months prior to the signature date on the application, if applicable. Documentation may include, but is not limited to, business ledgers, profit and loss statements and bank statements;

(f) The most recently filed federal tax return and all schedules for applicants who have income from self-employment or farming, fishing or ranching.

(g) A copy of any group insurance handbook, summary, or contract that is available to any applicant.

(h) A completed Group Insurance Information (GII) form, if the applicant has group insurance available to them.

(i) For applicants with no income, the completed No Income form or other signed statement explaining how the applicant is meeting their basic needs, such as food, clothing and shelter.

(8) Additional verification must be provided when FHIAP requests it.

(9) FHIAP may verify any factors affecting eligibility, benefit levels or any information reported, such as:

(a) Data received by FHIAP that is inconsistent with information on the FHIAP application.

(b) Information provided on the application is inconsistent;

(c) Other information received by FHIAP is inconsistent with information on the FHIAP application;

(d) Information reported on previous applications is inconsistent with a current FHIAP application.

(10) FHIAP may decide at any time during the application process that additional eligibility factors must be verified.

(11) FHIAP may deny an application or end ongoing subsidy when acceptable verification or required documentation is not provided.

Stat. Auth.: ORS 735.734, 735.722(2) & 735.728(2)
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0040
Pending Applications

(1) Whenever additional information is requested by FHIAP during the application process the application will be placed in a “pend” status.

(2) Whenever further information is requested by FHIAP during the application process, the applicant has 45 calendar days from the date on the request to provide the additional information. If the information requested by FHIAP is not rpostmarked within 30 calendar days from the date on the request, the Office will mail a "15-day notice" to the applicant advising that only 15 days remain in which to provide the additional information.

(3) If an applicant does not provide all requested information within 45 days of the initial request, the application will be denied.

(4) Once an applicant has been denied because the applicant failed to respond to the request for further information, the applicant must make a new reservation request to FHIAP to be sent an application in the future. Their name may be placed on the reservation list in the manner prescribed in OAR 442-005-0020.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0050
Eligibility

In order for an applicant to qualify for a FHIAP subsidy, applicants must:

(1) Be a resident of Oregon or a full-time college student with a parent who is a resident of Oregon.

(2) Be a United States citizen or a qualified non-citizen who meets the alien status requirement.

(3) Not be eligible for or receiving Medicare benefits.

(4) Have investments and savings that are available of no more than $10,000 on the last day of the month prior to the month the application is signed. Investments and Savings are not available if owned by or a beneficial interest in them is held by a separated spouse. FHIAP will determine when an applicant’s spouse is deemed separated for the purposes of this subsection (4).

(5) Have income of less than 185% of the Federal Poverty Level in effect at the time of determination. Income determination is outlined in OAR 442-005-0070.

(6) Meet one of the statutory definitions of family in ORS 735.720 (2) at the time of eligibility determination. To be included in the family size for FHIAP eligibility determination, the applicant’s family members must meet the definition of dependent under OAR 442-005-0010 (7).

(a) A dependent may not be counted in two separate households for the purposes of FHIAP and any other assistance program.

(b) If a dependent has been counted in more than one household for the purpose of obtaining benefits, that dependent will be removed from the family count for FHIAP and eligibility reassessed, if applicable.

(7) Meet either a period of uninsurance requirement or exceptions listed in OAR 442-005-0060.

(8) Not be incarcerated for more than 30 days or be a ward of the State.

(9) Provide necessary materials in order to allow for eligibility determination. If information submitted is inconsistent, and applicant may be denied.

(10) If applying for subsidy in the group market, must be able to enroll in an group insurance plan that meets the benchmark standard established by the Office within twelve months of eligibility determination. If an applicant to the group market does not have access to a group plan, the group plan they have access to does not meet the benchmark standard, or they cannot enroll into their group plan within twelve months of eligibility determination, the applicant will be denied and placed on the reservation list for an individual subsidy using the same date they were placed on the group reservation list.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0060
Period of Uninsurance Requirement

In order for an applicant to be eligible for a FHIAP subsidy, an applicant must have been without any health insurance coverage for six months immediately prior to either the signature date on the application, the date of eligibility determination, or any reservation entry date. This requirement does not apply if any applicant:

(1) Is currently enrolled in the OHP.

(2) Was enrolled in the OHP within the last 120 days.

(3) Is a former FHIAP member.

(4) Has enrolled in an insurance plan while on the reservation list as long as they have met the six-month period of uninsurance immediately prior to enrolling in the insurance plan.

(5) Has coverage through the Kaiser Child Health Program or any benefit plan authorized by ORS 735.700 – 735.714.

(6) Has a military insurance plan.

(7) Has enrolled in group coverage within the 120 days prior to getting on the FHIAP reservation list, as long as the applicant had been without any insurance coverage for six consecutive months immediately prior to becoming insured under the group plan.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0070
Income Determination

In order to qualify for FHIAP, an applicant must have average monthly gross income, from all sources, of up to 185 percent of the federal poverty level in effect at the time of determination. Subsidies will be approved on a sliding scale determined by income and family size.

(1) Average income from all sources, except income received from farming, fishing, ranching, or self-employment, will be determined using income received in the three-calendar months prior to the month in which the application was signed.

(2) FHIAP will determine if income received is considered farming, fishing or ranching by whether the income is reported on an IRS schedule F or J form. FHIAP will determine average income from farming, fishing or ranching by using gross receipts for the 12 months prior to the month the application was signed less deductions by either method (a or b) below. Average adjusted income will be determined by either method below (a or b) as specified by the applicant on the Farming, Ranching and Fishing Income Worksheet. Whichever method the applicant chooses to use will be the method used throughout that year’s eligibility determination, including appeal and contested case hearing processes.

(3) FHIAP will determine if the applicant or applicant’s spouse meets the definition of self-employment. Upon meeting the definition of self-employment, the average monthly gross receipts from self-employment and prior to FHIAP deductions will be determined using gross receipts received from the self-employed business during the six months prior to the month in which the application was signed. If the average gross monthly self-employment income during the six months prior to the month the application was signed exceeds $10,000.00, the applicant will be ineligible for FHIAP. Average adjusted income will be determined by either method below (a or b) as specified by the applicant on the Self-Employment Worksheet. Whichever method the applicant chooses to use will be the method used throughout that year’s eligibility determination, including appeal and contested case hearing processes.

(a) Income received from farming, fishing, ranching and self-employment will be reduced by 50 percent for business expenses; or

(b) Income received from farming, fishing, ranching and self-employment will be reduced by the actual allowable expenses incurred during the six or twelve months prior to the date the application was signed.

(A) The following are considered allowable expenses:

(i) Labor (wages paid to an employee or work contracted out) except when paid to the applicant, anyone in the applicant's family, or a business partner.

(ii) Raw materials, equipment, machinery or other durable goods used to make a product or provide a service, excluding personal vehicles and real property. FHIAP will determine whether a vehicle is considered a personal vehicle based upon information submitted by the applicant and information obtained from the Department of Motor Vehicles.

(iii) Interest paid to purchase income-producing property, such as equipment or capital assets.

(iv) Insurance premiums, taxes, assessments, and utilities paid on income-producing property.

(v) Service, repair, and rental of business equipment (including motor vehicles) and property that is owned, leased or rented, excluding personal vehicles. FHIAP will determine whether a vehicle is considered a personal vehicle based upon information submitted by the applicant and information obtained from the Department of Motor Vehicles.

(vi) Advertisements and business supplies.

(vii) Licenses, permits, legal, or professional fees.

(viii) Transportation costs at 20 cents per mile, if the cost is part of the business expense. Commuting expenses to and from the worksite are not considered part of the business expense. If applicant is able to prove actual expenses for fuel and maintenance on business vehicles, those amounts can be deducted in lieu of the mileage calculation. In no instance will both deductions be allowed.

(ix) Charges for telephone services that can be verified as a necessary expense for self-employment.

(x) One-third (33.3%) of utility costs when the business shares a physical address with the applicant's residence.

(xi Costs related to traveling to another area only when there is a reasonable possibility of deriving income from the trip, except for the cost of meals.

(xii) Business related bank and credit card fees.

(xiii) Bad debt.

(B) The following are not allowed as costs of producing self-employment income:

(i) Meals for the applicant or their family.

(ii) Payments on the principal of the purchase price of income-producing real estate.

(iii) Federal, state, and local income taxes, draws, or salaries paid to any family member, money set aside for personal retirement, and other work-related personal expenses (such as transportation, personal business, and entertainment expenses).

(iv) Depreciation.

(v) Costs related to traveling to another area when there is no reasonable possibility of deriving income from the trip.

(vi) Interest paid on credit card accounts.

(vii) Personal telephone charges.

(viii) Interest or principal payments on a mortgage when the business shares an address with the applicant's residence.

(ix) Rental payments for real property when the business shares a physical address with the applicant's residence.

(x) Losses incurred by another business.

(4) Income is available immediately upon receipt, or when the applicant has a legal interest in the income and the legal ability to make the income available, except in the following situations when it is considered available as indicated:

(a) For earned and unearned income:

(A) Income available prior to any deductions such as garnishments, taxes, payroll deductions, or voluntary payroll deductions will be considered as available; however, support payments as defined in OAR 442-005-0010(34) may be deducted from gross income if the applicant is able to prove the payments were made.

(B) Income usually paid monthly or on some other regular schedule, but paid early or late is treated as available on the regular payday.

(C) Payments made in a "lump-sum" will be divided out over the number of months the payment is for. "Lump sum" payments will only be divided if the applicant can provide proof of the period for which the payment was made.

(b) Earned income is available as follows:

(A) Income withheld or diverted at the request of an employee is considered available in the month the wages would have been paid;

(B) An advance or draw that will be subtracted from later wages is available when received.

(c) Payments that should legally be made directly to an applicant, but are paid to a third party on behalf of an applicant, are considered available the date that is on the check or stub.

(5) Income is not available if:

(a) The wages are withheld by an employer, with the exception of garnishment, even if in violation of the law;

(b) The income is paid jointly to the applicant and other individuals and the other individuals do not pay the applicant his/her share.

(c) It is received by a separated spouse. FHIAP will determine when an applicant's spouse is deemed separated for purposes of this subsection (5)(c).

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0080
Additional Eligibility Requirements in the Group Market

(1) Applicants on the group reservation list will be approved for a FHIAP subsidy only if a group plan that meets the benchmark standard is available to them or someone in their family at the time of application, even if enrollment in the plan is not immediate.

(2) If an applicant is sent an application based on availability of group insurance and does not have a group plan available to them or anyone in their family within 12 months of application, the application will be denied. The applicant will automatically be placed on the individual reservation list using the same date they were placed on the group reservation list.

(3) If an applicant on the group reservation list has access to a group insurance plan, but it does not meet the benchmark, the application will be denied and the applicant will be placed on the individual reservation list using the same date they were placed on the group reservation list.

(4) In the instance when FHIAP is not allowed as a qualifying event, the applicant must enroll during the employer's open enrollment period. The applicant will remain eligible for subsidy through their group insurance for 12 months.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0090
Determination – Approvals and Denials

(1) If the applicant is denied subsidy during the application process, FHIAP will send a letter advising the applicant of the decision. The letter will include information regarding the applicant of the decision. The letter will include information regarding the applicant's right to appeal or request a contested case hearing and the steps necessary to do so (ref. 442-005-0330). Applicants whose entire family are denied and wish to reapply must first get on the appropriate reservation list.

(2) If the applicant is approved for subsidy, FHIAP will send a letter advising the applicant of the decision. The letter will include information about who has been approved for subsidy and the level of subsidy to be paid.

(3) The subsidy eligibility period will be based on the subsidy approval date, not the effective date of enrolment in the insurance plan.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0100
Subsidy Levels

(1) When a family has average gross monthly income up to 125 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:

(a) 95 percent of the member's monthly premium amount in the individual health benefit plan market; or

(b) 95 percent of the member's share of the monthly premium amount in the group health benefit plan market.

(2) When a family has average gross monthly income from 125 up to 150 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:

(a) 90 percent of the member's monthly premium amount in the individual health benefit plan market; or

(b) 90 percent of the member's share of the monthly premium amount in the group health benefit plan market.

(3) When a family has average gross monthly income from 150 up to 170 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:

(a) 70 percent of the member's monthly premium amount in the individual health benefit plan market; or

(b) 70 percent of the member's share of the monthly premium amount in the group health benefit plan market.

(4) When a family has average gross monthly income from 170 up to 185 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:

(a) 50 percent of the member's monthly premium amount in the individual health benefit plan market; or

(b) 50 percent of the member's share of the monthly premium amount in the group health benefit plan market.

(5) The subsidy amounts will never exceed 50 percent, 70 percent, 90 percent, or 95 percent of the total premium based on percentage of federal poverty level in effect at the time of eligibility determination.

(6) With the exception of administrative error or audit, subsidy percentage levels will only be re-evaluated at reapplication. Subsidy dollar amounts may change, however, if the actual premium being subsidized changes.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0110

Applicant Referral to Health Insurance Producers

(1) FHIAP will provide assistance to FHIAP applicants requesting help with health benefit plan decisions.

(2) Applicants who wish to purchase an individual health benefit plan will be referred, upon their request, to participating producers.

(3) To qualify for referrals from FHIAP, health insurance producers must:

(a) Have a current Oregon resident health insurance, general lines producer license, or a nonresident health insurance or general lines producer license, if the nonresident licensee can service the member face to face;

(b) Complete training as required by FHIAP;

(c) Have Errors and Omissions Insurance, with limits of at least $500,000 per occurrence and $1,000,000 aggregate annually, in force during their participation in the Producer Referral Program and agree to notify FHIAP if Errors and Omissions coverage is no longer in force;

(d) Agree to provide the same level of client contact and service to customers receiving a FHIAP subsidy as is provided to other customers;

(e) Agree to help customers fill out an entire Oregon Medical Insurance Pool application if necessary;

(f) Agree to advise FHIAP when the sale of a health benefit plan to FHIAP applicants is completed, whether or not the coverage is a certified plan, or the prospective purchaser decides not to purchase any health benefit plan if requested by the Office; and

(g) Agree to inform customers if they or their dependents may be eligible for OHP.

(4) FHIAP reserves the right to remove any agent from the referral program at any time.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0120

Enrollment In Health Benefit Plans – Individual Market

(1) To remain eligible for subsidy assistance, an applicant must apply for coverage with an insurance plan within the timeframes outlined by FHIAP on the Certificate of Eligibility. The following rule (previously 442-004-0090(2) has been incorporated in section 442-005-0190, Enrollment in FHIAP – Group Market

(2) Approved applicants will no longer be eligible for a FHIAP subsidy if they fail to enroll into an insurance plan as outlined by FHIAP on the Certificate of Eligibility. Approved applicants who fail to enroll must get on a reservation list in order to receive an application to reapply for a FHIAP subsidy. The following rule (previously 442-004-0090(3) has been incorporated in section 442-005-0190, Enrollment in FHIAP – Group Market(3) Applicants approved for a subsidy in the individual market must use the subsidy to purchase a plan offered by a FHIAP-certified carrier that meets the benchmark standard. The following rule (previously 442-004-0090(4)(a) through (d) has been incorporated in section 442-005-0200, Vendor Set-up/State Accounting System – Group Market

(4) A family approved for a FHIAP subsidy may choose to enroll family members into different plans, including enrolling some family members in a group plan, some family members in an individual plan and some family members in the OHP as long as no family member is enrolled in OHP and FHIAP at the same time.

(5) If a person is enrolled in two insurance plans, FHIAP will subsidize only one plan.

(a) If one of the plans is a group plan that meets the benchmark, FHIAP will subsidize the group plan. If both plans are group plans that meet the benchmark standard, FHIAP will subsidize the plan that is most cost-effective to the Office.

(b) If both of the plans are individual, FHIAP will subsidize only a plan offered by a FHIAP-certified carrier that meets the benchmark standard. If both plans meet the benchmark standard, FHIAP will subsidize the plan that is most cost-effective to the Office.

(6) Any FHIAP applicant or member who is enrolled in an individual plan and being subsidized by FHIAP must enroll into a group plan if one becomes available to them, provided the group plan meets the benchmark standard. Members who fail to enroll into such a plan are no longer eligible for a FHIAP subsidy in the individual market.

(7) If the applicant is approved for individual insurance subsidy and has not yet enrolled in an individual insurance plan, FHIAP will begin to subsidize premiums no earlier than the first of the month following the date of the approval letter.

(8) If the applicant is approved for individual insurance subsidy and is already enrolled in the insurance plan, FHIAP may begin subsidizing premiums from the first of the month in which they are approved for subsidy. The subsidy eligibility period will be based on the subsidy approval date

(9) If a carrier elects to discontinue participation in the program, members served by that carrier will have to reapply for insurance coverage with another FHIAP-certified carrier and maintain continuous coverage in order to remain eligible for the subsidy. For the purposes of this section, continuous coverage may include a 120 calendar-day break in coverage.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0130

Member Invoicing – Individual Market

(1) Except for the first billing period, FHIAP will not pay the carrier until the member's portion of the premium has been received.

(2) Invoices are mailed to members one month in advance of the carrier due date to ensure timely payment to the carrier.

(3) Member payments are due to FHIAP by the date provided on the monthly invoice.

(4) Unpaid balances greater than $3.00 are mailed a reminder and given an extension on the original due date.

(5) If the payment is not postmarked by the due date on the reminder, FHIAP subsidy may be cancelled.

(6) If FHIAP fails to send a reminder, the member will be billed for two months during the next billing cycle. In these instances:

(a) FHIAP will not pay the carrier until the amount due has been paid.

(b) FHIAP will not be responsible for carrier non-payment terminations.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0140

Member Payments – Individual Market

(1) Member payments will be processed no less than each business day.

(2) Members will be notified of payments returned by the bank for Non-Sufficient Funds (NSF).

(a) A check that is returned for Non-Sufficient Funds is considered the same as non-payment.

(b) Replacement funds must be sent within 10 days of the date on the notification letter.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0150

Carrier Payments – Individual Market

(1) Member payments must be received before payment to the carrier will be made, except for the first billing period.

(2) In the event the member does not pay their portion of the first months' premiums, FHIAP will disenroll the member and apply normal overpayment collection practices for the member's portion only.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0160

Carrier Refunds – Individual Market

(1) FHIAP will resolve member overpayments by requesting a refund from the carrier; except for overpayments older than three months and overpayments resulting from member misrepresentation.

(2) FHIAP will seek carrier refunds within 30 days of overpayment determination.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0170
Member Refunds – Individual Market

(1) Member refunds will be processed no less than weekly.

(2) Member refunds will not be processed for amounts under $25.00 unless it is the final payment on a termed account.

(3) Members will receive refunds for their portion of any overpaid premium.

(4) Member refunds of premiums paid to a carrier will be processed upon receipt of the refund from the carrier.

(5) Current members billed incorrectly may request a refund or take a credit on their active account for refunds over $25.00.

(6) Member refunds for premium not yet sent to the carrier will be paid weekly even if an additional refund is due from the carrier as long as both refunds are over $25.00.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0180
Selection of Certified Carriers in the Individual Health Benefit Plan Market

Carriers may request to go through the certification process at any time. Selection criteria used to determine which carriers may be certified includes but is not limited to:

(1) Agree to a three-year commitment to be a FHIAP-certified carrier.

(2) Agree to electronic transferring of invoices and payments.

(3) Accept the Certificate of Eligibility in lieu of a first month's payment.

(4) Be an Oregon licensed health insurance company or health care service contractor holding a valid certificate of authority from the Department of Consumer and Business Services authorizing the transaction of health insurance.

(5) Be in the Oregon small employer-sponsored health benefit plan market (2-50 employees) and Oregon individual health benefit plan market.

(6) Have been in the individual or portability market for at least the last three consecutive years.

(7) Agree to accept FHIAP payment grace periods.

(8) The carrier shall remain responsible for notifying its FHIAP membership of premium rate increases.

(9) Offer one or more health benefit plans that meet FHIAP's benchmark requirements.

(10) Agree to give the Office of Private Health Partnerships a written 180-day notice of intent to withdraw from being a certified carrier.

(11) Agree that the — Office of Private Health Partnerships may cancel partnership with cause by giving 180-day written notice.

(12) If the Office determines at any time that an insufficient number of individual health benefit plan options are available, it may request additional Individual Health Benefit Plan carriers to be certified.

(13) The carrier discontinuing participation must notify each insured FHIAP member 90 calendar days before their coverage will be discontinued and inform each insured to contact FHIAP for assistance in obtaining new coverage.

(14) May give preference to carriers with statewide coverage.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0190
Enrollment in FHIAP – Group Market

(1) Any applicant approved for a subsidy in the group market must enroll in a group plan that meets the benchmark standard within 12 months of being approved for FHIAP. Applicants that do not enroll in a group plan within 12 months will have to get back on the reservation list in order to reapply for a subsidy.

(2) Any FHIAP applicant or member who is enrolled in an individual plan and being subsidized by FHIAP must enroll into a group plan if one becomes available to them, provided the group plan meets the benchmark standard. Members who fail to enroll into such a plan are no longer eligible for a FHIAP subsidy in the individual market.

(3) If the applicant is approved for a group insurance subsidy, FHIAP will subsidize premiums that pay for the full approval month, no matter what day in the approval month the decision is made. The subsidy eligibility period will be based on the subsidy approval date.

(4) Once enrolled, if a member loses their group coverage due to loss of employment, or the employer discontinues the group plan, FHIAP will subsidize a COBRA, portability plan, or individual plan.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0200
Vendor Set-up/State Accounting System – Group Market

Subsidy payments may be payable to:

(1) The member or member's employed spouse from whose pay check the premium is being deducted.

(2) Parents of member children.

(3) Carriers.

(a) Member payments must be received before payment to the carrier will be made, except for the first billing period.

(b) In the event the member does not pay their portion of the first months' premiums, FHIAP will disenroll the member and apply normal overpayment collection practices for the member's portion only.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0210
Employer Verification – Group Market

(1) Employer contribution changes – Members must report changes in circumstances to FHIAP as provided in 442-005-0260.

(2) Subsidy changes – FHIAP will request a new employer verification form if plan changes become evident through payroll deduction changes, member notification, etc. FHIAP will continue to subsidize the member at the documented rate until new rates are received. Underpayments will be paid to members when new rates are documented.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0220
Subsidy Payments – Group Market

(1) The amount FHIAP will subsidize is based on the monthly insurance premium less the employer's contribution.

(2) FHIAP will reimburse the eligible members' portion of the premium in the group market using submitted payment verification. Verification can include, but is not limited to payroll records, paycheck stubs, employer letters, carrier invoices, receipts, and cancelled check copies.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0230
COBRA/Portability

(1) Potential applicants with a COBRA or Portability plan are placed on FHIAP's reservation list.

(2) Members receiving group subsidy who lose their insurance coverage may opt for COBRA, Portability, or an Individual insurance plan and FHIAP will continue to provide premium subsidy.

(3) Members approved for group subsidy who lose their insurance coverage prior to using the FHIAP subsidy may opt to use their FHIAP subsidy toward COBRA, state continuation, or portability.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0240
Reapplication for Health Insurance Subsidy

(1) Eligibility for subsidy lasts for a maximum of twelve months.

(2) Members must reapply for subsidy once every 12 months after receiving their initial approval.

(3) FHIAP will send members an application at least 60 calendar days before their subsidy eligibility ends. The application will be mailed to the last known address of the member. The information provided by the member on this application will be used to determine the family's eligibility for the next 12 months.

(4) FHIAP will review eligibility during the reapplication process using the same requirements as outlined in OAR 442-005-0020.

(5) The application is mailed with a letter, outlining the review process and the due date for return of the reapplication materials.

(6) The member will have at least 45 calendar days from the date the application is mailed to return the reapplication materials. If the reapplication materials are not postmarked within 30 calendar days, the Office will mail a notice to the member Reminding them to return their application to FHIAP by the due date.

(7) If the reapplication materials are not postmarked by the due date, the application is denied and the applicant must make a new reservation in order to receive an application as space permits.

(8) Once the completed application materials are received FHIAP will take action on it. The action may be approval, denial, or a request for further information from the applicant.

(a) Reapplications that require more information to determine FHIAP eligibility will be placed in a "pend" status.

(b) Whenever further information is requested by FHIAP during the reapplication process, the applicant has 45 calendar days following the date of the request to provide the additional information. If the information requested by FHIAP is not postmarked within 30 calendar days from the date on the request, the Office will mail a notice to the member advising that only 15 days remain in which to provide the additional information.

(c) If a member does not provide all requested information within 45 calendar days of the initial request, the reapplication will be denied.

(d) Once a member has been denied because they failed to respond to the request for further information, the member must make a new reservation request to FHIAP to be sent an application in the future. Their name may be placed on the reservation list in the manner prescribed in OAR 442-005-0020.

(9) If a member is denied continued eligibility during the reapplication process, FHIAP will notify the member in writing of the reason for the denial, the effective date of the action, a phone number and resource for questions, and appeal and contested case hearing rights.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0250
Adding Dependents

(1) Members may add dependents to their FHIAP enrollment at any time throughout the 12-month eligibility period as long as the dependent meets the period of uninsurance requirement or exceptions outlined in OAR 442-005-0060.

(2) Premium rates and the member's portion of the premium could change as a result of adding dependents.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0260
Member Reporting

(1) Members must report changes in circumstance to FHIAP within 30 calendar days of their occurrence by phone or in writing. These circumstances include the following:

(a) Change of Name;

(b) Change in Employers;

(c) Changes to family composition including death, divorce, any family member becoming a ward of the state or being incarcerated for more than 30 continuous days;

(d) Change of home or mailing address, even if temporarily away (more than 30 days):

(e) If any FHIAP member drops health benefit coverage;

(f) Obtaining different or additional health benefit coverage;

(g) Any family member becomes ineligible for health benefit plan;

(h) Change in employer contribution for FHIAP members receiving subsidy in the group market;

(i) If group insurance becomes available to a member enrolled in the individual market as stipulated in OAR 442-005-0190(2).

(2) Failure to report any of the above changes may result in termination from the program, subsidy suspension, loss of insurance coverage or an overpayment.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0270
Termination of Subsidy

Termination from the FHIAP program occurs when:

(1) Payment of the member's share of the insurance premium is not postmarked by the date stipulated in correspondence from FHIAP;

(2) The member is no longer a resident of Oregon;

(3) The member terminates or is terminated from the member's health benefit plan and fails to notify FHIAP;

(4) The insurance plan that covers an eligible child of any member terminates or is terminated, and the member does not replace the eligible child's health insurance within 120 calendar days from the date FHIAP notifies the member to replace the child's coverage.

(5) The member is determined to be ineligible at reapplication or any time during the subsidy year. Ineligibility results if:

(a) A member is eligible for or receiving Medicare on or before the date the application was signed. Subsidy may remain in force for the remainder of the applicant's 12-month eligibility period if the applicant became eligible for Medicare after signing the application.

(b) A member is incarcerated beyond 30 continuous calendar days.

(c) Any member is enrolled in OHP and FHIAP simultaneously and fails to timely terminate from one program after being notified by FHIAP that they must do so.

(d) Any information submitted is inconsistent and does not allow for eligibility determination.

(e) FHIAP staff makes an administrative error when determining eligibility and the applicant should have been denied and the error is identified during an audit of the member's file.

(f) An applicant or member in the individual market becomes eligible for a benchmark-approved group plan with an employer contribution and doesn't enroll within 30 days of the first opportunity of enrollment in the group plan.

(g) The member failed to submit required or requested information or submitted inadequate or unclear information such that FHIAP cannot make an eligibility determination.

(6) In the group market, the member fails to provide monthly verification of coverage, premiums, and employer contribution within 30 days from the date FHIAP requests such documentation.

(7) The member fails to pay an overpayment amount as per OAR 442-005-0280.

(8) The member fails to return their reapplication within 45 days from the date it was mailed to them.

(9) A member is found to have committed misrepresentation on their FHIAP application. If a civil penalty is imposed, the member is ineligible to enroll or re-enroll in FHIAP.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0275
Misrepresentation/Civil Penalty

(1) FHIAP may investigate any applicant, member or former member for misrepresentation in obtaining subsidy benefits. Such investigations may be through random file audits or by management request.

(2) FHIAP may ask appropriate legal authorities to initiate civil or criminal action under Oregon laws when, in FHIAP's judgment, available evidence warrants such action.

(3) FHIAP may issue an intent to take disciplinary action against a member by giving notice of the opportunity for a contested case hearing.

(4) When a finding is made that an applicant or member has committed misrepresentation:

(a) The member is terminated from FHIAP and ineligible to re-enroll in FHIAP;

(b) The member is liable for repayment to FHIAP the full amount of overpayment FHIAP has established, regardless of any restitution amount ordered by a court;

(c) The applicant or member is liable for any civil penalty set by FHIAP up to a statutory limit of $1,000. The civil penalty amount will be set by using a sliding scale based on the amount of subsidy paid on the member's behalf.

Stat. Auth.: ORS 735.734, 735.740, & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0280
Overpayments

(1) Any overpayment amount is a debt owed to the State of Oregon and may be subject to collection. An overpayment may result from administrative error, member error, misrepresentation, or civil penalty.

(2) An overpayment is considered to be member error if it is caused by the member's misunderstanding or error. Examples include, but are not limited to, instances where the member intentionally or unintentionally:

(a) Did not provide correct or complete information to FHIAP;

(b) Did not report changes in circumstances to FHIAP;

(c) Claimed and was reimbursed for an ineligible subsidy period.

(3) An administrative error overpayment may be caused by any of the following circumstances:

(a) FHIAP committed a calculation, procedural, or typing error that was no fault of the member;

(b) FHIAP failed to compute or process a subsidy payment correctly.

(4) A misrepresentation error includes but is not limited to the member giving an inaccurate or deliberately false statement of fact that results in an inappropriate eligibility determination or an incorrect subsidy level calculation. Misrepresentation may result in a civil penalty.

(5) The FHIAP member is having the health insurance premium subsidized by another state government program, such as, but not limited to OHP, and such subsidy results in a double payment for the same health insurance premium.

(6) FHIAP will mail notification of overpayments to the member. This written notice shall:

(a) Inform the member of the amount of and the reason for the overpayment;

(b) Inform members of their appeal and contested case hearing rights.

(7) FHIAP will collect overpayment amounts in one lump sum if the member is financially able to repay the overpayment amount in that manner.

(8) If the member is financially unable to pay the amount due in one lump sum, FHIAP will accept regular installment payments as outlined in 442-005-0290 – Payment Plans.

(9) If FHIAP is unable to recover the overpayment amount from the member within overpayment guidelines:

(a) FHIAP may renegotiate the payment plan agreement or refer the balance to the Department of Revenue, the Department of Justice, or another outside agency for collection. If an account is referred to an outside agency for collection, any expenses incurred for collection will be added to the member's balance due.

(b) FHIAP may file civil action to obtain a court ordered judgment for the amount of the debt. FHIAP may also assert a claim for costs and fees associated with obtaining a court judgment for the debt. When a judgment for costs is awarded, FHIAP will collect this amount in addition to the overpayment amount, using the methods of recovery allowable under state law and administrative rule.

(10) If the member submits an appeal or contested case hearing request, FHIAP will discontinue any attempts at collection until the conclusion of the appeal or hearing.

(11) If the appeal decision is in the member's favor, FHIAP will refund any money collected as overpayment recovery as outlined in OAR 442-005-0280, 442-005-0290 and 442-005-0300.

(12) Any former FHIAP member with an outstanding overpayment balance who is reapplying for FHIAP subsidy must meet the regular eligibility criteria and be repaying their outstanding overpayment as follows:

(a) A minimum of $10 per month or the amount necessary to collect the overpayment amount in one year, whichever is greater, or

(b) An offset against any future monthly subsidy payment in the amount necessary to collect the overpayment amount in one year.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0290
Payment Plans

Subsidy overpayments that are paid on the member's behalf are the member's responsibility. Members may be eligible to establish a payment plan to reimburse FHIAP.

(1) Payment plans for Individual members who are currently enrolled:

(a) Members who have been billed at an incorrect subsidy level or premium rate will be responsible for repayment of their portion of the amount FHIAP overpaid the insurance carrier on their behalf.

(b) Members will have an option to either repay the overpayment amount in full or establish a payment arrangement.

(c) Payments established under a payment arrangement will consist of no less than the regular monthly member portion plus an amount sufficient to reduce the overpayment to zero within 120 days.

(d) If the overpayment cannot be paid within 120 days, special payment arrangements may be coordinated. Consideration for the payment plan will be the time remaining before the next reapplication period. The overpayment must be paid in full to FHIAP within 12 months unless an exception is negotiated.

(e) Once a payment plan is approved FHIAP sends the member a letter. The letter:

(A) Outlines the payment arrangement and informs members that they are responsible for making timely payments according to the established payment plan.

(B) Informs the member of what action FHIAP will take to collect the overpayment.

(f) If the member fails to follow the payment plan, the member may be terminated for non-payment. The unpaid balance will then be transferred to collections.

(2) Payment plans for group members who are currently enrolled:

(a) Members have an option to either repay the overpayment amount in full or establish a payment arrangement.

(b) Group member overpayments will be collected by reducing subsidy reimbursements on active accounts until the full overpayment is repaid,

(c) Group overpayments must be repaid within 120 days unless alternate timeframes are negotiated.

(d) Consideration for the payment plan will be the time remaining before the next reapplication period.

(e) The overpayment must be repaid within 12 months unless an exception is negotiated.

(3) Payment plans for inactive members: See Collections Section 442-005-0300.

(4) Terminated members with an outstanding unpaid balance, who are reapplying to the program, must establish payment arrangements in order to be eligible for re-enrollment.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0300
Collections

(1) FHIAP staff will reconcile terminated accounts with unpaid balances.

(2) FHIAP staff will notify the member in writing of the collection amount. The terminated member will have 21 days to appeal before further collection action is taken, unless appeal rights were already extended in other FHIAP correspondence.

(3) Terminated members may be eligible to establish a payment plan as outlined in OAR 442-005-0290.

(4) If FHIAP is unable to recover the unpaid balance from the terminated member or no payment is made within 90 days:

(a) FHIAP may renegotiate the collection agreement or refer the balance to the Department of Revenue, the Department of Justice, or another outside agency for collection. If an account is referred to an outside agency for collection, any expenses incurred for collection will be added to the member's balance due.

(b) FHIAP may file civil action to obtain a court ordered judgment for the amount of the debt. FHIAP may also assert a claim for costs and fees associated with obtaining a court judgment for the debt. When a judgment for costs is awarded, FHIAP will collect this amount in addition to the overpayment amount, using the methods of recovery allowable under state law and administrative rule.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0310
Audits

(1) Quality assurance audits will be performed to verify:

(a) FHIAP statutes, rules, policies and procedures are followed correctly.

(b) FHIAP procedures are effective.

(c) Eligibility is determined correctly.

(2) Audits may be performed on a directed or random basis.

(3) As a result of an audit:

(a) A member or former member may be determined ineligible for a FHIAP subsidy.

(b) A member or former member may be determined ineligible retroactively for a prior subsidy eligibility period.

(c) A subsidy level adjustment may be necessary for a current or previous determination period.

(4) An audit determination could result in an overpayment or underpayment to a member or former member.

(5) The member or former member must submit additional verification when FHIAP requests it.

(a) FHIAP may verify any factors affecting eligibility, benefit levels or any reported information. Such information includes, but is not limited to:

(A) Any information submitted by the member that is inconsistent.

(B) Information provided on the application that is inconsistent.

(C) Other information that is used as verification but is inconsistent with the information on the application.

(D) Information reported on previous application that is inconsistent with the current FHIAP application.

(b) FHIAP may decide at any time that additional eligibility factors must be verified.

(c) FHIAP may deny an application or end ongoing subsidy when requested verification is not provided.

(6) Requested verification includes the same information as listed in OAR 442-005-0030 as well as any other information that will verify information already submitted.

(7) If additional information is requested during a directed or random audit, the member has 30 days from the date of the Request for Information letter to submit the information. FHIAP will use the postmark date to deter-

mine timeliness. If a FHIAP member fails to cooperate with a FHIAP audit, the member may be disenrolled.

(8) If a decision differs from the original eligibility determination, FHIAP will notify the member in writing of the reason for the denial or change in determination, the effective date of the action, and the member's appeal and contested case hearing rights.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0320
Appeals

(1) All FHIAP correspondence that notifies applicants or members of decisions and determinations will include appeal language and outline the steps necessary to file an appeal.

(2) An applicant or member may appeal any decision made or action taken by FHIAP.

(3) To appeal a decision or action, the applicant or member must advise FHIAP in writing of their desire to appeal. The written appeal request must be postmarked within 21 calendar days of the date on the notice or action.

(4) The appeal request must include the reasons for the appeal, which shall be limited to the issue(s) cited in the decision or determination.

(5) On its own or if asked by an applicant or member, FHIAP may consider additional information during the appeal process. If further information is requested by FHIAP, the applicant or member has 15 calendar days from the date on the request to provide the additional information. If the information requested by FHIAP is not postmarked within 15 calendar days from the date on the request, the original decision will be upheld.

(6) Once FHIAP has made a decision on appeal, the applicant or member will be notified of the appeal decision.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0330
Contested Case Hearings

(1) An applicant or member may request a hearing on FHIAP's appeal decision.

(2) To receive a hearing, the hearing request must be in writing, signed by either the applicant, member, or their attorney and be postmarked no later than 21 calendar days following the date of the appeal decision notice.

(3) The hearing request must include the reasons for the hearing, which shall be limited to the issue(s) cited in the appeal decision notice.

(4) FHIAP will conduct a contested case hearing pursuant to ORS 183.413 to 183.470.

(5) Once a hearing is requested, FHIAP will not pursue collection of any alleged overpayment until FHIAP has issued a final order affirming the overpayment.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0340
Extenuating Circumstances

The Agency Administrator or designee will appoint a case management panel to review extenuating circumstance requests that may result in exceptions to application of the administrative rules. Requests relating to life circumstances beyond the applicant's control will be considered.

(1) Exceptions will not be granted for any eligibility requirements except the extension of timeframes associated with submitting information, including, but not limited to the application, income verification, appeal or hearing request and information specifically requested by FHIAP staff.

(2) Exceptions will also be considered for non-payment of the member's portion of the insurance premium.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0350
Rule Authorizing Agency Representative

(1) Subject to the approval of the Attorney General, a FHIAP officer or employee is authorized to appear on behalf of the agency in a hearing that may result in the change or termination of program benefits as well as in some cases imposing civil penalties.

(2) The agency representative may not make legal argument on behalf of the agency.

(a) "Legal argument" includes arguments on:

(A) The jurisdiction of the agency to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirement to an agency; and

(C) The application of court precedent to the facts of the particular contested case proceeding.

(b) "Legal argument" does not include presentation of evidence, examination and cross-examination of witnesses, or presentation of factual arguments or arguments on:

(A) The application of the facts to the statutes or rules directly applicable to the issues in the contested case;

(B) Comparison of prior actions of the agency in handling similar situations;

(C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case; and

(D) The admissibility of evidence or the correctness of procedures being followed.

(3) When an agency officer or employee represents the agency, the presiding officer shall 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 shall provide reasonable opportunity for the agency officer or employee to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after conclusion of the hearing.

(4) The presiding officer may limit an authorized representative's presentation of evidence, examination and cross-examination of witnesses, or presentation of factual arguments to insure the orderly and timely development of the hearing record, and shall not allow an authorized representative to present legal argument as defined in subsection (2)(a).

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

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Oregon Department of Education
Chapter 581

Rule Caption: Provisions for implementation of SB 300, Expanded Options, which promotes opportunities for high school students.
Adm. Order No.: ODE 12-2006
Filed with Sec. of State: 5-24-2006
Certified to be Effective: 5-24-06
Notice Publication Date: 3-1-06
Rules Adopted: 581-022-1362, 581-022-1363, 581-022-1364, 581-022-1365, 581-022-1366, 581-022-1367, 581-022-1368, 581-022-1369, 581-022-1370
Subject: 581-022-1362 Expanded Options Purpose: Describes the purpose of the Expanded Options Program created by ORS Chapter 340.

581-022-1363 Expanded Options Definitions: Defines terms to be used in carrying out the components of OAR 581-022-1362 through 581-022-1370.

581-022-1364 Expanded Options Requirements for Oregon Public School Districts: Outlines the specific requirements for Oregon school districts in carrying out the components of the statute.

581-022-1365 Expanded Options Annual Notice: Details the components school districts must include in their annual notice to students, parents and guardians regarding the Expanded Options Program.

581-022-1366 Expanded Options Annual Credit Hour Cap: Sets forth the formal school districts must use in determining the number of credit hours available to eligible students under the Expanded Options Program.

581-022-1367 Expanded Options Responsibilities of Eligible Students: Outlines the specific responsibilities of eligible students participating in the Expanded Options Program as described in the statute.

581-022-1368 Expanded Options State School Fund, Expenditures, Request for Waiver: Describes the process for districts to follow in allocating state school funds in support of Expanded Options, specifies the types of qualifying support expenditures, and provides conditions for school districts in requesting a waiver to allocate state school funds in support of Expanded Options.

581-022-1369 Expanded Options Report to Legislative committees and Joint Boards: Lists required components of the annual report

to be provided for the House and Senate committees, and the Joint Boards for Education by the Department of Education.

581-022-1370 Expanded Options Alternative Programs: Holds harmless any established or new program, agreement or plan that provides access for public high school students to a post-secondary course of the Expanded Options program requirements.

Rules Coordinator: Paula Merritt—(503) 947-5746

581-022-1362
Expanded Options – Purpose

The purpose of the program created by ORS Chapter 340 otherwise known as Expanded Options is to:

(1) Create a seamless education system for students enrolled in grades 11 and 12 to:

(a) Have additional options to continue or complete their education;

(b) Earn concurrent high school and college credits; and

(c) Gain early entry into post-secondary education.

(2) Promote and support existing accelerated college credit programs, and support the development of new programs that are unique to a community's secondary and postsecondary relationships and resources.

(3) Allow eligible students who participate in the Expanded Options Program to enroll full-time or part-time in an eligible post-secondary institution.

(4) Provide public funding to the eligible post-secondary institutions for educational services to eligible students to offset the cost of tuition, fees, textbooks, equipment and materials for students who participate in the Expanded Options Program.

Stat. Auth.: ORS 340.574
Stats. Implemented: ORS 340.574
Hist.: ODE 12-2006, f. & cert. ef. 5-24-06

581-022-1363
Expanded Options – Definitions

Definitions to be used in carrying out the components of OAR 581-022-1362 through 581-022-1370:

(1) "Expanded Options Program" means

(a) The program created in ORS Chapter 340.

(2) "Accelerated college credit program" means a program, agreement or plan that is intended to provide access for public high school students to a post-secondary course, including, but not limited to:

(a) Dual credit technical preparation programs, such as two-plus-two;

(b) Advanced placement; and

(c) International Baccalaureate.

(3) "At-risk student" means:

(a) A student who qualifies for a free or reduced lunch program; or

(b) A student who meets state or federal thresholds for poverty as indicated by eligibility for services under any or all of the following title sections of the No Child Left Behind Act of 2001; PL 107-110:

(A) Title IA Improving Academic Achievement of the Disadvantaged;

(B) Title IC Education of Migratory Children;

(C) Title ID Prevention and Intervention Programs for Children and Youth Who are Neglected, Delinquent, or At-Risk;

(D) Title III Language Instruction of Limited English Proficient and Immigrant Students;

(E) Title X Education of Homeless Children and Youth Program.

(4) "Duplicate course" means a course with a scope that is identical to the scope of another course.

(5) "Eligible post-secondary course" means

(a) Any nonsectarian course or program offered through an eligible post-secondary institution if the course or program may lead to high school completion, a certificate, professional certification, associate degree or baccalaureate degree.

(b) "Eligible post-secondary course" does not include a duplicate course offered at the student's resident school.

(c) "Eligible post-secondary course" includes:

(A) Academic and professional technical courses; and

(B) Distance education courses.

