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Secretary of State
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INFORMATION ABOUT ADMINISTRATIVE RULES

General Information

The Administrative Rules Unit, Archives Division, Secretary of State publishes the Oregon *Administrative Rules Compilation* and the online *Oregon Bulletin*. The *Oregon Administrative Rules Compilation* is an annual print publication containing complete text of Oregon Administrative Rules (OARs) filed through November 15 of the previous year. The *Oregon Bulletin* is a monthly online supplement that contains rule text adopted or amended after publication of the print Compilation, as well as Notices of Proposed Rulemaking and Rulemaking Hearing. The Bulletin also includes certain non-OAR items when they are submitted, such as Executive Orders of the Governor, Opinions of the Attorney General and Department of Environmental Quality cleanup notices.

Background on Oregon Administrative Rules

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

OAR Citations

Every Administrative Rule uses the same numbering sequence of a three-digit chapter number followed by a three-digit division number and a four-digit rule number (000-000-0000). For example, Oregon Administrative Rules, chapter 166, division 500, rule 0020 is cited as OAR 166-500-0020.

Understanding an Administrative Rule's "History"

State agencies operate in an environment of ever-changing laws, public concerns and legislative mandates which necessitate ongoing rulemaking. To track changes to individual rules and organize the original rule documents for permanent retention, the Administrative Rules Unit maintains history lines for each rule, located at the end of the rule text. OAR histories contain the rule's statutory authority, statutes implemented and dates of each authorized modification to the rule text. Changes are listed chronologically in abbreviated form, with the most recent change listed last. In the history line "OSA 4-1993, f. & cert. ef. 11-10-93," for example, "OSA" is short for Oregon State Archives; "4-1993" indicates this was 4th administrative rule filing by the Archives in 1993; "f. & cert. ef. 11-10-93" means the rule was filed and certified effective on November 10, 1993.

Locating Current Versions of Administrative Rules

The online version of the OAR Compilation is updated on the first of each month to include all rule actions filed with the Administrative Rules Unit by the 15th of the previous month. The annual printed OAR Compilation volumes contain text for all rules filed through November 15 of the previous year. Administrative Rules created or changed after publication in the print Compilation will appear in a subsequent edition of the online Bulletin. These are listed by rule number in the Bulletin's OAR Revision Cumulative Index, which is updated monthly. The listings specify each rule's effective date, rulemaking action, and the issue of the Bulletin that contains the full text of the adopted or amended rule.

Locating Administrative Rule Publications

Printed volumes of the Compilation are deposited in Oregon's Public Documents Depository Libraries listed in OAR 543-070-0000. Complete sets and individual volumes of the printed OAR Compilation may be ordered from the Administrative Rules Unit, Archives Division, 800 Summer Street NE, Salem, Oregon 97301, (503) 373-0701.

Filing Adminstrative Rules and Notices

All hearing and rulemaking notices, and permanent and temporary rules, are filed through the Administrative Rules Unit's online filing system. To expedite the rulemaking process, agencies are encouraged to file a Notice of Proposed Rulemaking Hearing specifying hearing date, time and location, and to submit their filings early in the submission period. All notices and rules must be filed by the 15th of the month to be included in the next month's Bulletin and OAR Compilation postings. Filings must contain the date stamp from the deadline day or earlier to be published the following month.

Administratrative Rules Coordinators and Delegation of Signing Authority

Each agency that engages in rulemaking must appoint a rules coordinator and file an Appointment of Agency Rules Coordinator form with the Administrative Rules Unit. Agencies that delegate rulemaking authority to an officer or employee within the agency must also file a Delegation of Rulemaking Authority form. It is the agency's responsibility to monitor the rulemaking authority of selected employees and keep the forms updated. The Administrative Rules Unit does not verify agency signatures as part of the rulemaking process.

Publication Authority

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

The official copy of an Oregon Administrative Rule is contained in the Administrative Order filed at the Archives Division. Any discrepancies with the published version are satisfied in favor of the Administrative Order.

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EXECUTIVE ORDER NO. 15 - 02

DETERMINATION OF A STATE OF DROUGHT EMERGENCY IN LAKE AND MALHEUR COUNTIES DUE TO DROUGHT AND LOW WATER CONDITIONS

At the request of Lake County (by Resolution 15-03-10 dated March 10, 2015) and Malheur County (by Resolution 2015-0648 dated March 4, 2015), and based on the recommendations of the Drought Council and the Water Availability Committee, and pursuant to ORS 401.165 and ORS 536.740, I find the continuing dry conditions, low snowpack, and lack of precipitation have caused natural and economic disaster conditions in Lake and Malheur Counties.

Projected forecasts are not expected to alleviate the severe drought conditions, and the drought is having significant economic impacts on agricultural, livestock, and natural resources in Malheur and Lake Counties.

The dry conditions present hardships for these communities: crops and agricultural and recreation investments are at risk; animals and plants that rely on Oregon's surface water supplies are threatened; and the risk of wildfires across the state is greatly increased. Current conditions are being monitored and analyzed by state agencies including the Department of Agriculture, the Department of Water Resources, and the Oregon Office of Emergency Management.

A timely response to the severe drought conditions is vital to the safety of persons and property and economic security of the citizens and businesses of Lake and Malheur Counties. I am therefore declaring that a severe, continuing drought emergency exists in Lake and Malheur Counties, and directing the following actions.

IT IS HEREBY ORDERED AND DIRECTED:

I. The Oregon Department of Agriculture is directed to coordinate and provide assistance in seeking federal resources to mitigate drought conditions and assist in agricultural recovery in Lake and Malheur Counties.

II. The Department of Water Resources and the Water Resources Commission are directed to coordinate and provide assistance to water users in Lake and Malheur Counties as the Department and Commission determine is necessary and appropriate in accordance with ORS 536.700 to 536.780.

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

IV. All other state agencies are directed to coordinate with the above agencies and to provide appropriate state resources as determined essential to assist affected political subdivisions and water users in Lake and Malheur Counties.

V. This Executive Order expires on December 31, 2015.

Done at Salem, Oregon this 16th day of March, 2015.

/s/ Kate Brown
Kate Brown
GOVERNOR

ATTEST

/s/ Jeanne Atkins
Jeanne Atkins
SECRETARY OF STATE

REQUEST FOR COMMENTS PROPOSED PROSPECTIVE PURCHASER AGREEMENT FOR MORRISON OIL SITE

COMMENTS DUE: 5 p.m., Wednesday, May 1, 2015
PROJECT LOCATION: 3747 N. Suttle Road in Portland, Oregon
PROPOSAL: The Department of Environmental Quality seeks comments on its proposed consent order for a prospective purchaser agreement with Barbara Spurgeon concerning its acquisition of real property located at 3747 N. Suttle Road, Portland, Oregon.

A remedial investigation of this property completed under DEQ oversight in 2011 showed that a lead-contaminated soil pile drives the remaining risk on the portion of the site (Tax Lot 800, 4.28 acres; DEQ ECSI Site# 800) addressed under this Prospective Purchaser Agreement (PPA). This soil stockpile is approximately 7,000 cubic yards, and was excavated when North Marine Drive was built at the north edge of this parcel in the early 1990s. Morrison Oil has treated the majority of this contaminated soil with a chemical fixative in preparation for disposal at a permitted solid waste landfill and is under unilateral order to complete soil treatment by December 2016.

Historically, oil product distribution businesses operated on this property, including the current owner Morrison Oil. Activities included use of now-decommissioned above ground tank farms and underground storage tanks. Since 1990, two of the warehouses on site were leased for companies for dry goods product storage, including racking systems and sandblast media.

The consent order requires Barbara Spurgeon to perform removal and permitted disposal of the treated soil by Dec. 30, 2016. The order also requires this purchaser to obtain DEQ approval for a confirmation investigation work plan in the vicinity of the pile locations, to conduct soil sampling for lead, and to submit test results to DEQ for review. If sampling results show that total lead levels average more than the occupational worker exposure threshold, the order requires Barbara Spurgeon to mitigate unacceptable risk conditions. The order provides two options for remedial action in this circumstance: additional soil removal with confirmation sampling and cover with a cap of clean fill; or installing an impervious cap and executing an Easement and Equitable Servitudes providing for institutional controls.

The removal of the soil and associated activities required in the order should return this underutilized industrial property to fully productive commercial use. Plans for the property include expansion of existing sand blast media sales operations and redevelopment of underutilized areas.

DEQ created the Prospective Purchaser Agreement Program in 1995 through amendments to the state's Environmental Cleanup Law. The prospective purchaser agreement is a tool that expedites the cleanup of contaminated property and encourages property transactions that would otherwise not likely occur because of the liabilities associated with purchasing a contaminated site.

The proposed consent order will provide Barbara Spurgeon with a release from liability for claims by the State of Oregon under ORS 465.200 to 465.545 and 465.990, 466.640, and 468B.310 regarding existing hazardous substance releases at or from the property. The proposed consent order also will provide Barbara Spurgeon with third party liability protection.

HOW TO COMMENT: Send comments to DEQ Project Manager Jay Collins at 2020 SW Fourth Ave., Ste 150, Portland, Oregon 97201 or collins.jay@deq.state.or.us. For more information contact the project manager at 503-229-5008.

Find information about requesting a review of DEQ project files at: http://www.deq.state.or.us/records/recordsRequestFAQ.htm

Find the file review application form at: http://www.deq.state.or.us/records/RecordsRequestForm.pdf

To access site summary information and other documents in the DEQ Environmental Cleanup Site Information database, go to http://www.deq.state.or.us/lq/ECSI/ecsi.htm, select "Search complete ECSI database", then enter 800 in the Site ID box and click "Submit" at the bottom of the page. Next, click the link labeled 800 in the Site ID/Info column. Alternatively, you may go directly to the database website for this page at http://www.deq.state.or.us/lq/ecsi/ecsilist.asp?SiteID=800&Bus_Name=&Address=&County=ALL&City=&Zip_Code=&LatitudeMin=&LatitudeMax=&LongitudeMin=&LongitudeMax=&Township=All&TownshipZone=N&Range=1&RangeZone=E&Section=All&ActionCode=All&Substance=None&Alias=None&Submit=Submit&listtype=.

If you do not have web access and want to review the project file contact the DEQ project manager.

THE NEXT STEP: DEQ will consider all public comments received by the date and time stated above before making a final decision regarding the proposed prospective purchaser agreement designed to assist in completion of removal actions pending at the site. A public notice of DEQ's final decision will be issued.

ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. Please notify DEQ of any special physical or language accommodations or if you need information in large print, Braille or another format. To make these arrangements, call DEQ at 503-229-5696 or toll free in Oregon at 800-452-4011; fax to 503-229-6762; or email to deqinfo@deq.state.or.us. People with hearing impairments may call 711.

PUBLIC NOTICE — REQUEST FOR COMMENTS PROPOSED PROSPECTIVE PURCHASER AGREEMENT WITH CITY OF ALBANY

COMMENTS DUE: 5 p.m., Friday, May 1, 2015
PROJECT LOCATION: 623 Lyon St.SE, Albany
PROPOSAL: The Oregon Department of Environmental Quality seeks comments on a proposed consent judgment for a Prospective Purchaser Agreement with the City of Albany concerning the City's proposed acquisition of real property located at 655 Lyon St. SE., in Albany. The City owns an adjacent property that houses the City's fire department staff and vehicles. The City proposes to purchase the property for the purpose of constructing a new and enlarged fire station to improve its emergency response services to its citizens.

The parcels to be acquired currently contain a retail space that houses an operating dry cleaner facility, and a separate building that has been used as a vehicle garage and service facility. Environmental investigations conducted by the DEQ's Dry Cleaner Program found legacy contaminants in soil and groundwater attributed to both past uses. DEQ has established that the contamination does not currently pose a risk to human health. However, redevelopment of the site as proposed by the City may uncover additional contamination beneath the dry cleaners.