(d) The provisions of Section 5 "Eligible post secondary course", subsections (a) through (c), do not apply to any post-secondary courses in which a student is enrolled in addition to being enrolled full-time in the student's resident school district. For purposes of the Expanded Options Program, a student is considered full-time if the student attends classes for credit in the secondary school for all available hours of instruction.

(6) "Eligible post-secondary institution" means:

(a) A community college;

(b) Institutions in the Oregon University System (University of Oregon, Oregon State University, Portland State University, Oregon Institute of Technology, Western Oregon University, Southern Oregon University, Eastern Oregon University); and

(c) The Oregon Health and Sciences University.

(7) "Eligible student" means

(a) A student who is enrolled in an Oregon public school and who:

(A) Is in grade 11 or 12 or who is 16 years of age or older at the time of enrollment in a course under the Expanded Options Program;

(B) Has developed an educational learning plan consistent with OAR 581-022-1130(3), Diploma Requirements; and

(C) Has not successfully completed four years of high school; or

(D) Who has completed course requirements for graduation, but not received a diploma.

(b) "Eligible student" does not include a foreign exchange student enrolled in a school under a cultural exchange program.

(8) "Extreme financial distress" means a decline in financial resources that would substantially impact the educational program the district offers to all students.

(9) "Individualized education program" means a written statement of an educational program for a child with a disability as described in OAR 581-015-0068, Special Education – Content of IEP.

(10) "Related Services" includes transportation and such developmental, corrective and other supportive services as are required to assist a student with a disability to benefit from special education and is consistent with OAR 581-015-0005, Special Education – Definitions.

(11) "Special Education" means specially designed instruction consistent with OAR 581-015-0005, Special Education – Definitions, to meet the unique needs of a student with a disability by adapting, as appropriate, the content, methodology, or delivery of instruction to address the unique needs of the student that result from the student's disability and to ensure access of the student to the general curriculum.

Stat. Auth.: ORS 340.574
Stats. Implemented: ORS 340.574
Hist.: ODE 12-2006, f. & cert. ef. 5-24-06

581-022-1364
Expanded Options – Requirements for Oregon Public School Districts

Each school district shall:

(1) Prior to February 1 of each year, notify all high school students and the students' parents or guardians of the Expanded Options Program as described in OAR 581-022-1365, Expanded Options – Annual Notice.

(2) Establish a process to identify dropouts as described in OAR 581-022-1365, Expanded Options – Annual Notice.

(3) Negotiate a financial agreement with any eligible post-secondary institution consistent with OAR 581-022-1368 State School Fund, Expenditures, Request for Waiver (2).

(4) Enter into an agreement with an eligible post-secondary institution that accepts a student for enrollment in an eligible post-secondary course that is a nontuition course or noncredit course pursuant to ORS 640.030 for the payment of the actual associated instructional costs.

(5) Review with the student and the student's parent or guardian the student's current status toward meeting all state and school district graduation requirements and the applicability of the proposed eligible post-secondary course with respect to fulfilling the student's remaining graduation requirements.

(6) Prior to an eligible student's beginning an eligible post-secondary course, notify the student of the number and type of credits the student will be granted upon successful completion of the course.

(a) School district boards shall have policies and procedures to award diploma credits to eligible students for eligible post-secondary courses completed under the Expanded Options Program. Those policies and procedures shall be consistent with OAR 581-022-1131, Credit Options.

(7) Establish an appeals process adopted by the local school district board to resolve disputes by the eligible students regarding number or type of credits the school district will grant or has granted for a particular eligible post-secondary course. The appeals process adopted by the school district board shall be consistent with OAR 581-022-1940, Appeals and Complaints.

(8) Be responsible for providing any special education and related services to participating students following state and federal law, and consistent with OAR 581-015-0005, Special Education.

(a) The resident school district of an eligible student participating in the Expanded Options Program shall be responsible for providing any required special education and related services to the student.

(b) A student who requires special education and related services shall be considered, for school purposes, a resident in the school district pursuant to ORS 339.133 and 339.134.

(9) Each school year, award no more that 330 quarter credit hours to eligible students per enrollment of 1,000 students or proportional credit hours as established in OAR 581-022-1366, Annual Credit Hour Cap; or

elect to exceed this quarter hour cap following the stipulations indicated in OAR 581-022-1366, Annual Credit Hour Cap.

(10) Apply credits granted to an eligible student to be counted toward high school graduation requirements and subject area requirements of the state and local school district consistent with OAR 581-022-1130, Diploma Requirements.

(11) Include in the student's education record evidence of successful completion of each eligible post-secondary course and credits granted.

(12) Include in the student's education record that the credits were earned at an eligible post-secondary institution.

(13) Each fiscal year, expend per student participating in the Expanded Options Program a minimum of 50 percent of the school district's general purpose grant per extended ADMw as outlined in OAR 581-022-1366, Expanded Options – Annual Credit Hour Cap, unless the school district has been granted a waiver by the Superintendent of Public Instruction, or the superintendent's designee, pursuant to OAR 581-022-1368 State School Fund, Expenditures, Request for Waiver.

(14) Provide the following data to the Department of Education on an annual basis in the format and timeline as determined by the Department of Education:

(a) Types of accelerated college credit programs offered,

(b) Number of high school credits earned under the Expanded Options Program,

(c) Number of college credits earned under the Expanded Options Program,

(d) Estimated college tuition cost savings for participating students,

(e) Number of students who had dropped out of high school but returned to high school to participate in the Expanded Options Program and earned a diploma,

(f) Number of participating students categorized by ethnicity and financial status,

(g) Number of participating talented and gifted students,

(h) Rural school district designation,

(i) If the individual district is classified as a small school district, the number of eligible students who wish to participate than are allowed under the respective credit hour caps established in OAR 581-022-1366, Annual Credit Hour Cap. Each school district may:

(15) Provide transportation services to eligible students who attend eligible post-secondary institutions within the boundaries of the school district pursuant to ORS 327.043.

(a) Any transportation costs incurred by a school district under this section shall be considered approved transportation costs for purposes of ORS 327.013(8).

(16) Determine which eligible post-secondary courses are duplicate courses to courses offered in the resident school district.

(a) School district boards shall have policies and procedures to determine duplicate course status consistent with 581-022-1363, Definitions.

(17) Request a waiver from the Superintendent of Public Instruction or the superintendent's designee of the requirement to expend per student participating in the Expanded Options Program a minimum of 50 percent of the school district's general purpose grant per extended ADMw, if the school district meets the conditions as described in 581-022-1368, State School Fund, Expenditures, Request for Waiver.

Stat. Auth.: ORS 340.574
Stats. Implemented: ORS 340.574
Hist.: ODE 12-2006, f. & cert. ef. 5-24-06

581-022-1365
Expanded Options – Annual Notice

(1) Prior to February 1 of each year, beginning with the 2005-06 school year, each school district must notify all high school students and the students' parents or guardians of the Expanded Options Program. The notification process must:

(a) Ensure that all at-risk students and their parents are notified about the Expanded Options Program; and

(b) Identify high school students who have dropped out of school and provide those students with information about the Expanded Options Program by sending information about the program to the last known address of the family of the student. It shall be a priority for school districts to provide information about the Expanded Options Program to high school students who have dropped out of school.

(2) The notice must include, but is not be limited to, the following:

(a) Definitions of "eligible student," "eligible post-secondary institution," and "eligible post-secondary course;"

(b) Purposes of the Expanded Options Program;

(c) Financial arrangements for tuition, textbooks, equipment and materials;

(d) Available transportation services;

(e) Effects of enrolling in the Expanded Options Program on the eligible student's ability to complete the required high school graduation requirements;

(f) Consequences of not maintaining satisfactory academic progress as defined by the eligible post-secondary institution, such as by failing or not completing an eligible post-secondary course;

(g) Participation in the Expanded Options Program is contingent on acceptance by an eligible post-secondary institution;

(h) Eligible students may not enroll in eligible post-secondary courses for more than the equivalent of two academic years, and eligible students who first enroll in grade 12 may not enroll in eligible post-secondary courses for more than the equivalent of one academic year;

(i) A student who has graduated from high school may not participate in the Expanded Options Program;

(j) An eligible student who has completed course requirements for graduation but has not received a diploma may participate;

(k) Notice(s) of any other program(s), agreement(s) or plan(s) in effect that provide access for public high school students to post-secondary courses;

(l) The district's responsibility for providing any required special education and related services to the student;

(m) The number of quarter credit hours that may be awarded each school year to eligible students by the resident high school;

(n) The district board's process for selecting eligible students to participate in the Expanded Options Program if the school district has not chosen to exceed the credit hour cap and has more eligible students who wish to participate than are allowed by the cap;

(o) Information about program participation priority for at-risk students;

(p) Exclusion of duplicate courses as determined by the resident school district;

(q) The process for a student to appeal the district's duplicate course determination to the Superintendent of Public Instruction or the Superintendent's designee;

(r) Exclusion of post-secondary courses in which a student is enrolled if the student is also enrolled full time in the resident secondary school; and

(s) Exclusion of foreign exchange students enrolled in a school under a cultural exchange program.

Stat. Auth.: ORS 340.574
Stats. Implemented: ORS 340.574
Hist.: ODE 12-2006, f. & cert. ef. 5-24-06

581-022-1366
Expanded Options – Annual Credit Hour Cap

(1) The number of quarter credit hours that may be awarded by a high school under the Expanded Options Program is limited to an amount equal to the number of students in grades 9 through 12 enrolled in the high school multiplied by a factor of 0.33. For example, the cap for a high school with 450 students in grades 9 through 12 would be 148.5 (450 x 0.33 = 148.5).

(2) For districts with more than one high school, the caps must be established separately for each high school.

(3) School districts may choose to exceed both the individual high school level cap(s) and the aggregate district level cap established under this rule.

(4) School districts choosing not to exceed the cap(s) established under this rule are required to establish a process for selecting eligible students for participation in the program. The process must give priority for participation to students who are "at risk" as defined in OAR 581-022-1363 Expanded Options – Definitions.

Stat. Auth.: ORS 340.574
Stats. Implemented: ORS 340.574
Hist.: ODE 12-2006, f. & cert. ef. 5-24-06

581-022-1367
Expanded Options – Responsibilities of Eligible Students

Each eligible student shall:

(1) Maintain satisfactory academic progress as defined by the eligible post-secondary institution.

(2) By March 1 of each year, notify the resident school district of intent to enroll in eligible post-secondary courses during the following school year.

(3) In cooperation with an advisory support team (may include the student, student's parent or guardian and a teacher or a counselor), develop an educational learning plan consistent with OAR 581-022-1130, Section (3) Diploma Requirements, which may include:

(a) Short-term and long-term learning goals and proposed activities,

(b) Relationship of the eligible post-secondary courses proposed under the Expanded Options Program and the student's learning goals.

(4) Acknowledge that participation in the Expanded Options Program is contingent on acceptance by an eligible post-secondary institution.

(5) Provide the school district with authorization to obtain a copy of grades in from each post-secondary institution for each eligible post-secondary course taken for credit or non credit that may lead to high school completion, a certificate, professional certification, associate degree or baccalaureate degree under the Expanded Options Program.

(6) Acknowledge that all textbooks, fees, equipment and materials provided and paid for under Expanded Options Program are the property of the resident school district.

(7) Be ineligible for any state student financial aid under ORS 348.040 to 348.280 and 348.505 to 348.695.

(8) Not enroll for more than the equivalent of two academic years.

(a) If first enrolled in grade 12, may not enroll in post-secondary courses for more than the equivalent of one academic year.

(b) If first enrolled in the middle of the school year, the time of participation shall be reduced proportionately.

(c) If enrolled in a year-round program and begins each grade in the summer session, summer sessions are not counted against the time of participation. Each eligible student may:

(9) Apply to an eligible post-secondary institution to enroll in eligible post-secondary courses offered by the eligible post-secondary institution.

(10) Apply to the resident school district for reimbursement for any textbooks, fees, equipment or materials purchased by the student that are required for an eligible post-secondary course.

(11) Appeal to the Superintendent of Public Instruction or the superintendent's designee a duplicate course designation by the resident school district.

(a) The superintendent or the superintendent's designee shall issue a decision on the appeal within 30 days of receipt of the appeal.

(b) If the superintendent or the superintendent's designee fails to issue a decision within 30 days of receipt of the appeal, the course shall be deemed to not be a duplicate course.

(A) The student may then enroll in the course under the Expanded Options Program, if the course and the student meet all other eligibility requirements.

Stat. Auth.: ORS 340.574
Stats. Implemented: ORS 340.574
Hist.: ODE 12-2006, f. & cert. ef. 5-24-06

581-022-1368
Expanded Options – State School Fund, Expenditures, Request for Waiver

(1) An eligible student enrolled in an eligible post-secondary course at an eligible post-secondary institution shall continue to be considered a resident pupil of the student's school district for purposes of calculation of the State School Fund grant under ORS 327.006 to 327.133 and 327.731.

(2) A school district shall negotiate a financial agreement with any eligible post-secondary institution that accepts a student for enrollment in an eligible post-secondary course for the payment of actual tuition, fees and other required instructional costs associated with the enrollment of the student in eligible post-secondary courses.

(3) In addition to any financial agreement entered into under Section (2), the resident school district of the eligible student shall enter into an agreement with an eligible post-secondary institution that accepts a student for enrollment in an eligible post-secondary course that is a nontuition course or noncredit course for the payment of the actual instructional costs associated with the student's attending the eligible post-secondary course at the institution.

(4) The amount of each school district's general purpose grant per extended ADMw as calculated under ORS 327.013 shall be determined each fiscal year by the Department of Education and made available to all school districts and, upon request, to any eligible post-secondary institution.

(5) Each fiscal year, a school district shall expend per student participating in the Expanded Options Program a minimum of 50 percent of the school district's general purpose grant per extended ADMw. Expenditures that qualify under this paragraph include amounts expended on tuition, fees, textbooks, equipment and materials required for an eligible post-secondary course.

(6) A school district may request a waiver from the Superintendent of Public Instruction or the superintendent's designee of the requirements of Section (5) of this rule. The superintendent or the superintendent's designee shall grant the waiver if:

(a) Compliance with the requirements of Section (5) would cause the school district extreme financial distress; or

(b) The school district offers dual credit technical preparation programs, such as two-plus-two programs, advanced placement or International Baccalaureate programs and other accelerated college credit programs, and:

(A) The programs offered by the school district serve all qualified applicants of existing programs; and

(B) There are no charges to at-risk students.

(7) Nothing in this section shall prohibit an eligible post-secondary institution from receiving additional state funding that may be available under any other law.

Stat. Auth.: ORS 340.574
Stats. Implemented: ORS 340.574
Hist.: ODE 12-2006, f. & cert. ef. 5-24-06

581-022-1369
Expanded Options –Report to Legislative Committees and Joint Boards

The Department of Education shall annually report on the Expanded Options Program to the Joint Boards of Education and the House and Senate committees relating to education. The report shall include:

(1) Types of accelerated college credit programs offered;

(2) Number of high school credits earned under the Expanded Options Program;

(3) Number of college credits earned under the Expanded Options Program;

(4) Estimated college tuition cost savings for participating students;

(5) Number of students who had dropped out of high school but returned to high school to participate in the Expanded Options Program and earned a diploma;

(6) Number of participating students categorized by ethnicity and financial status;

(7) Number of participating talented and gifted students;

(8) The level of participation in the Expanded Options Program by rural communities;

(9) The number of students living in rural communities who participated in the Expanded Options Program;

(10) Number of appeals of students regarding duplicate course designation to the Superintendent of Public Instruction or the superintendent's designee and the disposition of the students' appeals;

(11) Number of small school districts with more eligible students who wish to participate than are allowed under the respective credit hour caps established in OAR 581-022-1366 (1361), Expanded Options Annual Credit Hour Cap;

(12) Number of waivers of requirements granted under the provisions of OAR 581-022-1368, Expanded Options State School Fund, Expenditures, Request for Waiver, and the reasons for issuance of the waivers;

(13) Recommendations for changes to the Expanded Options Program to better serve students, including changes to the age limit restrictions for eligible students;

(14) Recommendations for funding changes to better serve students who wish to participate in the Expanded Options Program.

Stat. Auth.: ORS 340.574
Stats. Implemented: ORS 340.574
Hist.: ODE 12-2006, f. & cert. ef. 5-24-06

581-022-1370
Expanded Options – Alternative Programs

(1) Not withstanding ORS Chapter 340, any program, agreement or plan in effect on January 1, 2006, that provides access for public high school students to a post-secondary course is not affected by this chapter and may be continued or renewed at the discretion of the parties to the program, agreement or plan.

(2) Any new program, agreement or plan that is developed after January 1, 2006, and that is intended to provide access for public high school students to a post-secondary course may be initiated at the discretion of a school district and a post-secondary institution.

Stat. Auth.: ORS 340.574
Stats. Implemented: ORS 340.574
Hist.: ODE 12-2006, f. & cert. ef. 5-24-06

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Oregon Forest Resources Institute
Chapter 628

Rule Caption: Model Rules of Procedure.
Adm. Order No.: OFRI 1-2006
Filed with Sec. of State: 5-25-2006
Certified to be Effective: 5-25-06
Notice Publication Date:
Rules Amended: 628-001-0005

Subject: The Model Rules of Procedure under the Administrative Procedures Act, promulgated by the Attorney General effective January 1, 2006, are hereby adopted as rules of procedure of the Oregon Forest Resources Institute.
Rules Coordinator: Kathy Storm—(971) 673-2953

628-001-0005
Model Rules of Procedure

The Model Rules of Procedure under the Administrative Procedures Act, promulgated by the Attorney General effective January 1, 2006, are hereby adopted as rules of procedure of the Oregon Forest Resources Institute.

Stat. Auth.: ORS 526.645
Stats. Implemented: ORS 183.341
Hist.: FRI 1-1992, f. 4-9-92, cert. ef. 4-10-92; OFRI 1-2006, f. & cert. ef. 5-25-06

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Oregon Housing and Community Services
Chapter 813

Rule Caption: Defines eligibility criteria for tax credits and designates the term of the tax credit.
Adm. Order No.: OHCS 7-2006
Filed with Sec. of State: 5-17-2006
Certified to be Effective: 5-17-06
Notice Publication Date: 4-1-06
Rules Adopted: 813-110-0012, 813-110-0050
Rules Amended: 813-110-0005, 813-110-0010, 813-110-0015, 813-110-0020, 813-110-0021, 813-110-0022, 813-110-0023, 813-110-0025, 813-110-0030, 813-110-0033, 813-110-0035, 813-110-0040
Subject: 813-110-0005 sets forth the purpose for the Rules. Clarification language has been incorporated. 813-110-0010 clarifies the common terms and definitions found within the Rules. 813-110-0012 defines eligible sponsors to participate in the program. Amendments to 813-110-0015 updates the application requirements to participate in the program and how the tax credits can be utilized. Amendments to 813-110-0020 consists of administrative changes and does not include any substantive changes. 813-110-0021 provides clarification language requiring a firm commitment of financing as part of the application process. Amendments to 813-110-0022 consists of administrative changes only. 813-110-0023 clarifies prioritization and notice requirements for applications placed on standby. Amendments to 813-110-0025 provides clarification language regarding the certification of eligible projects. Amendments to 813-110-0030, 813-110-0033, 813-110-0035 and 813-110-0040 consists of administrative changes only. 813-110-0050 adds waiver language already provided for in statute.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-110-0005
Purpose and Objectives

The rules of OAR 813, division 110, are established to define and carry out the provisions of ORS 317.097 as amended by 1995 Legislation (the Act), as they pertain to the Department. The Department certifies Projects sponsored by government entities, nonprofit corporations and certain persons as identified in ORS 317.097 to allow a lending institution to claim a tax credit against Oregon taxes as provided in the Act. The Department also certifies that balances of loans to qualifying projects fall within the cap on outstanding loans identified in ORS 317.097(6), and designates the period, not to exceed 20 years, for which the credit will be allowed. The purpose of the program is to encourage the provision of housing for lower-income Oregonians.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1994(Temp), f. & cert. ef. 3-25-94; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0010
Definitions

All terms are used in OAR 813, division 110, as defined in the Act, as provided in OAR 813-005-0005 and herein. As used in these rules, unless the context indicates otherwise:

(1) "Application" means a request signed by a Sponsor for Certification of a Project.

(2) "Cap" means the maximum amount of tax credits as set by the Legislature in ORS 317.097(6).

(3) "Certification" means the written verification by the Department to a Lender that a Project is a qualified Project for which the Lending Institution may claim a tax credit under the provisions of the Act.

(4) "Department" means the Oregon Housing and Community Services Department.

(5) "Firm Commitment of Financing" means the Lending Institution's agreement to make a loan to a specific borrower on a specific property and which will contain all of the terms and conditions that the borrower has to satisfy before said loan can be funded. Payment of a commitment fee by the borrower to the Lending Institution may be required as a condition precedent to issuance of such an agreement.

(6) "Housing Payments" as used in the Act means rent or purchase price for a sponsored Project.

(7) "Consolidated Plan" means the plan approved by the US Department of Housing and Urban Development (HUD) which describes the needs, resources, priorities and proposed activities to be undertaken with respect to HUD programs.

(8) "Lending Institution" means any bank, mortgage banking company, federal savings bank, savings bank, stock savings bank, savings and loan association, national bank, credit union or federal savings and loan association maintaining an office in this state. "Lending Institution" also includes any community development corporation, as defined in ORS 708.444(4), that is organized under the Oregon Nonprofit Corporation Law, and that meets the conditions described in ORS 708.444(2)(a) and (e).

(9) "Letter of Intent" means a proposal for financing by a Lending Institution subject to the borrower's compliance with certain terms stipulated by the Lending Institution.

(10) "Median Income" shall be the area median family income, adjusted for family size, as published from time to time by HUD.

(11) "Project" means one or more units of housing, including refinanced housing, which will be rented to or owned by households whose incomes are less than 80 percent of Median Income. The use of a Project for eligible occupants shall be maintained for the term of the credit, in accordance with the Act, unless terminated at the discretion of the Department. If there is a foreclosure, deed-in-lieu, or an involuntary transfer where title transfers to the Lending Institution, that Lending Institution may dispose of the property at its sole discretion.

(12) "Rents Charged at the Market Interest Rate" means the rents that would be required, if the lender charged the market interest rate, in order to make the project financially feasible.

(13) "Rent Reduction" means the amount rents are reduced from the Rents Charged at the Market Interest Rate as a result of the OAHTC subsidy.

(14) "Rent Pass Through" means the amount of Rent Reduction made available to the tenants because of the reduced interest rate attributable to the OAHTC subsidy.

(15) "Sponsor" is a borrower who is a nonprofit corporation, state or local government entity including but not limited to a housing authority, which may be a controlling general partner in a limited partnership.

(16) "Tenant" means a renter who occupies or will occupy a unit in a Project, or a homeowner who is the borrower in an owner-occupied community rehabilitation program.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1994(Temp), f. & cert. ef. 3-25-94; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0012
Sponsor Criteria

(1) A Sponsor may be any Person, subject to the approval of the Department and including a nonprofit or local government entity but not limited to a housing authority, that enters into restrictive covenants regarding the rents on the property and eligibility of occupants.

(2) A Sponsor may be an authorized agent of a Lending Institution in a local owner-occupied community rehabilitation program.

(3) A Sponsor may be a borrower that reloans the proceeds of a loan to participating individuals in a community rehabilitation program.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0015
Application Requirements

(1) The Department may provide tax credits from the OAHTC Program subject to availability of credits in the Program through a process which may include, but is not limited to, a first-come first-reviewed or competitive review process. At the time credits are made available, the Sponsor shall submit a written Application for Certification to the Department. The Application shall provide information that includes, but is not limited to:

(a) Name, address and telephone number of the Sponsor;

(b) Proof of eligible nonprofit corporation or governmental organizational status, if applicable;

(c) Background and experience of Sponsor and management agent with housing for low-income persons, if applicable;

(d) A firm Commitment of Financing including an estimated comparable market interest rate for the proposed loan, the estimated reduced interest rate, and the estimated amount of savings which will be passed on to Tenants as reduced housing payments;

(e) Name, address and contact person of the eligible Lending Institution making the loan;

(f) A description of the Project, including the type of housing or program involved; number and type of housing units to be provided, including the number of bedrooms; the address where the Project is or will be located; and the federal, state and local agencies or organizations involved in financing or managing the Project; and

(g) A Certification that includes, at a minimum, the statement that all information in the Application is true, complete and accurately the Project.

(2) In addition, the Sponsor shall demonstrate in writing that at the time the Project is initially rented or purchased, and thereafter for the term of the credit, the Sponsor will pass the benefits of the Project's reduced loan interest rate to Tenant households whose earning are less than 80 percent of Median Income at the time of initial occupancy and shall execute restrictive covenants to be recorded at the time of loan closing. The OAHTC Certificate and Declaration of Restrictive Covenants may be processed concurrently at closing.

(3) The Sponsor shall pay a $100 nonrefundable fee to the Department for reviewing the Sponsor's Application. The fee must accompany the Sponsor's Application to the Department.

(4) The Program must be used to lower rents after all other subsidies have been applied. A Project utilizing other department programs must meet the minimum requirements of those programs before the tax credits will be considered. For example, if an applicant applies for LIHTC and indicates they are targeting 60% median income rents, the application must show the Project is feasible at the targeted 60% median rents without the tax credit subsidy. The tax credit subsidy applied to reduce rents below the 60% level. This subsidy, which in effect is the savings generated by the lower interest rate, must be passed through directly to the tenants in its entirety. However, such pass-through need not be distributed evenly among the units. Some units may receive more of a reduction than others, subsequently driving those rents down to even deeper levels.

(5) Rental units covered by Section 8 Project Based Assistance (PBA) are not eligible to be used to demonstrate pass-through savings for the Program. The rent reductions are not passed onto the tenants in the form of a rent reduction from what the tenant would otherwise pay, and therefore, would not achieve pass-through savings. Projects that are partially covered with PBA may choose to use Program tax credits on the remaining units to meet pass-through of interest savings as rent reductions to the tenants.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1994(Temp), f. & cert. ef. 3-25-94; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0020
Application Review

(1) The Department shall review the Application and decline or certify the Project, request additional information, or reserve tax credits within 90 calendar days of receiving the Application.

(2) In reviewing Applications for Certification, the Department, as appropriate, may consider, but is not limited to, the following:

(a) Sponsor, property management agent and other involved Person's experience in providing low-income housing;

(b) Estimated Rents Charged at the Market Interest Rate or purchase price at market interest rate for the type and location of housing to be provided;

(c) Dollar amount of estimated savings from the Rent Reduction;

(d) Estimated Rent Reduction or purchase price;

(e) How long the tax credits are needed to meet the Sponsor's goals of long term affordable housing;

(f) The Sponsor's statement that proposed Rent Reduction or reduced purchase price will be maintained for or offered to households whose annual incomes are less than 80 percent of Median Income;

(g) Restrictive covenants which provide for, but are not limited to, affordability, income and rent restrictions; and

(h) Certifying statement from the agent for the Lending Institution of a local owner-occupied community rehabilitation program, if applicable.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0021
Reservation in Lieu of Certification

(1) In place of a Firm Commitment of Financing, the applicant may submit a Letter of Intent to lend.

(2) An Application acceptable under OAR 813-110-0015 substituting a Letter of Intent for a Firm Commitment of Financing which passes the Department review under OAR 813-110-0020 may, subject to the availability under the Cap, receive a reservation of tax credits.

(3) A reservation shall be valid for 180 days.

(4) If a Firm Commitment of Financing is received by the Department prior to the expiration of a reservation, a Certification may be issued. Once the reservation is issued, it is a confirmed reservation unless the Lending Institution modifies the original Letter of Intent.

(5) A reservation may be extended by the Department at its sole discretion.

(6) A reservation may be made for a local government entity providing a community rehabilitation program for the period of proposed financing with extensions granted at the discretion of the Department.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0022
Set-Aside

(1) The Department may set aside a portion of the Cap for rural projects and projects with special needs.

(2) The Department, if directed by the State Housing Council, shall establish other set-asides to meet housing needs in various economic or geographic regions of the state from time to time.

(3) The Department shall publicize its intent to establish a set-aside prior to initiating the set-aside.

(4) In view of findings in conjunction with Oregon's Consolidated Plan study, the Department may exclude certain uses of the tax credits when the Cap is insufficient to meet special needs.

(5) The Department may request Sponsors of projects not meeting priority standards to show cause for prioritizing tax credits, including criteria similar to that used in the needs assessment of Oregon's Consolidated Plan.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0023
Standby Applications

The Department may, at its discretion, establish a standby list and criteria relating to it for Applications which are in excess of the Cap or a set-aside amount.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1994(Temp), f. & cert. ef. 3-25-94; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0025
Certification of Eligible Projects

(1) When the requirements of OAR 813-110-0015 are met and the total outstanding tax credits do not exceed the Cap, the Department shall provide Certification to a Lending Institution that:

(a) The proposed borrower is an eligible Sponsor;

(b) The proposed borrower has met the requirements of the Act and these rules to demonstrate the required benefits will be passed on to households earning less than 80 percent of Median Income;

(c) The length of the period eligible for tax credits; and

(d) The loan does not exceed the maximum limitation for total loan balances.

(2) Such Certification shall be based on the information provided by the Sponsor in the Application and accumulated from lender's annual reports as required by OAR 813-110-0030. The Certification shall be valid only if such information, other than estimates based on interest rates and other changes made with the approval of the Department, is unchanged at the time of loan closing for the Project and documentation that OAHTC restrictive covenants have been recorded.

(3) To establish the use of a certificate for a term loan, a lender shall complete the loan closing information section of the certificate and send the original to the Department along with evidence that OAHTC restrictive covenants have been recorded against the Project property.

(4) To establish the use of a certificate for a construction loan, a lender shall complete the loan closing information section of the certificate and send the original to the Department, and may record OAHTC restrictive covenants.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0030
Reporting Requirements

Lending Institutions claiming the state tax credit shall be sent a report form by the Department annually to assist the lending institution in notifying the Department by May 1 that the Lending Institution has met all requirements imposed by law to qualify for tax credits under the Act. Such notification shall not include any representation as to performance by the Sponsor. Such report shall be signed by an officer of the Lending Institution, and shall include, at a minimum, the name and address of the institution, name and phone number of a contact person, the number of loans for which tax credits will be claimed, the amount of credit claimed, the annual fee payment, the dates the loans were closed, the location of the Projects financed by those loans, the amount loaned for each Project, and the outstanding balances of all loans.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0033
Fees

(1) A base fee of 5percent of the annual tax credits claimed by an eligible Lending Institution plus $100 per month for each full month the annual report is delayed shall be paid by the Lending Institution to the Department.

(2) On Projects certified prior to September 29, 1991, all annual fees required in OAR 813-110-0033, except for any fees charged for delayed reports, shall be waived.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0035
Community Rehabilitation Project Certification

(1) OAR 813-110 does not establish requirements for certifications to households participating in a community rehabilitation program as provided in ORS 317.097(4)(b). The Department does not establish rules for local governments or their designated agents for certifying participants in a community rehabilitation program under their jurisdiction.

(2) A participant in a community rehabilitation program includes both individuals and nonprofit corporations or units of local government which reloan proceeds to individuals participating in a community rehabilitation program. When a local government or its designated agent certifies a participant in a community rehabilitation program, a copy shall be sent to the Department certifying that the loans included in a loan certification fall within the Cap.

(3) The local government entity shall certify to the Department that the local community rehabilitation standards will be met for all loans that will be included in the certified loan.

(4) A fee of $100 will cover each such Application accompanied by the designated agent's Certification and preferred listing for multiple lenders, if applicable.

(5) A separate Application is required to be submitted for each lender certification form requested.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0040
Monitoring

(1) If the owner of a Project is found to be out of compliance, the Department shall promptly notify the Lending Institution, the owner and its Sponsor, if applicable, and stipulate the problem, the required correction to the problem, and the date by which the problem shall be corrected.

(2) The Director of the Department shall determine the penalty to be paid by the owner and the date upon which further penalties may be further assessed if the problem is not corrected to the satisfaction of the Director.

(3) Penalties shall not exceed three times the eligible tax credit per year.

(4) Reports of misconduct shall be available to the owner/Sponsor for their review and comment within a reasonable time and further assessed following receipt of written explanation and documentation.

(5) Any penalties assessed shall be the liability of the owner and not the liability of the Lending Institution, a successor or assignee.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06

813-110-0050
Waiver

The Director may waive or modify any requirements of these Program rules, unless such waiver or modification would violate applicable state statute or federal regulations.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: OHCS 7-2006, f. & cert. ef. 5-17-06

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Oregon Liquor Control Commission
Chapter 845

Rule Caption: Amend rule regulating restrictions on liquor licenses and service permits to clarify statutory authority.
Adm. Order No.: OLCC 7-2006(Temp)
Filed with Sec. of State: 6-15-2006
Certified to be Effective: 6-15-06 thru 12-11-06
Notice Publication Date:
Rules Amended: 845-005-0355
Subject: This rule regulates how and when the Commission places restrictions on liquor licenses and service permits. The rule allows the Commission to place restrictions when there is a basis to cancel, suspend or deny the license or service permit, when a restriction may prevent recurrence of problems, or when the Commission determines that a restriction is in the public interest or convenience. Proposed amendments will clarify that restriction violations will be enforced as Category I violations based on the Commission's general statutory authority.
Rules Coordinator: Katie Hilton—(503) 872-5004

845-005-0355
Restricting License Privileges and Conduct of Operations

(1) The Commission may restrict a license or service permit when:

(a) In the absence of a restriction, the Commission has a basis to cancel, suspend/fine or deny the license or service permit;

(b) In addition to all or part of a suspension or fine, a restriction may prevent the recurrence of the problem(s) that caused the violation(s); or

(c) The Commission determines that a restriction is in the public interest or convenience.

(2) In determining public interest or convenience reasons to restrict a license or permit, the Commission considers factors that include but are not limited to:

(a) The character or environment of the neighborhood in which the licensed premises operate;

(b) The need to eliminate or prevent conditions that have contributed to or that the Commission reasonably believes will contribute to liquor or criminal law violations by the licensee, patrons of the licensed premises or the public; or

(c) The need to limit the availability of alcohol to minors, visibly intoxicated persons or street drinkers.

(3) The Commission has determined that it is not in the public interest or convenience to issue or renew:

(a) A license that allows off-premises sales in an area frequented by street drinkers, unless the Commission restricts the sales of the alcoholic beverages associated with street drinkers;

(b) A license to a relative or associate of a person whose license was cancelled, surrendered or not renewed because of problems at the premises that involved the person, unless the Commission restricts the relative or associate from permitting the person from being on the premises;

(c) A license or permit to a person who has a recent history or record of alcohol or drug problems, unless the Commission requires the person to complete an alcohol/drug treatment program and follow the program's recommendations regarding alcohol/drug use or to abstain from alcohol/drug use.

(4) When the Commission restricts a license or service permit, it notifies the licensee or permittee. If the licensee or permittee disagrees with the restriction, the licensee or permittee has the right to a hearing under the procedures in ORS chapter 183; OAR chapter 137, division 003; and OAR chapter 845, division 003.

(5) A licensee or permittee who has a restricted license or permit must exercise license or permit privileges only in compliance with the restriction(s). Failure to comply with the restriction(s) is a Category I violation.

(6) A restriction remains in effect until the Commission removes it. The licensee or permittee may ask the Commission to remove or modify a restriction. The written request must explain why the licensee or permittee believes the Commission should remove or modify the restriction. The Commission will notify the licensee or permittee, in writing, of its decision to approve or deny the request and the basis for its decision. If the Commission denies the request, the licensee or permittee has the right to a hearing under the procedures in ORS chapter 183; OAR chapter 137, division 003; and OAR chapter 845, division 003.

(7) As used in subsections (2)(c) and (3)(a) of this rule, "street drinkers" means people who drink unlawfully in streets, alleys, parks and other similar public places.

(8) As used in subsection (2)(b) of this rule, "conditions" means conditions in the immediate vicinity of the premises that are related to the exercise of the license privileges and conditions in the premises or in the areas around the premises that the applicant/licensee controls.

Stat. Auth.: ORS 471, including 471.030, 471.040, 471.730(1) & (5)
Stats. Implemented: ORS 471.405(1) & 183
Hist.: OLCC 19-2000, f. 12-6-00, cert. ef. 1-1-01; OLCC 6-2001, f. 8-15-01, cert. ef. 9-1-01; OLCC 7-2006(Temp), f. & cert. ef. 6-15-06 thru 12-11-06

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Oregon State Lottery
Chapter 177

Rule Caption: Amendment removes language specifying monetary value of a credit when playing a video lottery game.
Adm. Order No.: LOTT 6-2006(Temp)
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 6-26-06 thru 12-8-06
Notice Publication Date:
Rules Amended: 177-200-0010
Subject: The Oregon Lottery has initiated permanent rulemaking to amend this administrative rule to remove language specifying the monetary value of credit when playing a video lottery game.
Rules Coordinator: Mark W. Hohlt—(503) 540-1417

177-200-0010
Game Requirements

(1) **General:** To play a video lottery game, a player deposits cash into a video lottery terminal that displays the deposit as a number of credits to which the player is entitled. Each credit represents a monetary amount as specified in each video lottery game. The player purchases a game play by wagering one or more credits. A prize for a winning wager shall not exceed $600. Prizes are paid on the terminal in the form of credits. A player may wager the credits that the player has won on additional game plays or may direct the terminal to issue a cash slip for the remaining credits.

(2) **Bonus Game Plays:** In addition to the prizes paid as credits, and depending on the specific game, bonus game plays may be awarded to a player. A prize awarded on an individual bonus game play is independent of the original game play and may not exceed $600.

(3) **Odds of Winning:** A close approximation of the odds of winning some prize for each game must be displayed on a video lottery terminal screen. Each game also must display the amount wagered and the amount awarded for each possible winning occurrence based on the number of credits wagered on a game play.

(4) **Payout Tables:** Each game shall provide a method for a player to view payout tables for that game.

(5) **Age Requirement:** A player must be at least 21 years of age.

Stat. Auth.: ORS 461
Stats. Implemented: ORS 461.210
Hist.: LC 8-1991, f. & cert. ef. 11-25-91; LOTT 7-2003(Temp), f. & cert. ef. 6-5-03 thru 11-28-03; LOTT 15-2003, f. & cert. ef. 9-29-03; LOTT 6-2006(Temp), f. 6-12-06 cert. ef. 6-26-06 thru 12-8-06

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Oregon State Treasury
Chapter 170

Rule Caption: Terms, Conditions, and Reporting Requirements for an Agreement for Exchange of Interest Rates.
Adm. Order No.: OST 1-2006
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 4-1-06
Rules Amended: 170-060-1010
Subject: Clarifies terms, conditions and reporting requirements for local government issuers of bonds when entering into agreements for exchange of interest rates.
Rules Coordinator: Sally Furze—(503) 378-4990

170-060-1010
Terms, Conditions, and Reporting Requirements for an Agreement for Exchange of Interest Rates

(1) Definitions:

(a) "Issuer" means a public body as defined in ORS 288.605, (excluding the State of Oregon and its Agencies) and the Oregon Health and Science University.

(b) "Counterparty" shall mean the party to an agreement for the exchange of interest rates other than the Issuer and any guarantor of that party's obligations.

(c) "Swap Policy" means the written policy regarding the use of agreements for the exchange of interest rates adopted by the Issuer.

(d) "MDAC" or "Commission" means the Oregon Municipal Debt Advisory Commission.

(e) Terms not otherwise defined herein shall have the meanings ascribed to them in ORS 287.025, as amended by Chapter 443, Oregon Laws 2005 or as the same may be amended in the future.

(2) Issuers shall only enter into agreements for the exchange of interest rates as authorized by, and in compliance with, ORS 287.025, as amended by Chapter 443, Oregon Laws 2005 or as the same may be amended in the future.

(3) The notional amount of an agreement that relates to outstanding borrowing may not exceed the outstanding principal amount of the borrowing when the agreement is entered into. The notional amount of an agreement that relates to a borrowing that the Issuer expects to issue in the future may not exceed the principal amount of the borrowing reasonably anticipated to be outstanding when payments are required to commence under the agreement (as evidenced by a copy of the resolution, minutes of the board or other authorizing directive of the director or board as required by section 4 of this rule).

(4) With respect to an obligation or obligations that an Issuer has issued or will issue (as evidenced by a copy of the resolution, minutes of the board or other authorizing directive of the director or board), subject to ORS 287.025(7), as amended by Chapter 443 Oregon Laws 2005 or as the same may be amended in the future, the Issuer may designate the particular obligation to which an agreement relates after execution of the agreement. Such a designation after execution of the agreement shall be considered an agreement modification, and the Issuer shall notify the MDAC of such modification in accordance with this rule.

(5) The Issuer shall have adopted a Swap Policy as part of its ongoing responsibility to manage its debt obligations. In adopting a Swap Policy, the Issuer should review and consider the current edition of the Government Finance Officers Association Recommended Practice: "Use of Debt-Related Derivatives Products and the Development of a Derivatives Policy" and the "MDAC Sample Interest Rate Swap Policy". Included in the Swap Policy, the Issuer shall provide a general description of risks related to agreements for exchange of interest rates and the means by which the Issuer will address those risks. The Swap Policy shall also provide that an analysis of the risks and benefits of each agreement shall be presented to the governing body prior to executing such agreement.

(6) The Issuer shall notify the Commission of the execution of an agreement for the exchange of interest rates by delivering to the Debt

Management Division of the Office of the State Treasurer, 350 Winter Street NE, Suite 100, Salem, Oregon 97301 within 30-days of its execution, the following:

(a) An MDAC Form 3.

(b) An executed copy of the resolution, minutes of the board or other authorizing directive of the director or board, specifically authorizing the Issuer to engage and participate in an agreement for the exchange of interest rates. The authorization shall state the reason that the Issuer is authorizing the agreement, shall include a finding that the agreement is being executed for permitted purposes and complies with the authorizing act and this administrative rule.

(c) The Issuer's Swap Policy.

(d) The legal opinion, if any, addressing the validity of the Issuer's obligations under the agreement for the exchange of interest rates that is delivered in connection with the agreement.

(7) An agreement shall contain terms and conditions consistent with the Swap Policy adopted by the Issuer including, but not limited to:

(a) The notional amount of the agreement;

(b) Payment terms;

(c) The term of the agreement;

(d) Insurance, collateral or other assurances of payment provided in compliance with ORS 287.025 as amended by Chapter 443, Oregon Laws 2005 or as the same may be amended in the future;

(e) Provisions for termination in advance of the scheduled term;

(f) Events of default and related remedies;

(g) Assurances that the counterparty will maintain a minimum rating with respect to its termination payment obligations in one of the top three rating categories without gradation by at least two nationally recognized rating agencies or that the counterparty's obligations will be collateralized;

(h) Modifications to standard ISDA swap documentation, as specified in the Schedule as may be required by the Issuer's policy or governing law;

(i) Limitations on allowable collateral and frequency of the valuation of such collateral; and

(j) Agreement valuation methodology.

(8) The Issuer shall notify, in writing, the MDAC of any material change in the Issuer's obligations or benefits under the agreement for the exchange of interest rates that results from a reduction in the ratings of the Issuer, a Counterparty or guarantor.

(9) Agreement Modification or Termination. If after executing an agreement for the exchange of interest rates, the agreement is modified or terminated for any reason prior to its stated end date, the Issuer shall notify the MDAC, in writing, within 30-days after completion of the modification and identify the reasons for such termination or modification and the anticipated change in obligation to the Issuer resulting from the termination or modification.

Stat. Auth.: ORS 287.014 - 287.029 & Ch. 195, OL 2003
Stats. Implemented: ORS 287.014 - 287.029 & Ch. 195, OL 2003
Hist.: OST 6-2004(Temp), f. 7-12-04, cert. ef. 7-13-04 thru 12-30-04; OST 7-2004, f. & cert. ef. 11-18-04; OST 2-2005(Temp), f. 10-5-05, cert. ef. 10-6-05 thru 4-4-06; Administrative correction 4-19-06; OST 1-2006, f. & cert. ef. 6-1-06

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Oregon University System
Chapter 580

Rule Caption: To adopt the 2006–07 tuition and fee rates and the room/board changes.
Adm. Order No.: OSSHE 2-2006
Filed with Sec. of State: 6-8-2006
Certified to be Effective: 6-8-06
Notice Publication Date: 4-1-06
Rules Amended: 580-040-0040
Subject: To establish tuition and fees for the 2006-07 Academic Year, including room and board rates.
Rules Coordinator: Marcia M. Stuart—(541) 346-5749

580-040-0040
Academic Year Fee Book

The document entitled "Academic Year Fee Book 2006-07," dated June 2, 2006, is hereby amended by reference as a permanent rule. All prior adoptions of academic year fee documents are hereby repealed except as to rights and obligations previously acquired or incurred thereunder.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: HEB 4-1978, f. & ef. 6-15-78; HEB 5-1979, f. & ef. 7-20-79; HEB 11-1979, f. & ef. 8-22-79; HEB 1-1980, f. & ef. 4-18-80; HEB 7-1980, f. & ef. 6-18-80; HEB 11-1980, f. & ef. 8-20-80; HEB 4-1981(Temp), f. 6-30-81, ef. 7-1-81; HEB 5-1981, f. & ef. 8-18-81; HEB 15-1981(Temp), f. & ef. 12-18-81; HEB 5-1982, f. & ef. 7-14-82; HEB 4-1983, f. & ef. 7-29-83; HEB 4-1984, f. & ef. 6-20-84; HEB 5-1985, f. & ef. 8-12-85; HEB 12-1986, f. & ef. 7-30-86; HEB 6-1987, f. & ef. 8-4-87; HEB 8-1988, f.& cert. ef. 8-5-88; HEB 10-1988, f. & cert. ef. 11-16-88; HEB 3-1989, f. & cert. ef. 11-27-89; HEB 6-1989, f. & cert. ef. 7-28-89; HEB 7-1990, f. & cert. ef. 6-4-90; HEB 8-1990(Temp), f. & cert. ef. 7-26-90; HEB 12-1990, f. & cert. ef. 10-3-90; HEB 5-1991, f. & cert. ef. 8-15-91; HEB 8-1992, f. & cert. ef. 7-31-92; HEB 2-1993, f. & cert. ef. 2-5-93; HEB 5-1993, f. & cert. ef. 8-11-93; HEB 7-1994, f. & cert. ef. 8-4-94; HEB 3-1995, f. & cert. ef. 8-1-95; HEB 3-1996, f. & cert. ef. 8-8-96; HEB 5-1996, f. & cert. ef. 12-18-96; HEB 3-1997, f. & cert. ef. 7-24-97; OSSHE 4-1998, f. & cert. ef. 7-22-98; OSSHE 5-1998(Temp), f. & cert. ef. 8-21-98 thru 1-31-99; OSSHE 9-1998, f. & cert. ef. 12-23-98; OSSHE 3-1999(Temp), f. & cert. ef. 7-22-99 thru 1-14-00; OSSHE 4-1999, f. & cert. ef. 9-16-99; OSSHE 3-2000, f. & cert. ef. 7-26-00; OSSHE 4-2001, f. & cert. ef. 7-27-01; OSSHE 8-2002, f. & cert. ef. 8-14-02; OSSHE 2-2003, f. & cert. ef. 8-4-03; OSSHE 6-2004, f. & cert. ef. 6-15-04; OSSHE 2-2006, f. & cert. ef. 6-8-06

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Rule Caption: Implements guidelines permitting criminal records checks for prospective OUS employees, contractors, volunteeers and vendors.
Adm. Order No.: OSSHE 3-2006(Temp)
Filed with Sec. of State: 6-12-2006
Certified to be Effective: 6-12-06 thru 11-30-06
Notice Publication Date:
Rules Adopted: 580-023-0005, 580-023-0010, 580-023-0015, 580-023-0020, 580-023-0025, 580-023-0030, 580-023-0035, 580-023-0040, 580-023-0045, 580-023-0050, 580-023-0055, 580-023-0060, 580-023-0065
Subject: Authorizes the Chancellor's Office and OUS institutions to conduct criminal records checks on subject individuals who seek to provide services as an employee, contractor, vendor or volunteer that will be working or providing services in a capacity that is designated as a critical or security-sensitive position.
Rules Coordinator: Marcia M. Stuart—(503)

580-023-0005
Purpose

The Oregon University System is committed to protecting the security, safety, and health of faculty, staff, students, and others, as well as safeguarding the assets and resources of OUS and each of its universities. To meet these objectives, the Board delegates to the Chancellor and president of each university electing to conduct criminal records checks responsibility for developing institutional policies governing the conduct of criminal records checks. Institutional policies must be consistent with this rule and applicable Oregon state laws and federal law.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0010
Definitions

(1) "Criminal records check" means the process used by the Chancellor's Office and OUS institutions to conduct criminal records background checks on candidates to verify that candidate does not have any undisclosed criminal convictions or pending criminal charges and accurately states the disposition of criminal charges. A conviction includes a plea of no contest, plea of guilty, or any court determination of guilt. Criminal offender information will be obtained using computerized and/or fingerprint-based processes. Statewide criminal records checks will be performed by the Oregon State Police (OSP) using the Oregon Law Enforcement Data System. A nationwide criminal records check and/or a state-specific criminal records check may be obtained from the OSP through the Federal Bureau of Investigation (FBI).

(2) "Critical" or "Security-Sensitive Position" means and is limited to positions or contracts for services in which a person:

(a) Has direct access to persons under 18 years of age or to student residence facilities because the person's work duties require the person to be present in the residence facility;

(b) Is providing information technology services and has control over, or access to, information technology systems that would allow the person to harm the information technology systems or the information contained in the systems;

(c) Has access to information, the disclosure of which is prohibited by state or federal laws, rules or regulations, or information that is defined as confidential under state or federal laws, rules or regulations;

(d) Has access to property where chemicals, hazardous materials, and other items controlled by state or federal laws or regulations are located;

(e) Has access to laboratories, nuclear facilities or utility plants to which access is restricted in order to protect the health or safety of the public;

(f) Has fiscal, financial aid, payroll or purchasing responsibilities as one of the person's primary responsibilities; or

(g) Has access to personal information about employees or members of the public including Social Security Numbers, dates of birth, driver license numbers, medical information, personal financial information, or criminal background information.

(3) "Fingerprint-based criminal record check" means a criminal records check using subject individual's fingerprints. Fingerprint-based criminal record checks and criminal records checks may only be requested from the OSP for non-criminal justice purposes. If a nationwide criminal records check of a subject individual is necessary, the Chancellor's Office or OUS institutions may request that the OSP conduct the check, including fingerprint identification, through the FBI.

(4) "OUS institution" means an institution of higher education in the state of Oregon under the authority of the Oregon State Board of Higher Education.

(5) "Subject individual" means a person from whom the Chancellor's Office or OUS institutions may require criminal records checks as a condition to provide services as a contractor, vendor, employee, or volunteer. Subject individual includes persons currently serving as a contractor, vendor, employee, or volunteer who seek appointment as an employee, volunteer, or engagement as a contractor or vendor to a position that is designated as a critical or security-sensitive position.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0015
Criminal Records Check Policy

(1) The Chancellor's Office and OUS institutions are authorized to conduct criminal records checks only on subject individuals who seek to provide services as an employee, contractor, vendor, or volunteer that will be working or providing services in a capacity that is designated as a critical or security-sensitive position.

(2) Criminal records checks may not be performed on employees who are involuntarily transferred to a new position, unless the position is designated as a critical or security-sensitive position and requires a determination of fitness based on criminal records check.

(3) A determination of fitness based on a criminal records check for critical or security-sensitive positions is considered a minimal qualification of the position.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0020
Obtaining Criminal Offender Information

Any criminal records check policy instituted by the Chancellor's Office or OUS institution must be in consultation with the OSP and must be implemented through institution specific policies that include but need not be limited to:

(1) Specifying categories of subject individuals who are subject to criminal records checks.

(2) Specifying the information that may be required from a subject individual to permit a criminal record check.

(3) Specifying which programs or services are subject to the checks.

(4) Specifying the types of crimes that may be considered in reviewing criminal offender information of the subject individual.

(5) Specifying when a nationwide fingerprint-based criminal records check must be conducted. If a nationwide fingerprint-based criminal records check is to be required, the Chancellor's Office or OUS institution must take into consideration the additional cost associated with the check.

(6) Establish fees, if any, in an amount not to exceed the actual cost of acquiring and furnishing criminal records. An established fee may be waived by an appropriately designated official of the employer.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0025
Criminal Records Check Notice to Applicants

Application forms and solicitations for contract and vendor services must give notice to any prospective employee, contractor, vendor, or volunteer if the position requires a fingerprint-based criminal record check or criminal records check.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0030
Confidentiality of Criminal Records Checks

Any information obtained in the criminal records check is confidential. The Chancellor's Office and OUS institutions in adopting policies must restrict dissemination of information obtained in the criminal records check. Only those persons, as identified by the Chancellor's Office or OUS institutions, with a demonstrated and legitimate need to know the information may have access to criminal records check records.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0035
Subject Individual's Access to Criminal Offender Records

The Chancellor's Office and OUS institutions must permit a subject individual for whom a criminal records check was conducted to inspect the individual's own state and national criminal offender records and, if requested by the subject individual, provide the individual with a copy of the individual's own state and national criminal offender records.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0040
Pre-employment Status

The Chancellor's Office and OUS institutions must establish policies that specify when and under what conditions a subject individual will be hired, promoted, transferred, participate in training or orientation or engage in activities required of a critical or security-sensitive position or contract pending results of a criminal records check. These policies shall be clearly communicated as part of the Criminal Records Check Notice to Applicants pursuant to OAR 580-023-0025.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0045
False Statements or Refusal to Consent to Criminal Records Check

(1) The Chancellor's Office and OUS institutions must determine whether a subject individual is fit to hold a position, provide services, or be employed if the criminal records check evidences that the applicant made a false statement regarding the background information provided.

(2) If a subject individual refuses to consent to a criminal records check or refuses to be fingerprinted, the Chancellor's Office or OUS institution shall deny the employment of the individual, or deny any applicable position, or deny any request to provide volunteer services, or deny authority to provide contracted services.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0050
Fitness to Hold Position Based on Criminal Records Check

The Chancellor's Office and OUS institutions must use these rules and resulting policies to determine whether the subject individual is fit to hold a position, provide a service, or be employed based upon the criminal records check obtained, or on any false statement made regarding criminal history. In making the fitness determination, the Chancellor's Office or OUS institution must consider:

(1) The nature of the crime;

(2) The facts that support the conviction or pending indictment or that indicate the making of the false statement;

(3) The relevancy, if any, of the crime or the false statement to the specific requirements of the subject individual's proposed position, services, or employment; and

(4) Intervening circumstances relevant to the responsibilities and circumstances of the position, services, or employment. Intervening circumstances include but are not limited to:

(a) The passage of time since the commission of the crime;

(b) The age of the subject individual at the time of the crime;

(c) The likelihood of a repetition of offenses or of the commission of another crime;

(d) The subsequent commission of another relevant crime;

(e) Whether the conviction was set aside and the legal effect of setting aside the conviction; and

(f) A recommendation of an employer.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0055
Contested Case Process for Criminal Records Check

The Chancellor's Office and OUS institutions must establish a contested case process pursuant to ORS Chapter 183 by which a subject individual may appeal the determination that the individual is not fit to hold a position, provide services, or be employed on the basis of information obtained as a result of a criminal records check. Challenges to the accuracy or completeness of information provided by the OSP, the FBI, and agencies reporting information to the OSP or FBI must be made though the OSP, FBI, or reporting agency and not through the contested case process. Subject individuals may provide information that is contrary to that contained in the records received.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0060
Notice of Adverse Fitness Determination Based on Criminal Records Check

The Chancellor's Office or OUS institutions shall inform the subject individual who has been determined not to be fit, via certified mail, of such disqualification. The notice will indicate that the subject individual:

(1) Has a right to inspect and challenge their Oregon criminal offender information in accordance with the OSP procedures as adopted per ORS 181.555(3) and OAR 257-010-0035.

(2) May challenge the accuracy or completeness of any entry on the subject individual's criminal records obtained from the FBI by filing a challenge with the FBI in accordance with Title 28 Code of Federal Regulations Part 16.34 (28 CFR 16.34) or the then current regulation; and

(3) May appeal the determination of fitness through the process described in this rule.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

580-023-0065
Challenging a Fitness Determination

If a subject individual wishes to dispute an adverse fitness determination, the subject individual may appeal the determination by requesting a contested case hearing.

(1) The subject individual must notify the Chancellor's Office or OUS institution in writing of his/her intent to challenge the fitness determination and to request a contested case hearing not later than 14 calendar days from the date of the denial notice. The Chancellor's Office or OUS institution may extend the time to appeal if the Chancellor's Office or OUS institution determines the delay was caused by factors beyond the reasonable control of the subject individual.

(2) The Chancellor's Office and OUS institution has no jurisdiction over allegations that the criminal offender information received from OSP, the FBI, or other entities is inaccurate, incomplete, or maintained in violation of any federal or state law.

(3) The Chancellor's Office and OUS institution is entitled to rely on the criminal offender information supplied by OSP, the FBI, or other entities until the Chancellor's Office or OUS institution is notified that the information has been changed or corrected.

(4) Any contested case hearing under this rule is not open to the public.

(5) The issues at a contested case hearing shall be limited to whether the Chancellor's Office or OUS institution considered the relationship of the facts that support the conviction and all intervening circumstances to the position at issue in determining the fitness of the subject individual to hold the position, provide a service or be employed.

(6) The Chancellor or president of the university shall select an appropriate hearing officer. The role of the hearing officer is limited to conducting the hearing and developing a proposed order for the Chancellor or president or his/her designee.

Stat. Auth.: ORS 181.534 & 352.012
Stats. Implemented: ORS 181.534 & 352.012
Hist.: OSSHE 3-2006(Temp), f. & cert. ef. 6-12-06 through 11-30-06

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Oregon University System, Oregon Institute of Technology Chapter 578

Rule Caption: Amends the Schedule of Special Institution Fees and Charges.
Adm. Order No.: OIT 1-2006
Filed with Sec. of State: 6-2-2006
Certified to be Effective: 6-2-06
Notice Publication Date: 5-1-06
Rules Amended: 578-041-0030
Subject: 578-041-0030 - Amends the Schedule of Special Institution Fees and Charges. Amendments allow for increases, revisions, additions or deletions of special course fees and general service fees for fiscal year 2006-07. The schedule of subject fees may be obtained from the Oregon Institute of Technology office.
Rules Coordinator: Ceilia E. Foster—(541) 885-1105

578-041-0030
Special Institution Fees and Charges

(1) The Schedule of Special Institution Fees and Charges establishes charges for selected courses and general services for Oregon Institute of Technology for the academic year 2006-07 and are hereby adopted by reference.

(2) Copies of this fee schedule may be obtained from the Oregon Institute of Technology Finance and Administration Office.

Stat. Auth.: ORS 351
Stats. Implemented: ORS 351.070(2)
Hist.: OIT 1-1985, f. 1-10-85, ef. 2-1-85; OIT 1-1986, f. & ef. 9-4-86; OIT 4-1991, f. & cert. ef. 7-22-91; OIT 5-1992, f. & cert. ef. 9-24-92; OIT 1-1993, f. & cert. ef. 9-24-93; OIT 1-1995, f. & cert. ef. 7- 7-95; OIT 1-1996, f. & cert. ef. 9-11-96; OIT 2-1996; f. & cert. ef. 12-19-96; OIT 1-1997, f. & cert. ef. 12-31-97; OIT 2-1998, f. & cert. ef. 11-12-98; OIT 1-1999, f. & cert. ef. 8-26-99; OIT 1-2000, f. & cert. ef. 7-7-00; OIT 1-2001, f. & cert. ef. 7-19-01; OIT 1-2002, f. & cert. ef. 7-15-02; OIT 1-2003, f. & cert. ef. 6-11-03; OIT 1-2004, f. & cert. ef. 6-9-04; OIT 1-2005, f. & cert. ef. 6-10-05; OIT 1-2006, f. & cert. ef. 6-2-06

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Rule Caption: Amends the Parking Permits and Fees with text revisions.
Adm. Order No.: OIT 2-2006
Filed with Sec. of State: 6-2-2006
Certified to be Effective: 6-2-06
Notice Publication Date: 5-1-06
Rules Amended: 578-072-0030
Subject: 578-072-0030 - Amends the Parking Permits and Fees with text revisions. Amendments allow for increases and text revisions, for fiscal year 2006-07. The schedule of parking fees and text revisions may be obtained from the Oregon Institute of Technology office.
Rules Coordinator: Ceilia E. Foster—(541) 885-1105

578-072-0030
Parking Permit and Fees

(1) Students, faculty and staff permits (adhesive or hanging) will be issued for a fee of $84.00 per year or $38.00 per term. Vehicles with these permits must park in the parking areas.

(2) Two-wheeled (power and scooter) permits will be issued for a fee of $46.00 per year or $20.00 per term. Such vehicles must park in designated motorcycle parking areas.

(3) Bicycles must be licensed by the City of Klamath Falls. A parking permit is not required.

(4) Special permits may be issued at the Cashier's office under the following circumstances:

(a) Application for a Disabled Parking permit must be submitted to the Student Health Service. After approval by Student Health Service, a Disabled Parking permit may be purchased at the Cashier's office.

(b) Persons displaying either permanent or temporary disabled permits are authorized open parking on the campus in addition to parking in the areas designated as disabled parking.

(c) Temporary permits are issued at no charge by Campus Safety at the Information Booth on Campus Drive. Vehicles displaying temporary permits must park in the area designated by that permit. Students, faculty, and staff members are able to obtain up to 10 days per term of temporary parking permits. Temporary permits are official documents and may not be modified or altered in any way.

(d) Visitor permits are issued at no charge at the Information Booth on Campus Drive and must be displayed as indicated on the permit. A visitor is any person who is an OIT guest but is not officially affiliated with OIT.

(e) Special guest permits: Guest permits will be issued by Campus Safety.

(5) Service Vendor permits are issued by Facilities or Campus Safety for contractors, media personnel, and vendors performing work on campus.

(6) Up to three vehicles registered on a single hanging permit-additional charge $10.00.

(7) Replacement Permits: A replacement permit may be purchased for a substitute vehicle when the original vehicle is sold, damaged beyond repair, or when the permit is lost or damaged. In the event a permit is stolen,

a stolen permit report must be filed with Campus Safety before a replacement permit may be issued. An adhesive replacement permit may be obtained for a fee of $5.00 upon submission to the cashier of permit number evidence from the original permit. Replacement hanging permits are available at the full price of the original hanging permit. Possession of a lost or stolen permit may be grounds for criminal charges, and/or University disciplinary action, including revocation of parking privileges.

(8) Parking permits are issued by the academic year or for a term. Refunds will be made only if a parking permit is removed from the vehicle and returned to the Cashier within ten (10) days of the purchase date. No other refunds will be given.

(9) Parking permits are considered University records, and as such, may not be falsified, misused, forged, modified or altered in any way. Vehicles bearing forged or altered permits are subject to a fine, criminal proceedings, and/or discipline by the University.

Stat. Auth.: ORS 351
Stats. Implemented: ORS 351.070
Hist.: OIT 2, f. & ef. 9-7-76; OIT 10, f. & ef. 6-6-77; OIT 1-1978, f. & ef. 6-5-78; OIT 1-1979, f. & ef. 6-8-79; OIT 6-1980, f. & ef. 6-9-80; OIT 3-1985, f. 8-5-85, ef. 9-1-85; OIT 1-1988(Temp), f. 6-20-88, cert. ef. 7-1-88; OIT 3-1991, f. & cert. ef. 7-8-91; OIT 2-1992, f. & cert. ef. 7-21-92; OIT 1-1993, f. & cert. ef. 9-24-93; OIT 1-1994, f. & cert. ef. 8-25-94; OIT 1-1996, f. & cert. ef. 9-11-96; OIT 1-1997, f. & cert. ef. 12-31-97; OIT 2-1998, f. & cert. ef. 11-12-98; OIT 1-1999, f. & cert. ef. 8-26-99; OIT 1-2000, f. & cert. ef. 7-7-00; OIT 1-2001, f. & cert. ef. 7-19-01; OIT 1-2002, f. & cert. ef. 7-15-02; OIT 2-2005, f. & cert. ef. 6-10-05; OIT 2-2006, f. & cert. ef. 6-2-06

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Oregon University System, Southern Oregon University Chapter 573

Rule Caption: Freshman Live-In Requirement; Residence Hall Room and Board Agreement.
Adm. Order No.: SOU 2-2006
Filed with Sec. of State: 6-1-2006
Certified to be Effective: 6-1-06
Notice Publication Date: 3-1-06
Rules Amended: 573-070-0005, 573-070-0011
Subject: 573-070-0005 changed to require notarized parental approval to live off campus. 573-070-0011 revised to provide flexibility in accessing moving and room change fees. These fees have not been amended since 1996.
Rules Coordinator: Treasa Sprague—(541) 552-6319

573-070-0005
Freshman Live-In Requirement

Single freshmen students who enroll at Southern Oregon University within one year of high school graduation must live in the residence halls unless they are living with parents, legal guardians, or have notarized written parent or guardian approval to live off campus.

Stat. Auth.: ORS 351 & 352
Stats. Implemented: ORS 351.070
Hist.: SOSC 12, f. & ef. 8-26-77; SOSC 3-1979, f. 8-8-79, ef. 9-1-79; SOSC 6-1980(Temp), f. & ef. 9-23-80; SOSC 10-1980, f. & ef. 11-19-80; SOU 1-1998, f. & cert. ef. 4-23-98; SOU 2-2006, f. & cert. ef. 6-1-06

573-070-0011
Residence Hall Room and Board Agreement

(1) Each applicant for residence hall accommodations shall be required to sign a Room and Board Agreement before occupying a room. The Room and Board Agreement specifies all contractual obligations for resident students. All rules and regulations in the Room and Board Agreement are binding.

(2) Copies of the current Room and Board Agreement will be available in the Student Housing Office.

(3) If a student is evicted from, moves from, or otherwise leaves a residence hall, but does not withdraw from the institution, the student is assessed a per day fee for the remaining days of the agreement period.

(4) If a student changes rooms anytime during the contract period, the student will be assessed a $10.00 moving fee for each move not to exceed $50.00.

(5) If a student fails to follow procedures when completing a room change, the student is subject to a $20.00 improper moving fee not to exceed $50.00.

(6) With an approved petition a student may be released from his or her Residence Hall Room and Board Agreement without the per day penalty. The main criteria used in approving such a petition are as follows:

(a) Health reasons, verified by a licensed physician, preferably local, who is acceptable to the Housing Policy Committee;

(b) Student teaching or academic programs requiring the student to live in another community;

(c) If a student is a non-freshman and finds a suitable replacement to take over the agreement, i.e., someone not required by University policies to live in residence halls and someone who has not previously contacted the Housing Office;

(d) Being dropped from SOU for academic reasons.

(e) Officially withdrawing effective the current academic term.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOSC 6-1980(Temp), f. & ef. 9-23-80; SOSC 10-1980, f. & ef. 11-19-80; SOSC 4-1994, f. & cert. ef. 7-29-94; SOU 1-1998, f. & cert. ef. 4-23-98; SOU 1-2001, f. & cert. ef. 4-4-01; SOU 3-2002, f. & cert. ef. 12-30-02; SOU 1-2004, f. & cert. ef. 4-5-04; SOU 2-2006, f. & cert. ef. 6-1-06

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Teacher Standards and Practices Commission Chapter 584

Rule Caption: Adopts and amends rules recently considered at the Administrative Rule Hearing on April 12, 2006.
Adm. Order No.: TSPC 9-2006
Filed with Sec. of State: 6-15-2006
Certified to be Effective: 6-15-06
Notice Publication Date: 3-1-06
Rules Adopted: 584-010-0090, 584-036-0070
Rules Amended: 584-017-0070, 584-017-0100, 584-017-0175, 584-020-0041, 584-023-0005, 584-023-0015, 584-023-0025, 584-040-0005, 584-048-0020, 584-060-0052
Rules Repealed: 584-023-0020
Subject: 584-010-0090: *Program Completion — Field Operation Audit* — Creates a new administrative rule to define and describe the “C-2 Fast-Track.”

584-036-0070: *Expedited Service for Emergency Service* — Removed “Expedited Service” from the Fees administrative rule and created a new rule for ease of location.

584-017-0070: *School-Based Personnel for the Program* — Decreased experience requirement for teachers supervising student teaching and/or practica from three to two years.

584-017-0100: *Objectives for Initial Teaching License* — Revises rules to add new language related to strengthening the cultural competency focus of the Initial Teaching License.

584-017-0175: *Adding Authorization Levels to Existing Initial and Continuing Teaching License* — Reconciles the rule in Division 17 with the rule in Division 60 for adding grade authorization levels to existing Initial and Continuing Teaching Licenses.

584-020-0041: *Reporting Requirements* — Changes reporting requirements for Superintendents to include possible violations of all of the professional standards for behavior and not just a few.-

584-023-0005: *Registry and Renewal of Charter School Teachers* — Updates the rules to remove references to legislative bills and cites the appropriate statutes.

584-023-0015: *Standards of Competency and Ethics* — Updates the rules to remove references to legislative bills and cites the appropriate statutes.

584-023-0025: *Charter School Fees* — Modifies Charter School application fees to reflect the increase in fingerprint fees.

584-040-0005: *Standard Teaching License Requirements* — Clarifies that a Standard Teaching License in Special Education requires completion of a Master’s or equivalent in Special Education.

584-048-0020: *Renewal of Teaching Licenses* — Special Provisions — Makes editorial changes and clarifies that experience in a charter school may be used to renew an active teaching license.

584-060-0052: *Adding Authorization Levels to Existing Initial and Continuing Teaching Licenses* — Reconciles the rule in Division 60 with the rule in Division 17 for adding grade authorization levels to existing Initial and Continuing Teaching Licenses.

584-023-0020: *Renewal of Registration* — REPEAL — Charter School Registration language moved to 584-023-0005.
Rules Coordinator: Victoria Chamberlain—(503) 378-6813

584-010-0090
Program Completion — Field Operation Audit

(1) The Commission will provide to units a program completion fast-track option. The fast-track option will grant an expedited license to completers of Commission-approved programs.

(2) The license will be granted so long as it is evident that all requirements of the license have been met.

(3) For participating units, the Commission shall schedule annual field operation audits of the program completion process of each institution.

(a) The review shall audit five (5) percent of the files of program completers at the unit;

(b) A minimum of fifteen (15) files will be reviewed regardless of the number of program completers recommended by a unit for licensure; and

(c) In the event there are less than fifteen (15) files total, all files will be reviewed.

(4) The audit review team will be TSPC staff, including at least one (1) trained licensure evaluator.

(5) The review shall examine files and documents for each TSPC-approved program. These files and documents include:

(a) Documentation of degrees identified on the Program Completion Report, including:

(A) Degree level;

(B) Institution granting degree;

(C) Date degree granted; and

(D) Major, if specified;

(b) Coursework completion date;

(c) Documentation of subject-matter test scores. If the institution is source of data, then documentation of date reported to TSPC.

(d) Documentation of Basic Skills Test requirements;

(e) Documentation of test score on a test of Civil Rights Knowledge; and

(f) Basis for recommendation of program completion requirements.

(6) As part of the audit, the review team shall examine the following TSPC files and documents for randomly chosen audited candidates:

(a) PA1 forms submitted;

(b) PA1 character questionnaire cleared;

(c) Fingerprint and background check clearance;

(d) C1 — Educator application;

(e) Appropriate test score records;

(f) Fees;

(g) License issued, based on C-2 request and information; and

(h) Any appropriate correspondence based on licensure.

(4) All results of these audits shall be reported to the Commission by TSPC staff at the next regularly scheduled meeting.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.147 & 342.165
Hist.: TSPC 9-2006, f. & cert. ef. 6-15-06

584-017-0070
School-Based Personnel for the Program

The unit provides qualified school-based personnel for the program.

(1) The unit has policies for supervision of practica and student teaching experiences that state the responsibilities of the institutional supervisor and the school based supervisor and administrator.

(2) The unit selects qualified school based supervisors who have had two (2) years experience in early childhood, or elementary, or middle or high school immediately prior to supervision or instruction and who hold a valid license for current assignments.

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 1-2006(Temp), f. & cert. ef. 1-3-06 thru 1-30-06; TSPC 4-2006(Temp), f. & cert. ef. 2-3-06 thru 8-2-06; TSPC 9-2006, f. & cert. ef. 6-15-06

584-017-0100
Objectives for Initial Teacher License

The unit assures that candidates for an Initial Teaching License demonstrate knowledge, skills, and competencies in each of the five (5) teacher functions.

(1) Candidates plan instruction that supports student progress in learning and is appropriate for the developmental level and demonstrate they are able to:

(a) Select or write learning goals for units of instruction that are consistent with the school's long-term curriculum goals, State content standards and district standards, research findings on how students learn, and the physical and mental maturity of one's students;

(b) Determine the current performance level of one's students with respect to the learning goals established for a unit of instruction;

(c) Establish objectives within the unit of instruction that will be useful in formulating daily lessons and in evaluating the progress of students toward the attainment of unit goals;

(d) Determine content, skills, and processes that will assist students in accomplishing desired unit outcomes, and design learning activities that lead to their mastery;

(e) Select and organize materials, equipment and technologies needed to teach a unit of instruction;

(f) Design and adapt unit and lesson plans for all learners and exceptional learners, including but not limited to students with varying cultural, social, socio-economic and linguistic backgrounds; and

(g) Estimate the time required within a unit for teacher-directed instruction, student-managed learning and practice, student evaluation/reporting and reteaching/problem solving.

(2) Candidates establish a classroom climate conducive to learning and demonstrate they are able to:

(a) Affirm the dignity and worth of all students and provide the positive support students need to be effective learners;

(b) Establish, communicate, and maintain rules, procedures and behavioral expectations that provide a safe and orderly environment for learning, are appropriate to the level of development of students, and are consistent with laws governing student rights and responsibilities;

(c) Employ equitable practices that are just and that support a least restrictive environment for all students;

(d) Model and reinforce classroom social behavior that supports student learning and development;

(e) Use knowledge of the influence of the physical, social, and emotional climates of students' homes and the community to optimize motivation, learning, and behavior;

(f) Monitor student conduct, and take appropriate action when misbehavior occurs;

(g) Interact thoughtfully and courteously with all students and their families and seek to resolve conflicts in a professional manner, respecting familial and community cultural contexts;

(h) Use classroom time effectively to provide maximum time for learning;

(i) Manage instructional transitions decisively and without loss of instructional time;

(j) Arrange and set up instructional materials and equipment in advance of class to facilitate their effective and efficient use during lessons; and

(k) Coordinate the use of instructional assistants, parent volunteers, student assistants, and other support personnel to achieve instructional objectives, if these resources are available in the school setting.

(3) Candidates engage students in planned learning activities and demonstrate they are able to:

(a) Choose organizational structures appropriate for the objectives of instruction;

(b) Communicate learning outcomes to be achieved and focus student interest on tasks to be accomplished;

(c) Implement instructional plans that employ knowledge of subject matter and basic skills;

(d) Use a variety of research-based educational practices that promote student learning and are sensitive to individual differences and diverse cultures;

(e) Emphasize instructional techniques that promote critical thinking and problem solving, and that encourage divergent as well as convergent thinking; and

(f) Monitor the engagement of students in learning activities, and the progress they are making, to determine if the pace or content of instruction needs to be modified to assure that all students accomplish lesson and unit objectives.

(4) Candidates evaluate, act upon, and report student progress in learning and demonstrate they are able to:

(a) Select or develop non-biased, valid and reliable tests, performance measures, observations student interviews, or other formal or informal assessment procedures to determine the progress of all students;

(b) Document student progress in accomplishing State-adopted content standards and district standards, prepare data summaries that show this progress to others, and inform students, supervisors, and parents about progress in learning;

(c) Refine plans for instruction, establish alternative goals or environments, or make referrals when appropriate; and

(d) Assemble, reflect upon, interpret, and communicate evidence of one's own effectiveness as a teacher including evidence of success in fostering student progress in learning and use evidence of effectiveness in planning further intervention.

(5) Candidates exhibit professional behaviors, ethics, and values and demonstrate they are able to:

(a) Be dependable, conscientious, and punctual;

(b) Meet work schedule demands;

(c) Be aware of the importance of dressing appropriately;

(d) Be aware of, and act in accordance with, school policies and practices;

(e) Understand the organizational culture and expectations that operate within a school and that impact students and student learning;

(f) Interact constructively and respectfully with students, colleagues, administrators, supervisors, school staff, families, and members of the community;

(g) Collaborate with parents, colleagues, and members of the community to provide internal and external assistance to students and their families to promote student learning;

(h) Perform advisory functions for students in formal and informal settings;

(i) Function as a member of an interdisciplinary team to achieve long-term curriculum goals, and State content standards and district standards;

(j) Exhibit energy, drive and determination to make one's school and classroom the best possible environment for teaching and learning; and

(k) Exhibit energy, drive and determination to become a professional educator.

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 6-2002, f. & cert. ef. 10-23-02; TSPC 9-2006, f. & cert. ef. 6-15-06

584-017-0175
Adding Authorization Levels to Existing Initial and Continuing Teaching Licenses

(1) The unit makes provisions for adding authorizations to Initial and Continuing Teaching Licenses.

(2) A candidate seeking to add the next contiguous authorization to an existing Initial or Continuing Teaching License will:

(a) Successfully complete at least six (6) quarter hours or four (4) 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 (1) work sample to document teaching effectiveness at the new authorization level:

(A) A practicum of two (2) semester hours or three (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; or

(B) Verification of one (1) year of experience teaching the new subject-area at least one (1) hour each day or the equivalent on either an optional assignment of ten (10) hours or less or on an approved conditional assignment permit (CAP) as allowed by OAR 584-060-0081.

(3) A candidate may add an authorization level that is not contiguous to an existing Initial or Continuing Teaching License if:

(a) The candidate successfully completes an approved program at that level. Completion of the approved program shall include 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, 342.147 & 342.165
Hist.: TSPC 7-1999, f. & cert. ef. 10-8-99; TSPC 6-2002, f. & cert. ef. 10-23-02; TSPC 2-2005, f. & cert. ef. 4-15-05; TSPC 9-2006, f. & cert. ef. 6-15-06

584-020-0041
Reporting Requirements

(1) For purposes of this rule, "chief administrator" means:

(a) The superintendent, head teacher or person designated by a school district board as district school clerk under ORS 332.515 of a school district, or education service district;

(b) The chief administrative officer of the Oregon School for the Deaf and the Oregon School for the Blind; or

(c) The chief administrative officer of a private elementary or secondary school under ORS 345.505 to 345.585, regardless of whether the school is registered as a private school with the Department of Education.

(2) Educators subject to being reported under this rule include:

(a) Any educator possessing a TSPC-issued licensed;

(b) Any educator holding a charter school registration;

(c) Any pre-service candidate placed in a public or private school for purposes of program completion pursuant to any program described in Division 17 of these administrative rules.

(3) A chief administrator shall report to the Executive Director within thirty (30) days the name of any person described in subsection (2) above, when after appropriate investigation the chief administrator reasonably believes the person may have committed any act which may constitute one (1) of the designated acts of gross neglect of duty under OAR 584-020-0040(4), subsections (a) to (i), (k) to (o) or (q) or one of the designated acts of gross unfitness listed under OAR 584-020-0040(5), subsections (a) to (e).

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.143 & 342.175 - 342.190
Hist.: TS 4-1993, f. & cert. ef. 9-29-93; TS 4-1997, f. 9-25-97, cert. ef. 10-4-97; TSPC 5-1999(Temp), f. & cert. ef. 8-24-99 thru 2-19-00; TSPC 7-1999, f. & cert. ef. 10-8-99; TSPC 1-2001, f. & cert. ef. 1-17-01; TSPC 9-2006, f. & cert. ef. 6-15-06

584-023-0005
Registry of Charter School Teachers

No persons shall serve as a teacher (as defined in ORS 342.120) in a public charter school unless such person either holds a valid Oregon teaching license issued by TSPC or is registered with TSPC as a charter school teacher in accordance with ORS 342.125(5).

(1) TSPC shall create a Public Charter School Registry for all non-licensed persons who are employed as teachers in any charter school.

(2) To enroll in the Registry, an applicant and the employing charter school shall submit to TSPC, on forms established by the commission, a joint application, which shall include the following documentation and other data required by the commission for purposes of conducting a background check through the Oregon State Police Law Enforcement Data System, the Federal Bureau of Investigation and an interstate clearinghouse of revoked and suspended licenses.

(a) Description of the specific teaching position the applicant will fill with the employing charter school;

(b) Fingerprints on forms prescribed by the Oregon State Police;

(c) Completed character questionnaire specified by OAR 584-036-0060;

(d) Resume of applicant's postsecondary education; and

(e) A list of any professional licenses held.

(3) Successful completion of the background checks disclosing no disqualifying materials shall entitle the registrant to serve as a teacher as defined in ORS 342.120 in the employing charter school for a period of up to three (3) years or until employment with the employing charter school ceases, whichever occurs first.

(4) The registration is only valid to teach in the position described in the application to TSPC.

(5) A registration may be renewed for an additional three-year term upon joint application of the registrant and employing charter school on forms established by the Commission and upon the payment of the applicable fee.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.125, 338.135
Hist.: TSPC 5-1999(Temp), f. & cert. ef. 8-24-99 thru 2-19-00; TSPC 7-1999, f. & cert. ef. 10-8-99; TSPC 9-2006, f. & cert. ef. 6-15-06

584-023-0015
Standards of Competence and Ethics

The provisions of ORS 342.120 to 342.430 and the Rules in OAR Chapter 584 relating to the issuance, denial, continuation, renewal, lapse, revocation, suspension or reinstatements of licenses shall be applicable to all teachers enrolled in the Registry.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.125, 338.135
Hist.: TSPC 5-1999(Temp), f. & cert. ef. 8-24-99 thru 2-19-00; TSPC 7-1999, f. & cert. ef. 10-8-99; TSPC 9-2006, f. & cert. ef. 6-15-06

584-023-0025
Charter School Fees

TSPC shall charge a fee of $75, or such other amount as may hereafter be allowed by law, for each original application and for each renewal application. This fee shall include the costs of fingerprints and criminal history checks.

Stat. Auth.: ORS 342.175
Stats. Implemented: ORS 342.125 & 338.135
Hist.: TSPC 5-1999(Temp), f. & cert. ef. 8-24-99 thru 2-19-00; TSPC 7-1999, f. & cert. ef. 10-8-99; TSPC 10-2005(Temp), f. & cert. ef. 11-15-05 thru 4-30-06; TSPC 5-2006, f. & cert. ef. 2-10-06; TSPC 9-2006, f. & cert. ef. 6-15-06

584-036-0070
Expedited Service for Emergency License

(1) An employer and an applicant may jointly request an emergency license or other eligible license by 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 expedited service fee pursuant to OAR 584-036-0055.

(2) 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 non-emergency license have been met.

(3) The Commission may limit the number of applications from an employing district to a maximum of one hundred (100) in any two-day period.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.17
Hist.: TSPC 4-2006(Temp), f. & cert. ef. 2-3-06 thru 8-2-06; TSPC 9-2006, f. & cert. ef. 6-15-06

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 (5) years and is renewable repeatedly under conditions specified below. It is valid for regular teaching at one (1) or more designated authorization levels in one (1) 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 (1) of the following ways:

(a) Three (3) years of one-half (.5) time or more experience is required; or

(b) For persons holding a Basic Teaching License prior to January 1, 1990, two (2) years of experience or three (3) years of one-half time or more experience, whichever is less.

(4) Notwithstanding subsection (5) below, the applicant must provide evidence of one (1) of the following:

(a) Completion of an approved Standard Teaching License program which culminates with forty-five (45) 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 (1) 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 (2) of the basic subject matter endorsements outlined in OAR 584-038-0010 through 584-038-0280. Fifteen (15) 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 forty-five (45) quarter hours of upper-division or graduate study beyond the bachelor's degree.

(5) The holder of a Basic Teaching License with a Basic Special Education endorsement must qualify for a Standard Teaching License in the following manner:

(a) Upon expiration of the second Basic Teaching License, the holder of a Basic Special Education endorsement must qualify for a Standard Teaching License with a Standard Special Education endorsement by verifying fifteen (15) quarter hours or ten (10) semester hours of graduate preparation in special education.

(b) 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.)

(6) 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.

(7) 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.

(8) 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 (1) academic year as a full-time licensed educator or two (2) 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 six (6) semester hours or nine (9) quarter hours of academic credit, germane to teaching licensure, from a regionally accredited college or university; or

(d) Completion of one hundred eighty (180) 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 (1) quarter hour of preparation equals twenty (20) days of successful experience.

(9) 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; TSPC 9-2005, f. & cert. ef. 11-15-05; TSPC 9-2006, f. & cert. ef. 6-15-06

584-048-0020
Renewal of Teaching Licenses — Special Provisions

(1) An applicant for renewal of a teaching license for which only one (1) year of experience is required for renewal may submit verification of twelve (12) months of service in the Armed Forces, the Peace Corps, or VISTA during the life of the current license. An applicant who qualifies under this section is permitted one (1) renewal based on such experience.

(2) An applicant who meets all requirements for the Standard Teaching License except teaching experience in Oregon schools will be granted a third Basic Teaching License without further preparation. Thereafter, if the experience requirement has not been met, the applicant may renew the Basic Teaching License upon verification of one (1) of the following properly assigned educational experiences, if appropriate, during the life of the license:

(a) One (1) academic year full-time; or

(b) Two (2) academic years half-time or more; or

(c) One hundred eighty (180) days as a substitute; or

(d) Completion of six (6) semester hours or nine (9) quarter hours of preparation in an approved institution; or

(e) A combination of (a) – (d) above may be submitted in satisfaction of this requirement in which one quarter hour of preparation equals twenty (20) days of experience.

(3)(a) An applicant for renewal of a Basic, Initial, Standard, Continuing, or Five-Year Teaching License may provide verification of volunteer experience or employment as an instructional assistant in Oregon schools in lieu of one (1) year of full-time teaching experience or in lieu of nine (9) quarter hours of additional preparation.

(b) A combination of volunteer or instructional assistant experience and credit may be submitted in accordance with the provisions set forth below:

(A) One hundred and twenty (120) hours of volunteer or instructional assistant experience may be substituted for up to three (3) credit hours as experience necessary for renewal, provided the experience is obtained within one (1) academic school year;

(B) All nine (9) credits needed for renewal may be obtained if three hundred sixty (360) hours of volunteer or instructional assistant experience is verified.

(4) An applicant for renewal of a Basic, Initial, Standard, Continuing, or Regular Teaching License may provide verification of employment in a charter school as acceptable experience in lieu of one (1) year of full-time teaching experience or in lieu of nine (9) quarter hours of additional preparation.

(a) Verification of the charter school experience must be provided on a TSPC PEER form and must be signed by an educator holding a TSPC license or a TSPC charter school registration.

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 6-1980, f. & ef. 12-23-80; TS 1-1982, f. & ef. 1-5-82; TSPC 6-1983, f. & ef. 10-18-83; TS 6-1984, f. 12-27-84, ef. 1-15-85; TS 8-1986, f. 12-19-86, ef. 1-15-87; TS 1-1988, f. 1-14-88, ef. 1-15-88; TS 2-1989, f. & cert. ef. 2-16-89; TS 3-1989, f. & cert. ef. 7-31-89; TS 7-1989, f. & cert. ef. 12-13-89; TS 1-1992, f. & cert. ef. 1-15-92; TS 5-1993, f. & cert. ef. 10-7-93; TSPC 5-2001, f. & cert. ef. 12-13-01; TSPC 9-2006, f. & cert. ef. 6-15-06

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) A program of at least six (6)quarter hours or four (4) 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. Verification from the institution at which the program is completed is required to add the authorization; and

(b) One of the following practicum experiences, which must include preparation of one (1) work sample to document teaching effectiveness at the new authorization level:

(A) A practicum of two (2) semester hours or three (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; or

(B) Verification of one (1) year of experience teaching the new subject-area at least one (1) hour each day or the equivalent on either an optional assignment of ten (10) hours or less or on an approved conditional assignment permit (CAP) as allowed by OAR 584-060-0081.