The City has agreed to conduct the following activities under the proposed consent judgment for a Prospective Purchaser Agreement:

- Prior to building demolition, the City will prepare a Media Management Plan for contaminated materials for use by contractors working at the site.
- After building demolition, but before any site redevelopment, DEQ will perform additional environmental investigation of soil and/or groundwater beneath the dry cleaner building to determine if any cleanup is needed to protect future workers at the Property.

If DEQ determines cleanup of dry cleaning related contamination is needed, it will conduct the necessary cleanup in coordination with the City's redevelopment plans, prior to construction of the new fire station. Groundwater remediation is likely unnecessary, but if so, DEQ will conduct groundwater remediation in coordination with the City.

- The City will conduct any required investigation and cleanup of contamination not associated with dry cleaning solvent at the vehicle garage building, when that building is removed.
- The City and DEQ will investigate and determine whether a broken sanitary sewer line currently serving the dry cleaners should be repaired, sealed, or removed as appropriate to prevent impacts to the environment.
- DEQ may require institutional controls in the form of an Easement and Equitable Servitude to limit certain uses on (?) the property, and to maintain engineering controls or contingencies for future

cleanup at the vehicle garage building. These actions will be further evaluated following the assessment beneath the dry cleaner building and considering the City's planned use for the vehicle garage building.

DEQ created the Prospective Purchaser Agreement Program in 1995 through amendments to the State's Environmental Cleanup Law. The PPA is a tool that expedites the cleanup of contaminated property and encourages property transactions that would otherwise not likely occur because of the liabilities associated with purchasing a contaminated site.

The proposed consent judgment will provide the City of Albany with a release from liability for claims by the State of Oregon under ORS 465.200 to 465.545 and 465.990, 466.640, and 468B.310 regarding existing hazardous substance releases at or from the property. The proposed consent judgment will also provide the City with third party liability protection.

HOW TO COMMENT: Send comments to DEQ Project Manager Don Hanson at 165 E. 7th Ave., Suite 100, Eugene, OR 97401 or email him at hanson.don@deq.state.or.us. For more information contact the project manager by email or by phone at 541-687-7349.

Find information about requesting a review of DEQ project files at: http://www.deq.state.or.us/records/recordsRequestFAQ.htm

Find the file review application form at: http://www.deq.state.or.us/records/RecordsRequestForm.pdf

To access site summary information and other documents in the DEQ Environmental Cleanup Site Information database, go to http://www.deq.state.or.us/lq/ECSI/ecsi.htm, select "Search complete ECSI database", then enter ECSI# 1491 in the Site ID box and click "Submit" at the bottom of the page. Next, click the link labeled ECSI # 1491 in the Site ID/Info column. Alternatively, you may go directly to the database website for this page at http://www.deq.state.or.us/Webdocs/Forms/Output/FPController.ashx?SourceId=1491&SourceIdType=11.

If you do not have web access and want to review the project file contact the DEQ project manager.

THE NEXT STEP: DEQ will consider all public comments received by the date and time stated above before making a final decision regarding the proposed prospective purchaser agreement. A public notice of DEQ's final decision will be issued.

ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. Please notify DEQ of any special physical or language accommodations or if you need information in large print, Braille or another format. To make these arrangements, call DEQ at 503-229-5696 or toll free in Oregon at 800-452-4011; fax to 503-229-6762; or email to deqinfo@deq.state.or.us. People with hearing impairments may call 711.

REQUEST FOR COMMENTS PROPOSED CLEANUP AT REED COLLEGE SERVICE STATION

COMMENTS DUE: 5 p.m., Thursday, April 30, 2015

PROJECT LOCATION: 5216 SE 28th Ave., Portland

PROPOSAL: Odyssey Property Holdings, on behalf of Reed College, is proposing to remove over 400 cubic yards of contaminated soil from the site of a former service station on the northeast corner of the intersection of SE 28th Ave. and SE Steele St. in Portland, and to place restrictive covenants on the future use of the site.

HIGHLIGHTS: A fuel service station operated at the site from 1970 to 1978. The site was purchased on behalf of Reed College in 2004. Subsequent investigations have identified petroleum-contaminated soil and groundwater in the vicinity of the former fuel islands, and soil and groundwater contaminated with a mixture of petroleum and solvents in the vicinity of a former oil/water separator. Without remediation, contaminant concentrations in the soil and soil gas will pose an unacceptable risk through vapor intrusion into indoor air if the site is redeveloped for urban residential use. The site does not pose an unacceptable risk to public health or the environment in its current state.

HOW TO COMMENT: Send comments to DEQ Project Manager Kevin Dana at 2020 SW 4th Ave., Suite 400, Portland, Oregon, 97201 or dana.kevin@deq.state.or.us. For more information contact the project manager at 503-229-5369.

Find information about requesting a review of DEQ project files at: http://www.deq.state.or.us/records/RecordsRequestFAQ.htm

Find the File Review Application form at: http://www.deq.state.or.us/records/RecordsRequestForm.pdf

To access site summary information and other documents in the DEQ Environmental Cleanup Site Information database, go to http://www.deq.state.or.us/lq/ECSI/ecsi.htm, select "Search complete ECSI database", then enter 4803 in the Site ID box and click "Submit" at the bottom of the page. Next, click the link labeled 4803 in the Site ID/Info column. Alternatively, you may go directly to the database website for this page at http://www.deq.state.or.us/lq/ECSI/ecsidetail.asp?seqnbr=4803.

If you do not have web access and want to review the project file contact the DEQ project manager.

THE NEXT STEP: DEQ will consider all public comments received by the close of the comment period before making a final decision regarding the proposed cleanup.

ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. If you need information in another format, please contact DEQ toll free in Oregon at 800-452-4011, email at deqinfo@deq.state.or.us, or 711 for people with hearing impairments.

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 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. Oral comments may be submitted at the appropriate time during a rulemaking hearing as outlined in OAR 137-001-0030.

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

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

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

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Board of Examiners for Engineering and Land Surveying
Chapter 820

Rule Caption: Amend rules related to examination and registration renewal requirements; housekeeping.
Stat. Auth.: ORS 672.160, 672.170 & 672.255
Other Auth.: ORS 670.310
Stats. Implemented: ORS 672.002–672.325
Proposed Amendments: 820-010-0417, 820-010-0440, 820-010-0465, 820-010-0505, 820-010-0621
Last Date for Comment: 4-23-15, Close of Business
Summary: OAR 820-010-0417— Nature of Examination for Structural Engineer (SE): Clarifies the prerequisite of licensure is to hold a license in a branch other than Structural; renumbers.

OAR 820-010-0440 — Schedule of Examinations: Due to the move to computer-based testing, revises the schedule for the fundamental examinations (year-round in testing windows) and revises the language related to the administration of the California Geotechnical examination. Also revises the name of the Agricultural examination to Agricultural and Biological.

OAR 820-010-0465 — Application for Readmission to Examination: Clarifies the requirements for further preparation to an examination and differentiates the national examinations from the Oregon Specific examinations. Adds clarification of the validity for an application to a computer-based examination.

OAR 820-010-0505 — Biennial Renewal of Registration or Certification: Adds language contained in other rules (OAR 820-015-0026 & 820-050-0010) related to the grace period requests that may be made at the time of renewal.

OAR 820-010-0621 — Final Documents: Adds the reference of ORS 672.028(2) to the rule; housekeeping.
Rules Coordinator: Mari Lopez
Address: Board of Examiners for Engineering and Land Surveying, 670 Hawthorne Ave. SE, Suite 220, Salem, OR 97301
Telephone: (503) 362-2666

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Board of Nursing
Chapter 851

Rule Caption: Fees for Prescriptive Authority for Certified Registered Nurse Anesthetists; Correct fees for Clinical Nurse Specialists

Date:	Time:	Location:
4-16-15	9 a.m.	17938 SW Upper Boones Ferry Rd Portland, OR 97224

Hearing Officer: Gary Hickmann, Board President
Stat. Auth.: ORS 678.150 & 678.410 & 678.282
Stats. Implemented: ORS 678.410
Proposed Amendments: 851-002-0030, 851-002-0035
Last Date for Comment: 4-16-15, 5 p.m.
Summary: To apply fees to the request from Certified Nurse Anesthetists for prescriptive privileges. These fees are identical to the fees currently being charged to Nurse Practitioners and Clinical Nurse Specialists for the same privilege to be added to their license.

Removal of the Extension of Limited License fee of $95 from the Clinical Nurse Specialist License type. This fee is not valid for any license type and appears only under the Clinical Nurse Specialist category.
Rules Coordinator: Peggy A. Lightfoot
Address: Board of Nursing, 17938 SW Upper Boones Ferry Rd., Portland, OR 97224
Telephone: (971) 673-0638

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Bureau of Labor and Industries
Chapter 839

Rule Caption: Amending rule regarding agency response to objections to investigative subpoenas.
Stat. Auth.: ORS 651.060, 658.220 & 659A.800
Stats. Implemented: ORS 279C, 651, 652, 653, 658 & 659A
Proposed Amendments: 839-002-0065
Last Date for Comment: 4-21-15, Close of Business
Summary: The amended rule would clarify the procedure by which BOLI enforcement divisions would respond to an objection filed by a person served with an investigative subpoena by clarifying timelines for objecting to subpoenas and for the division's response to objections and by cross referencing the administrative rule setting out permissible grounds for objections. The amendment would provide for division discretion in responding to objections based on cost of compliance with a subpoena, allowing division to determine use of resources based on circumstances rather than mandatorily. The amendment would also clarify that the division may engage in communication with a person objecting to a subpoena to determine whether the division's objective and objecting person's concerns can be addressed by mutual agreement, avoiding costly enforcement actions.
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
Chapter 125

Rule Caption: Repealing the Lease Non-appropriation Rule in the Leasing rules.

Date:	Time:	Location:
4-15-15	1:30 p.m.	Dept. of Administrative Services 1225 Ferry St. SE, Olallie Butte Conference Rm. Salem, OR 97301

Hearing Officer: Shannon Ryan
Stat. Auth.: ORS 184.340 & 276.428

Other Auth.: Article XI, Section 7 of the Oregon Constitution
Stats. Implemented: ORS 276.428
Proposed Repeals: 125-120-0180
Last Date for Comment: 4-16-15, 5 p.m.
Summary: The proposed rule repeal updates the leasing office quarters rules to align with statute and respond to contemporary best practice recommendations.
Rules Coordinator: Janet Chambers
Address: Department of Administrative Services, 155 Cottage St. NE, Salem, OR 97301
Telephone: (503) 378-5522

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Department of Agriculture,
Oregon Processed Vegetable Commission
Chapter 647

Rule Caption: Amend rules related to assessment rates

Date:	Time:	Location:
4-23-15	7:30 p.m.	1320 Capitol St. NE Salem, OR

Hearing Officer: Scott Iverson
Stat. Auth.: ORS 576.051–576.595
Stats. Implemented: ORS 576.051–576.595
Proposed Amendments: 647-010-0010
Last Date for Comment: 4-23-15, Close of Hearing
Summary: The proposed rule amendments set the assessment rates for the six processed vegetable crops governed by the commission.
Rules Coordinator: Misty Slagle
Address: Department of Agriculture, Processed Vegetable Commission, 6745 SW Hampton, Suite 101, Portland, OR 97223
Telephone: (503) 924-1181

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Department of Consumer and Business Services,
Insurance Division
Chapter 836

Rule Caption: Revising definition of mental or nervous condition and clarifying exceptions and exclusions allowed.

Date:	Time:	Location:
4-30-15	10:30 a.m.	Dept. of Consumer and Business Services Labor and Industries Bldg. 350 Winter St. NE, Rm. E Salem, OR 97301

Hearing Officer: Jeannette Holman
Stat. Auth.: ORS 731.244 & 743A.168
Stats. Implemented: ORS 743A.168 & 743.190
Proposed Adoptions: 836-053-1407, 836-053-1408
Proposed Amendments: 836-053-1404
Last Date for Comment: 5-6-15, 5 p.m.
Summary: Many health care providers and insurers are transitioning from using classification codes found in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" (DSM-IV) to the coding in the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition" (DSM-5). Until all users have transitioned entirely to the DSM-5, it is necessary to include applicable diagnostic codes from both versions in defining mental or nervous condition for purposes of the mandatory requirements of Oregon's mental health parity statute. These rules add appropriate diagnostic codes from the DSM-5 to the rule and clarify allowable exceptions and exclusions to the mental health parity statute.
Rules Coordinator: Jenny Craig
Address: Department of Consumer and Business Services, Insurance Division, 350 Winter St. NE, Salem, OR 97301
Telephone: (503) 947-7484

Department of Energy,
Energy Facility Siting Council
Chapter 345

Rule Caption: Amend EFSC rules relating to the Council's balancing authority for consistency with Oregon statutes.

Date:	Time:	Location:
4-22-15	10 a.m.	Oregon Dept. of Energy 625 Marion St. NE Salem, OR 97301

Hearing Officer: Jason Sierman
Stat. Auth.: ORS 469.470 & 469.501
Stats. Implemented: ORS 469.501(3) & 469.503(1)
Proposed Amendments: 345-022-0000, 345-027-0070
Last Date for Comment: 4-23-15, 5 p.m.
Summary: In 2013, ORS 469.501(3) and ORS 469.503(1) were amended by Oregon Laws 2013, Chapter 263, Sections 1 and 2. These statutes grant the Energy Facility Siting Council (EFSC or "the Council") its "balancing authority." As amended, these statutes authorize the Council to issue a site certificate or amended site certificate for a facility that does not meet one or more of the applicable Council standards if the Council finds that the overall public benefits of the facility outweigh any adverse effects on a resource or interest protected by the applicable standards the facility does not meet. The 2013 amended statutory language added "applicable" to the standards to which the authority applies; and replaced "the damage to the resource" with "any adverse effects on a resource or interest" under ORS 469.501(3) and ORS 469.503(1). These amendments require changes to the Council's existing balancing authority rules to accurately reflect the statutory language. Most of the proposed language changes occur in OAR Chapter 345, Division 22; one proposed change is in Division 27.

The Council requests public comment on these draft rules. The Council also requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business. A call-in number is available for the public hearing. Please see the Oregon Department of Energy website for hearing details and other materials: http://www.oregon.gov/energy/Siting/Pages/council-rulemaking.aspx
Rules Coordinator: Jason Sierman
Address: Department of Energy, Energy Facility Siting Council, 625 Marion St. NE , Salem, OR 97301
Telephone: (503) 373-2127

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Department of Human Services,
Aging and People with Disabilities and
Developmental Disabilities
Chapter 411

Rule Caption: Residential Care and Assisted Living Facility Abuse Investigations

Date:	Time:	Location:
5-15-15	1 p.m.	Human Services Bldg., Rm. 160 500 Summer Street NE Salem, OR 97301

Hearing Officer: Staff
Stat. Auth.: ORS 410.070 & 443.450
Other Auth.: HB 4151
Stats. Implemented: ORS 441.705–745, 443.400–455 & 443.991
Proposed Amendments: 411-054-0120
Proposed Repeals: 411-054-0120(T)
Last Date for Comment: 5-21-15, 5 p.m.
Summary: The Department of Human Services (Department) is proposing to amend the rules for residential care and assisted living facilities in OAR chapter 411, division 054 to change the definition of sexual abuse to comply with H.B. 4151.

Minor wording, formatting, punctuation, and grammar adjustments were made to the rules as well.
Rules Coordinator: Kimberly Colkitt-Hallman

Address: Department of Human Services, Aging and People with Disabilities and Developmental Disabilities, 500 Summer St. NE, E48, Salem, OR 97301
Telephone: (503) 945-6398

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Rule Caption: Investigations of Potential Elder Abuse in Nursing Facilities

Date:	Time:	Location:
5-15-15	1:30 p.m.	Human Services Bldg., Rm. 160 500 Summer St. NE Salem, OR 97301

Hearing Officer: Staff
Stat. Auth.: ORS 441.630, 441.650, 441.676, 441.677 & 441.715
Other Auth.: HB 4151 (2014 Regular Session) 2014 OL Ch. 104
Stats. Implemented: ORS 441.630, 441.650, 441.676, 441.677 & 441.715
Proposed Amendments: 411-085-0005, 411-085-0010, 411-085-0013, 411-085-0015, 411-085-0030, 411-085-0040, 411-085-0060, 411-085-0310, 411-085-0350, 411-085-0360, 411-085-0370, 411-089-0010, 411-089-0020, 411-089-0030, 411-089-0040, 411-089-0050, 411-089-0070, 411-089-0075, 411-089-0100, 411-089-0110, 411-089-0120, 411-089-0130, 411-089-0140
Proposed Repeals: 411-085-0005(T), 411-085-0010(T), 411-085-0013(T), 411-085-0015(T), 411-085-0030(T), 411-085-0040(T), 411-085-0060(T), 411-085-0310(T), 411-085-0350(T), 411-085-0360(T), 411-085-0370(T), 411-089-0010(T), 411-089-0020(T), 411-089-0030(T), 411-089-0040(T), 411-089-0050(T), 411-089-0070(T), 411-089-0075(T), 411-089-0100(T), 411-089-0110(T), 411-089-0120(T), 411-089-0130(T), 411-089-0140(T)
Last Date for Comment: 5-21-15, 5 p.m.
Summary: The Department of Human Services (Department) is proposing to amend the rules in OAR chapter 411-085, 089 to make permanent temporary changes that were implemented on January 1, 2015. The proposed amendments implement House Bill 4151 (2014 Regular Session) and make necessary changes to make the rules reflect current Department policy and practice by:

- Amending the definition of "sexual abuse" used by corrective action coordinators to determine enhanced civil penalties as required by HB 4151. Following the substantiation of alleged "abuse" in nursing facilities, this definition is used to determine the amount of an enhanced civil penalty the nursing facility corrective action coordinator applies in any given case. This definition is not used by investigators in the field; this definition is only used by corrective action coordinators to determine enhanced civil penalties.
- Replacing name of division with the new name of the office, "Office of Licensing and Regulatory Oversight (OLRO)" and listing the responsibilities of the office.
- Amending definitions to be consistent with current Department terminology.
- Amending program and division names throughout the rules to ensure current agency program names are correctly referenced.
- Amending the amount of time local APD and AAA offices have to complete an abuse investigation report to ensure consistency with the HB 4151 requirement of completing investigations within120 days.
- Making minor wording, formatting, punctuation, and grammatical adjustments to the rules.

Written comments may be submitted via e-mail to Kimberly.Colkitt-Hallman@state.or.us or mailed to 500 Summer Street NE, E48 Salem, Oregon, 97301-1064. All comments received will be given equal consideration before the Department proceeds with the permanent rulemaking.
Rules Coordinator: Kimberly Colkitt-Hallman
Address: Department of Human Services, Aging and People with Disabilities and Developmental Disabilities, 500 Summer St. NE, E48, Salem, OR 97301
Telephone: (503) 945-6398

Department of Justice
Chapter 137

Rule Caption: Implementing Legislation Regarding Issuance of Disqualification Orders and Civil Penalties for Reporting Violations

Date:	Time:	Location:
5-8-15	1:30 p.m.	Department of Justice 1515 SW 5th Ave., #410 Portland, OR 97201

Hearing Officer: DOJ Staff
Stat. Auth.: ORS 128.670 & 128.769
Other Auth.: HB 2060 (2013) (2013 OL Ch. 260); HB 4081 (2014) (2014 OL Ch. 8)
Stats. Implemented: ORS 128.620, 128.650, 128.660, 128.670, 128.760, 128.763 & 128.769
Proposed Adoptions: 137-010-0032
Proposed Amendments: 137-010-0005, 137-010-0010, 137-010-0015, 137-010-0020, 137-010-0025, 137-010-0033, 137-010-0034, 137-010-0040, 137-010-0041
Proposed Repeals: 137-010-0042
Last Date for Comment: 5-14-15, 5 p.m.
Summary: Proposed Rule 137-010-0032 implements HB 2060 (2013). HB 2060 authorizes the Attorney General to issue orders disqualifying certain registered charities from being eligible to receive contributions that are tax deductible as charitable donations for Oregon income tax purposes if they spend on average less than 30% of expenditures on program services. The disqualified status must also be disclosed in solicitations to prospective donors. The legislation is intended to address a small but persistent number of charities that consistently spend most of the donations they receive on fundraising and administration, rather than on the charitable programs that prompted donations. Disqualification orders will be based on the charities' own Internal Revenue Service (IRS) Form 990 financial reports and issued in accordance with the notice and hearing requirements of the Administrative Procedures Act. The proposed rule contains a number of exemptions from its application to ensure the rule is consistent with the purposes of the legislation. Among the organizations exempted from application of the rule are small organizations that are not required to file the full IRS Form 990, organizations that are accumulating revenues for specific purposes such as capital or endowment campaigns, private foundations, and organizations that receive most of their income from sources other than tax deductible donations.

The proposed rule amendments also implement HB 4081 (2014). HB 4081 sets forth acts and practices that violate the Department's registration and reporting requirements, including failing to register or willfully filing false reports with the Department. The legislation specifies a variety of actions the Attorney General can take in response to reporting violations and increases the Department's administrative civil penalty authority from $1,000 to $2,000 per violation. The proposed rule amendments include revisions necessary to implement HB 4081, including revising the maximum civil penalty to $2,000 to correspond to the legislation. Other proposed rule amendments include using the term "organizations" rather than "corporations and trustees" in order to be consistent with existing statutory language, revising certain reporting thresholds to more closely correspond to IRS filing thresholds, and other minor housekeeping changes for clarity and consistency.