(2) A candidate may add an authorization level that is not contiguous to an existing Initial or Continuing Teaching License if:

(a) The candidate 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; TSPC 9-2006, f. & cert. ef. 6-15-06

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Rule Caption: Adopts and amends rules that will revise the Initial and Continuing Administrator and School Counselor Licenses.
Adm. Order No.: TSPC 10-2006(Temp)
Filed with Sec. of State: 6-15-2006
Certified to be Effective: 7-1-06 thru 12-27-06
Notice Publication Date:
Rules Adopted: 584-017-0442, 584-017-0452, 584-080-0002, 584-080-0012, 584-080-0022
Rules Amended: 584-017-0251, 584-017-0261, 584-048-0090, 584-080-0001, 584-080-0031
Rules Suspended: 584-080-0011, 584-080-0021
Subject: 584-017-0442 — *Objectives for Initial School Counselor License*: Renumbered and adopted as Temporary rule (Previously 584-017-0440). This rule was repealed and was scheduled to be replaced by the new “standards” rule. Adoption of the new standard has been postponed for further reflection and input from the field.

584-017-0452 — *Objectives for Continuing School Counselor License*: Renumbered and adopted as Temporary rule (previously 584-017-0450). This rule was repealed and was scheduled to be replaced by the new “standards” rule. Adoption of the new standard has been postponed for further reflection and input from the field.

584-080-0002 — *Definitions for Division 80*: New administrative rule contains definitions for Division 80.

584-080-0012 — *Initial Administrator License (IAL)*: New rule replacing 584-080-0011 for Initial Admin License.

584-080-0022 — *Continuing Administrator License (CAL)*: New rule replacing 584-080-0021 for Continuing Administrator License.

584-017-0251 — *Knowledge, Skills & Abilities Required for Initial Administrator License*: Amends the date to July 1, 2007 (changed from January 1, 2007) for existing Initial Administrator Programs to implement the new standards. Applies to all new programs approved by the Commission after January 1, 2005.

584-017-0261 — *Knowledge, Skills & Abilities Required for Continuing Administrator License*: Amends the date to July 1, 2007 (changed from January 1, 2007) for existing Continuing Administrator Programs to implement the new standards. Applies to all new programs approved by the Commission after January 1, 2005.

584-048-0090 — *Renewal of Administrative License — Special Provisions*: Clarifies that recent educational experience is required to renew the Initial Administrator License.

584-080-0001 — *Purpose*: The amended rule is designed to strengthen Oregon educational leadership.

584-080-0031 — *Continuing Superintendent License*: Amends the current language to recognize work above and beyond the Continuing Administrator License.

584-080-0011 — *Initial Administrator License* - REPEAL.

584-080-0021 — *Continuing Administrator License* - REPEAL.

Rules Coordinator: Victoria Chamberlain—(503) 378-6813

584-017-0251
Knowledge, Skills and Abilities Required for Initial Administrator License

(1) Visionary Leadership: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by facilitating the development, articulation, implementation, and stewardship of a school or district vision of learning supported by the school community.

(a) Candidates develop a vision. Candidates:

(A) Develop a vision of learning for a school that promotes the success of all students; and

(B) Base this vision on culturally relevant knowledge and theories, including but not limited to an understanding of learning goals in a democratic and pluralistic society, the diversity of learners and learners’ needs, schools as interactive social and cultural systems, and social and organizational change.

(b) Candidates articulate a vision. Candidates:

(A) Demonstrate the ability to articulate the components of this vision for a school and the leadership processes necessary to implement and support the vision;

(B) Demonstrate the ability to use data-based research strategies and strategic planning processes that focus on student learning to inform the development of a vision, drawing on relevant information sources such as student assessment results, student and family demographic data, and an analysis of community needs; and

(C) Demonstrate the ability to communicate the vision to staff, parents, students, and community members through the use of symbols, ceremonies, stories, and other activities.

(c) Candidates implement a vision. Candidates:

(A) Can formulate the initiatives necessary to motivate staff, students, and families to achieve the school’s vision; and

(B) Develop plans and processes for implementing the vision (e.g., articulating the vision and related goals, encouraging challenging standards, facilitating collegiality and teamwork, structuring significant work, ensuring appropriate use of student assessments, providing autonomy, supporting innovation, delegating responsibility, developing leadership in others, and securing needed resources).

(d) Candidates steward a vision. Candidates:

(A) Demonstrate an understanding of the role effective communication skills play in building a shared commitment to the vision;

(B) Design or adopt a system for using data-based research strategies to regularly monitor, evaluate, and revise the vision; and

(C) Assume stewardship of the vision through various methods.

(e) Candidates promote community involvement in the vision. Candidates:

(A) Demonstrate the ability to involve community members in the, realization of the vision and in related school improvement efforts; and

(B) Acquire and demonstrate the skills needed to communicate effectively with all stakeholders about implementation of the vision.

(2) Instructional Improvement: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by promoting a positive school culture, providing an effective instructional program, applying best practice to student learning, and designing comprehensive professional growth plans for staff.

(a) Candidates promote positive school culture. Candidates:

(A) Assess school culture using multiple methods and implement context-appropriate strategies that capitalize on the diversity (e.g., population, language, disability, gender, race, socio-economic) of the school community to improve school programs and culture.

(b) Candidates provide effective instructional program. Candidates:

(A) Demonstrate the ability to facilitate activities that apply principles of effective instruction to improve instructional practices and curricular materials;

(B) Demonstrate the ability to make recommendations regarding the design, implementation, and evaluation of a curriculum that fully accommodates learners' diverse needs;

(C) Demonstrate the ability to use and promote technology and information systems to enrich curriculum and instruction, to monitor instructional practices and provide staff the assistance needed for improvement;

(D) Demonstrate the ability to use aggregated and disaggregated student achievement data to develop effective instructional programs;

(E) Demonstrate the ability to use individual and group achievement data to develop school improvement plans; and

(F) Are able to use a variety of assessment tools and techniques to improve student achievement.

(c) Candidates apply best practice to student learning. Candidates:

(A) Demonstrate the ability to assist school personnel in understanding and applying best practices for student learning;

(B) Apply human development theory, proven learning and motivational theories, and concern for diversity to the learning process; and

(C) Demonstrate an understanding of how to use appropriate research strategies to promote an environment for improved student achievement.

(d) Candidates design comprehensive professional growth plans. Candidates:

(A) Apply human development theory, proven learning and motivational theories, and concern for diversity to the learning process; and

(B) Demonstrate an understanding of how to use appropriate research strategies to promote an environment for improved student achievement.

(3) Effective Management: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by managing the organization, operations, and resources in a way that promotes a safe, efficient, and effective learning environment.

(a) Candidates manage the organization. Candidates:

(A) Demonstrate the ability to optimize the learning environment for all students by applying appropriate models and principles of organizational development and management, including research and data driven decision- making with attention to indicators of equity, effectiveness, and efficiency;

(B) Develop plans of action for focusing on effective organization and management of fiscal, human and material resources, giving priority to student learning, safety, curriculum, and instruction; and

(C) Have knowledge of licensure rules and apply them properly to assignment of personnel.

(b) Candidates manage operations. Candidates:

(A) Demonstrate the ability to involve staff in conducting operations and setting priorities using appropriate and effective needs assessment, research-based data, and group process skills to build consensus, communicate, and resolve conflicts in order to align resources with the organizational vision; and

(B) Develop communications plans for staff to develop their family and community collaboration skills.

(c) Candidates manage resources. Candidates:

(A) Use problem-solving skills and knowledge of strategic, long-range, and operational planning (including applications of technology) in the effective, legal, and equitable use of fiscal, human, and material resource allocation and alignment that focuses on teaching and learning; and

(B) Creatively seek new resources to facilitate learning.

(4) Inclusive Practice: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by collaborating with families and other community members, responding to diverse community interests and needs, and mobilizing community resources in order to demonstrate and promote ethical standards of democracy, equity, diversity, and excellence, and to promote communication among diverse groups.

(a) Candidates collaborate with families and other community members. Candidates:

(A) Demonstrate an ability to bring together, the resources of family members and the community to positively affect student learning;

(B) Demonstrate an ability to involve all families in the education of their children based on the belief that families have the best interests of their children in mind;

(C) Demonstrate the ability to-use public information and research-based knowledge of issues and trends to collaborate with families and community members;

(D) Apply an understanding of community relations models, marketing strategies and processes, data-based decision- making, and communications theory to create frameworks for school, family, business, community, government, and higher education partnerships;

(E) Develop various methods of outreach aimed at business, religious, political, and service organizations;

(F) Demonstrate the ability to involve families and other stakeholders in school decision-making processes, reflecting an understanding that schools are an integral part of the larger community;

(G) Demonstrate the ability to collaborate with community agencies to integrate health, social, and other services; and

(H) Develop a comprehensive program of community relations and demonstrate the ability to work with the media.

(b) Candidates respond to community interests and needs. Candidates:

(A) Demonstrate active involvement within the community, including interactions with individuals and groups with conflicting perspectives;

(B) Demonstrate the ability to use appropriate assessment strategies and research methods to understand and accommodate diverse school and community conditions and dynamics;

(C) Provide leadership to programs serving students with special and exceptional needs; and

(D) Demonstrate the ability to capitalize on the diversity (cultural, ethnic, racial, economic, and special interest groups) of the school community to improve school programs and meet the diverse needs of all students.

(c) Candidates mobilize community resources. Candidates:

(A) Demonstrate an understanding of and ability to use community resources, including youth services, to support student achievement, solve school problems, and achieve school goals;

(B) Demonstrate how to use school resources and social service agencies to serve the community; and

(C) Demonstrate an understanding of ways to use public resources and funds appropriately and effectively to encourage communities to provide new resources to address emerging student problems.

(5) Ethical Leadership: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by acting with integrity, fairly, and in an ethical manner.

(a) Candidates act with integrity. Candidates:

(A) Demonstrate a respect for the rights of others with regard to confidentiality and dignity and engage in honest interactions promote such respect; and

(B) Demonstrate behaviors that are honest and consistent.

(b) Candidates act fairly. Candidates:

(A) Demonstrate the ability to combine impartiality, sensitivity to student diversity, and ethical considerations in their interactions with others;

(B) Make decisions using an inclusive process; and

(C) Understand and avoid any conflict of interest and avoid the appearance of impropriety.

(c) Candidates act ethically. Candidates:

(A) Make and explain decisions based upon ethical and legal principles; and

(B) Demonstrate respect and diligence regarding the law and compliance with its requirements.

(6) Socio-Political Context: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by understanding, responding to, and influencing the larger political, social, economic, legal, and cultural context.

(a) Candidates understand the larger context. Candidates:

(A) Act as informed consumers of educational theory and concepts appropriate to school context and can demonstrate the ability to apply appropriate research methods to a school context;

(B) Demonstrate the ability to explain how the legal and political systems and institutional framework of schools have shaped a school and community, as well as the opportunities available to children and families in a particular school;

(C) Demonstrate the ability to analyze the complex causes of poverty and other disadvantages and their effects on families, communities, children, and learning;

(D) Demonstrate an understanding of the policies, laws, and regulations enacted by local, state, and federal authorities that affect schools, especially those that might improve educational and social opportunities;

(E) Demonstrate the ability to describe the economic factors shaping a local community and the effects economic factors have on local schools;

(F) Demonstrate the ability to analyze and describe the cultural diversity in a school community;

(G) Can describe community norms and values and how they relate to the role of the school in promoting social justice; and

(H) Demonstrate the ability to explain various theories of change and conflict resolution and the appropriate application of those models to specific communities.

(b) Candidates respond to the larger context. Candidates:

(A) Demonstrate the ability to communicate with members of a school community concerning trends, issues, and potential changes in the environment in which the school operates, including maintenance of an ongoing dialogue with representatives of diverse community groups.

(c) Candidates influence the larger context. Candidates:

(A) Demonstrate the ability to engage students, parents, and other members of the community in advocating for adoption of improved policies and laws;

(B) Apply their understanding of the larger political, social, economic, legal, and cultural context to develop activities and policies that benefit students and their families; and

(C) Advocate for policies, programs and instructional strategies that promote equitable learning opportunities and success for all students, regardless of native language, socioeconomic background, ethnicity, gender, disability, or other individual characteristics.

(7) Practicum Experience: The practicum provides significant opportunities for candidates to synthesize and apply the knowledge and practice and develop the skills identified in Standards 1-6 through substantial, sustained, standards-based work in real settings, planned and guided cooperatively by the institution and school district personnel for graduate credit.

(a) The practicum will be substantial. Candidates:

(A) Demonstrate the ability to accept genuine responsibility for leading, facilitating, and making decisions typical of those made by educational leaders. The experience(s) should provide candidates with substantial responsibilities that increase overtime in amount and complexity and involve direct interaction and involvement with staff, students, parents, and community leaders; and

(B) Each candidate should have a minimum of six months (or equivalent, see note below) of full-time practicum experience.

(b) The practicum will be sustained. Candidates:

(A) Participate in planned practicum activities during the entire course of the program, including an extended period of time near the conclusion of the program to allow for candidate application of knowledge and skills on a full-time basis.

(c) The practicum will be standards-based. Candidates:

(A) Apply skills and knowledge articulated in these standards as well as state and local standards for educational leaders; and

(B) Experiences are designed to accommodate candidates' individual needs.

(d) The practica will be in real settings. Candidates:

(A) Experiences occur in multiple that allow for the demonstration of a wide range of relevant knowledge and skills; and

(B) Experiences include work with appropriate community organizations such as service groups and local businesses.

(e) The practica will be planned and guided cooperatively. Candidates:

(A) Experiences are planned cooperatively by the individual, the site supervisor, and institution personnel to provide inclusion of appropriate opportunities to apply skills, knowledge, and research contained in the standards. These three individuals work together to meet candidate and program needs; and

(B) Mentors are provided training to guide the candidate during the practicum experience.

(f) The practicum will be for credit. Candidates:

(g) Earn graduate credit for their practicum experience.

(8) These rules are effective upon filing and shall apply to all new programs approved by the Commission after January 1, 2005. Existing approved administrator programs must implement these standards by no later than July 1, 2007.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120, 342.147 & 342.165
Hist.: TSPC 1-2005, f. & cert. ef. 1-21-05; TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-017-0261
Knowledge, Skills and Abilities for Continuing Administrator License

(1) Visionary Leadership: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by facilitating the development, articulation, implementation, and stewardship of a school or district vision of learning supported by the school community.

(a) Candidates develop a vision. Candidates:

(A) Develop and demonstrate the skills needed to work with a board of education to facilitate the development of a vision of learning for a school district that promotes the success of all students;

(B) Base development of the vision on relevant knowledge and theories applicable to school-level leaders applied to a school district context;

(C) Use data-based research strategies to create a vision that takes into account the diversity of learners in a district; and

(D) Demonstrate knowledge of ways to use a district's vision to mobilize additional resources to support the vision.

(b) Candidates articulate a vision. Candidates:

(A) Demonstrate the ability to articulate the components of this vision for a district and the leadership processes necessary to implement and support the vision;

(B) Demonstrate the ability to use data-based research strategies and strategic planning processes that focus on student learning to develop a vision, drawing on relevant information sources such as student assessment results, student and family demographic data, and an analysis of community needs; and

(C) Demonstrate the ability to communicate the vision to school boards, staff, parents, students, and. community members through the use of symbols, ceremonies, stories, and other activities

(c) Candidates implement a vision. Candidates:

(A) Demonstrate the ability to plan programs to motivate staff, students, and families to achieve a school district's vision; and

(B) Design research-based processes to effectively implement a district vision throughout an entire school district and community.

(d) Candidates steward a vision. Candidates:

(A) Demonstrate the ability to align and, as necessary, redesign administrative policies and practices required for full implementation of a district vision; and

(B) Understand the theory and research related to organizational and educational leadership and engage in the collection, organization, and analysis of a variety of information, including student performance data, required to assess progress toward a district's vision, mission, and goals.

(e) Candidates promote community involvement in the vision. Candidates:

(A) Demonstrate the ability to bring together and communicate effectively with stakeholders within the district and the larger community concerning implementation and realization of the vision.

(2) Instructional Improvement: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by promoting a positive school culture, providing an effective instructional program, applying best practice to student learning, and designing comprehensive professional growth plans for staff.

(a) Candidates promote positive school culture. Candidates:

(A) Develop a sustained approach to improve and maintain a positive district culture for learning that capitalizes on multiple aspects of diversity to meet the learning needs of all students.

(b) Candidates provide effective instructional program. Candidates:

(A) Demonstrate an understanding of a variety of instructional research methodologies and can analyze the comparable strengths and weaknesses of each method;

(B) Are able to use qualitative and quantitative data, appropriate research methods, technology, and information systems to develop a long-range plan for a district that assesses the district's improvement and accountability systems;

(C) Demonstrate the ability to use and promote technology and information systems to enrich district curriculum and instruction, monitor instructional practices, and provide assistance to administrators who have needs for improvement;

(D) Demonstrate the ability to allocate and justify resources to sustain the instructional program;

(E) Demonstrate the ability to use aggregated and disaggregated student achievement data to develop district instructional programs;

(F) Demonstrate the ability to use individual and group achievement data to develop district improvement plans; and

(G) Are able to use a variety of assessment tools and techniques to improve student achievement for all students.

(c) Candidates apply best practice to student learning. Candidates:

(A) Demonstrate the ability to facilitate and engage in activities that use best practices and sound educational research to improve instructional programs;

(B) Demonstrate an ability to assist school and district personnel in understanding and applying best practices for student learning;

(C) Understand and can apply human development theory, proven learning, and motivational theories, and concern for the diversity to the learning process; and

(D) Understand how to use appropriate research strategies to profile student performance in a district and analyze differences among subgroups.

(d) Candidates design comprehensive professional growth plans. Candidates:

(A) Demonstrate knowledge of adult learning strategies and the ability to apply technology and research to professional development design focusing on authentic problems and tasks, mentoring, coaching, conferencing, and other techniques that promote new knowledge and skills in the workplace;

(B) Demonstrate the ability to use strategies such as observations and collaborative reflection to help form comprehensive professional growth plans with district and school personnel; and

(C) Develop personal professional growth plans that reflect commitment to life-long learning and best practices.

(3) Effective Management: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by managing the organization, operations, and resources in a way that promotes a safe, efficient, and effective learning environment.

(a) Candidates manage the organization. Candidates:

(A) Demonstrate the ability to use research-based knowledge of learning, teaching, student-development, organizational development, and data management to optimize learning for all students;

(B) Demonstrate an ability to manage time effectively and to deploy financial and human resources in -a way that promotes student achievement;

(C) Demonstrate the ability to organize a district based on indicators of equity; effectiveness, and efficiency and can apply legal principles that promote educational equity; and

(D) Demonstrate an understanding of how to apply legal principles to promote educational equity and provide a safe, effective and efficient facility.

(b) Candidates manage operations. Candidates:

(A) Demonstrate the ability to involve stakeholders in aligning resources and priorities to maximize ownership and accountability;

(B) Can use appropriate and effective needs assessment, research-based data, and group process skills to build consensus, communicate, and resolve conflicts in order to align resources with the district version;

(C) Develop staff communication plans for integrating district's schools and divisions; and

(D) Develop a plan to promote and support community collaboration among district personnel.

(c) Candidates manage resources. Candidates:

(A) Use problem-solving skills and knowledge of strategic, long-range, and operational planning (including applications of technology) in the effective, legal, and equitable use of fiscal, human, and material resource allocation that focuses on teaching and learning;

(B) Creatively seek new resources to facilitate learning;

(C) Apply an understanding of school district finance structures and models to ensure that adequate financial resources are allocated equitably for the district;

(D) Apply and assess current technologies for management, business procedures, and scheduling; and

(E) Apply licensure rules to ensure qualified staff are placed in all positions throughout the district.

(4) Inclusive Practice: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by collaborating with families and other community members, responding to diverse community interests and needs, and mobilizing community resources in order to demonstrate and promote ethical standards of democracy, equity, diversity, and excellence, and to promote communication among diverse groups.

(a) Candidates collaborate with families and other community members. Candidates:

(A) Demonstrate the ability to facilitate the planning and implementation of programs and services that bring together the resources of families and the community to positively affect student learning;

(B) Demonstrate an ability to use public information and research-based knowledge of issues and trends to collaborate with community members and community organizations to have a positive affect on student learning;

(C) Apply an understanding of community relations models, marketing strategies and processes, data driven decision-making, and communication theory to craft frameworks for school, business, community, government, and higher education partnerships;

(D) Demonstrate an ability to develop and implement a plan for nurturing relationships with community leaders and reaching out to different business, religious, political, and service organizations to strengthen programs and support district goals;

(E) Demonstrate an ability to involve community members, groups, and other stakeholders in district decision-making, reflecting an understanding of strategies to capitalize on the, district's integral role in the larger community;

(F) Demonstrate the ability to collaborate with community agencies to integrate health, social, and other services in the schools to address student and family conditions that affect learning;

(G) Demonstrate the ability to conduct community relations that reflects knowledge of effective media relations and that models effective media relations practices; and

(H) Develop and implement strategies that support the involvement of families in the education of their children that reinforces for district staff a belief that families have the best interests of their children in mind.

(b) Candidates respond to community interests and needs. Candidates:

(A) Facilitate and engage in activities that reflect an ability to inform district decision-making by collecting and organizing formal and informal information from multiple stakeholders;

(B) Demonstrate the ability to promote maximum involvement with, and visibility within the community;

(C) Demonstrate the ability to interact effectively with individuals and groups that reflect conflicting perspectives;

(D) Demonstrate the ability to effectively and appropriately assess, research, and Ian for diverse district and community conditions and dynamics and capitalize on the diversity of the community to improve district performance and student achievement; and

(E) Demonstrate the ability to advocate for students with special and exceptional needs.

(c) Candidates mobilize community resources. Candidates:

(A) Demonstrate an understanding of and ability to use community resources, including youth services that enhance student achievement, to solve district problems and accomplish district goals;

(B) Demonstrate how to use district resources to the community to solve issues of joint concern; and

(C) Demonstrate an understanding of ways to use public resources and funds appropriately and effectively to encourage communities to provide new resources to address emerging student problems.

(5) Ethical Leadership: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by acting with integrity, fairly, and in an ethical manner.

(a) Candidates act with integrity. Candidates:

(A) Demonstrate a respect for the rights of others with regard to confidentiality and dignity and engage in honest interactions promote such respect; and

(B) Demonstrate behaviors that are honest and consistent.

(b) Candidates act fairly. Candidates:

(A) Demonstrate the ability to combine impartiality, sensitivity to student diversity, and ethical considerations in their interactions with others;

(B) Make decisions using an inclusive process; and

(C) Understand and avoid any conflict of interest and avoid the appearance of impropriety.

(c) Candidates act ethically. Candidates:

(A) Make and explain decisions based upon ethical and legal principles; and

(B) Demonstrate respect and diligence regarding the law and compliance with its requirements.

(6) Socio-Political Context: Candidates who complete the program are educational leaders who have the knowledge, ability, and cultural competence to improve learning and achievement to ensure success of all students by understanding, responding to, and influencing the larger political, social, economic, legal, and cultural context.

(a) Candidates understand the larger context. Candidates:

(A) Demonstrate the ability to use appropriate research methods, theories, and concepts to improve district operations;

(B) Demonstrate an understanding of the complex causes of poverty and other disadvantages and their effects on families, communities, children, and learning;

(C) Demonstrate an understanding of the policies, laws, and regulations enacted by local, state, and federal authorities affecting a specific district;

(D) Can explain the system for financing public schools and its effects on the equitable distribution of educational opportunities within a district;

(E) Demonstrate the ability to work with political leaders at the local, state, and national level;

(F) Can apply an understanding of how specific laws at the local, state, and federal level affect school districts and residents; and

(G) Espouse positions in response to proposed policy changes that would benefit or harm districts and explain how proposed policies and laws might improve educational and social opportunities for specific communities.

(b) Candidates respond to the larger context. Candidates:

(A) Demonstrate the ability to engage students, parents, members of the school board, and other community members in advocating for adoption of improved policies and laws;

(B) Apply their understanding of the larger political, social, economic, legal, and cultural context to develop activities and policies that benefit their district and its students; and

(C) Demonstrate the ability to communicate regularly with all segments of the district community concerning trends, issues, and policies affecting the district.

(c) Candidates influence the larger context. Candidates:

(A) Demonstrate an understanding of how to develop lines of communication with local, state, and federal authorities and actively advocate for improved policies, laws, and regulations, affecting a specific district, both directly and through organizations representing schools, educators, or others with similar interests; and

(B) Demonstrate the ability to advocate for policies, programs and instructional strategies that promote equitable learning opportunities and success for all students, regardless of native language, socioeconomic background, ethnicity, gender, disability, or other individual characteristics.

(7) Practicum Experience: The practicum provides significant opportunities for candidates to synthesize and apply the knowledge and practice and develop the skills identified in Standards 1-6 through substantial, sustained, standards-based work in real settings, planned and guided cooperatively by the institution and school district personnel for graduate credit.

(a) The practicum will be substantial. Candidates:

(A) Demonstrate the ability to accept genuine responsibility for leading, facilitating, and making decisions typical of those made by educational leaders. The experience(s) should provide practicum students with substantial responsibilities that increase overtime in amount and complexity and involve direct interaction and involvement with staff, students, parents, and community leaders; and

(B) Each candidate should have a minimum of six (6) months (or equivalent, see note below) of full-time practicum experience.

(b) The practicum will be sustained. Candidates:

(A) Participate in planned practicum activities during the entire course of the program, including an extended period of time near the conclusion of the program to allow for candidate application of knowledge and skills on a full-time basis.

(c) The practicum will be standards-based. Candidates:

(A) Apply skills and knowledge articulated in these standards as well as state and local standards for educational leaders; and

(B) Experiences are designed to accommodate candidates' individual needs.

(d) The practica will be in real settings. Candidates:

(A) Experiences occur in multiple district settings that allow for the demonstration of a wide range of relevant knowledge and skills; and

(B) Experiences include work with appropriate community organizations, parent groups and school boards.

(e) The practica will be planned and guided cooperatively. Candidates:

(A) Experiences are planned cooperatively by the individual, the site supervisor, and institution personnel to provide inclusion of appropriate opportunities to apply skills, knowledge, and research contained in the standards. These three individuals work together to meet candidate and program needs; and

(B) Mentors are provided training to guide the candidate during the practicum experience.

(f) The practicum will be for credit. Candidates.

(g) Earn graduate credit for their practicum experience.

(8) These rules are effective upon filing and shall apply to all new programs approved by the Commission after January 1, 2005. Existing approved administrator programs must implement these standards by no later than July 1, 2007.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120, 342.147 & 342.165
Hist.: TSPC 1-2005, f. & cert. ef. 1-21-05; TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-017-0442
Objectives for Initial School Counselor License

The unit ensures that a candidate for Initial School Counselor License possess the knowledge, skills, and competencies required for a school counselor.

(1) Candidates develop and implement plans which promote social and emotional development.

(2) Candidates establish programs appropriate for group, individual, and family counseling.

(3) Candidates demonstrate interpersonal skills, working with others and communicating with community members.

(4) Candidates practice and promote group process, crisis resolution, anger management and violence prevention.

(5) Candidates demonstrate ethical standards and knowledge of legal frameworks unique to counseling.

(6) Candidates collaborate with social service agencies providing services to students and families.

(7) Candidates support school to work transition and career planning.

(8) Candidates assist with curriculum coordination as it relates to guidance activities.

(9) Candidates understand student assessment as it relates to academic, career counseling and personal/social development.

(10) Candidates assist with goal setting, learning skills and the development of self-directed learners.

(11) Candidates support and develop plans which respect difference and promote communication among diverse groups.

(12) Candidates collaborate with school staff, families, and community members to meet individual student needs.

(13) Candidates assist staff to understand the needs of all students.

(14) Candidates demonstrate effective counseling techniques for individuals and small groups.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120, 342.147 & 342.165
Hist.: TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-017-0452
Objectives for Continuing School Counselor License

The unit provides an approved program through which candidates document the advanced competencies required for a Continuing School Counselor License.

(1) The candidate is able to document an understanding of and ability to apply emerging research on counseling, learning, and school improvement to increase comprehensive counseling program effectiveness.

(2) The candidate is able to implement research-based educational practices that ensure student achievement and are sensitive to individual differences, diverse cultures, and ethnic backgrounds.

(3) The candidate is able to collaborate with colleagues, staff, parents, and the public to enhance the student's performance.

(4) The candidate is able to demonstrate effective leadership in communication with diverse and special interest organizations.

(5) The candidate is able to demonstrate an advanced understanding of laws applicable to counselors.

(6) The candidate completes an additional four hundred (400) clock hours of supervised practicum in a public school.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120, 342.147 & 342.165
Hist.: TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-048-0090
Renewal of Administrative License — Special Provisions

(1) An applicant may submit verification of twelve (12) months service in the Armed Forces, Peace Corps, or VISTA during the validity of the Basic, Initial, Standard, or Continuing Administrative License. An applicant who qualifies under this section is permitted one (1) additional renewal of the Basic or Initial Administrative License before having to qualify for the Standard or Continuing Administrative License or is permitted one (1) renewal of the Standard or Continuing Administrative License on the basis of this experience.

(2) An applicant who meets all requirements for the Standard Administrative License except the requirement of three (3) years of experience in Oregon schools will be granted a fourth Basic Administrative License without further preparation. Thereafter, if the experience requirement has not been met, the applicant may renew the Basic Administrative License upon verification of either one (1) year of full-time successful administrative experience or completion of nine (9) quarter hours of additional preparation germane to the license and endorsement from an approved institution during the life of the current Basic Administrative License. A combination of such experience and credit may be submitted in

satisfaction of this requirement in which one (1) quarter hour of preparation equals twenty (20) days of successful experience.

(3) An applicant who meets all requirements for the Continuing Administrator License except administrative experience in Oregon schools and documentation of the advanced competencies for the Continuing Administrator License may renew the Initial Administrator License contingent upon recent educational experience. However, the applicant must acquire the Continuing Administrator License within three (3) years after accepting a contracted position of half time or more in an Oregon school.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.200 & 342.400
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 6-1984, f. 12-27-84, ef. 1-15-85; TS 1-1988, f. 1-14-88, ef. 1-15-88; TS 6-1989, f. & cert. ef. 10-6-89; TS 1-1992, f. & cert. ef. 1-15-92; TSPC 5-2001, f. & cert. ef. 12-13-01; TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-080-0001
Purpose

(1) These rules establish an administrator licensure program that is designed to strengthen Oregon educational leadership. Specifically, Oregon licensed administrators will be instructional leaders with the knowledge, skills and abilities to close the achievement gap, implement visionary literacy programs and demonstrate exemplary instructional leadership. Oregon administrators will be leaders in demonstrating culturally competent strategies to ensure an equitable education for every Oregon student. Oregon-approved programs and licensure have the following characteristics:

(2) The administrator licensure standards are designed to recognize the developmental levels of students;

(3) The Initial Administrator License requires at least three (3) years of properly assigned licensed experience in public schools, regionally accredited private schools, registered private schools or other federal or state-regulated schools. Additionally, programs for the Initial Administrator License will emphasize a school-level context.

(4) The Continuing Administrator License requires demonstrated competency in a broad spectrum of Oregon-specific administrator skills and experience at both the building and district levels. Additionally, programs for the Continuing Administrator License will emphasize a district level context.

(5) Continuing professional development is integral to continuous administrator licensure.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 143, 342.153, 342.165 & 342.223 - 232
Hist.: TSPC 2-1998, f. 2-4-98, cert. ef. 1-15-99; TSPC 4-1999, f. & cert. ef. 8-2-99; TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-080-0002
Definitions for Division 080

(1) "Application:" A request for an Oregon license authorizing service in public schools or a request for reinstatement or renewal of such license. As used in these rules, "application" includes the Application Form, C-1, the fee, and all supporting documents necessary for the evaluation for the license. A copy of the C-1 can be found on TSPC's Web page at: www.tspc.state.or.us.

(2) "Appropriately Assigned:" Assignments for administrator, teacher, supervisor, school counselor, school psychologist, or school nurse duties for which the person involved holds the proper license, endorsements and authorizations. See OAR 584-080-0081.

(3) "Approved Institution:" A U.S. regionally accredited institution of higher education approved to prepare licensed personnel by a U.S. governmental jurisdiction in which the institution is located. See definition of "Regional Accrediting Associations" at OAR 584-005-0005(99).

(4) "Approved Programs:" An Oregon program of educator preparation leading to licensure approved by TSPC and offered by a regionally accredited Oregon institution. As it applies to out-of-state programs, a program approved by the licensure body of any U.S. governmental jurisdiction authorized to approve educator preparation programs.

(5) "Completion of Approved Program:" The applicant has met the institution's academic requirements and any additional state or federal requirements and has obtained the institution's recommendation for licensure.

(6) "Out of State Licenses or Certificates:" A license or certificate valid for full-time employment which is at least equivalent to the Oregon license being requested and is issued by one of the United States, a U.S. jurisdiction (American Samoa, Commonwealth of Northern Marianas, District of Columbia, Guam, Puerto Rico, and Virgin Islands), or the U.S. Department of Defense.

(7) "Personal Qualifications:" Personal qualifications for licensure including attainment of at least eighteen (18) years of age and possessing good moral character and mental and physical health necessary for employment as an educator.

(8) "Regional Accrediting Associations:" Colleges and universities approved for teacher education must be accredited by the appropriate regional association at the time the degree or program is completed. The regional associations are: New England Association of Schools and Colleges, Commission on Institutions of Higher Education; North Central Association of Colleges and Schools, The Higher Learning Commission; Northwest Commission on Colleges and Universities; Middle States Association of Colleges and Schools, Commission on Higher Education; Southern Association of Colleges and Schools, Commission on Colleges; or Western Association of Schools and Colleges, Accrediting Commission for Senior Colleges and Universities.

(9) "Renewal:" Extension of validity of a current license. An application for renewal must be submitted prior to the expiration date stated on the license. See OAR 584 div 48.

(10) "Teacher:" Includes all licensed employees in the public schools or employed by an education service district who have direct responsibility for instruction, coordination of educational programs or supervision or evaluation of teachers and who are compensated for their services from public funds. "Teacher" does not include a school nurse as defined in ORS 342.455.

(11) "Year of Experience:" A period of at least eight (8) consecutive months of full-time work or two (2) consecutive years of one-half time or more while holding a license valid for the assignment.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 143, 342.153, 342.165 & 342.223 - 232
Hist.: TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-080-0011
Initial Administrator License

Upon filing a correct and complete application in form and manner prescribed by the commission, a qualified applicant shall be granted an Initial Administrator License. This license is issued for three years plus time to the applicant's next birth date and for an applicant who is not a superintendent is renewable once under conditions specified below. It is valid for school administration at all age or grade levels in any position and for substitute teaching at any level in any specialty.

(1) To be eligible for an Initial Administrator License, an applicant must satisfy all of the following general preparation requirements:

(a) Three academic years of experience as a full-time licensed educator, on any license appropriate for the assignment, in a public school or regionally accredited private school in any state or other U.S. jurisdiction or in one or more of the following schools in Oregon: an education service district school, a state-operated or state-supported school, a federal school, a private elementary or secondary school registered by the state Department of Education, or a private proprietary career school licensed by the superintendent of public instruction.

(b) 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 degree approved by the commission, together with an equally accredited bachelor's degree.

(c) Completion in Oregon or another U.S. jurisdiction, as part of the master's degree or separately, of an initial graduate program in school administration at an institution approved for administrator education by the commission.

(d) Completion of practica approved by the commission in school administration for early childhood or elementary students, and for middle level or high school students, as part of the initial graduate program or separately.

(e) A passing score as currently specified by the commission on a test of professional knowledge for school administrators, or five years of experience on a license valid for the assignment administering full time in a public school or regionally accredited private school in a U.S. jurisdiction before holding any Oregon license.

(f) A passing score as currently specified by the commission on a test of basic verbal and computational skills, unless the applicant held an Oregon educator license before 1985 or has a regionally accredited doctor's degree.

(g) 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.

(h) A passing score on tests of knowledge of Oregon school law and finance at the conclusion of or in lieu of a course or courses approved by the commission, unless the applicant completed the initial school administration program in Oregon.

(2) To be eligible for an Initial Administrator License, an applicant must satisfy a recent experience requirement in one of the following ways during the three-year period immediately preceding application:

(a) Completion of an approved administrator 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 administrator licensure, from a regionally accredited college or university.

(3) To be eligible for an Initial Administrator License, an applicant must furnish fingerprints in the manner prescribed by the commission.

(4) For an administrator who is not a superintendent, the Initial Administrator License can be renewed once for three years upon completion of recent educational experience verified by either:

(a) Completion of one academic year of educational work in any capacity at full time or two consecutive years at half-time, or 180 days of substitution in administration or teaching, in one or more of the following organizations: a public school or a regionally accredited private school in any U.S. governmental jurisdiction, a state or federal school in Oregon, an Oregon private elementary or secondary school registered by the state Department of Education, an Oregon private proprietary career school licensed by the superintendent of public instruction, a degree-granting college or university in Oregon, a special state-supported school in Oregon, the state Department of Education itself, the Teacher Standards and Practices Commission, the Department of Human Resources, a juvenile court school in Oregon, an Oregon education service district, or a school operated by the U.S. Department of Defense; or

(b) Completion of 6 semester hours or 9 quarter hours of preparation completed in an approved institution during the life of the current administrator license.

(5) A superintendent cannot renew the Initial Administrator License but instead upon its expiration must qualify for a Continuing Administrator License.

NOTE: See OAR 584-048-0090 for Special Provisions for renewing an Initial Administrator 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 5-2001, f. & cert. ef. 12-13-01; Suspended by TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-080-0012
Initial Administrator License (IAL)

(1) Upon filing a correct and complete application in form and manner prescribed by the commission, a qualified applicant shall be granted an Initial Administrator License.

(2) The Initial Administrator License is valid for three (3) years and may be renewed under the conditions set forth in subsections below.

(3) The Initial Administrator License is valid for school administration at all age or grade levels in any administrative position. This license is also valid for substitute teaching at any level in any specialty. (See, OAR 584-060-0181 for explanation of Substitute Teaching.)

(4) To be eligible for an Initial Administrator License, an applicant must satisfy all of the following provisions within this subsection. The applicant must:

(a) Educator Fitness: Possess the personal qualifications for licensure including attainment of at least eighteen (18) years of age and possessing good moral character and mental and physical health necessary for employment as an educator;

(b) Licensed Experience: Have three (3) academic years of experience as a full-time licensed educator on any license appropriate for the assignment in:

(A) A public school or regionally accredited private school in any state or other U.S. jurisdiction; or

(B) In one or more of the following schools in Oregon:

(i) An education service district school;

(ii) A state-operated or state-supported school;

(iii) A federal school;

(iv) A private elementary or secondary school registered by the state Department of Education; or

(v) A private proprietary career school licensed by the superintendent of public instruction.

(c) Master's Degree: Hold 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 degree approved by the commission, together with an equally accredited bachelor's degree;

(d) Approved Administrator Program: Complete, as part of the master's degree or separately, an initial graduate program in school administration at an institution approved for administrator education;

(A) A candidate for initial licensure who has completed an administrator preparation program outside the state of Oregon must:

(i) Have completed at least eighteen (18) semester hours or twenty-seven (27) quarter hours of graduate credit in school administration or educational leadership; and

(ii) Receive a passing score on tests of knowledge of Oregon school law and finance at the conclusion of or in lieu of a course or courses approved by the commission.

(e) Civil Rights: 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. If the applicant is making first application for the Initial Administrator License from out-of-state, an applicant may submit an affidavit for the first Oregon license assuring that the applicant has read Discrimination and the Oregon Educator and has completed the self-study questions. An emergency license will be issued for 90 days during which time the applicant must complete the civil rights requirement.

(f) Fingerprints: Furnish fingerprints in the manner prescribed by the commission. (See OAR 584-036-0062 for Criminal Records Check Requirement.)

(g) First Aid Card: Hold a valid first aid card. An emergency license will be issued to the educator for up to ninety (90) days until the applicant has demonstrated possession of a valid first aid card; and

(h) Recency: Satisfy a recent experience requirement in one of the following ways during the three-year period immediately preceding application:

(A) Completion of an approved administrator 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 (1) academic year as a full-time licensed educator or two (2) 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 six (6) semester hours or nine (9) quarter hours of academic credit, germane to administrator licensure, from a regionally accredited college or university.

(5) Renewal: The Initial Administrator License may be renewed up to two times if the applicant makes progress toward completion of the Continuing Administrator License by completing at least six (6) semester hours or nine (9) quarter hours of academic credit in an approved Continuing Administrator License Program upon each renewal. A transcript of the completed coursework is required for renewal. (See OAR 584-048-0090 for additional "Special Provisions" which may apply to renewing an Initial Administrator License).

(6) Reinstatement for Administrator Experience: An applicant may reinstate an expired Initial Administrator License for one three-year period for the purposes of completing the administrative experience requirements for the Continuing Administrator License under the following conditions:

(a) The applicant has completed all requirements for the CAL except for the administrative experience required;

(b) The application includes a request from a district for reinstatement; and

(c) The applicant demonstrates educational recency within the three (3) years prior to the application for reinstatement of the license.

(7) Incomplete CAL Programs: Initial Administrator License holders who are unable to complete the academic requirements for the Continuing Administrator License within nine (9) years after the Initial Administrator License was first granted may only take an administrator position upon joint application with an employing district requesting a Restricted Transitional Administrator License.

(8) Licenses issued prior to October 13, 2003: All Initial Administrator Licenses for positions other than a Superintendent issued after January 1, 1999 and prior to and including October 13, 2003 have ten (10) years to complete the requirements of the Continuing Administrator License. Initial Administrator Licenses issued after October 13, 2003, with the exception of Superintendents subject to subsection (9) below, have nine (9) years, or two (2) renewal cycles to complete the requirements of the Continuing Administrator License.

(9) Superintendency on the Initial Administrative License: The Continuing Administrator Licensure program must be completed within the three (3) years following the next renewal of the Initial Administrator License if the holder of an Initial Administrator License takes a position as a Superintendent at any time within the life of the Initial Administrator License.

Stat. Auth.: ORS 342

Stats. Implemented: ORS 342.120 - 143, 342.153, 342.165 & 342.223 - 232

Hist.: TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-080-0021
Continuing Administrator License

Upon filing a correct and complete application in form and manner prescribed by the commission, a qualified applicant shall be granted a Continuing Administrator License. This license is issued for five years and for an applicant who is not a superintendent or superintendent-principal is renewable repeatedly under conditions specified below. It is valid for school administration at all age or grade levels in any position and for substitute teaching at any level in any specialty.

(1) To be eligible for a Continuing Administrator License, an applicant must have completed, beyond both the master's degree and the integrated or separate initial graduate program in school administration, an advanced program in administrative competencies consisting of at least 18 semester hours or 27 quarter hours of graduate credit or the equivalent. If credit is not awarded directly by an institutional program for continuing licensure approved by the commission, all advanced administrator competencies must be validated through assessment by such a program. Exceptionally, the applicant may qualify for waiver of the advanced institutional program or the assessment of advanced competencies by having a regionally accredited doctor's degree in school administration.