Please submit written comments or questions to Kate Medema, Public Affairs Coordinator, Oregon Dept. of Justice, 1515 SW 5th Ave., #410, Portland, OR 97201 or via email to Kate.e.medema@state.or.us.
Rules Coordinator: Carol Riches
Address: Department of Justice, 1162 Court St. NE, Salem, OR 97301
Telephone: (503) 947-4700

Department of Transportation,
Highway Division
Chapter 734

Rule Caption: Establishment of Speed Limits on Interstate Highways and Locations of Interstate Speed Limits
Stat. Auth.: ORS 184.616, 184.619, 810.010, 810.180, Ch. 819, OL 2003
Stats. Implemented: ORS 810.180, Ch. 819, OL 2003
Proposed Amendments: 734-020-0010, 734-020-0011
Last Date for Comment: 4-21-15, Close of Business
Summary: ORS 810.180 authorizes the Department of Transportation to conduct speed zone investigations and set speeds on most public roads, including interstate highways. Wording has been changed for better understanding within 734-020-0010(3)(d) and 734-020-0010(3)(e)(A). As amended, 734-020-0011, the location of the 65 mph to 55 mph speed limit transition would move further south by 0.92 miles as allowed within 734-020-0010(3). Beginning at the California/Oregon border on I-5, the speed limit is currently 55 mph. The speed limit transitions to 65 mph near the base of the Siskiyou Mountain Range, approximately 3 miles south of the City of Ashland. In the northbound direction at the location of this recommended change, this section of roadway opens up into long tangent sections with no sharp curves. In the southbound direction, the roadway is wider due to an expanded shoulder that is used by trucks as a climbing lane. Further south (where the 55 mph will remain), the roadway transitions to sharper curves. ODOT believes the transition from 65 mph to 55 mph should be moved further south (further uphill), closer to curves warranting slower speeds.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Highway Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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Department of Transportation,
Motor Carrier Transportation Division
Chapter 740

Rule Caption: Annual readoption of IRP, HVUT and IFTA regulations
Stat. Auth.: ORS 184.616, 184.619, 823.011 & 826.003
Stats. Implemented: ORS 803.370(5), 825.490, 825.494, 825.555, 826.005 & 826.007
Proposed Amendments: 740-200-0010, 740-200-0020, 740-200-0040
Last Date for Comment: 4-21-15, Close of Business
Summary: The proposed amendment constitutes an adoption of the rules of the International Registration Plan (IRP) to the date of January 1, 2015. Title 26 Code of Federal Regulations Part 41 (HVUT) requires the State to confirm proof of payment of the tax, and require proof of payment by the State as a condition of issuing a registration for a highway motor vehicle. The amendment of OAR 740- 740-200-0020 adopts HVUT and amendments with the effective date of January 1, 2015, and ensures Oregon remains current with national commercial motor vehicle registration standards. International Fuel Tax Agreement (IFTA) and associated material are applicable to Oregon-based motor carriers who participate in IFTA as a way to report and pay fuel tax to other jurisdictions. The revision to OAR 740-200-0040 adopts the most recent version of IFTA and associated material as the procedures and guidelines for Oregon-based IFTA participants with the effective date of January 1, 2015 to ensure Oregon remains current with the international IFTA standards.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Motor Carrier Transportation Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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Rule Caption: Amendment of federal safety and hazardous materials transportation regulations affecting motor carriers.
Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232, 825.252 & 825.258
Stats. Implemented: ORS 823.061, 825.210, 825.250, 825.252 & 825.258
Proposed Amendments: 740-100-0010, 740-100-0065, 740-100-0070, 740-100-0080, 740-100-0085, 740-100-0090, 740-110-0010
Last Date for Comment: 4-21-15, Close of Business
Summary: These rules contain the annual adoption of federal motor carrier safety and hazardous materials transportation regulations. In addition, these rules cover the adoption of international standards related to driver, vehicle and hazardous materials out-of-service violations. The changes are necessary to ensure Oregon's motor carrier safety, hazardous materials, and driver, vehicle and hazardous materials out-of-service requirements are current with national and international standards.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Motor Carrier Transportation Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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Department of Transportation,
Rail Division
Chapter 741

Rule Caption: Amends Oregon Railroad Hazardous Materials Transportation Rules

Date:	Time:	Location:
5-5-15	3 p.m.	Blue Mt. Community College, Rm. ST200 2411 NW Carden Ave. Pendleton, OR
5-5-15	6 p.m.	Blue Mt. Community College, Rm. ST200 2411 NW Carden Ave. Pendleton, OR
5-6-15	3 p.m.	Deschutes Public Library, Brooks Rm. 601 Wall St. Bend, OR
5-6-15	6 p.m.	Deschutes Public Library, Brooks Rm. 601 Wall St. Bend, OR
5-7-15	3 p.m.	Klamath Community College, Rm. H138 7390 S 6th St. Klamath Falls, OR
5-7-15	6 p.m.	Klamath Community College, Rm. H138 7390 S 6th St. Klamath Falls, OR
5-11-15	3 p.m.	Keizer City Hall, Rm. Iris B 930 Chemewa Rd. Keizer, OR
5-11-15	6 p.m.	Keizer City Hall, Rm. Iris B 930 Chemewa Rd. Keizer, OR

Hearing Officer: June Carlson
Stat. Auth.: ORS 184.616, 184.619, 823.011, 823.061 & 824.086
Stats. Implemented: ORS 824.080–824.092
Proposed Adoptions: 741-510-0015, 741-510-0025, 741-510-0027, 741-510-0035, 741-510-0045, 741-510-0050
Proposed Amendments: 741-510-0010, 741-510-0020
Proposed Repeals: 741-510-0030 , 741-510-0040
Last Date for Comment: 5-12-15, 12 p.m.
Summary: This rulemaking modernizes existing OAR and establishes roles and responsibilities for communications and notifications of hazardous materials rail transport and incident response. Additionally, these rules reestablish consistency with Federal laws and rules.
Rules Coordinator: Lauri Kunze

Address: Department of Transportation, Rail Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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Higher Education Coordinating Commission, Department of Community Colleges and Workforce Development
Chapter 589

Rule Caption: Removes restriction on the designation of major or areas of study in community college programs.

Date:	Time:	Location:
4-15-15	1 p.m.	775 Court St. NE Salem, OR 97301

Hearing Officer: Kelly Dickinson
Stat. Auth.: ORS 326.051
Stats. Implemented: ORS 341.425 & 341.465
Proposed Amendments: 589-006-0100
Last Date for Comment: 4-22-15, 5 p.m.
Summary: A change in this rule is necessary to delete 589-006-0100 (10) and thereby remove the restriction from designation of major or areas of study as a component of an Associate of Arts Oregon Transfer and Associate of Science degree award title. The restriction poses a barrier to student success and degree completion. Identifying a major and establishing an education plan is an important factor in retention and completion and facilitates smooth transitions between two- and four-year institutions. Community College Instructional Administrators and University Provost Council have been consulted and support this rule change as a means to improve advising, transfer, and degree completion.
Rules Coordinator: Kelly Dickinson
Address: Department of Community Colleges and Workforce Development, 775 Court St. NE, Salem, OR 97301
Telephone: (503) 378-5690

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Landscape Architect Board
Chapter 804

Rule Caption: Adoption of 2015–2017 Operating Budget

Date:	Time:	Location:
4-21-15	1:30 p.m.	Association Center 707 13th St. SE Salem, OR

Hearing Officer: Christine Valentine
Stat. Auth.: ORS 671.415, 182.462 & 670.310
Stats. Implemented: ORS 671.415 & 182.462
Proposed Amendments: 804-001-0002
Last Date for Comment: 4-21-15, 5 p.m.
Summary: This rule revision will adopt the 2015-2017 biennial budget of the Board with a spending limit of $428,103 . The Board approved the recommended 2015-2017 budget on February 26, 2015 for rulemaking purposes. The Board is now presenting the budget for review by its registrants and other interested parties. Individuals may view a copy of the budget rule and details on the Board's web page or may request copies by contacting the Board's administrative office.
Rules Coordinator: Christine Valentine
Address: Landscape Architect Board, 707 13th St. SE, Suite 114, Salem, OR 97301
Telephone: (503) 589-0093

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Oregon Board of Naturopathic Medicine
Chapter 850

Rule Caption: Clarifies the Board's authority to conduct Law Enforcement Data System (LEDS) checks on licensees
Stat. Auth.: ORS 685.125 & 685.195
Stats. Implemented: ORS 685.195
Proposed Amendments: 850-030-0020
Last Date for Comment: 4-30-15, 2 p.m.
Summary: Clarifies the Board's authority to conduct criminal background checks as part of the license renewal, in order to assure fitness to practice. Full text is available at Oregon.gov/obnm
Rules Coordinator: Anne Walsh
Address: Oregon Board of Naturopathic Medicine, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0193

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Oregon Health Authority, Addictions and Mental Health Division: Mental Health Services
Chapter 309

Rule Caption: Permanent amendments to OAR 309-114 regarding informed consent for client's significant procedures.

Date:	Time:	Location:
5-19-15	9 a.m.	500 Summer St. NE, Rm. 137 D Salem, OR 97301

Hearing Officer: Nola Russell
Stat. Auth.: ORS 413.042 & 179.040
Stats. Implemented: ORS 179.321, 426.070 & 426.385
Proposed Amendments: 309-114-0000, 309-114-0010, 309-114-0015
Last Date for Comment: 5-24-15, Close of Business
Summary: These rules prescribe standards and procedures to be observed by personnel of state institutions operated by Division in obtaining informed consent to significant procedures, as defined by these rules, from patients of such state institutions. These rules do not apply to routine medical procedures. The purpose of these rules is to assure that the rights of patients are protected with respect to significant procedures.
Rules Coordinator: Marcus Kroloff
Address: Oregon Health Authority, Addictions and Mental Health Division: Mental Health Services, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-9717

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Rule Caption: Permanent amendments to OAR 309-031 regarding admissions and transfers of Oregon State Hospital patients.

Date:	Time:	Location:
5-19-15	9 a.m.	500 Summer St. NE, Rm. 137 D Salem, OR 97301

Hearing Officer: Nola Russell
Stat. Auth.: ORS 413.042, 161.390, 179.360 & 179.040
Stats. Implemented: ORS 161.390, 426.005–426.702, 179.360 & 179.040
Proposed Amendments: 309-031-0010
Last Date for Comment: 5-25-15, Close of Business
Summary: This rule prescribes procedures for state institutions serving persons committed to the Division by a court of criminal jurisdiction and persons ordered to a state institution by the Psychiatric Security Review Board or Oregon Health Authority. This rule also designates the state institution to receive other dangerous persons in certain instances.
Rules Coordinator: Marcus Kroloff
Address: Oregon Health Authority, Addictions and Mental Health Division: Mental Health Services, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-9717

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Oregon Health Authority, Division of Medical Assistance Programs
Chapter 410

Rule Caption: Amending PDL November 20, 2014 DUR/P&T Action

Date:	Time:	Location:
4-15-15	10:30 a.m.	500 Summer St. NE, Rm. 160 Salem, OR 97301

Hearing Officer: Sandy Cafourek

Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.325, 414.330–414.414, 414.312 & 414.316
Stats. Implemented: ORS 414.065, 414.325, 414.334, 414.361, 414.369, 414.371, 414.353 & 414.354
Proposed Amendments: 410-121-0030
Proposed Repeals: 410-121-0030(T)
Last Date for Comment: 4-17-15, 5 p.m.
Summary: The Pharmaceutical Services Program administrative rules (division 121) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows:

410-121-0030:
Preferred:
Epinephrine Injection;
Estradiol;
Legend Prenatal Vitamins;
Risperidone Microspheres.
Non-Preferred:
Bendroflumethiazide;
Boceprevir (Victrelis®);
Memantine HCL (Namenda XR®);
NPH, Human Insulin Isophane;
Telaprevir (Incivek®).

Rules Coordinator: Sandy Cafourek
Address: Oregon Health Authority, Division of Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6430

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Rule Caption: Update Reference to Current Covered and Non-Covered Dental Services Document, Incorporate Changes to Prioritized List
Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Proposed Amendments: 410-123-1220, 410-123-1260
Proposed Repeals: 410-123-1220(T), 410-123-1260(T)
Last Date for Comment: 4-17-15, 5 p.m.
Summary: Effective January 1, 2015, the Health Evidence Review Commission (HERC) added four oral health codes to funded lines of the Prioritized List of Health Services (Prioritized List). These codes are 99188, D1535, D9219, and D9931.The Authority is amending OAR 410-123-1220 and OAR 410-123-1260 to reflect these changes.
Rules Coordinator: Sandy Cafourek
Address: Oregon Health Authority, Division of Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6430

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Oregon Health Authority, Health Licensing Office, Board of Direct Entry Midwifery
Chapter 332

Rule Caption: Add education/training for purchasing/administering antibiotics for Group B Streptococcal prophylaxis including disclosure to patients.