(2) To be eligible for a Continuing Administrator License, an applicant must have three years of successful experience on transitional or initial licenses administering at least half time in one or more of the following schools in Oregon: a public elementary or secondary school, an education service district school, a state-operated or state-supported school, a federal school, a private elementary or secondary school accredited by the Northwest Association of Schools and Colleges, a private elementary or secondary school registered by the state Department of Education, or a private proprietary career school licensed by the superintendent of public instruction.

(3) Unless issued to a superintendent or superintendent-principal, the Continuing Administrator License can always be renewed for five years whenever two requirements have been met during the preceding five-year period:

(a) Completion of one academic year as a full-time licensed educator or two consecutive years as a half-time licensed educator or 180 days of substitution in administration or teaching, on any license appropriate for the assignment, in one or more of the following schools in Oregon: a public elementary or secondary school, an education service district school, a state-operated or state-supported school, a federal school, a private elementary or secondary school accredited by the Northwest Association of Schools and Colleges, a private elementary or secondary school registered by the state Department of Education, or a private proprietary career school licensed by the superintendent of public instruction.

(b) Establishment, maintenance, and reporting of a continuing professional development plan in accordance with OAR 584-090.

(4) Whether a superintendent or superintendent-principal can renew the Continuing Administrator License depends on the timing of application. When issued originally or on renewal to a superintendent, the Continuing Administrator License is valid until five years have elapsed since the superintendency was first held on either initial or continuing license, and it cannot be renewed thereafter. When issued originally or on renewal to a superintendent-principal, the Continuing Administrator License is valid until nine years have elapsed since the superintendency was first held on either initial or continuing license, and it cannot be renewed thereafter. At the point of expiration in either case, the applicant must qualify for a Continuing Superintendent 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 4-2001, f. & cert. ef. 9-21-01; Suspended by TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-080-0022
Continuing Administrator License (CAL)

(1) Upon filing a correct and complete application in form and manner prescribed by the commission, a qualified applicant shall be granted a Continuing Administrator License.

(2) The Continuing Administrator License is issued for five years and is renewable repeatedly under conditions specified below.

(3) The Continuing Administrator License is valid for school administration at all age or grade levels in any position and for substitute teaching at any level in any specialty.

(4) To be eligible for a Continuing Administrator License, an applicant must satisfy all of the following provisions within this subsection. The applicant must:

(a) Educator Fitness: Possess the personal qualifications for licensure including attainment of at least eighteen (18) years of age and possessing good moral character and mental and physical health necessary for employment as an educator;

(b) Master's Degree: Hold a master's degree or higher;

(c) Program of Advanced Competency: Complete beyond both the master's degree and beyond the initial graduate program in school administration, an advanced program in administrative competencies consisting of at least 18 semester hours or 27 quarter hours of graduate credit or the equivalent.

(A) Advanced Program Waiver: Exceptionally, the applicant may qualify for waiver of the advanced institutional program or the assessment of advanced competencies by having a regionally accredited doctor's degree in school administration or educational leadership;

(B) Out-of-State Advanced Program:

(i) If the eighteen (18) semester hours or twenty-seven (27) quarter hours beyond the master's degree, required in subsection (c) above, was completed out-of-state, no additional validation will be required so long as the applicant also has five (5) years of administrative experience on any unrestricted out-of-state administrator license.

(ii) The out-of-state experience may be cumulative and need not be continuous in one state.

(iii) If the applicant does not have five (5) years of administrative experience, the advanced program will be evaluated by the Commission to determine equivalency. The evaluation will be based upon an established rubric representing the equivalent programs offered by Oregon approved administrator preparation programs.

(iv) After TSPC evaluation, additional coursework may be required to acquire the Continuing Administrator License.

(d) First Aid Card: Hold a valid first aid card. An emergency license will be issued to the educator for up to ninety (90) days until the applicant has demonstrated possession of a valid first aid card; and

(e) Fingerprints: Furnish fingerprints in the manner prescribed by the commission; and (See OAR 584-036-0062 for Criminal Records Check Requirement.)

(f) Civil Rights: 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. If the applicant is making their first application for the Initial Administrator License from out-of-state, an applicant may submit an affidavit for the first Oregon license assuring that the applicant has read Discrimination and the Oregon Educator and has completed the self-study questions. An emergency license will be issued for 90 days during which time the applicant must complete the civil rights requirement;

(g) Professional Knowledge Test: A passing score on a test of professional administrator knowledge or completion of alternative assessment pursuant to OAR 584-052-0030 et seq. approved by the Commission.

(h) Experience on an Administrative License: Have three (3) years of one-half time or more experience on any administrator license appropriate for the assignment in a public or accredited private school setting.

(5) The Continuing Administrator License may be renewed for five (5) years upon completion of experience and professional development under the following circumstances:

(a) Completion of licensed education experience during the life of the license under any of the following conditions:

(A) One (1) academic year as a full-time licensed educator on any valid Oregon license appropriate for the assignment;

(B) Two (2) consecutive years as a half-time licensed educator; or

(C) One hundred eighty (180) days of substitution in administration or teaching, on any license appropriate for the assignment, in any K-12 public or private school or district registered or licensed by the Oregon Department of Education; and

(b) Completion of continuing professional development requirements in accordance with OAR 584-090-0001 et seq.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 143, 342.153, 342.165 & 342.223 - 232
Hist.: TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

584-080-0031
Continuing Superintendent License

(1) Upon filing a correct and complete application in form and manner prescribed by the commission, a qualified applicant shall be granted a Continuing Superintendent License.

(2) The Continuing Superintendent License is issued for five (5) years and is renewable repeatedly under conditions specified below.

(3) The Continuing Superintendent License is voluntary and is valid for school administration at all age or grade levels in any position and for substitute teaching at any level in any specialty. [See OAR 584-060-0181 for explanation of Substitute Teaching.]

(4) To be eligible for Continuing Superintendent License, an applicant must have:

(a) Completed, beyond the advanced administrator program specified in OAR 584-080-0022 an advanced education leadership or school administration program consisting of at least twelve (12) semester hours or eight-

een (18) quarter hours of graduate credit or the equivalent; or in the alternative, hold a regionally accredited doctor's degree in school administration or educational leadership.

(A) Completion of the advanced program must be verified by the institution offering the program or through official transcripts.

(B) Doctorates in programs other than school administration or educational leadership do not qualify for this license.

(b) Three (3) years of half (.5) time or more experience on a transitional, initial, continuing, or out-of-state administrative license valid for the assignment functioning as a superintendent in a public school district, education service district, or regionally accredited private school system.

(5) The Continuing Superintendent License may be renewed for five years upon completion of experience and professional development under the following circumstances:

(a) Completion of licensed education experience during the life of the license under any of the following conditions:

(A) One academic year as a full-time licensed educator on any valid Oregon license appropriate for the assignment;

(B) Two consecutive years as a half-time licensed educator; or

(C) One hundred eighty (180) days of substitution in administration or teaching, on any license appropriate for the assignment, in any K-12 public or private school or district registered or licensed by the Oregon Department of Education; and

(b) Completion of continuing professional development requirements in accordance with OAR 584-090-0001 et seq.

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 4-2001, f. & cert. ef. 9-21-01; TSPC 10-2006(Temp), f. 6-15-06, cert. ef. 7-1-06 thru 12-27-06

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137-047-0270	1-1-06	Amend	2-1-06
137-047-0275	1-1-06	Amend	2-1-06
137-047-0280	1-1-06	Amend	2-1-06
137-047-0285	1-1-06	Amend	2-1-06
137-047-0300	1-1-06	Amend	2-1-06
137-047-0330	1-1-06	Amend	2-1-06
137-047-0400	1-1-06	Amend	2-1-06
137-047-0410	1-1-06	Amend	2-1-06
137-047-0700	1-1-06	Amend	2-1-06
137-047-0730	1-1-06	Amend	2-1-06
137-047-0740	1-1-06	Amend	2-1-06
137-047-0745	1-1-06	Amend	2-1-06
137-047-0800	1-1-06	Amend	2-1-06
137-047-0810	1-1-06	Adopt	2-1-06
137-048-0100	1-1-06	Amend	2-1-06
137-048-0110	1-1-06	Amend	2-1-06
137-048-0120	1-1-06	Amend	2-1-06
137-048-0130	1-1-06	Amend	2-1-06
137-048-0200	1-1-06	Amend	2-1-06
137-048-0210	1-1-06	Amend	2-1-06
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137-048-0260	1-1-06	Amend	2-1-06
137-048-0300	1-1-06	Amend	2-1-06
137-048-0310	1-1-06	Amend	2-1-06
137-048-0320	1-1-06	Amend	2-1-06
137-049-0100	1-1-06	Amend	2-1-06
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137-049-0160	1-1-06	Amend	2-1-06
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137-049-0220	1-1-06	Amend	2-1-06
137-049-0260	1-1-06	Amend	2-1-06
137-049-0280	1-1-06	Amend	2-1-06
137-049-0290	1-1-06	Amend	2-1-06
137-049-0300	1-1-06	Amend	2-1-06
137-049-0310	1-1-06	Amend	2-1-06
137-049-0320	1-1-06	Amend	2-1-06
137-049-0330	1-1-06	Amend	2-1-06
137-049-0360	1-1-06	Amend	2-1-06
137-049-0370	1-1-06	Amend	2-1-06
137-049-0380	1-1-06	Amend	2-1-06
137-049-0390	1-1-06	Amend	2-1-06
137-049-0395	1-1-06	Adopt	2-1-06
137-049-0400	1-1-06	Amend	2-1-06
137-049-0420	1-1-06	Amend	2-1-06
137-049-0430	1-1-06	Amend	2-1-06
137-049-0440	1-1-06	Amend	2-1-06
137-049-0450	1-1-06	Amend	2-1-06
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137-049-0620	1-1-06	Amend	2-1-06
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137-049-0645	1-1-06	Adopt	2-1-06
137-049-0650	1-1-06	Amend	2-1-06
137-049-0660	1-1-06	Amend	2-1-06
137-049-0670	1-1-06	Amend	2-1-06
137-049-0680	1-1-06	Amend	2-1-06
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137-055-2045	1-3-06	Adopt	2-1-06
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137-055-2140	1-3-06	Amend	2-1-06
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137-055-3020	1-3-06	Amend(T)	2-1-06
137-055-3060	1-3-06	Amend(T)	2-1-06
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137-055-3220	1-3-06	Amend	2-1-06
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137-055-3240(T)	1-3-06	Repeal	2-1-06
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137-055-3400	1-3-06	Amend	2-1-06
137-055-3420	1-3-06	Amend	2-1-06
137-055-3420(T)	1-3-06	Repeal	2-1-06
137-055-3430	1-3-06	Amend	2-1-06
137-055-3430(T)	1-3-06	Repeal	2-1-06
137-055-3440	1-3-06	Amend	2-1-06
137-055-3440(T)	1-3-06	Repeal	2-1-06
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137-055-3500(T)	1-3-06	Repeal	2-1-06
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137-055-3660	1-3-06	Amend	2-1-06
137-055-4060	1-3-06	Amend	2-1-06
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137-055-4160	1-3-06	Amend	2-1-06
137-055-4300	1-3-06	Amend	2-1-06
137-055-4320	1-3-06	Amend	2-1-06
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137-055-4560	1-3-06	Amend	2-1-06
137-055-5020	1-3-06	Amend	2-1-06
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137-055-5110	1-3-06	Amend	2-1-06
137-055-5110(T)	1-3-06	Repeal	2-1-06
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137-055-5120(T)	1-3-06	Repeal	2-1-06
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137-055-5240(T)	1-3-06	Repeal	2-1-06
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137-055-5510(T)	1-3-06	Repeal	2-1-06
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137-055-5520(T)	1-3-06	Repeal	2-1-06
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166-400-0015	4-17-06	Am. & Ren.	6-1-06
166-400-0020	4-17-06	Am. & Ren.	6-1-06
166-400-0025	4-17-06	Am. & Ren.	6-1-06
166-400-0030	4-17-06	Am. & Ren.	6-1-06
166-400-0035	4-17-06	Am. & Ren.	6-1-06
166-400-0040	4-17-06	Am. & Ren.	6-1-06
166-400-0045	4-17-06	Am. & Ren.	6-1-06
166-400-0050	4-17-06	Am. & Ren.	6-1-06
166-400-0055	4-17-06	Am. & Ren.	6-1-06
166-400-0060	4-17-06	Am. & Ren.	6-1-06
166-400-0065	4-17-06	Am. & Ren.	6-1-06
170-030-0055	12-15-05	Adopt	1-1-06
170-060-1010	6-1-06	Amend	7-1-06
177-010-0100	3-1-06	Amend	4-1-06
177-035-0000	12-31-05	Repeal	2-1-06
177-035-0110	12-31-05	Repeal	2-1-06
177-035-0115	12-31-05	Repeal	2-1-06
177-035-0120	12-31-05	Repeal	2-1-06
177-035-0130	12-31-05	Repeal	2-1-06
177-035-0140	12-31-05	Repeal	2-1-06
177-035-0150	12-31-05	Repeal	2-1-06
177-035-0160	12-31-05	Repeal	2-1-06
177-035-0200	12-31-05	Repeal	2-1-06
177-035-0210	12-31-05	Repeal	2-1-06
177-035-0220	12-31-05	Repeal	2-1-06
177-035-0230	12-31-05	Repeal	2-1-06
177-035-0300	12-31-05	Repeal	2-1-06
177-035-0310	12-31-05	Repeal	2-1-06
177-035-0400	12-31-05	Repeal	2-1-06
177-035-0600	12-31-05	Repeal	2-1-06
177-036-0000	12-31-05	Adopt	2-1-06
177-036-0000(T)	12-31-05	Repeal	2-1-06
177-036-0010	12-31-05	Adopt	2-1-06
177-036-0010(T)	12-31-05	Repeal	2-1-06
177-036-0020	12-31-05	Adopt	2-1-06
177-036-0020(T)	12-31-05	Repeal	2-1-06
177-036-0030	12-31-05	Adopt	2-1-06
177-036-0030(T)	12-31-05	Repeal	2-1-06
177-036-0040	12-31-05	Adopt	2-1-06
177-036-0040(T)	12-31-05	Repeal	2-1-06
177-036-0050	12-31-05	Adopt	2-1-06
177-036-0050(T)	12-31-05	Repeal	2-1-06
177-036-0055	12-31-05	Adopt	2-1-06
177-036-0055(T)	12-31-05	Repeal	2-1-06
177-036-0060	12-31-05	Adopt	2-1-06
177-036-0060(T)	12-31-05	Repeal	2-1-06
177-036-0070	12-31-05	Adopt	2-1-06
177-036-0070(T)	12-31-05	Repeal	2-1-06
177-036-0080	12-31-05	Adopt	2-1-06
177-036-0080(T)	12-31-05	Repeal	2-1-06
177-036-0090	12-31-05	Adopt	2-1-06
177-036-0090(T)	12-31-05	Repeal	2-1-06
177-036-0100	12-31-05	Adopt	2-1-06
177-036-0100(T)	12-31-05	Repeal	2-1-06
177-036-0110	12-31-05	Adopt	2-1-06
177-036-0110(T)	12-31-05	Repeal	2-1-06
177-036-0115	12-31-05	Adopt	2-1-06
177-036-0115(T)	12-31-05	Repeal	2-1-06
177-036-0120	12-31-05	Adopt	2-1-06
177-036-0120(T)	12-31-05	Repeal	2-1-06
177-036-0130	12-31-05	Adopt	2-1-06
177-036-0130(T)	12-31-05	Repeal	2-1-06
177-036-0140	12-31-05	Adopt	2-1-06
177-036-0140(T)	12-31-05	Repeal	2-1-06
177-036-0150	12-31-05	Adopt	2-1-06
177-036-0150(T)	12-31-05	Repeal	2-1-06
177-036-0160	12-31-05	Adopt	2-1-06
177-036-0160(T)	12-31-05	Repeal	2-1-06
177-036-0170	12-31-05	Adopt	2-1-06
177-036-0170(T)	12-31-05	Repeal	2-1-06
177-036-0180	12-31-05	Adopt	2-1-06

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177-036-0190(T)	12-31-05	Repeal	2-1-06
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177-036-0200(T)	12-31-05	Repeal	2-1-06
177-036-0210	12-31-05	Adopt	2-1-06
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177-037-0000	12-31-05	Adopt	2-1-06
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177-037-0010(T)	12-31-05	Repeal	2-1-06
177-037-0020	12-31-05	Adopt	2-1-06
177-037-0020(T)	12-31-05	Repeal	2-1-06
177-037-0030	12-31-05	Adopt	2-1-06
177-037-0030(T)	12-31-05	Repeal	2-1-06
177-037-0040	12-31-05	Adopt	2-1-06
177-037-0040(T)	12-31-05	Repeal	2-1-06
177-037-0050	12-31-05	Adopt	2-1-06
177-037-0050(T)	12-31-05	Repeal	2-1-06
177-037-0060	12-31-05	Adopt	2-1-06
177-037-0060(T)	12-31-05	Repeal	2-1-06
177-037-0070	12-31-05	Adopt	2-1-06
177-037-0070(T)	12-31-05	Repeal	2-1-06
177-040-0000	3-1-06	Amend	4-1-06
177-040-0010	12-31-05	Amend	2-1-06
177-040-0017	12-31-05	Amend	2-1-06
177-040-0017(T)	12-31-05	Repeal	2-1-06
177-040-0026	11-23-05	Amend(T)	1-1-06
177-040-0026	1-25-06	Amend	3-1-06
177-040-0026(T)	1-25-06	Repeal	3-1-06
177-040-0029	12-31-05	Amend	2-1-06
177-040-0105	12-31-05	Amend	2-1-06
177-040-0160	4-27-06	Amend	6-1-06
177-040-0300	3-1-06	Adopt	4-1-06
177-040-0310	3-1-06	Adopt	4-1-06
177-040-0320	3-1-06	Adopt	4-1-06
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177-050-0037	12-31-05	Amend	2-1-06
177-070-0025	12-31-05	Amend	2-1-06
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177-070-0035(T)	12-31-05	Repeal	2-1-06
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177-083-0020	4-9-06	Adopt	5-1-06
177-083-0030	4-9-06	Adopt	5-1-06
177-083-0040	4-9-06	Adopt	5-1-06
177-083-0050	4-9-06	Adopt	5-1-06
177-083-0060	4-9-06	Adopt	5-1-06
177-083-0070	4-9-06	Adopt	5-1-06
177-085-0005	12-31-05	Amend	2-1-06
177-085-0005(T)	12-31-05	Repeal	2-1-06
177-085-0015	12-31-05	Amend	2-1-06
177-085-0015(T)	12-31-05	Repeal	2-1-06
177-085-0020	12-31-05	Amend	2-1-06
177-085-0020(T)	12-31-05	Repeal	2-1-06
177-085-0025	12-31-05	Amend	2-1-06
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177-085-0030	12-31-05	Amend	2-1-06
177-085-0030(T)	12-31-05	Repeal	2-1-06
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177-085-0065(T)	12-31-05	Repeal	2-1-06
177-200-0010	6-26-06	Amend(T)	7-1-06
177-200-0020	12-31-05	Amend	2-1-06
177-200-0020(T)	12-31-05	Repeal	2-1-06
213-001-0000	4-12-06	Amend	5-1-06
213-003-0001	4-12-06	Amend	5-1-06
213-005-0002	4-12-06	Amend	5-1-06
213-013-0001	4-12-06	Amend	5-1-06
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220-001-0050	5-15-06	Repeal	6-1-06
220-005-0005	12-30-05	Amend(T)	2-1-06
220-005-0005	5-15-06	Repeal	6-1-06
220-005-0010	12-30-05	Amend(T)	2-1-06
220-005-0010	5-15-06	Repeal	6-1-06
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220-005-0110	5-15-06	Repeal	6-1-06
220-005-0115	12-30-05	Amend(T)	2-1-06
220-005-0115	5-15-06	Repeal	6-1-06
220-005-0120	12-30-05	Amend(T)	2-1-06
220-005-0120	5-15-06	Repeal	6-1-06
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220-005-0135	12-30-05	Amend(T)	2-1-06
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220-005-0140	12-30-05	Amend(T)	2-1-06
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220-005-0150	12-30-05	Amend(T)	2-1-06
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220-005-0170	5-15-06	Repeal	6-1-06
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220-005-0210	5-15-06	Repeal	6-1-06
220-005-0220	12-30-05	Amend(T)	2-1-06
220-005-0220	5-15-06	Repeal	6-1-06
220-005-0225	12-30-05	Adopt(T)	2-1-06
220-005-0225	5-15-06	Repeal	6-1-06
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220-005-0230	5-15-06	Repeal	6-1-06
220-005-0240	12-30-05	Suspend	2-1-06
220-005-0240	5-15-06	Repeal	6-1-06
220-005-0245	12-30-05	Adopt(T)	2-1-06
220-005-0245	5-15-06	Repeal	6-1-06
220-005-0250	12-30-05	Amend(T)	2-1-06
220-005-0250	5-15-06	Repeal	6-1-06
220-010-0020	12-30-05	Amend(T)	2-1-06
220-010-0020	5-15-06	Repeal	6-1-06
220-010-0030	12-30-05	Amend(T)	2-1-06
220-010-0030	5-15-06	Repeal	6-1-06
220-010-0050	12-30-05	Amend(T)	2-1-06
220-010-0050	5-15-06	Repeal	6-1-06
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220-010-0200	5-15-06	Repeal	6-1-06
220-010-0300	12-30-05	Amend(T)	2-1-06
220-010-0300	5-15-06	Repeal	6-1-06
220-030-0035	12-30-05	Amend(T)	2-1-06
220-030-0035	5-15-06	Repeal	6-1-06
220-040-0015	12-30-05	Amend(T)	2-1-06
220-040-0015	5-15-06	Repeal	6-1-06
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220-040-0025	5-15-06	Repeal	6-1-06
220-040-0035	12-30-05	Amend(T)	2-1-06
220-040-0035	5-15-06	Repeal	6-1-06
220-040-0045	12-30-05	Amend(T)	2-1-06
220-040-0045	5-15-06	Repeal	6-1-06
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220-050-0105	12-30-05	Suspend	2-1-06
220-050-0105	5-15-06	Repeal	6-1-06
220-050-0110	12-30-05	Amend(T)	2-1-06
220-050-0110	5-15-06	Repeal	6-1-06
220-050-0140	12-30-05	Amend(T)	2-1-06
220-050-0140	5-15-06	Repeal	6-1-06
220-050-0150	12-30-05	Suspend	2-1-06
220-050-0150	5-15-06	Repeal	6-1-06
220-050-0300	12-30-05	Amend(T)	2-1-06
220-050-0300	5-15-06	Repeal	6-1-06
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250-020-0266	3-28-06	Amend	5-1-06
250-020-0350	3-28-06	Amend	5-1-06
255-015-0003	4-5-06	Amend	5-1-06
255-036-0010	4-5-06	Amend	5-1-06
255-037-0010	4-5-06	Amend	5-1-06
255-060-0011	3-20-06	Amend(T)	5-1-06
255-060-0011	6-14-06	Amend	7-1-06
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255-075-0035	12-29-05	Amend	2-1-06
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257-050-0040	11-18-05	Amend	1-1-06
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257-050-0125	3-31-06	Amend	5-1-06
257-050-0140	11-18-05	Amend	1-1-06
257-050-0140	3-31-06	Amend	5-1-06
257-050-0145	11-18-05	Adopt	1-1-06
257-050-0145	3-31-06	Amend	5-1-06
257-050-0150	11-18-05	Amend	1-1-06
257-050-0150	3-31-06	Amend	5-1-06
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259-009-0005	1-24-06	Amend	3-1-06
259-009-0059	1-23-06	Adopt(T)	3-1-06
259-009-0059	5-3-06	Adopt	6-1-06
259-009-0059(T)	5-3-06	Repeal	6-1-06
259-009-0062	1-24-06	Amend	3-1-06
259-009-0065	1-24-06	Amend	3-1-06
259-012-0005	6-9-06	Amend	7-1-06
259-012-0010	6-9-06	Amend	7-1-06
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259-060-0015	5-15-06	Amend	6-1-06
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259-060-0300	5-15-06	Amend	6-1-06
259-060-0305	5-15-06	Amend	6-1-06
259-060-0405	5-15-06	Amend	6-1-06
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259-061-0130	5-15-06	Adopt	6-1-06
259-061-0140	5-15-06	Adopt	6-1-06
259-061-0150	5-15-06	Adopt	6-1-06
259-061-0160	5-15-06	Adopt	6-1-06
259-061-0170	5-15-06	Adopt	6-1-06
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259-061-0260	5-15-06	Adopt	6-1-06
274-010-0100	1-27-06	Amend	3-1-06
274-010-0115	1-27-06	Amend	3-1-06
274-010-0120	1-27-06	Amend	3-1-06
274-010-0135	1-27-06	Amend	3-1-06
274-010-0140	1-27-06	Repeal	3-1-06
274-010-0145	1-27-06	Amend	3-1-06
274-010-0150	1-27-06	Repeal	3-1-06
274-010-0155	1-27-06	Amend	3-1-06
274-010-0160	1-27-06	Amend	3-1-06
274-010-0170	1-27-06	Amend	3-1-06
274-010-0175	1-27-06	Amend	3-1-06
274-012-0001	2-23-06	Adopt(T)	4-1-06
274-012-0001	4-25-06	Adopt	6-1-06
274-012-0001(T)	4-25-06	Repeal	6-1-06
274-012-0100	2-23-06	Adopt(T)	4-1-06
274-012-0100	4-25-06	Adopt	6-1-06
274-012-0100(T)	4-25-06	Repeal	6-1-06
274-012-0105	2-23-06	Adopt(T)	4-1-06
274-012-0105	4-25-06	Adopt	6-1-06
274-012-0105(T)	4-25-06	Repeal	6-1-06
274-012-0110	2-23-06	Adopt(T)	4-1-06
274-012-0110	4-25-06	Adopt	6-1-06
274-012-0110(T)	4-25-06	Repeal	6-1-06
274-012-0115	2-23-06	Adopt(T)	4-1-06
274-012-0115	4-25-06	Adopt	6-1-06
274-012-0115(T)	4-25-06	Repeal	6-1-06
274-012-0120	2-23-06	Adopt(T)	4-1-06
274-012-0120	4-25-06	Adopt	6-1-06
274-012-0120(T)	4-25-06	Repeal	6-1-06
274-012-0125	2-23-06	Adopt(T)	4-1-06
274-012-0125	4-25-06	Adopt	6-1-06
274-012-0125(T)	4-25-06	Repeal	6-1-06
274-012-0130	2-23-06	Adopt(T)	4-1-06
274-012-0130	4-25-06	Adopt	6-1-06
274-012-0130(T)	4-25-06	Repeal	6-1-06
274-012-0131	2-23-06	Adopt(T)	4-1-06
274-012-0131	4-25-06	Adopt	6-1-06
274-012-0131(T)	4-25-06	Repeal	6-1-06
274-020-0340	12-27-05	Amend	2-1-06
274-030-0600	12-23-05	Adopt(T)	2-1-06
274-030-0605	12-23-05	Adopt(T)	2-1-06
274-030-0610	12-23-05	Adopt(T)	2-1-06
274-030-0615	12-23-05	Adopt(T)	2-1-06
274-030-0620	12-23-05	Adopt(T)	2-1-06
274-030-0621	12-23-05	Adopt(T)	2-1-06
274-030-0630	12-23-05	Adopt(T)	2-1-06
274-030-0640	12-23-05	Adopt(T)	2-1-06
274-040-0030	3-31-06	Amend(T)	5-1-06
274-040-0030	5-30-06	Amend	7-1-06
274-040-0030(T)	5-30-06	Repeal	7-1-06
274-045-0060	12-27-05	Amend	2-1-06
291-001-0100	6-1-06	Adopt(T)	7-1-06
291-047-0005	1-1-06	Amend	2-1-06
291-047-0010	1-1-06	Amend	2-1-06
291-047-0020	1-1-06	Repeal	2-1-06
291-047-0021	1-1-06	Adopt	2-1-06
291-047-0025	1-1-06	Repeal	2-1-06
291-047-0061	1-1-06	Adopt	2-1-06
291-047-0065	1-1-06	Adopt	2-1-06
291-047-0070	1-1-06	Adopt	2-1-06
291-047-0075	1-1-06	Adopt	2-1-06
291-047-0080	1-1-06	Adopt	2-1-06
291-047-0085	1-1-06	Adopt	2-1-06
291-047-0090	1-1-06	Adopt	2-1-06
291-047-0095	1-1-06	Adopt	2-1-06
291-047-0100	1-1-06	Adopt	2-1-06

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OAR Number	Effective	Action	Bulletin
291-047-0105	1-1-06	Adopt	2-1-06
291-047-0110	1-1-06	Adopt	2-1-06
291-047-0115	1-1-06	Am. & Ren.	2-1-06
291-047-0120	1-1-06	Am. & Ren.	2-1-06
291-047-0125	1-1-06	Am. & Ren.	2-1-06
291-047-0130	1-1-06	Am. & Ren.	2-1-06
291-047-0135	1-1-06	Am. & Ren.	2-1-06
291-047-0140	1-1-06	Am. & Ren.	2-1-06
291-063-0010	1-1-06	Amend	2-1-06
291-063-0016	1-1-06	Amend	2-1-06
291-063-0030	1-1-06	Amend	2-1-06
291-063-0050	1-1-06	Amend	2-1-06
291-077-0020	2-15-06	Amend	3-1-06
291-077-0030	2-15-06	Amend	3-1-06
291-077-0033	2-15-06	Amend	3-1-06
291-077-0035	2-15-06	Amend	3-1-06
291-104-0005	6-1-06	Amend	7-1-06
291-104-0010	12-7-05	Amend	1-1-06
291-104-0010	6-1-06	Amend	7-1-06
291-104-0015	12-7-05	Amend	1-1-06
291-104-0030	12-7-05	Amend	1-1-06
291-104-0035	12-7-05	Amend	1-1-06
291-104-0111	6-1-06	Adopt	7-1-06
291-104-0116	6-1-06	Adopt	7-1-06
291-104-0125	6-1-06	Adopt	7-1-06
291-104-0130	6-1-06	Adopt	7-1-06
291-104-0135	6-1-06	Adopt	7-1-06
291-130-0006	3-13-06	Amend	4-1-06
291-130-0010	3-13-06	Repeal	4-1-06
291-130-0011	3-13-06	Adopt	4-1-06
291-130-0016	3-13-06	Am. & Ren.	4-1-06
291-130-0020	3-13-06	Amend	4-1-06
291-130-0021	3-13-06	Adopt	4-1-06
291-130-0030	3-13-06	Amend	4-1-06
291-130-0050	3-13-06	Amend	4-1-06
291-130-0060	3-13-06	Amend	4-1-06
291-130-0070	3-13-06	Repeal	4-1-06
291-130-0080	3-13-06	Adopt	4-1-06
309-012-0000	6-1-06	Repeal	6-1-06
309-012-0005	6-1-06	Repeal	6-1-06
309-120-0000(T)	1-1-06	Repeal	2-1-06
309-120-0005(T)	1-1-06	Repeal	2-1-06
309-120-0015	1-1-06	Repeal	2-1-06
309-120-0020	1-1-06	Repeal	2-1-06
309-120-0021(T)	1-1-06	Repeal	2-1-06
309-120-0070	1-1-06	Adopt	2-1-06
309-120-0070(T)	1-1-06	Repeal	2-1-06
309-120-0075	1-1-06	Adopt	2-1-06
309-120-0075(T)	1-1-06	Repeal	2-1-06
309-120-0080	1-1-06	Adopt	2-1-06
309-120-0080(T)	1-1-06	Repeal	2-1-06
309-120-0200	1-1-06	Am. & Ren.	2-1-06
309-120-0205	1-1-06	Am. & Ren.	2-1-06
309-120-0210	1-1-06	Adopt	2-1-06
309-120-0215	1-1-06	Adopt	2-1-06
309-120-0220	1-1-06	Adopt	2-1-06
309-120-0225	1-1-06	Adopt	2-1-06
309-120-0230	1-1-06	Adopt	2-1-06
309-120-0235	1-1-06	Adopt	2-1-06
309-120-0240	1-1-06	Adopt	2-1-06
309-120-0245	1-1-06	Adopt	2-1-06
309-120-0250	1-1-06	Adopt	2-1-06
309-120-0255	1-1-06	Adopt	2-1-06
309-120-0260	1-1-06	Adopt	2-1-06
309-120-0265	1-1-06	Adopt	2-1-06
309-120-0270	1-1-06	Am. & Ren.	2-1-06
309-120-0275	1-1-06	Am. & Ren.	2-1-06
309-120-0280	1-1-06	Am. & Ren.	2-1-06
309-120-0285	1-1-06	Am. & Ren.	2-1-06
309-120-0290	1-1-06	Am. & Ren.	2-1-06
309-120-0295	1-1-06	Am. & Ren.	2-1-06
325-005-0015	2-6-06	Adopt	3-1-06
325-010-0001	2-6-06	Adopt	3-1-06
325-010-0005	2-6-06	Adopt	3-1-06
325-010-0010	2-6-06	Adopt	3-1-06
325-010-0015	2-6-06	Adopt	3-1-06
325-010-0020	2-6-06	Adopt	3-1-06
325-010-0025	2-6-06	Adopt	3-1-06
325-010-0030	2-6-06	Adopt	3-1-06
325-010-0035	2-6-06	Adopt	3-1-06
325-010-0040	2-6-06	Adopt	3-1-06
325-010-0045	2-6-06	Adopt	3-1-06
325-010-0050	2-6-06	Adopt	3-1-06
325-010-0055	2-6-06	Adopt	3-1-06
325-010-0060	2-6-06	Adopt	3-1-06
330-070-0010	1-1-06	Amend	2-1-06
330-070-0013	1-1-06	Amend	2-1-06
330-070-0014	1-1-06	Amend	2-1-06
330-070-0020	1-1-06	Amend	2-1-06
330-070-0021	1-1-06	Amend	2-1-06
330-070-0022	1-1-06	Amend	2-1-06
330-070-0025	1-1-06	Amend	2-1-06
330-070-0026	1-1-06	Amend	2-1-06
330-070-0040	1-1-06	Amend	2-1-06
330-070-0045	1-1-06	Amend	2-1-06
330-070-0048	1-1-06	Amend	2-1-06
330-070-0055	1-1-06	Amend	2-1-06
330-070-0059	1-1-06	Amend	2-1-06
330-070-0060	1-1-06	Amend	2-1-06
330-070-0062	1-1-06	Amend	2-1-06
330-070-0063	1-1-06	Amend	2-1-06
330-070-0064	1-1-06	Amend	2-1-06
330-070-0073	1-1-06	Amend	2-1-06
330-070-0089	1-1-06	Amend	2-1-06
330-070-0097	1-1-06	Amend	2-1-06
330-090-0105	1-1-06	Amend	2-1-06
330-090-0110	1-1-06	Amend	2-1-06
330-090-0120	1-1-06	Amend	2-1-06
330-090-0130	1-1-06	Amend	2-1-06
330-110-0010	4-3-06	Amend	5-1-06
330-110-0016	4-3-06	Amend	5-1-06
330-110-0042	4-3-06	Amend	5-1-06

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OAR Number	Effective	Action	Bulletin
330-110-0050	4-3-06	Amend	5-1-06
330-110-0055	4-3-06	Amend	5-1-06
331-405-0020	1-1-06	Amend	1-1-06
331-405-0030	1-1-06	Amend	1-1-06
331-405-0045	1-1-06	Adopt	1-1-06
331-410-0000	1-1-06	Amend	1-1-06
331-410-0010	1-1-06	Amend	1-1-06
331-410-0020	1-1-06	Amend	1-1-06
331-410-0030	1-1-06	Amend	1-1-06
331-410-0040	1-1-06	Amend	1-1-06
333-001-0000	6-1-06	Repeal	6-1-06
333-001-0005	6-1-06	Repeal	6-1-06
333-008-0000	1-1-06	Amend	2-1-06
333-008-0010	1-1-06	Amend	2-1-06
333-008-0020	12-1-05	Amend	1-1-06
333-008-0020	1-1-06	Amend	2-1-06
333-008-0025	1-1-06	Adopt	2-1-06
333-008-0030	1-1-06	Amend	2-1-06
333-008-0040	1-1-06	Amend	2-1-06
333-008-0050	1-1-06	Amend	2-1-06
333-008-0060	1-1-06	Amend	2-1-06
333-008-0070	1-1-06	Amend	2-1-06
333-008-0080	1-1-06	Amend	2-1-06
333-008-0090	1-1-06	Amend	2-1-06
333-008-0110	1-1-06	Adopt	2-1-06
333-008-0120	1-1-06	Adopt	2-1-06
333-012-0260	4-17-06	Amend	6-1-06
333-012-0265	1-1-06	Amend(T)	2-1-06
333-012-0265	4-17-06	Amend	6-1-06
333-012-0265(T)	4-17-06	Repeal	6-1-06
333-018-0015	4-17-06	Amend	6-1-06
333-018-0030	1-1-06	Amend(T)	2-1-06
333-018-0030	4-17-06	Amend	6-1-06
333-018-0030(T)	4-17-06	Repeal	6-1-06
333-019-0031	4-17-06	Amend	6-1-06
333-019-0036	1-1-06	Amend	2-1-06
333-025-0100	1-1-06	Amend	2-1-06
333-025-0105	1-1-06	Amend	2-1-06
333-025-0110	1-1-06	Amend	2-1-06
333-025-0115	1-1-06	Amend	2-1-06
333-025-0120	1-1-06	Amend	2-1-06
333-025-0135	1-1-06	Amend	2-1-06
333-025-0140	1-1-06	Amend	2-1-06
333-025-0160	1-1-06	Amend	2-1-06
333-025-0165	1-1-06	Adopt	2-1-06
333-050-0010	1-27-06	Amend	3-1-06
333-050-0020	1-27-06	Amend	3-1-06
333-050-0040	1-27-06	Amend	3-1-06
333-050-0050	1-27-06	Amend	3-1-06
333-050-0060	1-27-06	Amend	3-1-06
333-050-0080	1-27-06	Amend	3-1-06
333-050-0090	1-27-06	Amend	3-1-06
333-050-0100	1-27-06	Amend	3-1-06
333-050-0130	1-27-06	Amend	3-1-06
333-052-0030	6-5-06	Adopt	7-1-06
333-052-0040	6-5-06	Adopt	7-1-06
333-052-0050	6-5-06	Adopt	7-1-06
333-052-0060	6-5-06	Adopt	7-1-06
333-052-0065	6-5-06	Adopt	7-1-06
333-052-0070	6-5-06	Adopt	7-1-06
333-052-0075	6-5-06	Adopt	7-1-06
333-052-0080	6-5-06	Adopt	7-1-06
333-052-0090	6-5-06	Adopt	7-1-06
333-052-0100	6-5-06	Adopt	7-1-06
333-052-0110	6-5-06	Adopt	7-1-06
333-052-0120	6-5-06	Adopt	7-1-06
333-052-0130	6-5-06	Adopt	7-1-06
333-061-0020	1-31-06	Amend	3-1-06
333-061-0030	1-31-06	Amend	3-1-06
333-061-0032	1-31-06	Amend	3-1-06
333-061-0036	1-31-06	Amend	3-1-06
333-061-0040	1-31-06	Amend	3-1-06
333-061-0042	1-31-06	Amend	3-1-06
333-061-0043	1-31-06	Amend	3-1-06
333-061-0057	1-31-06	Amend	3-1-06
333-061-0060	1-31-06	Amend	3-1-06
333-061-0070	1-31-06	Amend	3-1-06
333-061-0071	1-31-06	Amend	3-1-06
333-061-0072	1-31-06	Amend	3-1-06
333-061-0090	1-31-06	Amend	3-1-06
333-061-0097	1-31-06	Amend	3-1-06
333-061-0215	1-31-06	Amend	3-1-06
333-061-0220	1-31-06	Amend	3-1-06
333-061-0230	1-31-06	Amend	3-1-06
333-061-0235	1-31-06	Amend	3-1-06
333-061-0245	1-31-06	Amend	3-1-06
333-061-0250	1-31-06	Amend	3-1-06
333-061-0260	1-31-06	Amend	3-1-06
333-061-0265	1-31-06	Amend	3-1-06
333-061-0270	1-31-06	Amend	3-1-06
333-061-0290	1-31-06	Amend	3-1-06
333-064-0060	2-8-06	Amend(T)	3-1-06
333-064-0060	4-6-06	Amend	5-1-06
333-076-0101	3-2-06	Amend(T)	4-1-06
333-076-0125	3-2-06	Amend(T)	4-1-06
333-076-0130	3-2-06	Amend(T)	4-1-06
333-076-0135	3-2-06	Amend(T)	4-1-06
333-510-0045	1-1-06	Amend(T)	2-1-06
333-670-0000	4-17-06	Suspend	6-1-06
333-670-0010	4-17-06	Suspend	6-1-06
333-670-0020	4-17-06	Suspend	6-1-06
333-670-0030	4-17-06	Suspend	6-1-06
333-670-0040	4-17-06	Suspend	6-1-06
333-670-0050	4-17-06	Suspend	6-1-06
333-670-0060	4-17-06	Suspend	6-1-06
333-670-0070	4-17-06	Suspend	6-1-06
333-670-0080	4-17-06	Suspend	6-1-06
333-670-0090	4-17-06	Suspend	6-1-06
333-670-0100	4-17-06	Suspend	6-1-06
333-670-0110	4-17-06	Suspend	6-1-06
333-670-0120	4-17-06	Suspend	6-1-06
333-670-0130	4-17-06	Suspend	6-1-06

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OAR Number	Effective	Action	Bulletin
333-670-0140	4-17-06	Suspend	6-1-06
333-670-0150	4-17-06	Suspend	6-1-06
333-670-0160	4-17-06	Suspend	6-1-06
333-670-0170	4-17-06	Suspend	6-1-06
333-670-0180	4-17-06	Suspend	6-1-06
333-670-0190	4-17-06	Suspend	6-1-06
333-670-0200	4-17-06	Suspend	6-1-06
333-670-0210	4-17-06	Suspend	6-1-06
333-670-0220	4-17-06	Suspend	6-1-06
333-670-0230	4-17-06	Suspend	6-1-06
333-670-0240	4-17-06	Suspend	6-1-06
333-670-0250	4-17-06	Suspend	6-1-06
333-670-0260	4-17-06	Suspend	6-1-06
333-670-0270	4-17-06	Suspend	6-1-06
333-670-0280	4-17-06	Suspend	6-1-06
334-010-0010	1-5-06	Amend	2-1-06
334-010-0015	1-5-06	Amend	2-1-06
334-010-0015	2-16-06	Amend(T)	4-1-06
334-010-0017	1-5-06	Amend	2-1-06
334-010-0033	1-5-06	Amend	2-1-06
334-010-0050	1-5-06	Amend	2-1-06
335-005-0025	5-8-06	Amend	6-1-06
335-005-0030	5-8-06	Adopt	6-1-06
335-005-0035	5-8-06	Adopt	6-1-06
335-070-0040	5-8-06	Amend	6-1-06
335-070-0060	5-8-06	Amend	6-1-06
335-070-0065	5-8-06	Amend	6-1-06
335-080-0005	5-8-06	Amend	6-1-06
335-095-0010	5-8-06	Amend	6-1-06
335-095-0030	5-8-06	Amend	6-1-06
335-095-0055	5-8-06	Amend	6-1-06
337-010-0030	2-6-06	Amend	3-1-06
340-011-0605	5-12-06	Adopt	6-1-06
340-012-0027	3-31-06	Amend	5-1-06
340-012-0053	3-31-06	Amend	5-1-06
340-012-0054	3-31-06	Amend	5-1-06
340-012-0055	3-31-06	Amend	5-1-06
340-012-0060	3-31-06	Amend	5-1-06
340-012-0065	3-31-06	Amend	5-1-06
340-012-0066	3-31-06	Amend	5-1-06
340-012-0067	3-31-06	Amend	5-1-06
340-012-0068	3-31-06	Amend	5-1-06
340-012-0071	3-31-06	Amend	5-1-06
340-012-0072	3-31-06	Amend	5-1-06
340-012-0073	3-31-06	Amend	5-1-06
340-012-0074	3-31-06	Amend	5-1-06
340-012-0079	3-31-06	Amend	5-1-06
340-012-0081	3-31-06	Amend	5-1-06
340-012-0082	3-31-06	Amend	5-1-06
340-012-0083	3-31-06	Amend	5-1-06
340-012-0097	3-31-06	Amend	5-1-06
340-012-0130	3-31-06	Amend	5-1-06
340-012-0135	3-31-06	Amend	5-1-06
340-012-0140	3-31-06	Amend	5-1-06
340-012-0155	3-31-06	Amend	5-1-06
340-045-0033	12-28-05	Amend	2-1-06
340-110-0001	3-15-06	Amend	4-1-06
340-110-0020	3-15-06	Amend	4-1-06
340-110-0061	3-15-06	Amend	4-1-06
340-122-0040	3-17-06	Amend	5-1-06
340-122-0045	3-17-06	Repeal	5-1-06
340-122-0115	3-17-06	Amend	5-1-06
340-200-0020	3-14-06	Amend	4-1-06
340-200-0040	3-14-06	Amend	4-1-06
340-200-0040	3-31-06	Amend	5-1-06
340-216-0060	3-14-06	Amend	4-1-06
340-238-0040	3-14-06	Amend	4-1-06
340-238-0050	3-14-06	Amend	4-1-06
340-238-0060	3-14-06	Amend	4-1-06
340-244-0030	3-14-06	Amend	4-1-06
340-244-0040	3-14-06	Amend	4-1-06
340-244-0220	3-14-06	Amend	4-1-06
340-257-0010	1-1-06	Adopt(T)	2-1-06
340-257-0020	1-1-06	Adopt(T)	2-1-06
340-257-0030	1-1-06	Adopt(T)	2-1-06
340-257-0040	1-1-06	Adopt(T)	2-1-06
340-257-0050	1-1-06	Adopt(T)	2-1-06
340-257-0060	1-1-06	Adopt(T)	2-1-06
340-257-0070	1-1-06	Adopt(T)	2-1-06
340-257-0080	1-1-06	Adopt(T)	2-1-06
340-257-0090	1-1-06	Adopt(T)	2-1-06
340-257-0100	1-1-06	Adopt(T)	2-1-06
340-257-0110	1-1-06	Adopt(T)	2-1-06
340-257-0120	1-1-06	Adopt(T)	2-1-06
340-257-0130	1-1-06	Adopt(T)	2-1-06
340-257-0150	1-1-06	Adopt(T)	2-1-06
340-257-0160	1-1-06	Adopt(T)	2-1-06
350-011-0004	5-1-06	Amend	5-1-06
350-012-0006	5-1-06	Amend	5-1-06
350-012-0007	5-1-06	Amend	5-1-06
350-012-0008	5-1-06	Amend	5-1-06
350-012-0009	5-1-06	Adopt	5-1-06
350-013-0001	5-1-06	Amend	5-1-06
350-016-0004	5-1-06	Amend	5-1-06
350-050-0030	5-1-06	Amend	5-1-06
350-050-0035	5-1-06	Adopt	5-1-06
350-050-0040	5-1-06	Amend	5-1-06
350-050-0045	5-1-06	Adopt	5-1-06
350-050-0050	5-1-06	Amend	5-1-06
350-050-0060	5-1-06	Amend	5-1-06
350-050-0070	5-1-06	Amend	5-1-06
350-050-0075	5-1-06	Repeal	5-1-06
350-050-0080	5-1-06	Amend	5-1-06
350-050-0085	5-1-06	Amend	5-1-06
350-050-0090	5-1-06	Amend	5-1-06
350-050-0100	5-1-06	Amend	5-1-06
350-050-0110	5-1-06	Repeal	5-1-06
407-001-0000	6-1-06	Adopt	6-1-06
407-001-0005	6-1-06	Adopt	6-1-06
407-001-0010	6-1-06	Adopt	6-1-06
407-005-0000	3-1-06	Adopt	4-1-06
407-005-0005	3-1-06	Adopt	4-1-06

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407-005-0020	3-1-06	Adopt	4-1-06
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407-005-0030	3-1-06	Adopt	4-1-06
407-010-0001	3-1-06	Adopt	4-1-06
407-045-0000	6-1-06	Adopt	7-1-06
407-045-0010	6-1-06	Adopt	7-1-06
407-045-0020	6-1-06	Adopt	7-1-06
407-045-0030	6-1-06	Adopt	7-1-06
407-045-0040	6-1-06	Adopt	7-1-06
407-045-0050	6-1-06	Adopt	7-1-06
407-045-0060	6-1-06	Adopt	7-1-06
407-045-0070	6-1-06	Adopt	7-1-06
407-045-0080	6-1-06	Adopt	7-1-06
407-045-0090	6-1-06	Adopt	7-1-06
407-045-0100	6-1-06	Adopt	7-1-06
407-045-0110	6-1-06	Adopt	7-1-06
407-050-0000	11-28-05	Adopt(T)	1-1-06
407-050-0000	5-26-06	Adopt	7-1-06
407-050-0005	11-28-05	Adopt(T)	1-1-06
407-050-0005	5-26-06	Adopt	7-1-06
407-050-0010	11-28-05	Adopt(T)	1-1-06
407-050-0010	5-26-06	Adopt	7-1-06
410-001-0000	6-1-06	Amend	6-1-06
410-001-0005	6-1-06	Amend	6-1-06
410-001-0010	6-1-06	Repeal	6-1-06
410-001-0020	6-1-06	Amend	6-1-06
410-001-0030	6-1-06	Repeal	6-1-06
410-002-0000	6-1-06	Repeal	6-1-06
410-011-0000	1-1-06	Am. & Ren.	1-1-06
410-011-0010	1-1-06	Am. & Ren.	1-1-06
410-011-0020	1-1-06	Am. & Ren.	1-1-06
410-011-0030	1-1-06	Am. & Ren.	1-1-06
410-011-0040	1-1-06	Am. & Ren.	1-1-06
410-011-0050	1-1-06	Am. & Ren.	1-1-06
410-011-0060	1-1-06	Am. & Ren.	1-1-06
410-011-0070	1-1-06	Am. & Ren.	1-1-06
410-011-0080	1-1-06	Am. & Ren.	1-1-06
410-011-0090	1-1-06	Am. & Ren.	1-1-06
410-011-0100	1-1-06	Am. & Ren.	1-1-06
410-011-0110	1-1-06	Am. & Ren.	1-1-06
410-011-0120	1-1-06	Am. & Ren.	1-1-06
410-050-0861	7-1-06	Amend	7-1-06
410-120-0000	1-1-06	Amend	1-1-06
410-120-0000	7-1-06	Amend	7-1-06
410-120-0250	1-1-06	Amend	2-1-06
410-120-1180	7-1-06	Amend	7-1-06
410-120-1200	1-1-06	Amend	1-1-06
410-120-1200	7-1-06	Amend	7-1-06
410-120-1210	1-1-06	Amend	1-1-06
410-120-1210	7-1-06	Amend	7-1-06
410-120-1230	7-1-06	Amend	7-1-06
410-120-1260	7-1-06	Amend	7-1-06
410-120-1280	1-1-06	Amend	2-1-06
410-120-1280	7-1-06	Amend	7-1-06
410-120-1295	1-1-06	Amend	1-1-06
410-120-1295	1-1-06	Amend(T)	1-1-06
410-120-1295	1-1-06	Amend(T)	2-1-06
410-120-1295(T)	1-1-06	Repeal	1-1-06
410-120-1340	7-1-06	Amend	7-1-06
410-120-1400	7-1-06	Amend	7-1-06
410-120-1460	7-1-06	Amend	7-1-06
410-120-1560	7-1-06	Amend	7-1-06
410-120-1855	7-1-06	Amend	7-1-06
410-120-1960	7-1-06	Amend	7-1-06
410-121-0030	7-1-06	Amend	7-1-06
410-121-0040	3-15-06	Amend(T)	4-1-06
410-121-0060	7-1-06	Amend	7-1-06
410-121-0100	7-1-06	Amend	7-1-06
410-121-0140	7-1-06	Amend	7-1-06
410-121-0147	1-1-06	Amend	1-1-06
410-121-0147	7-1-06	Amend	7-1-06
410-121-0149	1-18-06	Adopt(T)	3-1-06
410-121-0150	7-1-06	Amend	7-1-06
410-121-0155	7-1-06	Amend	7-1-06
410-121-0157	4-1-06	Amend	5-1-06
410-121-0157	4-1-06	Amend(T)	5-1-06
410-121-0157	6-1-06	Amend	7-1-06
410-121-0160	7-1-06	Amend	7-1-06
410-121-0190	12-1-05	Amend	1-1-06
410-121-0300	1-1-06	Amend	2-1-06
410-121-0300	4-1-06	Amend(T)	5-1-06
410-121-0300	6-1-06	Amend	7-1-06
410-121-0320	1-1-06	Amend	2-1-06
410-122-0010	7-1-06	Amend	7-1-06
410-122-0040	7-1-06	Amend	7-1-06
410-122-0080	7-1-06	Amend	7-1-06
410-122-0180	7-1-06	Amend	7-1-06
410-122-0190	12-1-05	Amend	1-1-06
410-122-0204	7-1-06	Amend	7-1-06
410-122-0240	7-1-06	Amend	7-1-06
410-122-0300	7-1-06	Amend	7-1-06
410-122-0320	7-1-06	Amend	7-1-06
410-122-0325	7-1-06	Amend	7-1-06
410-122-0330	7-1-06	Amend	7-1-06
410-122-0340	7-1-06	Amend	7-1-06
410-122-0400	7-1-06	Amend	7-1-06
410-122-0510	7-1-06	Amend	7-1-06
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410-122-0700	7-1-06	Amend	7-1-06
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410-125-0141	1-1-06	Amend	2-1-06
410-125-0141	7-1-06	Amend	7-1-06
410-125-0142	7-1-06	Amend	7-1-06
410-125-0155	7-1-06	Amend	7-1-06
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410-125-0181	7-1-06	Amend	7-1-06
410-125-0190	1-1-06	Amend	2-1-06
410-125-0190	7-1-06	Amend	7-1-06
410-125-0195	1-1-06	Amend	2-1-06

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410-129-0200	7-1-06	Amend	7-1-06
410-129-0240	7-1-06	Amend	7-1-06
410-129-0260	7-1-06	Amend	7-1-06
410-129-0280	7-1-06	Amend	7-1-06
410-130-0180	7-1-06	Amend	7-1-06
410-130-0190	7-1-06	Amend	7-1-06
410-130-0200	7-1-06	Amend	7-1-06
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410-130-0680	7-1-06	Amend	7-1-06
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410-131-0280	7-1-06	Amend	7-1-06
410-132-0140	12-1-05	Repeal	1-1-06
410-136-0320	7-1-06	Amend	7-1-06
410-136-0340	7-1-06	Amend	7-1-06
410-136-0350	7-1-06	Amend	7-1-06
410-136-0360	7-1-06	Amend	7-1-06
410-136-0420	12-1-05	Amend	1-1-06
410-136-0420	7-1-06	Amend	7-1-06
410-138-0600	2-7-06	Adopt(T)	3-1-06
410-138-0600	7-1-06	Adopt	7-1-06
410-138-0610	2-7-06	Adopt(T)	3-1-06
410-138-0610	7-1-06	Adopt	7-1-06
410-138-0620	2-7-06	Adopt(T)	3-1-06
410-138-0620	7-1-06	Adopt	7-1-06
410-138-0640	2-7-06	Adopt(T)	3-1-06
410-138-0640	7-1-06	Adopt	7-1-06
410-138-0660	2-7-06	Adopt(T)	3-1-06
410-138-0660	7-1-06	Adopt	7-1-06
410-138-0680	2-7-06	Adopt(T)	3-1-06
410-138-0680	7-1-06	Adopt	7-1-06
410-138-0700	2-7-06	Adopt(T)	3-1-06
410-138-0700	7-1-06	Adopt	7-1-06
410-138-0710	2-7-06	Adopt(T)	3-1-06
410-138-0710	7-1-06	Adopt	7-1-06
410-138-0720	2-7-06	Adopt(T)	3-1-06
410-138-0720	7-1-06	Adopt	7-1-06
410-138-0740	2-7-06	Adopt(T)	3-1-06
410-138-0740	7-1-06	Adopt	7-1-06
410-138-0760	2-7-06	Adopt(T)	3-1-06
410-138-0760	7-1-06	Adopt	7-1-06
410-138-0780	2-7-06	Adopt(T)	3-1-06
410-138-0780	7-1-06	Adopt	7-1-06
410-140-0080	7-1-06	Amend	7-1-06
410-140-0180	7-1-06	Amend	7-1-06
410-140-0320	12-1-05	Amend	1-1-06
410-140-0400	12-1-05	Amend	1-1-06
410-141-0000	1-1-06	Amend	1-1-06
410-141-0000	7-1-06	Amend	7-1-06
410-141-0010	3-1-06	Adopt	3-1-06
410-141-0010(T)	3-1-06	Repeal	3-1-06
410-141-0060	1-1-06	Amend	1-1-06
410-141-0060	5-4-06	Amend(T)	6-1-06
410-141-0060	7-1-06	Amend	7-1-06
410-141-0070	1-1-06	Amend	1-1-06
410-141-0070	7-1-06	Amend	7-1-06
410-141-0080	1-1-06	Amend	1-1-06
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410-141-0160	1-1-06	Amend	1-1-06
410-141-0180	7-1-06	Amend	7-1-06
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410-141-0300	7-1-06	Amend	7-1-06
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410-141-0400	7-1-06	Amend	7-1-06
410-141-0405	7-1-06	Amend	7-1-06
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410-147-0060	7-1-06	Amend	7-1-06
410-147-0080	7-1-06	Amend	7-1-06
410-147-0085	7-1-06	Amend	7-1-06
410-147-0120	7-1-06	Amend	7-1-06
410-147-0125	7-1-06	Amend	7-1-06
410-147-0140	7-1-06	Amend	7-1-06
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410-147-0320	7-1-06	Amend	7-1-06
410-147-0360	7-1-06	Amend	7-1-06
410-147-0365	1-1-06	Amend	1-1-06
410-147-0400	7-1-06	Amend	7-1-06
410-147-0460	7-1-06	Amend	7-1-06
410-147-0480	7-1-06	Amend	7-1-06

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410-147-0620	7-1-06	Amend	7-1-06
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411-001-0000	6-1-06	Repeal	6-1-06
411-001-0010	6-1-06	Amend	6-1-06
411-001-0100	6-1-06	Amend	6-1-06
411-001-0110	6-1-06	Amend	6-1-06
411-001-0120	6-1-06	Amend	6-1-06
411-015-0000	6-1-06	Amend	7-1-06
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411-015-0008	6-1-06	Adopt	7-1-06
411-015-0010	6-1-06	Amend	7-1-06
411-015-0015	2-1-06	Amend	3-1-06
411-015-0015	6-1-06	Amend	7-1-06
411-015-0100	12-29-05	Amend	2-1-06
411-015-0100	6-1-06	Amend	7-1-06
411-018-0000	12-12-05	Amend	1-1-06
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411-020-0010	4-1-06	Amend	5-1-06
411-020-0015	4-1-06	Amend	5-1-06
411-020-0020	4-1-06	Amend	5-1-06
411-020-0030	4-1-06	Amend	5-1-06
411-021-0000	4-1-06	Amend	5-1-06
411-021-0005	4-1-06	Amend	5-1-06
411-021-0010	4-1-06	Amend	5-1-06
411-021-0015	4-1-06	Amend	5-1-06
411-021-0020	4-1-06	Amend	5-1-06
411-021-0025	4-1-06	Amend	5-1-06
411-030-0020	12-21-05	Amend(T)	2-1-06
411-030-0020	6-1-06	Amend	7-1-06
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411-030-0040	1-13-06	Amend(T)	2-1-06
411-030-0040	6-1-06	Amend	7-1-06
411-030-0050	12-21-05	Amend(T)	2-1-06
411-030-0050	6-1-06	Amend	7-1-06
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411-030-0070	12-21-05	Amend(T)	2-1-06
411-030-0070	6-1-06	Amend	7-1-06
411-030-0080	6-1-06	Amend	7-1-06
411-030-0090	6-1-06	Amend	7-1-06
411-031-0020	11-16-05	Amend(T)	1-1-06
411-031-0020	5-1-06	Amend	6-1-06
411-031-0020(T)	5-1-06	Repeal	6-1-06
411-031-0040	5-1-06	Amend	6-1-06
411-031-0050	11-16-05	Amend(T)	1-1-06
411-031-0050	5-1-06	Amend	6-1-06
411-031-0050(T)	5-1-06	Repeal	6-1-06
411-055-0003	2-1-06	Amend	3-1-06
411-055-0003(T)	2-1-06	Repeal	3-1-06
411-055-0190	1-18-06	Amend(T)	3-1-06
411-056-0007	2-1-06	Amend	3-1-06
411-056-0007(T)	2-1-06	Repeal	3-1-06
411-056-0020	1-18-06	Amend(T)	3-1-06
411-070-0005	2-1-06	Amend	3-1-06
411-070-0010	2-1-06	Amend	3-1-06
411-070-0015	2-1-06	Amend	3-1-06
411-070-0020	2-1-06	Amend	3-1-06
411-070-0025	2-1-06	Amend	3-1-06
411-070-0027	2-1-06	Amend	3-1-06
411-070-0029	2-1-06	Amend	3-1-06
411-070-0035	2-1-06	Amend	3-1-06
411-070-0040	2-1-06	Amend	3-1-06
411-070-0043	2-1-06	Amend	3-1-06
411-070-0045	2-1-06	Amend	3-1-06
411-070-0050	2-1-06	Amend	3-1-06
411-070-0080	2-1-06	Amend	3-1-06
411-070-0085	2-1-06	Amend	3-1-06
411-070-0091	2-1-06	Amend	3-1-06
411-070-0095	2-1-06	Amend	3-1-06
411-070-0100	2-1-06	Amend	3-1-06
411-070-0105	2-1-06	Amend	3-1-06
411-070-0110	2-1-06	Amend	3-1-06
411-070-0115	2-1-06	Amend	3-1-06
411-070-0120	2-1-06	Amend	3-1-06
411-070-0125	2-1-06	Amend	3-1-06
411-070-0130	2-1-06	Amend	3-1-06
411-070-0140	2-1-06	Amend	3-1-06
411-070-0300	2-1-06	Amend	3-1-06
411-070-0302	2-1-06	Amend	3-1-06
411-070-0305	2-1-06	Amend	3-1-06
411-070-0310	2-1-06	Amend	3-1-06
411-070-0315	2-1-06	Amend	3-1-06
411-070-0330	2-1-06	Amend	3-1-06
411-070-0335	2-1-06	Amend	3-1-06
411-070-0340	2-1-06	Amend	3-1-06
411-070-0345	2-1-06	Amend	3-1-06
411-070-0350	2-1-06	Amend	3-1-06
411-070-0359	2-1-06	Amend	3-1-06
411-070-0365	2-1-06	Amend	3-1-06
411-070-0370	2-1-06	Amend	3-1-06
411-070-0375	2-1-06	Amend	3-1-06
411-070-0385	2-1-06	Amend	3-1-06
411-070-0400	2-1-06	Amend	3-1-06
411-070-0415	2-1-06	Amend	3-1-06
411-070-0420	2-1-06	Amend	3-1-06
411-070-0425	2-1-06	Amend	3-1-06
411-070-0428	2-1-06	Amend	3-1-06
411-070-0430	2-1-06	Amend	3-1-06
411-070-0435	2-1-06	Amend	3-1-06
411-070-0452	2-1-06	Amend	3-1-06
411-070-0458	2-1-06	Repeal	3-1-06

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411-070-0464	2-1-06	Amend	3-1-06
411-070-0465	2-1-06	Amend	3-1-06
411-070-0470	2-1-06	Amend	3-1-06
411-088-0020	1-18-06	Amend(T)	3-1-06
411-200-0010	4-1-06	Amend	5-1-06
411-200-0020	4-1-06	Amend	5-1-06
411-200-0030	4-1-06	Amend	5-1-06
411-200-0040	4-1-06	Amend	5-1-06
411-310-0010	4-5-06	Amend	5-1-06
411-310-0020	4-5-06	Amend	5-1-06
411-310-0030	4-5-06	Amend	5-1-06
411-310-0040	4-5-06	Amend	5-1-06
411-310-0050	4-5-06	Amend	5-1-06
411-310-0060	4-5-06	Amend	5-1-06
411-310-0070	4-5-06	Amend	5-1-06
411-315-0010	4-5-06	Amend	5-1-06
411-315-0020	4-5-06	Amend	5-1-06
411-315-0030	4-5-06	Amend	5-1-06
411-315-0050	4-5-06	Amend	5-1-06
411-315-0060	4-5-06	Amend	5-1-06
411-315-0070	4-5-06	Amend	5-1-06
411-315-0080	4-5-06	Amend	5-1-06
411-315-0090	4-5-06	Amend	5-1-06
411-320-0020	11-23-05	Amend(T)	1-1-06
411-320-0020	2-1-06	Amend	3-1-06
411-320-0020(T)	2-1-06	Repeal	3-1-06
411-320-0030	11-23-05	Amend(T)	1-1-06
411-320-0030	2-1-06	Amend	3-1-06
411-320-0030(T)	2-1-06	Repeal	3-1-06
411-320-0040	11-23-05	Amend(T)	1-1-06
411-320-0040	2-1-06	Amend	3-1-06
411-320-0040(T)	2-1-06	Repeal	3-1-06
411-320-0050	11-23-05	Amend(T)	1-1-06
411-320-0050	2-1-06	Amend	3-1-06
411-320-0050(T)	2-1-06	Repeal	3-1-06
411-320-0060	2-1-06	Amend	3-1-06
411-320-0070	11-23-05	Amend(T)	1-1-06
411-320-0070	2-1-06	Amend	3-1-06
411-320-0070(T)	2-1-06	Repeal	3-1-06
411-320-0080	11-23-05	Amend(T)	1-1-06
411-320-0080	2-1-06	Amend	3-1-06
411-320-0080(T)	2-1-06	Repeal	3-1-06
411-320-0090	11-23-05	Amend(T)	1-1-06
411-320-0090	2-1-06	Amend	3-1-06
411-320-0090(T)	2-1-06	Repeal	3-1-06
411-320-0100	11-23-05	Amend(T)	1-1-06
411-320-0100	2-1-06	Amend	3-1-06
411-320-0100(T)	2-1-06	Repeal	3-1-06
411-320-0110	11-23-05	Amend(T)	1-1-06
411-320-0110	2-1-06	Amend	3-1-06
411-320-0110(T)	2-1-06	Repeal	3-1-06
411-320-0120	11-23-05	Amend(T)	1-1-06
411-320-0120	2-1-06	Amend	3-1-06
411-320-0120(T)	2-1-06	Repeal	3-1-06
411-320-0130	11-23-05	Amend(T)	1-1-06
411-320-0130	2-1-06	Amend	3-1-06
411-320-0130(T)	2-1-06	Repeal	3-1-06
411-320-0140	11-23-05	Amend(T)	1-1-06
411-320-0140	2-1-06	Amend	3-1-06
411-320-0140(T)	2-1-06	Repeal	3-1-06
411-320-0160	11-23-05	Amend(T)	1-1-06
411-320-0160	2-1-06	Amend	3-1-06
411-320-0160(T)	2-1-06	Repeal	3-1-06
411-320-0170	11-23-05	Amend(T)	1-1-06
411-320-0170	2-1-06	Amend	3-1-06
411-320-0170(T)	2-1-06	Repeal	3-1-06
411-340-0020	5-1-06	Amend	6-1-06
411-340-0030	5-1-06	Amend	6-1-06
411-340-0040	5-1-06	Amend	6-1-06
411-340-0050	5-1-06	Amend	6-1-06
411-340-0060	5-1-06	Amend	6-1-06
411-340-0110	5-1-06	Amend	6-1-06
411-340-0120	5-1-06	Amend	6-1-06
411-340-0130	5-1-06	Amend	6-1-06
411-340-0140	5-1-06	Amend	6-1-06
411-340-0150	5-1-06	Amend	6-1-06
411-340-0160	5-1-06	Amend	6-1-06
411-340-0170	5-1-06	Amend	6-1-06
411-340-0180	5-1-06	Amend	6-1-06
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413-001-0005	6-1-06	Repeal	7-1-06
413-010-0081	2-6-06	Adopt(T)	3-1-06
413-010-0082	2-6-06	Adopt(T)	3-1-06
413-010-0083	2-6-06	Adopt(T)	3-1-06
413-010-0084	2-6-06	Adopt(T)	3-1-06
413-010-0085	2-6-06	Adopt(T)	3-1-06
413-010-0086	2-6-06	Adopt(T)	3-1-06
413-010-0086	4-13-06	Amend(T)	5-1-06
413-015-0115	1-1-06	Amend(T)	2-1-06
413-015-0200	12-1-05	Amend	1-1-06
413-015-0205	12-1-05	Amend	1-1-06
413-015-0210	12-1-05	Amend	1-1-06
413-015-0211	12-1-05	Adopt	1-1-06
413-015-0212	12-1-05	Adopt	1-1-06
413-015-0213	12-1-05	Adopt	1-1-06
413-015-0215	12-1-05	Amend	1-1-06
413-015-0220	12-1-05	Amend	1-1-06
413-015-0300	1-1-06	Amend(T)	2-1-06
413-015-0302	1-1-06	Adopt(T)	2-1-06
413-015-0305	1-1-06	Amend(T)	2-1-06
413-015-0310	1-1-06	Amend(T)	2-1-06
413-015-0405	1-1-06	Amend(T)	2-1-06
413-015-0405	2-1-06	Amend	3-1-06
413-015-0405	2-1-06	Amend(T)	3-1-06
413-015-0405(T)	2-1-06	Suspend	3-1-06
413-015-0505	3-1-06	Amend	4-1-06
413-015-0505(T)	3-1-06	Repeal	4-1-06
413-015-0510	3-1-06	Amend	4-1-06
413-015-0510(T)	3-1-06	Repeal	4-1-06
413-015-0511	3-1-06	Amend	4-1-06
413-015-0511(T)	3-1-06	Repeal	4-1-06

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413-015-0512(T)	3-1-06	Repeal	4-1-06
413-015-0513	3-1-06	Amend	4-1-06
413-015-0513(T)	3-1-06	Repeal	4-1-06
413-015-0514	3-1-06	Amend	4-1-06
413-015-0514(T)	3-1-06	Repeal	4-1-06
413-015-0710	2-1-06	Amend	3-1-06
413-015-0720	1-1-06	Amend(T)	2-1-06
413-015-0900	1-1-06	Amend(T)	2-1-06
413-015-1000	1-1-06	Amend(T)	2-1-06
413-020-0140	2-1-06	Amend	3-1-06
413-040-0110	2-1-06	Amend	3-1-06
413-040-0135	2-1-06	Amend	3-1-06
413-040-0140	2-1-06	Amend	3-1-06
413-050-0100	1-1-06	Repeal	2-1-06
413-050-0110	1-1-06	Repeal	2-1-06
413-050-0120	1-1-06	Repeal	2-1-06
413-050-0130	1-1-06	Repeal	2-1-06
413-050-0140	1-1-06	Repeal	2-1-06
413-080-0100	1-1-06	Repeal	2-1-06
413-080-0110	1-1-06	Repeal	2-1-06
413-080-0120	1-1-06	Repeal	2-1-06
413-080-0130	1-1-06	Repeal	2-1-06
413-080-0140	1-1-06	Repeal	2-1-06
413-080-0150	1-1-06	Repeal	2-1-06
413-090-0300	2-1-06	Amend	3-1-06
413-090-0310	2-1-06	Amend	3-1-06
413-090-0380	2-1-06	Amend	3-1-06
413-110-0100	5-1-06	Amend	6-1-06
413-110-0110	5-1-06	Amend	6-1-06
413-110-0120	5-1-06	Amend	6-1-06
413-110-0130	5-1-06	Amend	6-1-06
413-130-0010	1-1-06	Amend(T)	2-1-06
413-130-0080	1-1-06	Amend(T)	2-1-06
413-140-0010	1-1-06	Amend(T)	2-1-06
413-140-0030	1-1-06	Amend(T)	2-1-06
413-200-0210	5-15-06	Amend(T)	6-1-06
413-200-0220	5-15-06	Amend(T)	6-1-06
413-200-0307	3-1-06	Amend(T)	4-1-06
414-061-0070	3-16-06	Amend(T)	5-1-06
414-061-0080	1-1-06	Amend	2-1-06
414-350-0000	1-1-06	Amend(T)	2-1-06
414-350-0000	6-13-06	Amend	7-1-06
414-350-0010	1-1-06	Amend(T)	2-1-06
414-350-0010	6-13-06	Amend	7-1-06
414-350-0020	1-1-06	Amend(T)	2-1-06
414-350-0020	6-13-06	Amend	7-1-06
414-350-0030	1-1-06	Amend(T)	2-1-06
414-350-0030	6-13-06	Amend	7-1-06
414-350-0050	1-1-06	Amend(T)	2-1-06
414-350-0050	6-13-06	Amend	7-1-06
414-350-0100	1-1-06	Amend(T)	2-1-06
414-350-0100	6-13-06	Amend	7-1-06
414-350-0120	1-1-06	Amend(T)	2-1-06
414-350-0120	6-13-06	Amend	7-1-06
414-350-0140	1-1-06	Amend(T)	2-1-06
414-350-0140	6-13-06	Amend	7-1-06
414-350-0160	1-1-06	Amend(T)	2-1-06
414-350-0160	6-13-06	Amend	7-1-06
414-350-0170	1-1-06	Amend(T)	2-1-06
414-350-0170	6-13-06	Amend	7-1-06
414-350-0220	1-1-06	Amend(T)	2-1-06
414-350-0220	6-13-06	Amend	7-1-06
414-350-0235	1-1-06	Amend(T)	2-1-06
414-350-0235	6-13-06	Amend	7-1-06
414-350-0250	1-1-06	Amend(T)	2-1-06
414-350-0250	6-13-06	Amend	7-1-06
414-700-0060	12-15-05	Amend(T)	1-1-06
414-700-0060	4-23-06	Amend	6-1-06
415-001-0005	6-1-06	Repeal	6-1-06
415-001-0010	6-1-06	Repeal	6-1-06
416-310-0000	2-7-06	Repeal	3-1-06
416-310-0010	2-7-06	Repeal	3-1-06
416-310-0020	2-7-06	Repeal	3-1-06
416-310-0030	2-7-06	Repeal	3-1-06
416-425-0000	11-22-05	Adopt	1-1-06
416-425-0010	11-22-05	Adopt	1-1-06
416-425-0020	11-22-05	Adopt	1-1-06
416-480-0000	2-17-06	Amend	4-1-06
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416-480-0020	2-17-06	Amend	4-1-06
416-480-0040	2-17-06	Amend	4-1-06
416-480-0060	2-17-06	Amend	4-1-06
416-480-0070	2-17-06	Amend	4-1-06
416-480-0080	2-17-06	Amend	4-1-06
416-530-0010	3-20-06	Amend	5-1-06
416-530-0040	3-20-06	Amend	5-1-06
416-600-0000	2-17-06	Amend	4-1-06
416-600-0010	2-17-06	Amend	4-1-06
416-600-0020	2-17-06	Amend	4-1-06
416-600-0030	2-17-06	Amend	4-1-06
416-600-0040	2-17-06	Amend	4-1-06
416-600-0050	2-17-06	Amend	4-1-06
416-650-0000	2-7-06	Repeal	3-1-06
416-650-0010	2-7-06	Repeal	3-1-06
416-650-0020	2-7-06	Repeal	3-1-06
416-650-0030	2-7-06	Repeal	3-1-06
416-650-0040	2-7-06	Repeal	3-1-06
416-650-0050	2-7-06	Repeal	3-1-06
417-001-0001	6-1-06	Amend	7-1-06
436-001-0003	1-17-06	Amend	2-1-06
436-001-0005	1-17-06	Amend	2-1-06
436-009-0004	4-1-06	Amend	4-1-06
436-009-0005	4-1-06	Amend	4-1-06
436-009-0006	4-1-06	Amend	4-1-06
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436-009-0020	4-1-06	Amend	4-1-06
436-009-0022	4-1-06	Amend	4-1-06
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436-009-0030	4-1-06	Amend	4-1-06

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436-009-0050	4-1-06	Amend	4-1-06
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436-009-0070	4-1-06	Amend	4-1-06
436-009-0080	4-1-06	Amend	4-1-06
436-009-0090	4-1-06	Amend	4-1-06
436-010-0005	1-1-06	Amend	1-1-06
436-010-0005	7-1-06	Amend	7-1-06
436-010-0008	1-1-06	Amend	1-1-06
436-010-0210	1-1-06	Amend	1-1-06
436-010-0210	7-1-06	Amend	7-1-06
436-010-0220	1-1-06	Amend	1-1-06
436-010-0220	7-1-06	Amend	7-1-06
436-010-0230	1-1-06	Amend	1-1-06
436-010-0230	7-1-06	Amend	7-1-06
436-010-0240	1-1-06	Amend	1-1-06
436-010-0240	7-1-06	Amend	7-1-06
436-010-0250	1-1-06	Amend	1-1-06
436-010-0265	1-1-06	Amend	1-1-06
436-010-0265	7-1-06	Amend	7-1-06
436-010-0270	1-1-06	Amend	1-1-06
436-010-0275	7-1-06	Amend	7-1-06
436-010-0280	1-1-06	Amend	1-1-06
436-010-0280	7-1-06	Amend	7-1-06
436-010-0290	1-1-06	Amend	1-1-06
436-010-0300	1-1-06	Amend	1-1-06
436-010-0340	1-1-06	Amend	1-1-06
436-015-0005	6-1-06	Amend(T)	6-1-06
436-015-0008	1-1-06	Amend	1-1-06
436-015-0030	1-1-06	Amend	1-1-06
436-015-0030	6-1-06	Amend(T)	6-1-06
436-015-0040	1-1-06	Amend	1-1-06
436-015-0040	6-1-06	Amend(T)	6-1-06
436-015-0070	1-1-06	Amend	1-1-06
436-015-0080	1-1-06	Amend	1-1-06
436-015-0110	1-1-06	Amend	1-1-06
436-030-0003	1-1-06	Amend	1-1-06
436-030-0005	1-1-06	Amend	1-1-06
436-030-0007	1-1-06	Amend	1-1-06
436-030-0009	1-1-06	Amend	1-1-06
436-030-0015	1-1-06	Amend	1-1-06
436-030-0020	1-1-06	Amend	1-1-06
436-030-0023	1-1-06	Amend	1-1-06
436-030-0034	1-1-06	Amend	1-1-06
436-030-0055	1-1-06	Amend	1-1-06
436-030-0065	1-1-06	Amend	1-1-06
436-030-0115	1-1-06	Amend	1-1-06
436-030-0155	1-1-06	Amend	1-1-06
436-030-0165	1-1-06	Amend	1-1-06
436-030-0175	1-1-06	Amend	1-1-06
436-030-0185	1-1-06	Amend	1-1-06
436-030-0575	1-1-06	Amend	1-1-06
436-030-0580	1-1-06	Amend	1-1-06
436-035-0005	1-1-06	Amend	1-1-06
436-035-0007	1-1-06	Amend	1-1-06
436-035-0008	1-1-06	Amend	1-1-06
436-035-0009	1-1-06	Amend	1-1-06
436-035-0011	1-1-06	Amend	1-1-06
436-035-0012	1-1-06	Amend	1-1-06
436-035-0016	1-1-06	Amend	1-1-06
436-035-0017	1-1-06	Amend	1-1-06
436-035-0019	1-1-06	Amend	1-1-06
436-035-0110	1-1-06	Amend	1-1-06
436-035-0190	1-1-06	Amend	1-1-06
436-035-0230	1-1-06	Amend	1-1-06
436-035-0330	1-1-06	Amend	1-1-06
436-035-0340	1-1-06	Amend	1-1-06
436-035-0350	1-1-06	Amend	1-1-06
436-035-0360	1-1-06	Amend	1-1-06
436-035-0380	1-1-06	Amend	1-1-06
436-035-0390	1-1-06	Amend	1-1-06
436-035-0395	1-1-06	Amend	1-1-06
436-035-0400	1-1-06	Amend	1-1-06
436-035-0410	1-1-06	Amend	1-1-06
436-035-0420	1-1-06	Amend	1-1-06
436-035-0430	1-1-06	Amend	1-1-06
436-035-0500	1-1-06	Amend	1-1-06
436-050-0003	1-1-06	Amend	1-1-06
436-050-0008	1-1-06	Amend	1-1-06
436-050-0100	1-1-06	Amend	1-1-06
436-050-0110	1-1-06	Amend	1-1-06
436-050-0170	1-1-06	Amend	1-1-06
436-050-0220	1-1-06	Amend	1-1-06
436-050-0230	1-1-06	Amend	1-1-06
436-055-0008	7-1-06	Amend	7-1-06
436-055-0070	1-1-06	Amend	1-1-06
436-055-0070	7-1-06	Amend	7-1-06
436-055-0085	1-1-06	Adopt	1-1-06
436-055-0085	7-1-06	Amend	7-1-06
436-055-0100	1-1-06	Amend	1-1-06
436-055-0110	7-1-06	Amend	7-1-06
436-055-0120	7-1-06	Repeal	7-1-06
436-060-0002	1-1-06	Amend	1-1-06
436-060-0008	1-1-06	Amend	1-1-06
436-060-0009	1-1-06	Amend	1-1-06
436-060-0010	1-1-06	Amend	1-1-06
436-060-0015	1-1-06	Amend	1-1-06
436-060-0017	1-1-06	Amend	1-1-06
436-060-0020	1-1-06	Amend	1-1-06
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436-060-0035	1-1-06	Amend	1-1-06
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436-060-0060	1-1-06	Amend	1-1-06
436-060-0095	1-1-06	Amend	1-1-06
436-060-0095	7-1-06	Amend	7-1-06
436-060-0105	1-1-06	Amend	1-1-06
436-060-0135	1-1-06	Amend	1-1-06
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436-060-0180	1-1-06	Amend	1-1-06
436-060-0190	1-1-06	Amend	1-1-06
436-060-0200	1-1-06	Amend	1-1-06
436-060-0500	1-1-06	Amend	1-1-06
436-060-0510	1-1-06	Adopt	1-1-06
436-070-0020	1-27-06	Amend(T)	3-1-06
436-070-0020	7-1-06	Amend	7-1-06
436-070-0020(T)	7-1-06	Repeal	7-1-06
436-105-0500	1-1-06	Amend	1-1-06
436-110-0002	1-1-06	Amend	1-1-06
436-110-0005	1-1-06	Amend	1-1-06
436-110-0310	1-1-06	Amend	1-1-06
436-110-0326	1-1-06	Amend	1-1-06
436-110-0327	1-1-06	Amend	1-1-06
436-110-0335	1-1-06	Amend	1-1-06
436-110-0337	1-1-06	Amend	1-1-06
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436-120-0008	1-1-06	Amend	1-1-06
436-120-0320	1-1-06	Amend	1-1-06
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436-120-0900	1-1-06	Amend	1-1-06
437-001-0001	2-14-06	Amend	3-1-06
437-002-0005	12-14-05	Amend	1-1-06
437-002-0100	12-14-05	Amend	1-1-06
437-002-0260	12-14-05	Amend	1-1-06
437-002-0280	12-14-05	Amend	1-1-06
437-002-0300	12-14-05	Amend	1-1-06
437-003-0001	4-28-06	Amend	6-1-06
437-004-1040	3-1-07	Repeal	7-1-06
437-004-1041	3-1-07	Adopt	7-1-06
440-001-0000	5-9-06	Amend	6-1-06
440-001-0005	2-14-06	Amend	3-1-06
441-001-0005	5-17-06	Amend	7-1-06
441-049-1001	5-4-06	Amend	6-1-06
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441-750-0020	1-9-06	Repeal	2-1-06
441-750-0030	1-9-06	Repeal	2-1-06
441-750-0040	1-9-06	Repeal	2-1-06
441-780-0010	1-9-06	Repeal	2-1-06
441-780-0020	1-9-06	Repeal	2-1-06
441-780-0030	1-9-06	Repeal	2-1-06
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441-780-0050	1-9-06	Repeal	2-1-06
441-780-0060	1-9-06	Repeal	2-1-06
441-780-0070	1-9-06	Repeal	2-1-06
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441-910-0030	1-1-06	Amend	1-1-06
441-910-0040	1-1-06	Amend	1-1-06
441-910-0050	1-1-06	Amend	1-1-06
441-910-0055	1-1-06	Am. & Ren.	1-1-06
441-910-0060	1-1-06	Repeal	1-1-06
441-910-0070	1-1-06	Repeal	1-1-06
441-910-0080	1-1-06	Amend	1-1-06
441-910-0090	1-1-06	Amend	1-1-06
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441-930-0040	2-22-06	Repeal	4-1-06
441-930-0050	2-22-06	Repeal	4-1-06
441-930-0060	2-22-06	Repeal	4-1-06
441-930-0070	2-22-06	Amend	4-1-06
441-930-0080	2-22-06	Adopt	4-1-06
441-930-0200	2-22-06	Repeal	4-1-06
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441-930-0220	2-22-06	Amend	4-1-06
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441-930-0300	2-22-06	Amend	4-1-06
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441-930-0330	2-22-06	Amend	4-1-06
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441-930-0350	2-22-06	Amend	4-1-06
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442-004-0010	6-1-06	Repeal	7-1-06
442-004-0020	6-1-06	Repeal	7-1-06
442-004-0030	6-1-06	Repeal	7-1-06
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442-004-0050	6-1-06	Repeal	7-1-06
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442-004-0070	6-1-06	Repeal	7-1-06
442-004-0080	1-17-06	Amend(T)	3-1-06
442-004-0080	6-1-06	Repeal	7-1-06
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442-004-0150	6-1-06	Repeal	7-1-06
442-004-0160	1-17-06	Amend(T)	3-1-06
442-004-0160	6-1-06	Repeal	7-1-06
442-004-0170	1-17-06	Amend(T)	3-1-06
442-004-0170	6-1-06	Repeal	7-1-06
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442-005-0100	6-1-06	Adopt	7-1-06
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442-005-0130	6-1-06	Adopt	7-1-06
442-005-0140	6-1-06	Adopt	7-1-06
442-005-0150	6-1-06	Adopt	7-1-06
442-005-0160	6-1-06	Adopt	7-1-06
442-005-0170	6-1-06	Adopt	7-1-06
442-005-0180	6-1-06	Adopt	7-1-06
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442-005-0280	6-1-06	Adopt	7-1-06
442-005-0290	6-1-06	Adopt	7-1-06
442-005-0300	6-1-06	Adopt	7-1-06
442-005-0310	6-1-06	Adopt	7-1-06
442-005-0320	6-1-06	Adopt	7-1-06
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442-005-0350	6-1-06	Adopt	7-1-06
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443-002-0030	1-1-06	Amend	2-1-06
443-002-0060	1-1-06	Amend	2-1-06
443-002-0070	1-1-06	Amend	2-1-06
443-002-0080	1-1-06	Amend	2-1-06
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443-002-0095	1-1-06	Adopt	2-1-06
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443-002-0120	1-1-06	Amend	2-1-06
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445-050-0115	6-15-06	Amend	7-1-06
445-050-0125	12-29-05	Amend(T)	2-1-06
445-050-0125	6-15-06	Amend	7-1-06
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445-050-0135	6-15-06	Amend	7-1-06
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459-005-0610	2-1-06	Amend	3-1-06
459-007-0001	2-1-06	Amend	3-1-06
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459-007-0003(T)	2-1-06	Repeal	3-1-06
459-007-0005	2-1-06	Amend	3-1-06
459-007-0005(T)	2-1-06	Repeal	3-1-06
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459-007-0090	2-1-06	Amend	3-1-06
459-007-0090(T)	2-1-06	Repeal	3-1-06
459-007-0095	2-1-06	Repeal	3-1-06
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459-010-0014	1-1-06	Amend	2-1-06
459-010-0040	4-5-06	Repeal	5-1-06
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459-013-0300	2-1-06	Repeal	3-1-06
459-014-0030	4-5-06	Amend	5-1-06
459-017-0060	3-1-06	Amend	4-1-06
459-050-0060	4-5-06	Amend	5-1-06
459-070-0001	1-1-06	Amend	2-1-06
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459-080-0150	4-5-06	Amend	5-1-06
461-001-0010	6-1-06	Amend	7-1-06
461-101-0010	1-1-06	Amend	2-1-06
461-101-0010	6-1-06	Amend	7-1-06
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461-105-0010	4-1-06	Amend	5-1-06
461-105-0050	4-1-06	Repeal	5-1-06
461-105-0060	4-1-06	Amend	5-1-06
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461-105-0080	4-1-06	Repeal	5-1-06
461-105-0090	4-1-06	Repeal	5-1-06
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461-115-0530	6-1-06	Amend(T)	7-1-06
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461-120-0110	4-1-06	Amend	5-1-06
461-120-0125	4-1-06	Amend	5-1-06
461-120-0510	1-1-06	Amend	2-1-06
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461-135-0506	4-1-06	Amend	5-1-06
461-135-0570	4-1-06	Amend	5-1-06
461-135-0701	1-1-06	Amend	2-1-06
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461-135-0950(T)	4-1-06	Repeal	5-1-06
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461-135-1120	6-1-06	Amend	7-1-06
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461-135-1175	6-1-06	Adopt	7-1-06
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461-155-0150	4-1-06	Amend(T)	5-1-06
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461-155-0235	1-24-06	Amend	3-1-06
461-155-0235	6-1-06	Amend	7-1-06
461-155-0250	1-1-06	Amend	2-1-06
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461-165-0140	4-1-06	Amend	5-1-06
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461-180-0100	4-1-06	Amend	5-1-06
461-180-0130	1-1-06	Amend	2-1-06
461-185-0050	1-1-06	Amend	2-1-06
461-190-0161	1-1-06	Amend	2-1-06
461-190-0195	1-1-06	Adopt	2-1-06
461-190-0211	1-1-06	Amend	2-1-06
461-190-0241	1-1-06	Amend	2-1-06
461-195-0301	1-1-06	Amend	2-1-06
461-195-0303	1-1-06	Amend	2-1-06
461-195-0305	1-1-06	Amend	2-1-06
461-195-0310	1-1-06	Amend	2-1-06
461-195-0315	1-1-06	Amend	2-1-06
461-195-0320	1-1-06	Amend	2-1-06
461-195-0321	1-1-06	Amend	2-1-06
461-195-0325	1-1-06	Amend	2-1-06
461-195-0350	1-1-06	Amend	2-1-06
461-195-0621	4-1-06	Amend	5-1-06
471-010-0040	12-25-05	Amend	2-1-06
471-010-0050	4-23-06	Amend	6-1-06
471-015-0015	1-1-06	Amend	2-1-06