Date:	Time:	Location:
4-28-15	9 a.m.	Health Licensing Office Rhoades Conference Rm. 700 Summer St. NE, Suite 320 Salem, OR 97301

Hearing Officer: Samantha Patnode
Stat. Auth.: ORS 676.615, 676.586, 687.425 687.480 & 687.493
Stats. Implemented: ORS 687.425 687.480 & 687.493
Proposed Amendments: 332-015-0030, 332-020-0010, 332-025-0020, 332-025-0110, 332-026-0000, 332-026-0010
Last Date for Comment: 4-28-15, 5 p.m.
Summary: During the 2013 Legislative Session HB 2997 was enacted allowing licensed direct entry midwives (LDM) to purchase and administer antibiotics for Group B Streptococcal prophylaxis. The proposed rule will require that LDMs licensed prior to January 1, 2016 obtain 10 hours of instruction including pharmacology and intravenous administration of antibiotic before their annual renewal date in 2016. LDMs licensed after January 1, 2016 must successfully compete the initial legend drugs and devices program totaling 50 hours of instruction which includes pharmacology and intravenous administration of antibiotics.

The proposed rule also listed the antibiotics approved for purchase and administration by an LDM including Penicillin, Ampicillin, Cefazolin or Clindamycin.

The proposed rule requires each licensed direct entry midwife disclose to each patient whether or not they have received the initial legend drugs and devices training. The rule also requires the disclosure is documented within the patient records of care.
Rules Coordinator: Samantha Patnode
Address: Health Licensing Office, Board of Direct Entry Midwifery, 700 Summer St. NE, Suite 320, Salem, OR 97304
Telephone: (503) 373-1917

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Oregon Health Authority, Oregon Educators Benefit Board
Chapter 111

Rule Caption: Clarifying participation requirements for the OEBB benefits program

Date:	Time:	Location:
4-22-15	10:30 a.m.	PEBB/OEBB Boardroom 1225 Ferry St. SE Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860–243.886
Stats. Implemented: ORS 243.864(1)(a)
Proposed Amendments: 111-020-0010
Last Date for Comment: 4-30-15, 5 p.m.
Summary: OAR 111-020-0010 is amended to clarify participation requirements for the OEBB benefits program and limits Local Governments electing to participate in the OEBB benefits program on or after April 1, 2015 to using the tiered rate structure.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 1225 Ferry St. SE, Suite B, Salem, OR 97301
Telephone: (503) 378-6588

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Rule Caption: Housekeeping amendments to align rule language with Qualified Status Change Matrix

Date:	Time:	Location:
4-22-15	10:30 a.m.	PEBB/OEBB Boardroom 1225 Ferry St. SE Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860–243.886
Stats. Implemented: 243.864(1)(a)
Proposed Amendments: 111-040-0040
Last Date for Comment: 4-30-15, 5 p.m.
Summary: Housekeeping amendments to OAR 111-040-0040 align rule language with revisions made to the Qualified Status Change (QSC) Matrix.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 1225 Ferry St. SE, Suite B, Salem, OR 97301
Telephone: (503) 378-6588

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Oregon Health Authority, Public Employees' Benefit Board
Chapter 101

Rule Caption: PEBB is amending its OARs permanently to conform with the Affordable Care Act's current regulations.

Date:	Time:	Location:
5-8-15	4 p.m.	PEBB 1225 Ferry St. SE Suite B Salem, OR

Hearing Officer: Chérie Taylor
Stat. Auth.: ORS 243.061–243.302, 659A.060–659A.069, 743.600–743.602 & 743.707
Stats. Implemented: ORS 243.061–243.302, 292.051 & 2007 OL Ch. 99
Proposed Amendments: 101-010-0005, 101-015-0005, 101-020-0002, 101-020-0005, 101-020-0012, 101-020-0045, 101-030-0010, 101-030-0015, 101-030-0020
Proposed Repeals: 101-010-0005(T), 101-015-0005(T), 101-020-0002(T), 101-020-0005(T), 101-020-0012(T), 101-020-0045(T), 101-030-0010(T), 101-030-0015(T), 101-030-0020(T)
Last Date for Comment: 5-8-15, Close of Business
Summary: PEBB is amending its OARs permanently to conform with the Affordable Care Act's current regulations.
Rules Coordinator: Chérie Taylor
Address: Oregon Health Authority, Public Employees' Benefit Board, 1225 Ferry St. SE, Suite B, Salem, OR 97301
Telephone: (503) 378-6296

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Oregon Public Employees Retirement System
Chapter 459

Rule Caption: Update the order of priority for deductions from a benefit payment.

Date:	Time:	Location:
4-28-15	3 p.m.	PERS Boardroom 11410 SW 68th Pkwy. Tigard, OR 97223

Hearing Officer: Daniel Rivas
Stat. Auth.: ORS 238.630, 238.650, 238.715(9) & 238A.450
Stats. Implemented: ORS 238 & 238A
Proposed Adoptions: 459-045-0070
Proposed Amendments: 459-005-0600, 459-005-0610
Last Date for Comment: 5-6-15, 5 p.m.
Summary: OAR 459-005-0600 establishes the order of priority for deductions, whether pre-tax or post-tax, from a monthly benefit. The rule has not been updated since 1998; PERS has experienced many changes since that time, so a number of changes are necessary. The proposed modifications clarify that if a member is subject to the benefit limitation under Internal Revenue Code section 415 and must receive a portion of their monthly benefit from the Benefit Equalization Fund under ORS 238.485, such allocation of the member's benefit payments takes precedence over all other payments. Deductions for administrable court orders, such as garnishments for restitution under ORS 238.447, have been added. And, finally, premium payments for PERS-sponsored health insurance were moved down in priority, as they are a voluntary deduction.

OAR 459-045-0070 is a new rule and establishes the order of priority for deductions, whether pre-tax or post-tax, from a member's pension benefit when a domestic relations order awards a portion of the member's benefit to an alternate payee (AP). Such AP awards can be reductions (AP is responsible for the income tax on their portion of the benefit) or deductions (member is responsible for the income tax on the entire benefit, including the amount paid to the AP). The order of priority is slightly different for each of these scenarios and is broken out separately in the rule.

Finally, section (12) of OAR 459-005-0610 has been deleted because the order of precedence for recovery of an overpayment or an erroneous payment is addressed in both OAR 459-005-0600 and OAR 459-045-0070 and therefore this section of the rule is now unnecessary.
Rules Coordinator: Daniel Rivas
Address: Oregon Public Employees Retirement System, PO Box 23700, Tigard, OR 97281
Telephone: (503) 603-7713

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Rule Caption: Clarify defined terms relating to filing an application for a disability retirement.

Date:	Time:	Location:
4-28-15	3 p.m.	PERS Boardrtoom 11410 SW 68th Pkwy. Tigard, OR 97223

Hearing Officer: Daniel Rivas
Stat. Auth.: ORS 238.650 & 238A.450
Stats. Implemented: ORS 238.320–238.345 & 238A.235
Proposed Amendments: 459-015-0020, 459-076-0020
Last Date for Comment: 5-6-15, 5 p.m.
Summary: These rules provide specific timeframes for a member to timely file an application for a disability retirement (Tier One/Tier Two) or benefit (OPSRP). The member cannot apply before they discontinue working, but they are not required to be terminated from employment. The definitions for "date of disability", "date of separation from service", and "date of termination" in OAR 459-015-0001 were updated and incorporated into the disability rules in October 2011. There were quite a number of rules that required updates and when OAR 459-015-0020 was edited to incorporate the updated defined terms, date of termination was inadvertently updated to date of separation from service in paragraph (6)(b) when it should have been updated in paragraph (6)(a). Also, date of termination in (6)(a) was updated to date of separation from service instead of date of disability. The proposed edits to the rule correctly update both paragraphs (6)(a) and (6)(b) and propose other minor edits for clarification.

The proposed update to 459-076-0020 incorporates the defined term "date of disability" in one place where it was missed in 2011 and makes other minor edits for clarification.
Rules Coordinator: Daniel Rivas
Address: Oregon Public Employees Retirement System, PO Box 23700, Tigard, OR 97281
Telephone: (503) 603-7713

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Rule Caption: Update rules to reflect 2015 Internal Revenue Code (IRC) and Social Security annual compensation limitations.

Date:	Time:	Location:
4-28-15	3 p.m.	PERS Boardroom 11410 SW 68th Pkwy. Tigard, OR 97223

Hearing Officer: Daniel Rivas
Stat. Auth.: ORS 238.630, 238.650, 238A.370 & 238A.450
Stats. Implemented: ORS 238 & 238A, 2007 OL Ch. 499 & 774
Proposed Amendments: 459-005-0525, 459-005-0545, 459-017-0060, 459-080-0500
Last Date for Comment: 5-6-15, 5 p.m.
Summary: The Internal Revenue Service (IRS) revises various dollar limits annually based on cost-of-living adjustments. These revisions are used throughout the PERS plan's statutes and rules, but revisions to the limits must be adopted by the legislature or PERS Board to be effective.

The proposed rule modifications incorporate these federal adjustments and are necessary to ensure PERS compliance with the IRC's limits on the amount of annual compensation allowed for determining contributions and benefits, annual benefits, and annual additions to PERS.

Secondly, under ORS 238.082, a Tier One or Tier Two retired member who is receiving Social Security benefits and who returns to PERS-covered employment may continue to receive their PERS retirement benefits so long as they work less than 1,040 hours or not exceed any related Social Security annual compensation limits. The proposed modifications to OAR 459-017-0060 adopt the 2015 Social Security earnings limitations. For these increases to be effective, the PERS Board has to adopt these rule modifications.
Rules Coordinator: Daniel Rivas
Address: Oregon Public Employees Retirement System, PO Box 23700, Tigard, OR 97281
Telephone: (503) 603-7713

Oregon State Marine Board
Chapter 250

Rule Caption: Define term "slow-no wake" and removal of 5 mph reference

Date:	Time:	Location:
4-21-15	6 p.m.	435 Commercial St. NE Salem, OR

Hearing Officer: Rachel Graham
Stat. Auth.: ORS 830.110
Stats. Implemented: ORS 830.110
Proposed Amendments: Rules in 250-010, 250-020, 250-030
Last Date for Comment: 4-21-15, Close of Hearing
Summary: This rulemaking will add a definition of the term "slow-no wake" in the definitions applicable to OAR Chapter 250 and amend the basic rule for slow-no wake to remove the words, "maximum 5 mph." In addition, the local and special area rules that use the term "slow-no wake" will be amended to remove the reference to 5 mph in relation to slow-no-wake speed.
Rules Coordinator: June LeTarte
Address: Oregon State Marine Board, P.O. Box 14145, Salem, OR 97309-5065
Telephone: (503) 378-2617

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Rule Caption: Rules for the placement of informational and regulatory waterway markers by public bodies and individuals

Date:	Time:	Location:
4-21-15	6 p.m.	435 Commercial St. NE Salem, OR

Hearing Officer: Rachel Graham
Stat. Auth.: ORS 830.110
Stats. Implemented: ORS 830.110
Proposed Adoptions: Rules in 250-010
Proposed Amendments: Rules in 250-010
Proposed Repeals: Rules in 250-010
Proposed Renumberings: Rules in 250-010
Proposed Ren. & Amends: Rules in 250-010
Last Date for Comment: 4-21-15, Close of Hearing
Summary: These rules describe the characteristics and standards for regulatory and informational waterway markers (buoys and signs) used on the waters of this state that convey official messages to boat operators. In addition, the rules establish procedures for public bodies and individuals to apply for a permit to place approved waterway markers of their own (those markers not placed by the US Coast Guard or the Oregon State Marine Board).
Rules Coordinator: June LeTarte
Address: Oregon State Marine Board, P.O. Box 14145, Salem, OR 97309-5065
Telephone: (503) 378-2617

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Oregon University System,
Oregon Institute of Technology
Chapter 578

Rule Caption: Amend the fee schedule of Special Institutional Fees and Parking Permits.

Date:	Time:	Location:
4-21-15	3:30 p.m.	27500 SW Parkway Ave. Wilsonville, OR 97070
4-23-15	4 p.m.	3201 Campus Dr., Mt. Bailey Klamath Falls, OR 97601

Hearing Officer: Michelle E.R. Meyer
Stat. Auth.: ORS 51
Stats. Implemented: ORS 351.070
Proposed Amendments: 578-041-0030, 578-072-0030
Last Date for Comment: 4-24-15, 5 p.m.
Summary: 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 2015-2016. The schedule of subject fees may be obtained from the Oregon Institute of Technology Business Affairs Office and available at http://www.oit.edu/college-costs/tuition-fees.

578-072-0030 — Amends Parking Permit and Fees. Amendment allows for increases, revisions and additions of parking fines.
Rules Coordinator: Denise Reid
Address: Oregon University System, Oregon Institute of Technology, 3201 Campus Drive, Klamath Falls, OR 97601
Telephone: (541) 885-1227

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Oregon University System,
Southern Oregon University
Chapter 573

Rule Caption: Special Fees

Date:	Time:	Location:
4-30-15	3 p.m.	1250 Siskiyou Blvd. Ashland, OR 97520

Hearing Officer: Treasa Sprague
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Amendments: 573-040-0005
Last Date for Comment: 4-30-15, 4 p.m.
Summary: The proposed rule amendments eliminate fees that are no longer necessary and establish, increase, or decrease fees to more accurately reflect the actual costs of instruction for certain courses and special services not otherwise funded through the institution's operating budget.
Rules Coordinator: Treasa Sprague
Address: Oregon University System, Southern Oregon University, 1250 Siskiyou Blvd., Ashland, OR 97520
Telephone: (541) 552-6319

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Water Resources Department
Chapter 690

Rule Caption: Well Construction Rules Regarding Special Area Standards, Definitions, Rule Clarifications, Setbacks, Dug Wells and Peizometers.

Date:	Time:	Location:
4-22-15	5 p.m.	Mosier Grange 900 4th Ave. Mosier, OR 97040
4-24-15	9 a.m.	North Mall Office Bldg. 725 Summer St. NE, Rm. 124A Salem, OR 97301

Hearing Officer: Kristopher Byrd
Stat. Auth.: ORS 183, 536, 537 & 540
Stats. Implemented: ORS 183, 536, 537 & 540
Proposed Amendments: 690-200-0020, 690-200-0028, 690-200-0050, 690-205-0185, 690-210-0030, 690-210-0130, 690-210-0140, 690-210-0150, 690-210-0155, 690-210-0190, 690-210-0220, 690-210-0230, 690-210-0270, 690-210-0320, 690-210-0380, 690-210-0400, 690-210-0410, 690-210-0420, 690-215-0200, 690-220-0115, 690-240-0005, 690-240-0355, 690-240-0475, 690-240-0525
Proposed Repeals: 690-215-0015
Last Date for Comment: 4-24-15, 5 p.m.
Summary: This rulemaking includes a number of changes regarding well construction. The changes include the following:

- Establishing special area standards for the Mosier area of Wasco County. The Mosier area has declining water levels due, in part, to improper well construction. These proposed rules address the construction of new wells in the Mosier area by requiring the licensed well constructor responsible to consult with the Water Resources Department prior to the permanent installation of casing and seal material. In addition, the rules require an additional notice period prior to the start of construction activities to allow the Department time to research information regarding the location of the proposed well and to have discussions about the proposed construction methods. Also, the proposed rules require the installation of a dedicated

measuring tube at the time of pump installation, repair or replacement so that the water level in the well can be determined at any time.

- Clarifying responsibilities regarding certain well and geotechnical hole construction, maintenance, alteration, conversion and abandonment activities.
- Clarifying the classification of injection wells installed for remediation purposes.
- Modifying the definition of silt so the definition in Division 200 matches the definition in Division 240.
- Correcting old and incorrect rule and table references and removing dates in rule that have expired.
- Clarifying the construction standards for dug wells.
- Establishing setback standards from permanent structures for new water wells in order to allow access for drilling equipment.
- Clarifying the protection methods for piezometers.
- Clarifying the location where constructor information is placed on a drilling machine.

Rules Coordinator: Joshua Spansail
Address: Water Resources Department, 725 Summer St. NE, Suite A, Salem, OR 97301
Telephone: (503) 986-0874

Board of Massage Therapists
Chapter 334

Rule Caption: Clarify verbiage in existing rule; and modify late fees.
Adm. Order No.: BMT 1-2015
Filed with Sec. of State: 3-12-2015
Certified to be Effective: 7-1-15
Notice Publication Date: 2-1-2015
Rules Amended: 334-001-0012, 334-001-0055, 334-001-0060, 334-010-0018, 334-010-0033, 334-020-0005, 334-040-0010
Subject: Amend maximum amount for late fees; clarify verbiage in existing rules (Budget, Board Member Stipend, Definitions, Criminal Background Check, Fitness Determinations, Facilities and Sanitation and Discipline).
Rules Coordinator: Ekaette Udosenata—(503) 365-8657

334-001-0012
Budget

The Oregon Board of Massage Therapists hereby adopts, and fully incorporates herein, the Oregon Board of Massage Therapists' 2015–2017 Biennium budget of $1,865,000.

Stat. Auth.: SB 1127, ORS 183 & 687.121
Stats. Implemented: Section 6, (1) & (2)
Hist.: BMT 2-1999(Temp), f. & cert. ef. 9-17-99 thru 3-15-00; BMT 1-2000, f. & cert. ef. 1-12-00; BMT 2-2000, f. & cert. ef. 8-3-00; BMT 1-2001, f. & cert. ef. 5-29-01; BMT 2-2003, f. & cert. ef. 6-17-03; BMT 2-2005(Temp), f. & cert. ef. 6-24-05 thru 6-30-05; BMT 3-2005, f. 6-24-05, cert. ef. 7-1-05; BMT 1-2007, f. & cert. ef. 6-29-07; BMT 2-2007, f. & cert. ef. 7-3-07; BMT 3-2009, f. & cert. ef. 7-2-09; BMT 3-2010, f. 12-22-10, cert. ef. 1-1-11; BMT 1-2011, f. & cert. ef. 4-21-11; BMT 2-2011, f. 6-29-11, cert. ef. 7-1-11; BMT 1-2013, f. 5-31-13, cert. ef. 7-1-13; BMT 1-2015, f. 3-12-15, cert. ef. 7-1-15

334-001-0055
Board Member Stipend

(1) The Oregon Board of Massage Therapists hereby adopts a board member stipend of $200.00 per month for each month a board member serves in their appointment

(2) The Oregon Board of Massage Therapists hereby adopts an additional board chair and vice chair stipend of $375.00 per month for each month that a member serves as board chair.

Stat. Auth.: ORS 182.460 & 687.121
Stats. Implemented: ORS 182.460 & 687.121
Hist.: BMT 1-2010, f. & cert. ef. 4-12-10; BMT 2-2010, f. 7-23-10, cert. ef. 7-26-10; BMT 3-2010, f. 12-22-10, cert. ef. 1-1-11; BMT 1-2011, f. & cert. ef. 4-21-11; BMT 1-2015, f. 3-12-15, cert. ef. 7-1-15

334-001-0060
Definitions

(1) "Advantageous" means in the Board's best interests, as assessed according to the judgment of the Board.

(2) "Award" means either the act or occurrence of the Board's identification of the Person with whom the Board will enter into a Contract.

(3) "Barter" means partial or complete trade or exchange of massage or bodywork services for any other type of goods or service other than money.

(4) "Board" means the State Board of Massage Therapists or its authorized representatives as provided by ORS 687.115.

(5) "Bodywork" means forms, methods, and styles including massage, that positively influence the body through various methods that may or may not include soft-tissue deformation, energy manipulation, movement reeducation, and postural reeducation.

(a) Pressure, friction, stroking, tapping, kneading, vibration or stretching by manual or mechanical means or gymnastics;

(b) Appliances, tools or devices;

(c) Topical preparations; or

(d) Hot and cold applications.

(6) "Boundary" means the limits in a professional relationship which create safety based on the needs of the client.

(7) "Boundary violation" means an alteration or shift in the limits of a professional relationship so that what is allowed in the relationship becomes ambiguous and/or may not be based on the needs of the client.

(8) "Caring" means acting in a manner in which things, events, people or relationships matter.

(9) "Certified Class or program" means a class or program that is approved by the Board and is offered:

(a) By a person or institution licensed as a career school under ORS 345.010 to 345.450; or

(b) By a community college or university approved by the Department of Education; or

(c) In another state and licensed or approved by the appropriate agency in that state.

(10) "Client" means any individual, group of individuals, or organization to whom an LMT provides massage

(11) "Client vulnerability" means factors which diminish a client's ability to be self-determining.

(12) "Compensation" means something given or received as payment including but not limited to bartering, tips, monies, donations, or services.

(13) "Conflict of interest" means any action or decision or recommendation by an LMT at the detriment of a client.

(14) "Contact hours" means actual hours in class under the instruction of and in the physical presence of an instructor; or an interactive distance learning course.

(15) "Contract" means an agreement for purchase, lease, rental or other acquisition or sale or other disposal by the Board of Goods or Services.

(16) "Contract Price" means, as the context requires;

(a) The maximum payments that the Board will make under a Contract if the Contractor fully performs under the Contract;

(b) The maximum not-to-exceed amount of payments specified in the Contract; or

(c) The unit prices for Goods and Services set forth in the Contract.

(17) "Contractor" means the Person with whom the Board enters into a Contract.

(18) "Critical Reflection" means a process whereby knowledge and action are connected to each other through the application of careful, conscious, deliberate reflection on:

(a) Personal practice (perceptions, assumptions, motivations, values, behaviors).

(b) Assessment and understanding of a situation.

(c) Likely or actual consequences or impact of one's actions.

(19) "Dual Relationship" means any relationship of a personal or business nature with a client that is in addition to or concurrent with a professional relationship in which the LMT is providing or has provided massage or bodywork services to that same client.

(20) "Ethics" means a system of valued societal beliefs and behaviors that may be used to guide and evaluate conduct to ensure the protection of an individual's person and rights.

(21) "Emergency" means circumstances that:

(a) Could not have been reasonably foreseen;

(b) Require prompt execution of a Contract to remedy the condition; and

(c) The circumstances create a substantial risk of loss or revenue, damage or interruption of services or substantial threat to property, public health, welfare or safety when the circumstances could not have been reasonably foreseen;

(22) Equivalent Credit Hours: are those credit hours as determined by the respective educational institution or its certified classes or programs

(23) Good moral character means

(a) An applicant has not ever before the date of application, been convicted of a felony or an offense involving moral turpitude or prostitution, solicitation, required to be a registered sex offender and other similar offense which has a reasonable relationship to the practice of massage;

(b) Has not ever before the date of application, been convicted of an act involving dishonest, fraud misrepresentation, gross negligence or incompetence or is not currently incarcerated or on community supervision after a period of incarceration in a local, state or federal penal institution for such an act;

(c) Has not ever before the date of application, had a professional license revoked or suspended by this state, a political subdivision of this state, or a regulatory board in another jurisdiction in the United States, or voluntarily surrendered a professional license in lieu of disciplinary action;

(d) Has not ever before the date of the application, had a massage therapy license revoked or suspended by any state or national massage certifying agency.

(24) "Goods and Services" or "Goods or Services" means supplies, equipment, materials and services including Personal Services and any personal property, including any tangible, intangible and intellectual property and rights and licenses in relation thereto, that the Board is authorized by law to procure.