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471-020-0021	1-8-06	Amend	2-1-06
471-030-0030	12-25-05	Repeal	2-1-06
471-030-0035	12-25-05	Amend	2-1-06
471-030-0036	1-8-06	Amend	2-1-06
471-030-0049	1-8-06	Amend	2-1-06
471-030-0050	12-25-05	Amend	2-1-06
471-030-0056	1-8-06	Adopt	2-1-06
471-030-0060	12-25-05	Amend	2-1-06
471-030-0065	12-25-05	Amend	2-1-06
471-030-0076	1-12-06	Amend(T)	2-1-06
471-030-0080	1-1-06	Amend	2-1-06
471-030-0125	3-12-06	Amend	4-1-06
471-030-0150	12-15-05	Amend	1-1-06
471-030-0174	12-25-05	Amend	2-1-06
471-031-0055	12-25-05	Amend	2-1-06
471-031-0057	12-25-05	Repeal	2-1-06
471-031-0090	1-1-06	Repeal	2-1-06
471-031-0139	2-5-06	Adopt	3-1-06
471-031-0140	2-5-06	Amend	3-1-06
471-031-0141	2-5-06	Amend	3-1-06
471-031-0142	2-5-06	Amend	3-1-06
471-031-0180	1-1-06	Repeal	2-1-06
471-040-0005	12-25-05	Amend	2-1-06
471-040-0007	3-5-06	Adopt	4-1-06
471-040-0008	3-5-06	Adopt	4-1-06
471-042-0005	12-25-05	Repeal	2-1-06
471-050-0001	12-25-05	Repeal	2-1-06
543-040-0020	2-14-06	Amend	3-1-06
543-040-0033	2-14-06	Repeal	3-1-06
543-050-0010	2-14-06	Repeal	3-1-06
543-060-0000	2-14-06	Amend	3-1-06
543-060-0010	2-14-06	Amend	3-1-06
543-060-0020	2-14-06	Amend	3-1-06
543-060-0030	2-14-06	Amend	3-1-06
543-070-0000	2-14-06	Amend	3-1-06
573-040-0005	3-31-06	Amend	5-1-06
573-070-0005	6-1-06	Amend	7-1-06
573-070-0011	6-1-06	Amend	7-1-06
574-001-0000	3-2-06	Amend	4-1-06
574-050-0005	3-2-06	Amend	4-1-06
575-060-0005	2-8-06	Amend	3-1-06
575-071-0000	3-1-06	Amend	4-1-06
575-071-0010	3-1-06	Amend	4-1-06
575-071-0020	3-1-06	Amend	4-1-06
575-071-0030	3-1-06	Amend	4-1-06
575-071-0035	3-1-06	Amend	4-1-06
575-071-0040	3-1-06	Amend	4-1-06
575-071-0050	3-1-06	Amend	4-1-06
575-071-0060	3-1-06	Amend	4-1-06
575-071-0070	3-1-06	Amend	4-1-06
575-074-0000	3-1-06	Adopt	4-1-06
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575-074-0010	3-1-06	Adopt	4-1-06
575-074-0015	3-1-06	Adopt	4-1-06
575-074-0020	3-1-06	Adopt	4-1-06
575-074-0025	3-1-06	Adopt	4-1-06
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577-001-0105	12-15-05	Amend	1-1-06
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577-001-0120	12-15-05	Amend	1-1-06
577-031-0131	3-10-06	Amend	4-1-06
577-060-0020	12-13-05	Amend	1-1-06
578-041-0030	6-2-06	Amend	7-1-06
578-072-0030	6-2-06	Amend	7-1-06
579-020-0006	4-14-06	Amend	5-1-06
580-023-0005	6-12-06	Adopt(T)	7-1-06
580-023-0010	6-12-06	Adopt(T)	7-1-06
580-023-0015	6-12-06	Adopt(T)	7-1-06
580-023-0020	6-12-06	Adopt(T)	7-1-06
580-023-0025	6-12-06	Adopt(T)	7-1-06
580-023-0030	6-12-06	Adopt(T)	7-1-06
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580-023-0040	6-12-06	Adopt(T)	7-1-06
580-023-0045	6-12-06	Adopt(T)	7-1-06
580-023-0050	6-12-06	Adopt(T)	7-1-06
580-023-0055	6-12-06	Adopt(T)	7-1-06
580-023-0060	6-12-06	Adopt(T)	7-1-06
580-023-0065	6-12-06	Adopt(T)	7-1-06
580-040-0040	6-8-06	Amend	7-1-06
580-043-0060	2-9-06	Adopt(T)	3-1-06
580-043-0065	2-9-06	Adopt(T)	3-1-06
580-043-0070	2-9-06	Adopt(T)	3-1-06
580-043-0075	2-9-06	Adopt(T)	3-1-06
580-043-0080	2-9-06	Adopt(T)	3-1-06
580-043-0085	2-9-06	Adopt(T)	3-1-06
580-043-0090	2-9-06	Adopt(T)	3-1-06
580-043-0095	2-9-06	Adopt(T)	3-1-06
581-001-0005	2-14-06	Amend(T)	3-1-06
581-011-0119	2-14-06	Amend	3-1-06
581-021-0042	1-20-06	Adopt	3-1-06
581-021-0044	2-14-06	Amend(T)	3-1-06
581-021-0110	2-21-06	Amend	4-1-06
581-022-1110	2-14-06	Amend	3-1-06
581-022-1120	2-14-06	Amend	3-1-06
581-022-1210	2-14-06	Amend	3-1-06
581-022-1360	12-15-05	Adopt(T)	1-1-06
581-022-1361	12-15-05	Adopt(T)	1-1-06
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581-022-1363	5-24-06	Adopt	7-1-06
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581-022-1366	5-24-06	Adopt	7-1-06
581-022-1367	5-24-06	Adopt	7-1-06
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581-022-1369	5-24-06	Adopt	7-1-06
581-022-1370	5-24-06	Adopt	7-1-06
581-022-1730	2-21-06	Amend	4-1-06

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581-022-1735	2-14-06	Amend	3-1-06
581-023-0040	2-21-06	Amend	4-1-06
581-024-0195	12-29-05	Adopt(T)	2-1-06
581-024-0205	12-29-05	Amend(T)	2-1-06
581-024-0206	12-29-05	Amend(T)	2-1-06
581-024-0208	12-29-05	Amend(T)	2-1-06
581-024-0210	12-29-05	Amend(T)	2-1-06
581-024-0215	2-21-06	Amend	4-1-06
581-024-0226	2-14-06	Suspend	3-1-06
581-024-0228	2-14-06	Suspend	3-1-06
581-024-0285	12-29-05	Amend(T)	2-1-06
582-001-0001	5-11-06	Repeal	6-1-06
582-001-0005	5-11-06	Amend	6-1-06
583-030-0005	12-7-05	Amend	1-1-06
583-030-0009	12-7-05	Adopt	1-1-06
583-030-0010	12-7-05	Amend	1-1-06
583-030-0011	12-7-05	Am. & Ren.	1-1-06
583-030-0015	12-7-05	Amend	1-1-06
583-030-0016	12-7-05	Amend	1-1-06
583-030-0020	12-7-05	Amend	1-1-06
583-030-0021	12-7-05	Repeal	1-1-06
583-030-0025	12-7-05	Amend	1-1-06
583-030-0030	12-7-05	Amend	1-1-06
583-030-0032	12-7-05	Am. & Ren.	1-1-06
583-030-0035	12-7-05	Amend	1-1-06
583-030-0036	12-7-05	Amend	1-1-06
583-030-0038	12-7-05	Adopt	1-1-06
583-030-0039	12-7-05	Am. & Ren.	1-1-06
583-030-0041	12-7-05	Amend	1-1-06
583-030-0042	12-7-05	Amend	1-1-06
583-030-0043	12-7-05	Amend	1-1-06
583-030-0044	12-7-05	Amend	1-1-06
583-030-0045	12-7-05	Amend	1-1-06
583-030-0046	12-7-05	Amend	1-1-06
583-030-0049	12-7-05	Amend	1-1-06
584-010-0090	6-15-06	Adopt	7-1-06
584-017-0070	1-3-06	Amend(T)	2-1-06
584-017-0070	2-3-06	Amend(T)	3-1-06
584-017-0070	6-15-06	Amend	7-1-06
584-017-0100	6-15-06	Amend	7-1-06
584-017-0175	6-15-06	Amend	7-1-06
584-017-0251	7-1-06	Amend(T)	7-1-06
584-017-0261	7-1-06	Amend(T)	7-1-06
584-017-0440	5-12-06	Repeal	3-1-06
584-017-0442	7-1-06	Adopt(T)	7-1-06
584-017-0450	5-12-06	Repeal	3-1-06
584-017-0452	7-1-06	Adopt(T)	7-1-06
584-020-0041	6-15-06	Amend	7-1-06
584-021-0170	1-1-06	Amend(T)	1-1-06
584-021-0170	2-10-06	Amend	3-1-06
584-021-0177	2-10-06	Amend	3-1-06
584-023-0005	6-15-06	Amend	7-1-06
584-023-0015	6-15-06	Amend	7-1-06
584-023-0020	6-15-06	Repeal	7-1-06
584-023-0025	2-10-06	Amend	3-1-06
584-023-0025	6-15-06	Amend	7-1-06
584-036-0055	1-1-06	Amend(T)	1-1-06
584-036-0055	2-10-06	Amend	3-1-06
584-036-0062	2-10-06	Amend	3-1-06
584-036-0070	2-3-06	Adopt(T)	3-1-06
584-036-0070	6-15-06	Adopt	7-1-06
584-040-0005	6-15-06	Amend	7-1-06
584-048-0020	6-15-06	Amend	7-1-06
584-048-0090	7-1-06	Amend(T)	7-1-06
584-052-0030	6-1-06	Amend	6-1-06
584-052-0031	6-1-06	Amend	6-1-06
584-052-0032	6-1-06	Amend	6-1-06
584-052-0033	6-1-06	Amend	6-1-06
584-060-0052	6-15-06	Amend	7-1-06
584-060-0120	5-12-06	Repeal	3-1-06
584-070-0013	4-1-06	Adopt(T)	3-1-06
584-070-0013	4-1-06	Amend(T)	4-1-06
584-080-0001	7-1-06	Amend(T)	7-1-06
584-080-0002	7-1-06	Adopt(T)	7-1-06
584-080-0011	7-1-06	Suspend	7-1-06
584-080-0012	7-1-06	Adopt(T)	7-1-06
584-080-0021	7-1-06	Suspend	7-1-06
584-080-0022	7-1-06	Adopt(T)	7-1-06
584-080-0031	7-1-06	Amend(T)	7-1-06
584-100-0002	2-3-06	Amend(T)	3-1-06
584-100-0002	6-1-06	Amend	6-1-06
584-100-0006	2-3-06	Amend(T)	3-1-06
584-100-0006	6-1-06	Amend	6-1-06
584-100-0011	2-3-06	Amend(T)	3-1-06
584-100-0011	6-1-06	Amend	6-1-06
584-100-0016	2-3-06	Amend(T)	3-1-06
584-100-0016	6-1-06	Amend	6-1-06
584-100-0021	2-3-06	Amend(T)	3-1-06
584-100-0021	6-1-06	Amend	6-1-06
584-100-0026	2-3-06	Amend(T)	3-1-06
584-100-0026	6-1-06	Amend	6-1-06
584-100-0031	2-3-06	Amend(T)	3-1-06
584-100-0031	6-1-06	Amend	6-1-06
584-100-0036	2-3-06	Amend(T)	3-1-06
584-100-0036	6-1-06	Amend	6-1-06
584-100-0037	2-10-06	Repeal	3-1-06
584-100-0038	2-3-06	Adopt(T)	3-1-06
584-100-0038	6-1-06	Adopt	6-1-06
584-100-0041	2-3-06	Amend(T)	3-1-06
584-100-0041	6-1-06	Amend	6-1-06
584-100-0051	2-3-06	Amend(T)	3-1-06
584-100-0051	6-1-06	Amend	6-1-06
584-100-0056	2-3-06	Amend(T)	3-1-06
584-100-0056	6-1-06	Amend	6-1-06
584-100-0061	2-3-06	Amend(T)	3-1-06
584-100-0061	6-1-06	Amend	6-1-06
584-100-0066	2-3-06	Amend(T)	3-1-06
584-100-0066	6-1-06	Amend	6-1-06
584-100-0071	2-3-06	Amend(T)	3-1-06
584-100-0071	6-1-06	Amend	6-1-06
584-100-0091	2-3-06	Amend(T)	3-1-06

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584-100-0096	6-1-06	Amend	6-1-06
584-100-0101	2-3-06	Amend(T)	3-1-06
584-100-0101	6-1-06	Amend	6-1-06
584-100-0106	2-3-06	Amend(T)	3-1-06
584-100-0106	6-1-06	Amend	6-1-06
589-002-0100	6-15-06	Amend(T)	7-1-06
589-007-0400	4-18-06	Amend	6-1-06
589-020-0210	6-15-06	Amend(T)	7-1-06
589-020-0225	6-15-06	Amend(T)	7-1-06
589-020-0260	6-15-06	Suspend	7-1-06
603-014-0055	7-1-06	Amend	7-1-06
603-021-0008	3-10-06	Repeal	4-1-06
603-021-0709	3-10-06	Repeal	4-1-06
603-024-0017	3-10-06	Amend	4-1-06
603-024-0211	3-10-06	Amend	4-1-06
603-024-0234	3-10-06	Amend	4-1-06
603-024-0547	3-10-06	Amend	4-1-06
603-025-0010	3-10-06	Amend	4-1-06
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603-025-0040	3-10-06	Repeal	4-1-06
603-025-0150	1-3-06	Amend(T)	2-1-06
603-025-0190	3-10-06	Amend	4-1-06
603-025-0210	3-10-06	Repeal	4-1-06
603-028-0010	3-10-06	Repeal	4-1-06
603-028-0500	3-10-06	Amend	4-1-06
603-052-0116	1-13-06	Amend	2-1-06
603-052-0117	1-13-06	Amend	2-1-06
603-052-0127	3-22-06	Amend	5-1-06
603-052-0129	1-13-06	Amend	2-1-06
603-052-0146	3-22-06	Repeal	5-1-06
603-052-0150	1-13-06	Amend	2-1-06
603-052-0349	1-13-06	Repeal	2-1-06
603-052-0355	1-13-06	Amend	2-1-06
603-052-0360	1-13-06	Amend	2-1-06
603-052-0385	1-13-06	Amend	2-1-06
603-052-1150	3-22-06	Amend	5-1-06
603-052-1200	1-13-06	Amend	2-1-06
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603-057-0006(T)	3-8-06	Repeal	4-1-06
603-057-0405	4-12-06	Amend	5-1-06
603-057-0410	4-12-06	Amend	5-1-06
603-057-0411	4-12-06	Amend	5-1-06
603-057-0412	4-12-06	Amend	5-1-06
603-057-0413	4-12-06	Amend	5-1-06
603-057-0415	4-12-06	Amend	5-1-06
603-057-0416	4-12-06	Amend	5-1-06
603-057-0417	4-12-06	Amend	5-1-06
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619-001-0020	12-15-05	Adopt	1-1-06
619-001-0030	12-15-05	Adopt	1-1-06
619-001-0040	12-15-05	Adopt	1-1-06
619-001-0050	12-15-05	Adopt	1-1-06
619-001-0060	12-15-05	Adopt	1-1-06
628-001-0005	5-25-06	Amend	7-1-06
629-001-0005	3-15-06	Amend	4-1-06
629-001-0010	1-1-06	Amend	1-1-06
629-001-0010(T)	1-1-06	Repeal	1-1-06
629-001-0025	1-1-06	Amend	1-1-06
629-001-0025(T)	1-1-06	Repeal	1-1-06
629-001-0057	1-13-06	Adopt	2-1-06
629-022-0320	5-2-06	Amend(T)	6-1-06
629-023-0410	1-3-06	Amend(T)	2-1-06
629-023-0410	6-1-06	Amend	6-1-06
629-023-0410(T)	6-1-06	Repeal	6-1-06
629-023-0420	1-3-06	Amend(T)	2-1-06
629-023-0420	6-1-06	Amend	6-1-06
629-023-0420(T)	6-1-06	Repeal	6-1-06
629-023-0430	1-3-06	Amend(T)	2-1-06
629-023-0430	6-1-06	Amend	6-1-06
629-023-0430(T)	6-1-06	Repeal	6-1-06
629-023-0440	1-3-06	Amend(T)	2-1-06
629-023-0440	6-1-06	Amend	6-1-06
629-023-0440(T)	6-1-06	Repeal	6-1-06
629-023-0450	1-3-06	Amend(T)	2-1-06
629-023-0450	6-1-06	Amend	6-1-06
629-023-0450(T)	6-1-06	Repeal	6-1-06
629-023-0460	1-3-06	Amend(T)	2-1-06
629-023-0460	6-1-06	Amend	6-1-06
629-023-0460(T)	6-1-06	Repeal	6-1-06
629-023-0490	1-3-06	Amend(T)	2-1-06
629-023-0490	6-1-06	Amend	6-1-06
629-023-0490(T)	6-1-06	Repeal	6-1-06
629-041-0520	7-1-06	Repeal	1-1-06
629-041-0535	7-1-06	Repeal	1-1-06
629-041-0545	7-1-06	Repeal	1-1-06
629-041-0547	7-1-06	Adopt	1-1-06
629-041-0557	7-1-06	Adopt	1-1-06
629-042-0100	5-9-06	Adopt	6-1-06
629-600-0100	1-1-06	Amend	1-1-06
629-600-0100(T)	1-1-06	Repeal	1-1-06
629-605-0100	1-1-06	Amend	1-1-06
629-605-0100(T)	1-1-06	Repeal	1-1-06
629-605-0150	1-1-06	Amend	1-1-06
629-605-0150(T)	1-1-06	Repeal	1-1-06
629-605-0170	1-1-06	Amend	1-1-06
629-605-0170(T)	1-1-06	Repeal	1-1-06
629-605-0173	1-1-06	Adopt	1-1-06
629-605-0173(T)	1-1-06	Repeal	1-1-06
629-605-0175	1-1-06	Amend	1-1-06
629-605-0175(T)	1-1-06	Repeal	1-1-06

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629-605-0180(T)	1-1-06	Repeal	1-1-06
629-605-0190	1-1-06	Amend	1-1-06
629-605-0190(T)	1-1-06	Repeal	1-1-06
629-605-0500	1-1-06	Amend	1-1-06
629-605-0500(T)	1-1-06	Repeal	1-1-06
629-610-0020	1-1-06	Amend	1-1-06
629-610-0020(T)	1-1-06	Repeal	1-1-06
629-610-0030	1-1-06	Amend	1-1-06
629-610-0030(T)	1-1-06	Repeal	1-1-06
629-610-0040	1-1-06	Amend	1-1-06
629-610-0040(T)	1-1-06	Repeal	1-1-06
629-610-0050	1-1-06	Amend	1-1-06
629-610-0050(T)	1-1-06	Repeal	1-1-06
629-610-0060	1-1-06	Amend	1-1-06
629-610-0060(T)	1-1-06	Repeal	1-1-06
629-610-0070	1-1-06	Amend	1-1-06
629-610-0070(T)	1-1-06	Repeal	1-1-06
629-610-0090	1-1-06	Amend	1-1-06
629-610-0090(T)	1-1-06	Repeal	1-1-06
629-615-0300	1-1-06	Amend	1-1-06
629-615-0300(T)	1-1-06	Repeal	1-1-06
629-623-0450	1-1-06	Amend	1-1-06
629-623-0450(T)	1-1-06	Repeal	1-1-06
629-623-0550	1-1-06	Amend	1-1-06
629-623-0550(T)	1-1-06	Repeal	1-1-06
629-623-0700	1-1-06	Amend	1-1-06
629-623-0700(T)	1-1-06	Repeal	1-1-06
629-625-0100	1-1-06	Amend	1-1-06
629-625-0100(T)	1-1-06	Repeal	1-1-06
629-625-0320	1-1-06	Amend	1-1-06
629-625-0320(T)	1-1-06	Repeal	1-1-06
629-625-0430	1-1-06	Amend	1-1-06
629-625-0430(T)	1-1-06	Repeal	1-1-06
629-630-0200	1-1-06	Amend	1-1-06
629-630-0200(T)	1-1-06	Repeal	1-1-06
629-630-0600	1-1-06	Amend	1-1-06
629-630-0600(T)	1-1-06	Repeal	1-1-06
629-630-0700	1-1-06	Amend	1-1-06
629-630-0700(T)	1-1-06	Repeal	1-1-06
629-630-0800	1-1-06	Amend	1-1-06
629-630-0800(T)	1-1-06	Repeal	1-1-06
629-635-0130	1-1-06	Amend	1-1-06
629-635-0130(T)	1-1-06	Repeal	1-1-06
629-640-0100	1-1-06	Amend	1-1-06
629-640-0100(T)	1-1-06	Repeal	1-1-06
629-640-0110	1-1-06	Amend	1-1-06
629-640-0110(T)	1-1-06	Repeal	1-1-06
629-640-0200	1-1-06	Amend	1-1-06
629-640-0200(T)	1-1-06	Repeal	1-1-06
629-640-0400	1-1-06	Amend	1-1-06
629-640-0400(T)	1-1-06	Repeal	1-1-06
629-645-0000	1-1-06	Amend	1-1-06
629-645-0000(T)	1-1-06	Repeal	1-1-06
629-645-0020	1-1-06	Amend	1-1-06
629-645-0020(T)	1-1-06	Repeal	1-1-06
629-645-0030	1-1-06	Amend	1-1-06
629-645-0030(T)	1-1-06	Repeal	1-1-06
629-645-0050	1-1-06	Amend	1-1-06
629-645-0050(T)	1-1-06	Repeal	1-1-06
629-650-0040	1-1-06	Amend	1-1-06
629-650-0040(T)	1-1-06	Repeal	1-1-06
629-660-0040	1-1-06	Amend	1-1-06
629-660-0040(T)	1-1-06	Repeal	1-1-06
629-660-0050	1-1-06	Amend	1-1-06
629-660-0050(T)	1-1-06	Repeal	1-1-06
629-665-0020	1-1-06	Amend	1-1-06
629-665-0020(T)	1-1-06	Repeal	1-1-06
629-665-0110	1-1-06	Amend	1-1-06
629-665-0110(T)	1-1-06	Repeal	1-1-06
629-665-0120	1-1-06	Amend	1-1-06
629-665-0120(T)	1-1-06	Repeal	1-1-06
629-665-0210	1-1-06	Amend	1-1-06
629-665-0210(T)	1-1-06	Repeal	1-1-06
629-665-0220	1-1-06	Amend	1-1-06
629-665-0220(T)	1-1-06	Repeal	1-1-06
629-665-0230	1-1-06	Amend	1-1-06
629-665-0230(T)	1-1-06	Repeal	1-1-06
629-665-0240	1-1-06	Amend	1-1-06
629-665-0240(T)	1-1-06	Repeal	1-1-06
629-670-0010	1-1-06	Amend	1-1-06
629-670-0010(T)	1-1-06	Repeal	1-1-06
629-670-0015	1-1-06	Amend	1-1-06
629-670-0015(T)	1-1-06	Repeal	1-1-06
629-670-0100	1-1-06	Amend	1-1-06
629-670-0100(T)	1-1-06	Repeal	1-1-06
629-670-0115	1-1-06	Amend	1-1-06
629-670-0115(T)	1-1-06	Repeal	1-1-06
629-670-0125	1-1-06	Amend	1-1-06
629-670-0125(T)	1-1-06	Repeal	1-1-06
629-670-0210	1-1-06	Amend	1-1-06
629-670-0210(T)	1-1-06	Repeal	1-1-06
629-672-0100	1-1-06	Amend	1-1-06
629-672-0100(T)	1-1-06	Repeal	1-1-06
629-672-0200	1-1-06	Amend	1-1-06
629-672-0200(T)	1-1-06	Repeal	1-1-06
629-672-0210	1-1-06	Amend	1-1-06
629-672-0210(T)	1-1-06	Repeal	1-1-06
629-672-0220	1-1-06	Repeal	1-1-06
629-672-0310	1-1-06	Amend	1-1-06
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635-006-0232	1-9-06	Amend	2-1-06
635-006-0810	1-1-06	Amend	1-1-06
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635-017-0090	1-1-06	Amend	1-1-06
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635-017-0095	1-1-06	Amend(T)	2-1-06
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635-018-0080	1-1-06	Amend	1-1-06
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635-019-0090	1-1-06	Amend	1-1-06
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635-021-0090	1-1-06	Amend	1-1-06
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635-075-0029	1-25-06	Amend	3-1-06
635-075-0035	1-25-06	Adopt	3-1-06
635-080-0015	1-1-06	Amend	1-1-06
635-080-0016	1-1-06	Amend	1-1-06
635-080-0066	1-1-06	Amend	1-1-06
635-080-0068	1-1-06	Amend	1-1-06
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635-080-0070	1-1-06	Amend	1-1-06
635-080-0071	1-1-06	Amend	1-1-06
635-110-0000	12-29-05	Amend	2-1-06
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635-180-0010	6-6-06	Repeal	7-1-06
635-180-0015	6-6-06	Amend	7-1-06
635-412-0005	1-9-06	Adopt	2-1-06
635-412-0015	1-9-06	Adopt	2-1-06
635-412-0020	1-9-06	Amend	2-1-06
635-412-0025	1-9-06	Amend	2-1-06
635-412-0035	1-9-06	Adopt	2-1-06
635-412-0040	1-9-06	Adopt	2-1-06
635-430-0025	6-14-06	Amend	7-1-06
644-010-0010	1-1-06	Amend	1-1-06
647-010-0010	6-1-06	Amend	6-1-06
660-004-0000	2-15-06	Amend	3-1-06

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660-033-0120	2-15-06	Amend	3-1-06
660-033-0130	2-15-06	Amend	3-1-06
660-034-0000	4-14-06	Amend	5-1-06
660-034-0010	4-14-06	Amend	5-1-06
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660-034-0040	4-14-06	Amend	5-1-06
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678-010-0020	1-27-06	Amend	3-1-06
678-010-0030	1-27-06	Amend	3-1-06
678-010-0040	1-27-06	Amend	3-1-06
678-010-0050	1-27-06	Amend	3-1-06
690-030-0085	1-30-06	Amend	3-1-06
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690-315-0020	11-22-05	Amend	1-1-06
690-315-0030	11-22-05	Amend	1-1-06
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690-315-0090	11-22-05	Amend	1-1-06
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731-007-0335	2-16-06	Adopt	4-1-06
731-007-0335(T)	2-16-06	Repeal	4-1-06
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731-035-0010	1-24-06	Adopt	3-1-06
731-035-0010(T)	1-24-06	Repeal	3-1-06
731-035-0020	11-21-05	Adopt(T)	1-1-06
731-035-0020	1-24-06	Adopt	3-1-06
731-035-0020(T)	1-24-06	Repeal	3-1-06
731-035-0030	11-21-05	Adopt(T)	1-1-06
731-035-0030	1-24-06	Adopt	3-1-06
731-035-0030(T)	1-24-06	Repeal	3-1-06
731-035-0040	11-21-05	Adopt(T)	1-1-06
731-035-0040	1-24-06	Adopt	3-1-06
731-035-0040(T)	1-24-06	Repeal	3-1-06
731-035-0050	11-21-05	Adopt(T)	1-1-06
731-035-0050	1-24-06	Adopt	3-1-06
731-035-0050(T)	1-24-06	Repeal	3-1-06
731-035-0060	11-21-05	Adopt(T)	1-1-06
731-035-0060	1-24-06	Adopt	3-1-06
731-035-0060(T)	1-24-06	Repeal	3-1-06
731-035-0070	11-21-05	Adopt(T)	1-1-06
731-035-0070	1-24-06	Adopt	3-1-06
731-035-0070(T)	1-24-06	Repeal	3-1-06
731-035-0080	11-21-05	Adopt(T)	1-1-06
731-035-0080	1-24-06	Adopt	3-1-06
731-035-0080(T)	1-24-06	Repeal	3-1-06
731-146-0010	5-25-06	Amend	7-1-06
731-147-0010	5-25-06	Amend	7-1-06
731-148-0010	5-25-06	Amend	7-1-06
731-149-0010	5-25-06	Amend	7-1-06
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734-020-0005	5-26-06	Amend	7-1-06
734-020-0005(T)	5-26-06	Repeal	7-1-06
734-030-0010	1-24-06	Amend	3-1-06
734-030-0025	1-24-06	Amend	3-1-06
734-073-0051	12-14-05	Amend	1-1-06
734-073-0130	12-14-05	Amend	1-1-06
734-074-0010	4-28-06	Amend	6-1-06
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735-020-0010	5-25-06	Amend	7-1-06
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735-020-0070	5-25-06	Amend	7-1-06
735-020-0070(T)	5-25-06	Repeal	7-1-06
735-022-0000	1-1-06	Amend(T)	1-1-06
735-022-0000	5-25-06	Amend	7-1-06
735-022-0000(T)	5-25-06	Repeal	7-1-06
735-024-0015	1-1-06	Amend(T)	1-1-06
735-024-0015	5-25-06	Amend	7-1-06
735-024-0015(T)	5-25-06	Repeal	7-1-06
735-024-0030	1-1-06	Amend(T)	1-1-06
735-024-0030	5-25-06	Amend	7-1-06
735-024-0030(T)	5-25-06	Repeal	7-1-06
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735-024-0070	5-25-06	Amend	7-1-06
735-024-0070(T)	5-25-06	Repeal	7-1-06
735-024-0075	1-1-06	Amend(T)	1-1-06
735-024-0075	5-25-06	Amend	7-1-06
735-024-0075(T)	5-25-06	Repeal	7-1-06
735-024-0077	1-1-06	Adopt(T)	1-1-06
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735-024-0077(T)	5-25-06	Repeal	7-1-06
735-024-0080	1-1-06	Amend(T)	1-1-06
735-024-0080	5-25-06	Amend	7-1-06
735-024-0080(T)	5-25-06	Repeal	7-1-06
735-024-0120	1-1-06	Amend(T)	1-1-06
735-024-0120	5-25-06	Amend	7-1-06
735-024-0120(T)	5-25-06	Repeal	7-1-06
735-024-0130	1-1-06	Amend(T)	1-1-06
735-024-0130	5-25-06	Amend	7-1-06
735-024-0130(T)	5-25-06	Repeal	7-1-06
735-024-0170	1-1-06	Amend(T)	1-1-06
735-024-0170	5-25-06	Amend	7-1-06
735-024-0170(T)	5-25-06	Repeal	7-1-06
735-028-0010	1-1-06	Amend(T)	1-1-06
735-028-0010	5-25-06	Amend	7-1-06
735-028-0010(T)	5-25-06	Repeal	7-1-06
735-028-0090	1-1-06	Amend(T)	1-1-06
735-028-0090	5-25-06	Amend	7-1-06
735-028-0090(T)	5-25-06	Repeal	7-1-06
735-028-0110	1-1-06	Amend(T)	1-1-06
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735-028-0110(T)	5-25-06	Repeal	7-1-06
735-032-0020	1-1-06	Amend(T)	1-1-06
735-032-0020	5-25-06	Amend	7-1-06
735-032-0020(T)	5-25-06	Repeal	7-1-06
735-042-0010	5-25-06	Amend	7-1-06
735-042-0020	5-25-06	Amend	7-1-06
735-046-0080	1-1-06	Suspend	1-1-06
735-046-0080	5-25-06	Repeal	7-1-06
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735-060-0130	12-14-05	Amend	1-1-06
735-062-0000	1-1-06	Amend	1-1-06
735-062-0030	11-18-05	Amend	1-1-06
735-062-0030(T)	11-18-05	Repeal	1-1-06
735-062-0075	4-15-06	Amend	5-1-06
735-062-0080	12-14-05	Amend	1-1-06
735-062-0105	11-18-05	Amend	1-1-06
735-062-0105(T)	11-18-05	Repeal	1-1-06
735-062-0110	11-18-05	Amend	1-1-06
735-062-0110(T)	11-18-05	Repeal	1-1-06
735-062-0115	11-18-05	Amend	1-1-06
735-062-0115(T)	11-18-05	Repeal	1-1-06
735-062-0120	11-18-05	Amend	1-1-06
735-062-0120(T)	11-18-05	Repeal	1-1-06
735-062-0130	1-1-06	Amend(T)	1-1-06
735-062-0130	2-15-06	Amend	3-1-06
735-062-0130(T)	2-15-06	Repeal	3-1-06
735-062-0135	11-18-05	Amend	1-1-06
735-062-0135(T)	11-18-05	Repeal	1-1-06
735-062-0190	12-14-05	Amend	1-1-06
735-062-0190(T)	12-14-05	Repeal	1-1-06
735-062-0320	12-14-05	Amend	1-1-06
735-064-0005	2-15-06	Amend	3-1-06
735-064-0040	2-15-06	Amend	3-1-06
735-064-0090	2-15-06	Amend	3-1-06
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735-064-0220(T)	12-14-05	Repeal	1-1-06
735-064-0235	12-14-05	Amend	1-1-06
735-070-0010	11-18-05	Amend	1-1-06
735-070-0010	1-1-06	Amend	1-1-06
735-070-0010(T)	11-18-05	Repeal	1-1-06
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735-070-0054	12-14-05	Amend	1-1-06
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735-076-0007	5-25-06	Am. & Ren.	7-1-06
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735-076-0035	5-25-06	Adopt	7-1-06
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735-076-0050	5-25-06	Amend	7-1-06
735-076-0052	5-25-06	Adopt	7-1-06
735-150-0005	1-1-06	Amend(T)	1-1-06
735-150-0005	5-25-06	Amend	7-1-06
735-150-0005(T)	5-25-06	Repeal	7-1-06
735-150-0010	1-1-06	Amend	1-1-06
735-150-0010	1-1-06	Amend(T)	1-1-06
735-150-0010	5-25-06	Amend	7-1-06
735-150-0010(T)	5-25-06	Repeal	7-1-06
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735-150-0040	1-1-06	Amend	1-1-06
735-150-0050	1-1-06	Amend	1-1-06
735-150-0055	1-1-06	Amend	1-1-06
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735-152-0000(T)	5-25-06	Repeal	7-1-06
735-152-0005	1-1-06	Amend(T)	1-1-06
735-152-0005	5-25-06	Amend	7-1-06
735-152-0005(T)	5-25-06	Repeal	7-1-06
735-152-0010	1-1-06	Amend(T)	1-1-06
735-152-0010	5-25-06	Amend	7-1-06
735-152-0010(T)	5-25-06	Repeal	7-1-06
735-152-0020	1-1-06	Amend(T)	1-1-06
735-152-0020	5-25-06	Amend	7-1-06
735-152-0020(T)	5-25-06	Repeal	7-1-06
735-152-0025	1-1-06	Adopt(T)	1-1-06
735-152-0025	5-25-06	Adopt	7-1-06
735-152-0025(T)	5-25-06	Repeal	7-1-06
735-152-0030	1-1-06	Suspend	1-1-06
735-152-0030	5-25-06	Repeal	7-1-06
735-152-0031	1-1-06	Adopt(T)	1-1-06
735-152-0031	5-25-06	Adopt	7-1-06
735-152-0031(T)	5-25-06	Repeal	7-1-06
735-152-0034	1-1-06	Adopt(T)	1-1-06
735-152-0034	5-25-06	Adopt	7-1-06
735-152-0034(T)	5-25-06	Repeal	7-1-06
735-152-0037	1-1-06	Adopt(T)	1-1-06
735-152-0037	5-25-06	Adopt	7-1-06
735-152-0037(T)	5-25-06	Repeal	7-1-06
735-152-0040	1-1-06	Amend(T)	1-1-06
735-152-0040	5-25-06	Amend	7-1-06
735-152-0040(T)	5-25-06	Repeal	7-1-06
735-152-0045	1-1-06	Adopt(T)	1-1-06
735-152-0045	5-25-06	Adopt	7-1-06
735-152-0045(T)	5-25-06	Repeal	7-1-06
735-152-0050	1-1-06	Amend(T)	1-1-06
735-152-0050	5-25-06	Amend	7-1-06
735-152-0050(T)	5-25-06	Repeal	7-1-06
735-152-0060	1-1-06	Adopt(T)	1-1-06
735-152-0060	5-25-06	Adopt	7-1-06
735-152-0060(T)	5-25-06	Repeal	7-1-06
735-152-0070	1-1-06	Adopt(T)	1-1-06
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735-152-0080(T)	5-25-06	Repeal	7-1-06
735-152-0090	1-1-06	Adopt(T)	1-1-06
735-152-0090	5-25-06	Adopt	7-1-06
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736-015-0035(T)	2-14-06	Repeal	3-1-06
736-050-0105	5-8-06	Amend	6-1-06
736-050-0110	5-8-06	Amend	6-1-06
736-050-0115	5-8-06	Amend	6-1-06
736-050-0120	5-8-06	Amend	6-1-06
736-050-0125	5-8-06	Amend	6-1-06
736-050-0130	5-8-06	Amend	6-1-06
736-050-0135	5-8-06	Amend	6-1-06
736-050-0140	5-8-06	Amend	6-1-06
736-050-0150	5-8-06	Amend	6-1-06
736-053-0100	2-27-06	Amend	4-1-06
736-053-0105	2-27-06	Amend	4-1-06
736-053-0110	2-27-06	Amend	4-1-06
736-053-0115	2-27-06	Amend	4-1-06
736-053-0120	2-27-06	Amend	4-1-06
736-053-0125	2-27-06	Amend	4-1-06
736-053-0130	2-27-06	Amend	4-1-06
736-053-0135	2-27-06	Adopt	4-1-06
736-053-0140	2-27-06	Adopt	4-1-06
738-015-0005	1-27-06	Amend	3-1-06

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OAR Number	Effective	Action	Bulletin
738-015-0075	1-27-06	Amend	3-1-06
740-010-0020	12-14-05	Adopt	1-1-06
740-010-0020(T)	12-14-05	Repeal	1-1-06
740-020-0010	4-28-06	Amend	6-1-06
740-050-0610	12-14-05	Amend	1-1-06
740-055-0300	12-14-05	Repeal	1-1-06
740-055-0320	12-14-05	Amend	1-1-06
740-100-0010	4-1-06	Amend	5-1-06
740-100-0010(T)	4-1-06	Repeal	5-1-06
740-100-0060	4-1-06	Amend	5-1-06
740-100-0070	4-1-06	Amend	5-1-06
740-100-0080	4-1-06	Amend	5-1-06
740-100-0090	4-1-06	Amend	5-1-06
740-100-0100	4-1-06	Amend	5-1-06
740-110-0010	4-1-06	Amend	5-1-06
740-200-0045	2-16-06	Adopt	4-1-06
801-001-0035	1-1-06	Amend	1-1-06
801-001-0055	1-1-06	Adopt	1-1-06
801-005-0010	1-1-06	Amend	1-1-06
801-010-0050	1-1-06	Amend	1-1-06
801-010-0080	1-1-06	Amend	1-1-06
801-020-0720	1-1-06	Amend	1-1-06
801-030-0005	1-1-06	Amend	1-1-06
801-030-0015	1-1-06	Amend	1-1-06
801-030-0020	1-1-06	Amend	1-1-06
801-040-0010	1-1-06	Amend	1-1-06
801-040-0070	1-1-06	Amend	1-1-06
801-040-0090	1-1-06	Amend	1-1-06
801-050-0005	12-15-05	Amend	1-1-06
801-050-0010	12-15-05	Amend	1-1-06
801-050-0020	12-15-05	Amend	1-1-06
801-050-0030	12-15-05	Amend	1-1-06
801-050-0035	12-15-05	Adopt	1-1-06
801-050-0040	12-15-05	Amend	1-1-06
801-050-0050	12-15-05	Repeal	1-1-06
801-050-0060	12-15-05	Amend	1-1-06
801-050-0065	12-15-05	Adopt	1-1-06
801-050-0070	12-15-05	Amend	1-1-06
801-050-0080	12-15-05	Amend	1-1-06
804-020-0055	12-13-05	Amend	1-1-06
804-030-0020	3-17-06	Amend	5-1-06
804-040-0000	3-17-06	Amend	5-1-06
806-001-0004	3-15-06	Amend	4-1-06
806-001-0005	3-15-06	Amend	4-1-06
806-010-0015	12-13-05	Amend	1-1-06
806-010-0033	6-7-06	Adopt	7-1-06
806-010-0037	12-13-05	Amend	1-1-06
806-010-0037	3-10-06	Amend	4-1-06
806-010-0075	3-10-06	Amend	4-1-06
806-010-0075	3-15-06	Amend(T)	4-1-06
806-020-0020	12-13-05	Amend	1-1-06
808-001-0008	4-1-06	Amend	5-1-06
808-002-0150	1-1-06	Adopt	2-1-06
808-002-0200	1-1-06	Amend	2-1-06
808-002-0250	1-1-06	Amend	2-1-06
808-002-0298	1-1-06	Repeal	2-1-06