(25) "Indorsement" means:

(a) The process of evaluating and recognizing the credentials of a person licensed in Oregon in another health care specialty that includes in its scope of practice, acts defined as massage: or

(b) The process of evaluating and recognizing the credentials of a massage or bodywork practitioner authorized to practice massage or bodywork in another jurisdiction.

(26) "Informed consent" means a process wherein clients have knowledge of what will occur, that participation is voluntary, and that the client is competent to give consent.

(27) "Licensee" means any person holding a license, permit, or certificate issued by this Board; an LMT

(28) "LMT" means a Licensed Massage Therapist.

(29) "Massage" or "massage therapy" is defined in ORS 687.011.

(30) "Non-Contact hours" means education hours independently acquired outside the

presence of an instructor.

(31) "Offer" means a response to a request for price quote or response to a Solicitation Document.

(32) "Offeror" means a Person who submits an Offer.

(33) Professional fitness means

(a) An applicant has not ever before the date of application, been convicted of a felony or an offense involving moral turpitude or prostitution, solicitation, required to be a registered sex offender and other similar offense which has a reasonable relationship to the practice of massage;

(b) Has not ever before the date of application, been convicted of an act involving dishonest, fraud misrepresentation, gross negligence or incompetence or is not currently incarcerated or on community supervision after a period of incarceration in a local, state or federal penal institution for such an act;

(c) Has not ever before the date of application, had a professional license revoked or suspended by this state, a political subdivision of this state, or a regulatory board in another jurisdiction in the United States, or voluntarily surrendered a professional license in lieu of disciplinary action;

(d) Has not ever before the date of the application, had a massage therapy license revoked or suspended by any state or national massage certifying agency.

(34) "Personal power" means recognizing and taking personal responsibility for the inherent power differential between the LMT and the client and recognizing and taking personal responsibility for the impact of professional decisions, actions and behavior on the client.

(35) "Power differential" means the basic inequality inherent in the professional relationship between an LMT and a client in terms of who has the advantage in the relationship. The LMT is presumed to have the advantage by virtue of the authority which emerges from the role of professional and the vulnerability which is automatically part of the role of client.

(36) "Practical Work Experience" means experience gained while employed or self-employed providing legal massage/bodywork to the public within the last five (5) years, in another state or jurisdiction.

(37) "Practice of massage" is defined in ORS 687.011.

(38) "Professional authority" means the power inherent in the professional role and which is derived from a combination of an LMT's specialized or expert knowledge, societal expectations, stated and unstated client expectations, and an LMT's personal power.

(39) "Professional relationship" means the relationship established when a LMT contracts with a client, verbally or in writing, to provide any service associated with the practice of massage or bodywork.

(40) "Professional role" means assuming the demands and responsibilities of professional authority by taking charge of the conditions which create and maintain client safety and trust in the professional-client relationship.

(41) "Scope" means the range and attributes of the Goods or Services described in the applicable Solicitation Document, or if no Solicitation Document, in the Contract.

(42) "Solicitation Document" means an Invitation to Bid, Request for Proposal or other document issued to invite Offers from prospective Contractors.

(43) "Specification" means any description of the physical or functional characteristics or of the nature of Goods or Services, including any requirement for inspecting, testing or preparing Goods or Services for delivery and the quantities of materials to be furnished under a Contract. Specifications generally will state the result to be obtained.

(44) "Split Fee" means giving or receiving a commission or payment, either monetary or otherwise, for the referral of patients.

(45) "Successful Completion" means the written receipt of credit from classes taken at a community college or university or the written receipt of a certificate from a program or private career school.

(46) "Written" or "Writing" means conventional paper documents, whether handwritten, typewritten or printed, in contrast to spoken words. It also includes electronic transmissions or facsimile documents when required by applicable law or permitted by a Solicitation Document or Contract.

Stat. Auth.: ORS 687.011 & 687.121
Stats. Implemented: ORS 687.011
Hist.: BMT 2-1998, f. & cert. ef. 7-22-98; BMT 1-2003, f. & cert. ef. 1-24-03; BMT 1-2009, f. 2-13-09, cert. ef. 3-1-09; BMT 3-2009, f. & cert. ef. 7-2-09; BMT 2-2011, f. 6-29-11, cert. ef. 7-1-11; BMT 4-2011, f. 12-1-11, cert. ef. 1-1-12; BMT 2-2012, f. 12-4-12, cert. ef. 1-1-13; BMT 1-2015, f. 3-12-15, cert. ef. 7-1-15

334-010-0018
Criminal Background Checks, Fitness Determinations

(1) The Board requires a criminal background check of all applicants for a massage therapist license to determine the professional fitness of an applicant. These must be provided on prescribed forms provided by the Board. Fingerprints may be obtained at a law enforcement office or at a private service acceptable to the Board. The Board must submit fingerprints to the Oregon Department of State Police for checks against state law enforcement data systems and national data sources. Any original fingerprint cards and/or any electronic fingerprint records must subsequently be destroyed by the Oregon Department of State Police. The Board requires completed fingerprint cards or any submitted electronic fingerprint of all applicants for an initial license; licensees applying to reinstate a lapsed license or licensees applying to reactivate an inactive license; and licensees under investigation to determine the professional fitness of an applicant or licensee.

(2) These rules are to be applied when evaluating the criminal background of all licensees and applicants for a massage therapist license and conducting professional fitness determinations based upon such history. The fact that the applicant has cleared the criminal background check does not guarantee the granting of a license.

(3) The Board may require fingerprints of any Oregon licensed massage therapist who is the subject of a complaint or investigation for the purpose of requesting a state or nationwide criminal background check.

(4) All criminal background checks must include, but not be limited to, all available state law enforcement data systems and national data sources, unless obtaining one or the other is an acceptable alternative.

(5) Additional information required. In order to conduct the Oregon and National Criminal Background Check and professional fitness determination, the Board may require additional information from the licensee/applicant as necessary, including but not limited to, proof of identity; residential history; names used while living at each residence; or additional criminal, judicial or other background information.

(6) Criminal offender information is confidential. Dissemination of information received under ORS 181.534 is only to people with a demonstrated and legitimate need to know the information. The information is part of the investigation of an applicant or licensee and as such is confidential pursuant to ORS 676.175(1).

(7) The Board must determine whether an individual is professionally fit to be granted a license. If an individual is determined to be unfit, then the individual may not be granted a license. The Board may make professional fitness determinations conditional upon applicant's acceptance of probation, conditions, limitations, or other restrictions upon licensure. Except as otherwise provided in section (1), in making the professional fitness determination the Board must consider:

(a) Criminal background check;

(b) The nature of the crime;

(c) The facts that support the conviction or pending indictment or that indicates the making of any false statement;

(d) The relevancy, if any, of the crime or the false statement to the specific requirements of applicant's or licensee's present or proposed license, services, employment, position, or permit;

(e) Any refusal to submit or consent to a criminal background check including, but not limited to, fingerprint identification;

(f) Any other pertinent information requested or obtained as a part of an investigation;

(g) Intervening circumstances relevant to the responsibilities and circumstances of the position, services, employment, license, or permit. 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.

(8) The Board may consider any conviction of any violation of the law for which the court could impose a punishment and in compliance with ORS 670.280. The Board may also consider any arrests, court records, Department of Motor Vehicle records, or other information that may be indicative of a person's inability to perform as a licensee with care and safety to the public.

(9) If an applicant or licensee is determined not to be professionally fit for a license, the applicant or licensee is entitled to a contested case process pursuant to ORS 183.413–183.470. Challenges to the accuracy of completeness of information provided by the Oregon Department of State Police, Federal Bureau of Investigation and agencies reporting information must be made through the Oregon Department of State Police, Federal Bureau of Investigation, or reporting agency and not through the contested case process pursuant to ORS 183. If an individual successfully contests the accuracy or completeness of information provided by the Oregon State Police, the FBI or other reporting agency, the Board must conduct a new criminal background check upon submission of a new request.

(10) If the applicant discontinues the application process or fails to cooperate with the criminal background check process, the application is considered incomplete.

Stat. Auth.: ORS 687 & 676

Stats. Implemented: ORS 181, 183, 687.041, 687.051, 687.081, 670.280

Hist.: BMT 4-2011, f. 12-1-11, cert. ef. 1-1-12; BMT 1-2012, f. 6-19-12, cert. ef. 7-1-12; BMT 1-2015, f. 3-12-15, cert. ef. 7-1-15

334-010-0033
Fees

(1) The fees are:

(a) $100 per biennial renewal for initial license;

(b) $50 per biennial renewal for initial license under 12 months;

(c) $150 per biennial renewal for active license;

(d) $50 per biennial renewal for inactive license;

(e) $25 per week, up to a maximum of $100, for any late renewal;

(f) $50 for exam/endorsement application processing;

(g) $150 for each practical examination;

(h) $100 for mailing list;

(i) $10 for license reprint;

(j) $10 for license verification;

(k) $250 Credentialing Review;

(l) Current Oregon State Police Criminal Background Check Fee;

(m) $50 initial facility permit;

(n) $250 facility permit transfer;

(o) $10 facility permit reprint and

(p) Other administrative fees as allowed by law.

(2) Application and licensure fees are not refundable

(3) Examination fees are refunded only when requested in writing and either:

(a) The applicant is unqualified by Oregon statutes, or

(b) Applicant requests refund postmarked at least 7 days prior to the exam.

Stat. Auth.: ORS 183, 687.121 & 182.456 - 182.472

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

Hist.: MTB 1-1986, f. & ef. 1-29-86; MTB 1-1989(Temp), f. & cert. ef. 7-27-89; MTB 1-1990, f. & cert. ef. 4-20-90; MTB 1-1992, f. & cert. ef. 7-28-92 (and corrected 8-6-92); BMT 2-1998, f. & cert. ef. 7-22-98; BMT 1-2000, f. & cert. ef. 1-12-00; BMT 2-2002, f. & cert. ef. 5-8-02; BMT 1-2003, f. & cert. ef. 1-24-03; BMT 4-2004, f. 10-22-04, cert. ef. 1-1-05; BMT 1-2006, f. & cert. ef. 1-5-06; BMT 1-2009, f. 2-13-09, cert. ef. 3-1-09; BMT 3-2009, f. & cert. ef. 7-2-09; BMT 3-2010, f. 12-22-10, cert. ef. 1-1-11; BMT 1-2011, f. & cert. ef. 4-21-11; BMT 4-2011, f. 12-1-11, cert. ef. 1-1-12; BMT 1-2012, f. 6-19-12, cert. ef. 7-1-12; BMT 2-2013, f. 11-26-13, cert. ef. 1-1-14; BMT 1-2015, f. 3-12-15, cert. ef. 7-1-15

334-020-0005
Facilities and Sanitation

(1) Permanent and Mobile structures:

(a) All permanent structures and mobile facilities where a LMT routinely conducts massage and bodywork must:

(A) Be established and maintained in accordance with all local, state and federal laws, rules & regulations;

(B) Obtain a facility permit to operate;

(i) Notify the Board office in writing, within 30 days of relocating the facility;

(ii) Keep posted and visible to the public, the facility permit with the correct location address;

(C) Facilities exempted from the permit process:

(i) Clinic or facility owned or operated by a person authorized to practice a profession by a health professional regulatory board, as defined in ORS 676.160;

(ii) A career school licensed under ORS 345.010 to 345.450; and

(iii) Clinics of a board approved massage therapy program.

(D) Provide a finished lavatory that

(i) Is well maintained,

(ii) Provides a system for sanitary disposal of waste products,

(iii) Is capable of being fully closed and locked from the inside,

(iv) Supplies hot and cold running water,

(v) Is supplied with liquid soap and single use towels,

(vi) Is supplied with toilet paper at each toilet, and

(E) Dispose of refuse sewage in a manner described by local and state law; and

(F) Follow applicable laws pertaining to public spas, pools, baths and showers.