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808-002-0328	1-1-06	Adopt	2-1-06
808-002-0330	1-1-06	Adopt	2-1-06
808-002-0338	1-1-06	Adopt	2-1-06
808-002-0340	1-1-06	Amend	2-1-06
808-002-0360	1-1-06	Amend	2-1-06
808-002-0455	1-1-06	Adopt	2-1-06
808-002-0460	1-1-06	Repeal	2-1-06
808-002-0490	1-1-06	Adopt	2-1-06
808-002-0495	1-1-06	Adopt	2-1-06
808-002-0500	1-1-06	Amend	2-1-06
808-002-0600	1-1-06	Repeal	2-1-06
808-002-0650	1-1-06	Adopt	2-1-06
808-002-0720	1-1-06	Repeal	2-1-06
808-002-0730	1-1-06	Amend	2-1-06
808-002-0734	1-1-06	Adopt	2-1-06
808-002-0735	1-1-06	Repeal	2-1-06
808-002-0745	1-1-06	Repeal	2-1-06
808-002-0810	1-1-06	Adopt	2-1-06
808-002-0875	1-1-06	Adopt	2-1-06
808-002-0885	1-1-06	Adopt	2-1-06
808-003-0010	1-1-06	Amend	2-1-06
808-003-0015	1-1-06	Amend	2-1-06
808-003-0035	1-1-06	Amend	2-1-06
808-003-0040	1-1-06	Amend	2-1-06
808-003-0045	1-1-06	Amend	2-1-06
808-003-0060	1-1-06	Amend	2-1-06
808-003-0105	1-1-06	Amend	2-1-06
808-003-0110	1-1-06	Amend	2-1-06
808-003-0130	1-1-06	Amend	2-1-06
808-003-0225	1-1-06	Adopt	2-1-06
808-003-0230	1-1-06	Adopt	2-1-06
808-003-0235	1-1-06	Adopt	2-1-06
808-003-0240	1-1-06	Adopt	2-1-06
808-003-0245	1-1-06	Adopt	2-1-06
808-003-0250	1-1-06	Adopt	2-1-06
808-003-0255	1-1-06	Adopt	2-1-06
808-003-0260	1-1-06	Adopt	2-1-06
808-004-0320	1-1-06	Amend	2-1-06
808-004-0600	1-1-06	Amend	2-1-06
808-005-0020	1-1-06	Amend	2-1-06
809-010-0001	12-7-05	Amend	1-1-06
809-015-0000	12-14-05	Amend	1-1-06
809-015-0005	12-14-05	Amend	1-1-06
809-030-0025	3-17-06	Amend	5-1-06
811-010-0084	2-9-06	Adopt(T)	3-1-06
811-010-0085	2-9-06	Amend	3-1-06
811-010-0093	3-27-06	Amend	5-1-06
811-010-0130	2-9-06	Adopt	3-1-06
811-015-0005	2-9-06	Amend	3-1-06
811-021-0005	2-9-06	Amend	3-1-06
812-001-0051	1-1-06	Am. & Ren.	1-1-06
812-001-0100	1-1-06	Am. & Ren.	1-1-06
812-001-0110	1-1-06	Am. & Ren.	1-1-06
812-001-0120	1-1-06	Am. & Ren.	1-1-06
812-001-0120	3-30-06	Amend	5-1-06
812-001-0130	1-1-06	Am. & Ren.	1-1-06

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812-001-0140	1-1-06	Am. & Ren.	1-1-06
812-001-0160	1-1-06	Am. & Ren.	1-1-06
812-001-0160	6-1-06	Amend	7-1-06
812-001-0180	6-1-06	Adopt	7-1-06
812-001-0200	1-1-06	Am. & Ren.	1-1-06
812-001-0200	1-11-06	Amend(T)	2-1-06
812-001-0200	3-30-06	Amend	5-1-06
812-001-0200(T)	3-30-06	Repeal	5-1-06
812-001-0300	1-1-06	Am. & Ren.	1-1-06
812-001-0305	1-1-06	Am. & Ren.	1-1-06
812-001-0310	1-1-06	Am. & Ren.	1-1-06
812-001-0500	1-1-06	Am. & Ren.	1-1-06
812-001-0510	1-1-06	Am. & Ren.	1-1-06
812-002-0040	1-1-06	Amend	1-1-06
812-002-0060	1-1-06	Amend	1-1-06
812-002-0100	1-1-06	Amend	1-1-06
812-002-0160	1-1-06	Amend	1-1-06
812-002-0190	1-1-06	Amend	1-1-06
812-002-0260	1-1-06	Amend	1-1-06
812-002-0260	6-1-06	Amend	7-1-06
812-002-0325	1-1-06	Amend	1-1-06
812-002-0340	1-1-06	Repeal	1-1-06
812-002-0350	1-1-06	Adopt	1-1-06
812-002-0360	1-1-06	Amend	1-1-06
812-002-0420	1-1-06	Amend	1-1-06
812-002-0430	1-1-06	Amend	1-1-06
812-002-0443	1-1-06	Amend	1-1-06
812-002-0520	1-1-06	Amend	1-1-06
812-002-0533	1-1-06	Adopt	1-1-06
812-002-0533	6-1-06	Amend	7-1-06
812-002-0537	1-1-06	Adopt	1-1-06
812-002-0540	1-1-06	Amend	1-1-06
812-002-0555	1-1-06	Repeal	1-1-06
812-002-0640	1-1-06	Amend	1-1-06
812-002-0670	1-1-06	Amend	1-1-06
812-002-0675	1-1-06	Amend	1-1-06
812-002-0700	1-1-06	Amend	1-1-06
812-002-0720	1-1-06	Amend	1-1-06
812-002-0740	1-1-06	Amend	1-1-06
812-002-0780	1-1-06	Amend	1-1-06
812-002-0800	1-1-06	Amend	1-1-06
812-003-0130	6-1-06	Amend	7-1-06
812-003-0170	1-1-06	Amend	1-1-06
812-003-0175	3-9-06	Adopt(T)	4-1-06
812-003-0180	6-1-06	Amend	7-1-06
812-003-0200	6-1-06	Amend	7-1-06
812-003-0240	1-1-06	Amend	1-1-06
812-003-0240	1-11-06	Amend(T)	2-1-06
812-003-0240	3-30-06	Amend	5-1-06
812-003-0240(T)	3-30-06	Repeal	5-1-06
812-003-0250	6-1-06	Amend	7-1-06
812-003-0260	6-1-06	Amend	7-1-06
812-003-0280	6-1-06	Amend	7-1-06
812-003-0420	1-1-06	Amend	1-1-06
812-004-0180	1-1-06	Amend	1-1-06
812-004-0195	1-1-06	Amend	1-1-06
812-004-0240	1-1-06	Amend	1-1-06
812-004-0250	1-1-06	Amend	1-1-06
812-004-0260	1-1-06	Amend	1-1-06
812-004-0300	1-1-06	Amend	1-1-06
812-004-0320	1-1-06	Amend	1-1-06
812-004-0325	1-1-06	Repeal	1-1-06
812-004-0340	1-1-06	Amend	1-1-06
812-004-0360	1-1-06	Amend	1-1-06
812-004-0420	1-1-06	Amend	1-1-06
812-004-0440	1-1-06	Amend	1-1-06
812-004-0450	1-1-06	Amend	1-1-06
812-004-0460	1-1-06	Amend	1-1-06
812-004-0470	1-1-06	Amend	1-1-06
812-004-0480	1-1-06	Amend	1-1-06
812-004-0500	1-1-06	Amend	1-1-06
812-004-0530	1-1-06	Amend	1-1-06
812-004-0590	1-1-06	Amend	1-1-06
812-005-0100	1-1-06	Am. & Ren.	1-1-06
812-005-0110	1-1-06	Am. & Ren.	1-1-06
812-005-0120	1-1-06	Am. & Ren.	1-1-06
812-005-0130	1-1-06	Am. & Ren.	1-1-06
812-005-0140	1-1-06	Am. & Ren.	1-1-06
812-005-0150	1-1-06	Am. & Ren.	1-1-06
812-005-0160	1-1-06	Am. & Ren.	1-1-06
812-005-0170	1-1-06	Am. & Ren.	1-1-06
812-005-0180	1-1-06	Am. & Ren.	1-1-06
812-005-0200	1-1-06	Am. & Ren.	1-1-06
812-005-0210	1-1-06	Am. & Ren.	1-1-06
812-005-0500	1-1-06	Am. & Ren.	1-1-06
812-005-0800	1-1-06	Am. & Ren.	1-1-06
812-005-0800	1-26-06	Amend	3-1-06
812-006-0010	6-1-06	Amend	7-1-06
812-006-0011	6-1-06	Amend	7-1-06
812-006-0012	1-1-06	Amend	1-1-06
812-006-0015	1-1-06	Adopt	1-1-06
812-006-0020	6-1-06	Amend	7-1-06
812-006-0030	1-1-06	Amend	1-1-06
812-006-0050	6-1-06	Amend	7-1-06
812-008-0050	3-2-06	Amend	4-1-06
812-008-0070	1-26-06	Amend	3-1-06
812-008-0072	1-26-06	Amend	3-1-06
812-008-0074	6-1-06	Amend	7-1-06
812-008-0078	1-26-06	Repeal	3-1-06
812-008-0090	3-2-06	Amend	4-1-06
812-008-0110	1-1-06	Amend	1-1-06
812-008-0202	3-2-06	Amend	4-1-06
812-009-0160	1-1-06	Amend	1-1-06
812-009-0320	1-1-06	Amend	1-1-06
812-009-0400	1-1-06	Amend	1-1-06
812-009-0420	1-1-06	Amend	1-1-06
812-009-0430	1-1-06	Amend	1-1-06
813-001-0000	1-31-06	Repeal	3-1-06
813-001-0002	1-31-06	Adopt	3-1-06
813-001-0002(T)	1-31-06	Repeal	3-1-06
813-001-0003	1-31-06	Am. & Ren.	3-1-06
813-001-0003(T)	1-31-06	Repeal	3-1-06

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813-001-0005	1-31-06	Repeal	3-1-06
813-001-0007	1-31-06	Adopt	3-1-06
813-001-0007(T)	1-31-06	Repeal	3-1-06
813-001-0008	1-31-06	Repeal	3-1-06
813-001-0011	1-31-06	Adopt	3-1-06
813-001-0011(T)	1-31-06	Repeal	3-1-06
813-001-0066	1-31-06	Repeal	3-1-06
813-001-0068	1-31-06	Repeal	3-1-06
813-001-0069	1-31-06	Repeal	3-1-06
813-001-0080	1-31-06	Repeal	3-1-06
813-001-0090	1-31-06	Repeal	3-1-06
813-005-0001	1-31-06	Adopt	3-1-06
813-005-0001(T)	1-31-06	Repeal	3-1-06
813-005-0005	1-31-06	Amend	3-1-06
813-005-0005(T)	1-31-06	Repeal	3-1-06
813-005-0010	1-31-06	Repeal	3-1-06
813-005-0015	1-31-06	Repeal	3-1-06
813-005-0016	1-31-06	Adopt	3-1-06
813-005-0016(T)	1-31-06	Repeal	3-1-06
813-005-0020	1-31-06	Repeal	3-1-06
813-005-0025	1-31-06	Repeal	3-1-06
813-005-0030	1-31-06	Repeal	3-1-06
813-009-0001	2-10-06	Amend(T)	3-1-06
813-009-0005	2-10-06	Amend(T)	3-1-06
813-009-0010	2-10-06	Amend(T)	3-1-06
813-009-0015	2-10-06	Amend(T)	3-1-06
813-009-0020	2-10-06	Amend(T)	3-1-06
813-009-0030	2-10-06	Adopt(T)	3-1-06
813-013-0001	1-5-06	Adopt(T)	2-1-06
813-013-0005	1-5-06	Adopt(T)	2-1-06
813-013-0010	1-5-06	Adopt(T)	2-1-06
813-013-0015	1-5-06	Adopt(T)	2-1-06
813-013-0020	1-5-06	Adopt(T)	2-1-06
813-013-0025	1-5-06	Adopt(T)	2-1-06
813-013-0030	1-5-06	Adopt(T)	2-1-06
813-013-0035	1-5-06	Adopt(T)	2-1-06
813-013-0040	1-5-06	Adopt(T)	2-1-06
813-013-0045	1-5-06	Adopt(T)	2-1-06
813-013-0050	1-5-06	Adopt(T)	2-1-06
813-013-0055	1-5-06	Adopt(T)	2-1-06
813-013-0060	1-5-06	Adopt(T)	2-1-06
813-040-0005	4-13-06	Amend(T)	5-1-06
813-040-0010	4-13-06	Amend(T)	5-1-06
813-040-0015	4-13-06	Amend(T)	5-1-06
813-040-0020	4-13-06	Amend(T)	5-1-06
813-040-0025	4-13-06	Amend(T)	5-1-06
813-040-0030	4-13-06	Amend(T)	5-1-06
813-040-0035	4-13-06	Amend(T)	5-1-06
813-040-0040	4-13-06	Amend(T)	5-1-06
813-040-0045	4-13-06	Amend(T)	5-1-06
813-110-0005	5-17-06	Amend	7-1-06
813-110-0010	5-17-06	Amend	7-1-06
813-110-0012	5-17-06	Adopt	7-1-06
813-110-0015	5-17-06	Amend	7-1-06
813-110-0020	5-17-06	Amend	7-1-06
813-110-0021	5-17-06	Amend	7-1-06
813-110-0022	5-17-06	Amend	7-1-06
813-110-0023	5-17-06	Amend	7-1-06
813-110-0025	5-17-06	Amend	7-1-06
813-110-0030	5-17-06	Amend	7-1-06
813-110-0033	5-17-06	Amend	7-1-06
813-110-0035	5-17-06	Amend	7-1-06
813-110-0040	5-17-06	Amend	7-1-06
813-110-0050	5-17-06	Adopt	7-1-06
813-140-0010	3-29-06	Amend(T)	5-1-06
813-140-0020	3-29-06	Amend(T)	5-1-06
813-140-0030	3-29-06	Amend(T)	5-1-06
813-140-0040	3-29-06	Amend(T)	5-1-06
813-140-0050	3-29-06	Amend(T)	5-1-06
813-140-0060	3-29-06	Amend(T)	5-1-06
813-140-0070	3-29-06	Renumber(T)	5-1-06
813-140-0080	3-29-06	Amend(T)	5-1-06
813-140-0090	3-29-06	Amend(T)	5-1-06
813-140-0110	3-29-06	Amend(T)	5-1-06
813-140-0120	3-29-06	Adopt(T)	5-1-06
817-005-0005	3-15-06	Amend	4-1-06
817-010-0065	3-15-06	Amend	4-1-06
817-010-0068	3-15-06	Amend	4-1-06
817-010-0101	3-15-06	Amend	4-1-06
817-010-0106	3-15-06	Amend	4-1-06
817-015-0050	3-15-06	Amend	4-1-06
817-015-0065	3-15-06	Amend	4-1-06
817-020-0305	3-15-06	Amend	4-1-06
817-030-0005	3-15-06	Amend	4-1-06
817-030-0015	3-15-06	Amend	4-1-06
817-030-0018	3-15-06	Amend	4-1-06
817-030-0020	3-15-06	Amend	4-1-06
817-030-0040	3-15-06	Amend	4-1-06
817-030-0045	3-15-06	Amend	4-1-06
817-030-0100	3-15-06	Amend	4-1-06
817-035-0010	3-15-06	Amend	4-1-06
817-035-0030	3-15-06	Amend	4-1-06
817-035-0110	3-15-06	Amend	4-1-06
817-040-0003	3-15-06	Amend	4-1-06
817-080-0005	3-15-06	Amend	4-1-06
817-090-0025	3-15-06	Amend	4-1-06
817-090-0035	3-15-06	Amend	4-1-06
817-090-0045	3-15-06	Amend	4-1-06
817-090-0050	3-15-06	Amend	4-1-06
817-090-0055	3-15-06	Amend	4-1-06
817-090-0065	3-15-06	Amend	4-1-06
817-090-0070	3-15-06	Amend	4-1-06
817-090-0075	3-15-06	Amend	4-1-06
817-090-0080	3-15-06	Amend	4-1-06
817-090-0085	3-15-06	Amend	4-1-06
817-090-0090	3-15-06	Amend	4-1-06
817-090-0095	3-15-06	Amend	4-1-06
817-090-0100	3-15-06	Amend	4-1-06
817-090-0105	3-15-06	Amend	4-1-06
817-090-0110	3-15-06	Amend	4-1-06
817-090-0115	3-15-06	Amend	4-1-06
817-100-0005	3-15-06	Amend	4-1-06

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OAR Number	Effective	Action	Bulletin
817-120-0005	3-15-06	Amend	4-1-06
818-001-0002	4-1-06	Amend	5-1-06
818-012-0030	4-1-06	Amend	5-1-06
818-015-0007	4-1-06	Amend	5-1-06
818-021-0011	4-1-06	Amend	5-1-06
818-021-0012	4-1-06	Amend	5-1-06
818-021-0025	4-1-06	Amend	5-1-06
818-021-0026	4-1-06	Adopt	5-1-06
818-026-0080	4-1-06	Amend	5-1-06
818-042-0115	4-1-06	Amend	5-1-06
818-042-0116	4-1-06	Amend	5-1-06
818-042-0117	4-1-06	Amend	5-1-06
820-010-0010	12-13-05	Amend	1-1-06
820-010-0205	12-13-05	Amend	1-1-06
820-010-0207	12-13-05	Adopt	1-1-06
820-010-0215	12-13-05	Amend	1-1-06
820-010-0230	12-13-05	Amend	1-1-06
820-010-0255	12-13-05	Amend	1-1-06
820-010-0305	12-13-05	Amend	1-1-06
820-010-0427	12-13-05	Adopt	1-1-06
820-010-0450	12-13-05	Amend	1-1-06
820-010-0465	12-13-05	Amend	1-1-06
820-010-0610	12-13-05	Amend	1-1-06
820-010-0618	12-13-05	Amend	1-1-06
820-010-0619	12-13-05	Adopt	1-1-06
820-010-0625	12-13-05	Amend	1-1-06
820-010-0635	12-13-05	Amend	1-1-06
836-005-0107	4-27-06	Amend	6-1-06
836-009-0011	4-14-06	Amend	5-1-06
836-011-0000	1-23-06	Amend	3-1-06
836-027-0200	2-13-06	Amend	3-1-06
836-042-0015	6-9-06	Amend	7-1-06
836-042-0045	6-9-06	Amend	7-1-06
836-052-0676	3-20-06	Amend	4-1-06
836-052-0696	3-20-06	Amend	4-1-06
836-053-0003	5-1-06	Adopt	6-1-06
836-053-0460	5-1-06	Amend	6-1-06
836-053-1400	4-14-06	Adopt	5-1-06
836-071-0180	1-31-06	Amend	3-1-06
836-071-0263	1-15-06	Adopt	2-1-06
836-071-0277	1-15-06	Amend	2-1-06
836-080-0430	3-10-06	Amend	4-1-06
836-080-0438	3-10-06	Amend	4-1-06
837-012-0510	3-10-06	Amend	4-1-06
837-012-0555	3-10-06	Amend	4-1-06
837-012-0620	3-10-06	Amend	4-1-06
837-012-0625	2-13-06	Amend(T)	2-1-06
837-012-0625	3-10-06	Amend	4-1-06
837-012-0750	2-13-06	Amend(T)	2-1-06
837-012-0750	3-10-06	Amend	4-1-06
837-012-0855	3-10-06	Amend	4-1-06
837-012-0900	3-10-06	Amend	4-1-06
837-012-0910	3-10-06	Amend	4-1-06
837-012-1200	6-15-06	Amend(T)	7-1-06
837-012-1210	6-15-06	Amend(T)	7-1-06
837-012-1220	6-15-06	Amend(T)	7-1-06
837-012-1230	6-15-06	Amend(T)	7-1-06
837-012-1240	6-15-06	Amend(T)	7-1-06
837-012-1250	6-15-06	Amend(T)	7-1-06
837-012-1260	6-15-06	Amend(T)	7-1-06
837-012-1270	6-15-06	Amend(T)	7-1-06
837-012-1280	6-15-06	Amend(T)	7-1-06
837-012-1290	6-15-06	Amend(T)	7-1-06
837-012-1300	6-15-06	Amend(T)	7-1-06
837-012-1310	6-15-06	Amend(T)	7-1-06
837-012-1320	5-5-06	Amend	6-1-06
837-012-1320	6-15-06	Amend(T)	7-1-06
837-012-1330	6-15-06	Amend(T)	7-1-06
837-012-1340	6-15-06	Amend(T)	7-1-06
837-012-1350	6-15-06	Amend(T)	7-1-06
837-012-1360	6-15-06	Amend(T)	7-1-06
837-012-1370	6-15-06	Amend(T)	7-1-06
837-012-1380	6-15-06	Amend(T)	7-1-06
837-012-1390	6-15-06	Amend(T)	7-1-06
837-012-1400	6-15-06	Amend(T)	7-1-06
837-012-1410	6-15-06	Amend(T)	7-1-06
837-012-1420	6-15-06	Amend(T)	7-1-06
837-039-0010	5-22-06	Amend	7-1-06
837-039-0015	5-22-06	Amend	7-1-06
837-039-0110	5-22-06	Amend	7-1-06
837-040-0001	2-1-06	Amend(T)	2-1-06
837-040-0001	6-12-06	Amend	7-1-06
837-040-0001(T)	6-12-06	Repeal	7-1-06
837-040-0010	2-1-06	Amend(T)	2-1-06
837-040-0010	6-12-06	Amend	7-1-06
837-040-0010(T)	6-12-06	Repeal	7-1-06
837-040-0020	2-1-06	Adopt(T)	2-1-06
837-040-0020	6-12-06	Adopt	7-1-06
837-040-0020(T)	6-12-06	Repeal	7-1-06
837-040-0140	2-1-06	Amend(T)	2-1-06
837-040-0140	6-12-06	Amend	7-1-06
837-040-0140(T)	6-12-06	Repeal	7-1-06
839-001-0420	1-1-06	Amend	2-1-06
839-001-0470	1-1-06	Amend	2-1-06
839-002-0002	3-20-06	Amend	5-1-06
839-002-0005	3-20-06	Amend	5-1-06
839-003-0020	3-20-06	Amend	5-1-06
839-003-0090	3-20-06	Amend	5-1-06
839-006-0131	3-17-06	Amend(T)	5-1-06
839-006-0136	3-20-06	Amend	5-1-06
839-006-0136(T)	3-20-06	Repeal	5-1-06
839-006-0145	3-20-06	Amend	5-1-06
839-006-0205	3-20-06	Amend	5-1-06
839-006-0305	3-20-06	Amend	5-1-06
839-006-0405	3-20-06	Amend	5-1-06
839-009-0260	3-24-06	Amend	5-1-06
839-009-0320	3-24-06	Amend	5-1-06
839-011-0084	4-18-06	Amend	6-1-06
839-014-0025	3-7-06	Repeal	4-1-06
839-014-0060	1-1-06	Amend	2-1-06
839-014-0100	1-1-06	Amend	2-1-06
839-014-0105	1-1-06	Amend	2-1-06

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839-014-0630	1-1-06	Amend	2-1-06
839-015-0002	3-7-06	Repeal	4-1-06
839-015-0130	3-1-06	Amend	4-1-06
839-015-0145	3-1-06	Amend	4-1-06
839-015-0155	1-1-06	Amend	2-1-06
839-015-0157	1-1-06	Amend	2-1-06
839-015-0160	1-1-06	Amend	2-1-06
839-015-0165	1-1-06	Amend	2-1-06
839-015-0200	1-1-06	Amend	2-1-06
839-015-0230	1-1-06	Amend	2-1-06
839-015-0260	1-1-06	Amend	2-1-06
839-015-0300	1-1-06	Amend	2-1-06
839-015-0300	3-1-06	Amend	4-1-06
839-015-0350	1-1-06	Amend	2-1-06
839-015-0500	1-1-06	Amend	2-1-06
839-015-0508	1-1-06	Amend	2-1-06
839-015-0600	1-1-06	Amend	2-1-06
839-015-0610	1-1-06	Amend	2-1-06
839-017-0001	3-7-06	Repeal	4-1-06
839-019-0002	3-7-06	Repeal	4-1-06
839-021-0102	5-15-06	Amend	6-1-06
839-021-0104	5-15-06	Amend	6-1-06
839-021-0220	5-15-06	Amend	6-1-06
839-025-0002	3-7-06	Repeal	4-1-06
839-025-0003	1-1-06	Amend	2-1-06
839-025-0004	1-1-06	Amend	2-1-06
839-025-0004	5-15-06	Amend(T)	6-1-06
839-025-0010	1-1-06	Amend	2-1-06
839-025-0015	1-1-06	Adopt	2-1-06
839-025-0020	1-1-06	Amend	2-1-06
839-025-0020	5-15-06	Amend(T)	6-1-06
839-025-0035	1-1-06	Amend	2-1-06
839-025-0037	5-15-06	Adopt(T)	6-1-06
839-025-0100	1-1-06	Amend	2-1-06
839-025-0100	5-15-06	Amend	6-1-06
839-025-0220	1-1-06	Amend	2-1-06
839-025-0230	1-1-06	Amend	2-1-06
839-025-0240	1-1-06	Repeal	2-1-06
839-025-0530	1-1-06	Amend	2-1-06
839-025-0700	1-1-06	Amend	2-1-06
839-025-0700	1-25-06	Amend	3-1-06
839-025-0700	2-9-06	Amend	3-1-06
839-025-0700	2-24-06	Amend	4-1-06
839-025-0700	4-1-06	Amend	5-1-06
839-025-0750	12-23-05	Amend	2-1-06
839-025-0750	3-13-06	Amend	4-1-06
839-030-0010	4-7-06	Amend	5-1-06
839-050-0010	3-20-06	Amend	5-1-06
839-050-0150	3-24-06	Amend	5-1-06
839-050-0300	3-24-06	Amend	5-1-06
845-003-0340	5-1-06	Amend	6-1-06
845-004-0020	1-1-06	Amend	2-1-06
845-004-0105	3-1-06	Adopt	4-1-06
845-005-0306	12-1-05	Amend	1-1-06
845-005-0355	6-15-06	Amend(T)	7-1-06
845-006-0301	2-1-06	Amend	3-1-06
845-006-0335	1-1-06	Amend	1-1-06
845-006-0427	5-1-06	Repeal	6-1-06
845-006-0430	2-1-06	Amend	3-1-06
845-010-0151	1-1-06	Amend	2-1-06
845-010-0170	1-1-06	Amend	2-1-06
845-015-0165	3-1-06	Amend	4-1-06
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847-008-0023	5-8-06	Adopt	6-1-06
847-010-0052	2-8-06	Amend	3-1-06
847-010-0073	5-8-06	Amend	6-1-06
847-020-0130	2-8-06	Amend(T)	3-1-06
847-020-0130	5-8-06	Amend	6-1-06
847-020-0140	2-8-06	Amend	3-1-06
847-020-0150	2-8-06	Amend	3-1-06
847-020-0170	2-8-06	Amend	3-1-06
847-020-0170	2-8-06	Amend(T)	3-1-06
847-020-0170	5-8-06	Amend	6-1-06
847-020-0180	2-8-06	Amend	3-1-06
847-020-0185	5-8-06	Adopt	6-1-06
847-031-0020	2-8-06	Amend	3-1-06
847-050-0010	5-8-06	Amend	6-1-06
847-050-0025	5-8-06	Amend	6-1-06
847-050-0026	2-8-06	Amend	3-1-06
847-050-0041	2-8-06	Amend	3-1-06
847-050-0065	2-8-06	Amend	3-1-06
848-001-0000	1-1-06	Amend	2-1-06
848-005-0020	1-1-06	Amend	2-1-06
848-005-0030	1-1-06	Amend	2-1-06
848-010-0015	1-1-06	Amend	2-1-06
848-010-0020	1-1-06	Amend	2-1-06
848-010-0026	1-1-06	Amend	2-1-06
848-010-0033	1-1-06	Amend	2-1-06
848-010-0035	1-1-06	Amend	2-1-06
848-010-0044	1-1-06	Amend	2-1-06
848-015-0010	1-1-06	Amend	2-1-06
848-015-0030	1-1-06	Amend	2-1-06
848-020-0030	1-1-06	Amend	2-1-06
848-020-0060	1-1-06	Amend	2-1-06
848-030-0000	1-1-06	Repeal	2-1-06
848-030-0010	1-1-06	Repeal	2-1-06
848-035-0010	4-14-06	Adopt	5-1-06
848-035-0015	4-14-06	Adopt	5-1-06
848-035-0020	4-14-06	Adopt	5-1-06
848-035-0030	4-14-06	Adopt	5-1-06
848-035-0040	4-14-06	Adopt	5-1-06
848-040-0105	1-1-06	Amend	2-1-06
848-040-0110	1-1-06	Amend	2-1-06
848-040-0115	1-1-06	Repeal	2-1-06
848-040-0117	1-1-06	Adopt	2-1-06
848-040-0120	1-1-06	Amend	2-1-06
848-040-0147	1-1-06	Adopt	2-1-06
848-045-0010	1-1-06	Amend	2-1-06
848-045-0020	1-1-06	Amend	2-1-06

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850-060-0226	12-12-05	Amend	1-1-06
851-001-0000	5-8-06	Amend	6-1-06
851-001-0005	5-8-06	Amend	6-1-06
851-002-0060	5-8-06	Amend	6-1-06
851-031-0006	12-21-05	Amend	2-1-06
851-031-0045	12-21-05	Amend	2-1-06
851-031-0088	2-22-06	Adopt	4-1-06
851-045-0025	12-21-05	Amend	2-1-06
851-050-0131	12-21-05	Amend	2-1-06
851-050-0131	2-22-06	Amend	4-1-06
851-050-0131	5-8-06	Amend	6-1-06
851-054-0040	5-8-06	Amend	6-1-06
851-061-0030	5-8-06	Amend	6-1-06
851-061-0080	5-8-06	Amend	6-1-06
851-061-0090	12-21-05	Amend	2-1-06
851-061-0090	5-8-06	Amend	6-1-06
851-061-0100	5-8-06	Amend	6-1-06
851-062-0010	12-21-05	Amend	2-1-06
851-063-0040	2-22-06	Amend	4-1-06
852-010-0080	7-1-06	Amend	5-1-06
852-020-0070	4-1-06	Amend	5-1-06
852-050-0006	4-1-06	Amend	5-1-06
852-050-0006	7-1-06	Amend	5-1-06
852-050-0012	4-1-06	Amend	5-1-06
852-050-0014	4-1-06	Amend	5-1-06
852-060-0025	12-8-05	Am. & Ren.	1-1-06
852-060-0027	12-8-05	Am. & Ren.	1-1-06
852-060-0028	12-8-05	Am. & Ren.	1-1-06
852-060-0075	3-8-06	Amend	4-1-06
852-080-0030	4-1-06	Amend	5-1-06
852-080-0040	4-1-06	Amend	5-1-06
855-006-0005	6-9-06	Amend	7-1-06
855-006-0010	6-9-06	Repeal	7-1-06
855-025-0001	12-15-05	Adopt	1-1-06
855-025-0001	6-9-06	Amend	7-1-06
855-025-0005	6-9-06	Adopt	7-1-06
855-025-0010	6-9-06	Adopt	7-1-06
855-025-0015	6-9-06	Adopt	7-1-06
855-025-0020	6-9-06	Adopt	7-1-06
855-025-0025	6-9-06	Adopt	7-1-06
855-025-0030	6-9-06	Adopt	7-1-06
855-025-0035	6-9-06	Adopt	7-1-06
855-025-0040	6-9-06	Adopt	7-1-06
855-025-0050	12-14-05	Adopt	1-1-06
855-025-0050	6-9-06	Amend	7-1-06
855-025-0060	6-9-06	Adopt	7-1-06
855-041-0063	12-15-05	Amend	1-1-06
855-041-0080	6-9-06	Amend	7-1-06
855-041-0200	6-9-06	Repeal	7-1-06
855-041-0203	6-9-06	Repeal	7-1-06
855-041-0205	6-9-06	Repeal	7-1-06
855-041-0500	6-9-06	Amend	7-1-06
855-041-0510	6-9-06	Amend	7-1-06
855-041-0520	6-9-06	Amend	7-1-06
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855-050-0039	7-1-06	Repeal	7-1-06
855-050-0041	7-1-06	Repeal	7-1-06
855-050-0042	7-1-06	Repeal	7-1-06
855-050-0043	7-1-06	Repeal	7-1-06
855-050-0070	7-1-06	Amend	7-1-06
855-080-0022	7-1-06	Amend	7-1-06
855-080-0023	7-1-06	Amend	7-1-06
855-080-0028	7-1-06	Amend	7-1-06
855-080-0031	7-1-06	Amend	7-1-06
855-080-0065	7-1-06	Amend	7-1-06
855-080-0070	7-1-06	Amend	7-1-06
855-080-0075	7-1-06	Amend	7-1-06
855-080-0095	7-1-06	Amend	7-1-06
855-080-0105	7-1-06	Amend	7-1-06
855-110-0005	6-9-06	Amend	7-1-06
856-010-0012	11-29-05	Amend	1-1-06
856-010-0026	1-30-06	Adopt	3-1-06
860-011-0001	4-14-06	Amend	5-1-06
860-011-0036	11-28-05	Adopt	1-1-06
860-011-0080	11-30-05	Amend	1-1-06
860-011-0080	12-21-05	Amend	2-1-06
860-012-0040	11-30-05	Amend	1-1-06
860-021-0008	11-30-05	Amend	1-1-06
860-021-0010	11-30-05	Amend	1-1-06
860-021-0033	11-30-05	Amend	1-1-06
860-021-0045	11-30-05	Amend	1-1-06
860-021-0120	2-27-06	Amend	4-1-06
860-021-0205	11-30-05	Amend	1-1-06
860-021-0326	11-30-05	Amend	1-1-06
860-021-0328	2-17-06	Adopt(T)	4-1-06
860-021-0335	11-30-05	Amend	1-1-06
860-021-0405	11-30-05	Amend	1-1-06
860-021-0405	2-27-06	Amend	4-1-06
860-021-0410	11-30-05	Amend	1-1-06
860-021-0414	11-30-05	Amend	1-1-06
860-021-0415	11-30-05	Amend	1-1-06
860-021-0420	11-30-05	Amend	1-1-06
860-021-0510	2-27-06	Amend	4-1-06
860-021-0550	2-27-06	Adopt	4-1-06
860-021-0550(T)	2-27-06	Repeal	4-1-06
860-021-0575	2-27-06	Adopt	4-1-06
860-022-0001	11-30-05	Amend	1-1-06
860-022-0017	11-30-05	Amend	1-1-06
860-022-0040	11-30-05	Amend	1-1-06
860-022-0046	11-30-05	Amend	1-1-06
860-022-0075	11-30-05	Adopt	1-1-06
860-023-0000	12-23-05	Amend	2-1-06
860-023-0001	11-30-05	Amend	1-1-06
860-023-0001	12-23-05	Amend	2-1-06
860-023-0005	11-30-05	Amend	1-1-06
860-023-0005	12-23-05	Amend	2-1-06
860-023-0020	11-30-05	Amend	1-1-06
860-023-0054	12-23-05	Adopt	2-1-06
860-023-0055	12-27-05	Amend	2-1-06
860-023-0080	11-30-05	Amend	1-1-06

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860-023-0110	11-30-05	Amend	1-1-06
860-023-0120	11-30-05	Amend	1-1-06
860-023-0130	11-30-05	Amend	1-1-06
860-023-0140	11-30-05	Amend	1-1-06
860-023-0150	11-30-05	Amend	1-1-06
860-023-0160	11-30-05	Amend	1-1-06
860-025-0001	11-30-05	Amend	1-1-06
860-026-0005	11-30-05	Amend	1-1-06
860-027-0001	11-30-05	Amend	1-1-06
860-027-0045	11-30-05	Amend	1-1-06
860-027-0120	11-30-05	Amend	1-1-06
860-027-0300	11-30-05	Amend	1-1-06
860-030-0005	11-30-05	Amend	1-1-06
860-030-0010	11-30-05	Amend	1-1-06
860-030-0015	11-30-05	Amend	1-1-06
860-030-0018	11-30-05	Amend	1-1-06
860-032-0012	12-27-05	Amend	2-1-06
860-034-0270	2-27-06	Amend	4-1-06
860-034-0275	2-27-06	Adopt	4-1-06
860-034-0275(T)	2-27-06	Repeal	4-1-06
860-034-0276	2-27-06	Adopt	4-1-06
860-034-0390	12-27-05	Amend	2-1-06
860-038-0005	11-30-05	Amend	1-1-06
860-038-0005	5-11-06	Amend	6-1-06
860-038-0300	11-30-05	Amend	1-1-06
860-038-0400	11-30-05	Amend	1-1-06
860-038-0410	11-30-05	Amend	1-1-06
860-038-0500	5-11-06	Amend	6-1-06
860-038-0520	5-11-06	Amend	6-1-06
860-038-0560	5-11-06	Amend	6-1-06
860-038-0580	5-11-06	Amend	6-1-06
860-038-0600	5-11-06	Amend	6-1-06
860-038-0620	5-11-06	Amend	6-1-06
860-038-0640	5-11-06	Amend	6-1-06
863-015-0186	1-1-06	Adopt(T)	2-1-06
863-015-0225	1-1-06	Adopt(T)	2-1-06
863-015-0230	1-1-06	Adopt(T)	2-1-06
875-001-0000	2-8-06	Amend	3-1-06
875-001-0005	2-8-06	Amend	3-1-06
875-001-0005	5-11-06	Amend	6-1-06
875-001-0010	2-8-06	Repeal	3-1-06
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875-005-0005	2-8-06	Adopt	3-1-06
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875-010-0000	5-11-06	Amend	6-1-06
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875-010-0006	5-11-06	Amend	6-1-06
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875-010-0030	2-8-06	Repeal	3-1-06
875-010-0045	2-8-06	Amend	3-1-06
875-010-0050	2-8-06	Amend	3-1-06
875-010-0055	2-8-06	Repeal	3-1-06
875-010-0060	2-8-06	Repeal	3-1-06
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875-015-0030	5-11-06	Amend	6-1-06
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875-020-0040	2-8-06	Amend	3-1-06
875-020-0055	2-8-06	Amend	3-1-06
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875-030-0010	5-11-06	Amend	6-1-06
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875-030-0025	2-8-06	Amend	3-1-06
875-030-0025	5-11-06	Amend	6-1-06
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875-030-0040	5-11-06	Amend	6-1-06
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877-020-0010	12-22-05	Amend	2-1-06
877-020-0012	12-22-05	Amend	2-1-06
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877-020-0031	12-22-05	Amend	2-1-06
877-020-0046	12-22-05	Amend	2-1-06
877-020-0050	12-22-05	Repeal	2-1-06
877-020-0055	12-22-05	Adopt	2-1-06
877-025-0000	12-22-05	Amend	2-1-06
877-025-0005	12-22-05	Amend	2-1-06
877-030-0040	12-22-05	Amend	2-1-06
877-030-0050	12-22-05	Amend	2-1-06
877-030-0070	12-22-05	Amend	2-1-06

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877-035-0012	12-22-05	Amend	2-1-06
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877-040-0015	12-22-05	Amend	2-1-06
877-040-0025	12-22-05	Repeal	2-1-06
877-040-0027	12-22-05	Repeal	2-1-06
877-040-0050	12-22-05	Amend	2-1-06
877-040-0055	12-22-05	Amend	2-1-06
877-040-0060	12-22-05	Repeal	2-1-06
877-040-0065	12-22-05	Repeal	2-1-06
877-040-0070	12-22-05	Repeal	2-1-06
918-001-0010	2-13-06	Amend	3-1-06
918-008-0000	3-1-06	Amend(T)	4-1-06
918-008-0010	3-1-06	Amend(T)	4-1-06
918-008-0020	3-1-06	Amend(T)	4-1-06
918-008-0030	3-1-06	Amend(T)	4-1-06
918-008-0060	3-1-06	Amend(T)	4-1-06
918-008-0075	1-1-06	Adopt	2-1-06
918-008-0080	1-1-06	Adopt	2-1-06
918-008-0085	1-1-06	Adopt	2-1-06
918-008-0090	1-1-06	Adopt	2-1-06
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918-008-0110	1-1-06	Adopt	2-1-06
918-008-0115	1-1-06	Adopt	2-1-06
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918-020-0090	1-1-06	Amend	2-1-06
918-050-0000	1-1-06	Amend	2-1-06
918-050-0010	1-1-06	Amend	2-1-06
918-050-0020	1-1-06	Amend	2-1-06
918-050-0030	1-1-06	Amend	2-1-06
918-050-0100	1-1-06	Amend	2-1-06
918-050-0110	1-1-06	Amend	2-1-06
918-050-0120	1-1-06	Amend	2-1-06
918-050-0130	1-1-06	Amend	2-1-06
918-050-0140	1-1-06	Amend	2-1-06
918-050-0150	1-1-06	Amend	2-1-06
918-050-0160	1-1-06	Amend	2-1-06
918-050-0170	1-1-06	Amend	2-1-06
918-050-0200	1-1-06	Repeal	2-1-06
918-050-0800	1-1-06	Amend	2-1-06
918-090-0000	1-1-06	Amend	1-1-06
918-090-0010	1-1-06	Amend	1-1-06
918-090-0200	1-1-06	Amend	1-1-06
918-090-0210	1-1-06	Amend	1-1-06
918-098-1000	4-1-06	Amend	5-1-06
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918-098-1010	4-1-06	Amend	5-1-06
918-098-1012	4-1-06	Amend	5-1-06
918-098-1015	4-1-06	Amend	5-1-06
918-098-1025	4-1-06	Amend	5-1-06
918-098-1210	4-1-06	Amend	5-1-06
918-098-1215	4-1-06	Amend	5-1-06
918-098-1300	4-1-06	Amend	5-1-06
918-098-1410	4-1-06	Amend	5-1-06
918-098-1450	4-1-06	Amend	5-1-06
918-098-1470	4-1-06	Amend	5-1-06
918-098-1600	4-1-06	Amend	5-1-06
918-098-1620	4-1-06	Amend	5-1-06
918-098-1630	4-1-06	Amend	5-1-06
918-100-0000	1-1-06	Amend	2-1-06
918-100-0030	1-1-06	Amend	2-1-06
918-225-0440	1-1-06	Repeal	2-1-06
918-225-0610	1-1-06	Amend	2-1-06
918-251-0030	1-1-06	Repeal	2-1-06
918-251-0040	1-1-06	Repeal	2-1-06
918-261-0025	1-1-06	Adopt	2-1-06
918-281-0000	4-1-06	Amend	5-1-06
918-281-0010	4-1-06	Amend	5-1-06
918-281-0020	4-1-06	Amend	5-1-06
918-283-0010	4-3-06	Amend(T)	5-1-06
918-305-0030	1-1-06	Amend	2-1-06
918-305-0110	1-1-06	Amend	2-1-06
918-305-0120	1-1-06	Amend	2-1-06
918-305-0130	1-1-06	Amend	2-1-06
918-305-0150	1-1-06	Amend	2-1-06
918-305-0160	1-1-06	Amend	2-1-06
918-305-0180	1-1-06	Amend	2-1-06
918-311-0030	10-1-06	Amend	7-1-06
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918-400-0230	1-1-06	Repeal	2-1-06
918-460-0015	2-1-06	Amend	3-1-06
918-525-0310	1-1-06	Amend	2-1-06
918-525-0410	1-1-06	Amend	2-1-06
918-525-0420	1-1-06	Amend	2-1-06
918-525-0520	1-1-06	Amend	2-1-06
918-690-0340	1-1-06	Repeal	2-1-06
918-690-0350	1-1-06	Repeal	2-1-06
918-695-0400	4-1-06	Amend	5-1-06
918-780-0035	4-4-06	Amend	5-1-06
918-780-0040	10-1-06	Amend	7-1-06