(b) All treatment spaces must:

(A) Provide for client privacy, both in-house and on-site;

(B) Be designated as used only for massage at the time of services;

(C) Provide for sufficient heating, cooling and ventilation for client comfort; and

(D) Provide illumination during cleaning.

(c) The facility and treatment space must be:

(A) Cleaned regularly and kept free of clutter, garbage or rubbish;

(B) Maintained in a sanitary manner; and

(C) Maintained free from flies, insects, rodents and all other types of pests.

(2) Outcall/On-site. Any temporary location where the LMT conducts massage and bodywork, the LMT must provide and utilize:

(a) Safe, sanitized and well-maintained equipment, tools and preparations;

(b) Sanitary linen practices; and

(c) Client privacy practices.

Stat. Auth.: ORS 687.121

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

Hist.: HB 88, f. 3-16-56; Renumbered from 333-035-0012; MTB 2-1985, f. & ef. 1-23-85; MTB 1-1986, f. & ef. 1-29-86; Renumbered from 334-010-0030; MTB 1-1992, f. & cert. ef. 7-28-92; BMT 2-1998, f. & cert. ef. 7-22-98; BMT 1-2009, f. 2-13-09, cert. ef. 3-1-09; BMT 2-2013, f. 11-26-13, cert. ef. 1-1-14; BMT 1-2015, f. 3-12-15, cert. ef. 7-1-15

334-040-0010
Discipline

The Board may deny, conditionally grant, restrict, suspend or revoke a license or permit, impose probation, reprimand, censure, impose remedial education or corrective actions, and/or impose a civil penalty for any of the following reasons:

(1) Practicing massage or representing one's self as a massage therapist without a current active license issued by the Board;

(2) Knowingly or recklessly making any false statement to the Board;

(3) Has been the subject of disciplinary action as a licensed healthcare professional by this or any other state or territory of the United States or by a foreign country and the Board determines that the cause of the disciplinary action would be a violation under ORS 687.011 to 687.250, 687.895 and 687.991 or OAR Chapter 334;

(4) Suspension or revocation of a license to practice massage in another jurisdiction based upon acts by the licensee similar to acts described in this section;

(5) Knowingly or recklessly falsifying an application or continuing education statement or documentation;

(6) Conviction of a crime in any state or jurisdiction;

(7) The use of false, deceptive, or misleading advertising, which includes but is not limited to, advertising massage using the term "massage" or any other term that implies a massage technique or method in any private or public communication or publication by a person licensed or not licensed by the Board as a massage therapist;

(8) Allowing the use of a license by an unlicensed person;

(9) Presenting as one's own license, the license of another;

(10) Practicing massage under a false or assumed name without notification to the Board;

(11) Impersonating another massage therapist;

(12) Assisting, employing, or permitting an unlicensed person to practice massage;

(13) Practicing or purporting to practice massage when the license has been revoked or suspended, lapsed or inactive;

(14) Practicing or offering to practice massage beyond the scope permitted by law;

(15) The use of intoxicants, drugs, controlled substances, or mind altering substances to such an extent as to impair or potentially impair the licensee's abilities to perform professional duties in a safe manner;

(16) Practicing massage with a physical or mental impairment that renders the therapist unable or potentially unable to safely conduct the practice of massage;

(17) Failing to keep the equipment and premises of the massage establishment in a clean and sanitary condition as required by rules of the Board;

(18) Refusing to permit the Board or its representatives to inspect the business premises of the licensee during regular business hours;

(19) Failing to cooperate with the Board in any licensing action or disciplinary proceeding, including but not limited to:

(a) Failure to furnish any requested papers or documents,

(b) Failure to provide in writing a full and complete explanation covering the matter contained in the complaint filed with the Board,

(c) Failure to respond to subpoenas issued by the Board whether or not the recipient is accused in the proceeding;

(20) Failing to comply with an order issued by the Board;

(21) Failure to obtain the required permits for facilities or in violation of OAR 334-010-0010.

(22) Failure to report to the Board information that a licensee has engaged in prohibited or unprofessional conduct as required in ORS 676.150.

(23) Unprofessional or dishonorable conduct which includes but is not limited to:

(a) Any conduct involving inappropriate physical contact or sexual misconduct which includes:

(A) Sexual abuse which is conduct which constitutes a violation of any provision of ORS 163.305 through 163.465;

(B) Sexual violation which is sex between the LMT and the client, whether initiated by the client or not, engaging in any conduct with a client that is sexual, or may be reasonably interpreted as sexual, including, but not limited to:

(i) Sexual intercourse;

(ii) Genital to genital contact;

(iii) Oral to genital contact; oral to anal contact;

(iv) Oral to oral contact except cardiopulmonary resuscitation; touching breasts or genitals or any sexualized body part for any purpose other than appropriate examination or treatment or where the client has refused or withdrawn consent; or

(v) Encouraging the client to masturbate in the presence of the LMT or masturbation by the LMT while the client is present.

(C) Sexual impropriety which is any behavior, gestures, or expressions that are seductive or sexually demeaning to a client; inappropriate procedures, including, but not limited to,

(i) Disrobing or draping practices that reflect a lack of respect for the client's privacy, deliberately watching a client dress or undress instead of providing privacy for disrobing;

(ii) Subjecting a client to an examination in the presence of students, assistants, or other parties without the explicit consent of the client or when consent has been withdrawn;

(iii) An examination or touching of genitals;

(iv) Inappropriate comments about or to the client, including but not limited to, making sexual comments about a client's body or clothing, making sexualized or sexually-demeaning comments to a client, comments on the client's or LMT's sexual orientation and making a request to date;

(v) Initiation by the LMT of conversation regarding the sexual problems, preferences or fantasies of the LMT; or

(vi) Kissing.

(b) Violating the client's rights of privacy, and confidentiality.

(c) photographing or filming the body or any body part or pose of a client without consent.

(d) Failure to disclose or release information about a client if required by law or on written consent of client.

(e) Intentionally harassing, abusing, or intimidating a client either physically or verbally.

(f) Any conduct or practice which could endanger the health or safety of a client or the public.

(g) Any conduct or practice which impairs the massage therapist's ability to safely and skillfully practice massage.

(h) Exercising undue influence on a client, including promotion or sale of services, goods, or appliances in such a manner as to exploit the client for the financial gain or self-gratification of the massage therapist.

(i) Routinely practicing in an incompetent manner.

(j) Conduct which would also constitute a violation of the Oregon Unlawful Trade Practices Act.

(k) Practicing a modality or technique without adequate training or licensure.

Stat. Auth.: ORS 687.081 & 687.121

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

Hist.: MTB 1-1990, f. & cert. ef. 4-20-90; MTB 1-1992, f. & cert. ef. 7-28-92; Sections (6) - (20)(h) Renumbered from 334-030-0020; BMT 2-1998, f. & cert. ef. 7-22-98; Renumbered from 334-030-0025 by BMT 1-2009, f. 2-13-09, cert. ef. 3-1-09; BMT 4-2011, f. 12-1-11, cert. ef. 1-1-12; BMT 2-2012, f. 12-4-12, cert. ef. 1-1-13; BMT 1-2013, f. 5-31-13, cert. ef. 7-1-13; BMT 2-2013, f. 11-26-13, cert. ef. 1-1-14; BMT 1-2015, f. 3-12-15, cert. ef. 7-1-15

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Board of Medical Imaging
Chapter 337

Rule Caption: Waiver process for persons without proper credential to perform computed tomography.
Adm. Order No.: BMI 1-2015
Filed with Sec. of State: 3-10-2015
Certified to be Effective: 3-10-15
Notice Publication Date: 12-1-2014
Rules Amended: 337-010-0011
Rules Repealed: 337-010-0011(T)
Subject: This waiver provision will enable the Board of Medical Imaging to allow, on a case-by-case basis, an imaging technologist who does not have an ARRT credential or, beginning in 2017, who has an ARRT credential but lacks the required computed tomography (CT) sub-specialty credential, to perform diagnostic computed tomography. In cases where it can be demonstrated that a technologist is competent to perform CT and where the technologist's availability to perform CT in rural hospitals is required by the hospital, this rule will allow the Board to waive the credential requirement.
Rules Coordinator: Ed Conlow—(971) 673-0216

337-010-0011
Qualifications of Computed Tomography Equipment Operators and Merged Technology Equipment Operators' Licensing

(1) Through December 31, 2016, an individual who operates computed tomography equipment for diagnosis must be credentialed by the American Registry of Radiologic Technologists in Computed Tomography (CT) or in Radiography with training in the operation of CT equipment in accordance with applicable RPS rules; currently OAR 333-106-0370 (x-ray) and 333-116-0880 (NM).

(2) Through December 31, 2016, in addition to qualifications to operate radiation therapy devices, Radiation Therapists operating CT for treatment planning must submit evidence of completion of a minimum of twelve (12) hours training in the use of computed tomography from an approved source as determined by the board.

(3) Through December 31, 2016, Nuclear Medicine Technologists who perform non-diagnostic attenuation CT exams with a hybrid scanner such as PET/CT, SPECT/CT or new emerging hybrid scanners must meet the training requirements in accordance with OAR 333-116-0880.

(4) Through December 31, 2016, in addition to qualifications to operate radionuclide imaging devices, Nuclear Medicine technologists may be granted a CT Technologist operator's license to perform diagnostic CT examinations if the following requirements are met:

(a) Credentialing by the American Registry of Radiologic Technologists in Computed Tomography, or

(b) The Board may grant authorization to allow Nuclear Medicine Technologists who are enrolled in a CT training program to perform diagnostic CT exams with direct supervision after they have completed a Board approved didactic training program that will allow the student to perform the ARRT required number of CT exams to sit for the ARRT (CT) exam. The authorization will be effective for 3 consecutive academic terms, and will expire automatically unless the Board is presented with evidence of passing the ARRT (CT) exam.

(5) Diagnostic Computed Tomography: On or after January 1, 2017, a licensee who operates computed tomography (CT) equipment, including cone beam CT, for diagnosis must be credentialed in Computed Tomography (CT) by either the American Registry of Radiologic Technologists or the Nuclear Medicine Technology Certification Board or have an active temporary CT license issued by OBMI.

(6) Computed Tomography/Nuclear Medicine Hybrid Imaging: On or after January 1, 2017, a positron Emission-Computed Tomography (PET/CT) or Single Photon Emission-Computed Tomography (SPECT/CT)

systems must be operated by technologists licensed by the Oregon Board of Medical Imaging.

(a) On or after January 1, 2017, a registered radiographer with the credential R.T. (R), or a registered radiation therapist with the credential R.T. (T) may only operate CT for attenuation, not for diagnostic purposes. They may operate the diagnostic portion of the CT hybrid imager if they hold a CT credential from ARRT, or have an active temporary CT license issued by OBMI.

(b) On or after January 1, 2017, registered certified nuclear medicine technologists with the active credentials R.T. (N) or CNMT (NMTCB) may operate SPECT and PET with non-diagnostic CT and the attenuation correction portion of the hybrid imager. Certified Nuclear Medicine technologists may operate the diagnostic portion of the CT scanner if they hold a CT credential or have an active temporary CT license issued by OBMI.

(7) Computed Tomography for Radiation Therapy Treatment Planning Purposes: On or after January 1, 2017, a licensee who operates CT equipment for radiation therapy treatment planning purposes must be credentialed in Radiation Therapy or CT by the ARRT.

(8) On a case-by-case basis, the board may waive a credential requirement of this rule for a licensed technologist, based upon the board's determination that the following two conditions are met:

(a) The licensee seeking a waiver:

(A) Has substantial experience, as determined by the board, practicing computed tomography; and

(B) Seeks to perform computed tomography as an employee or contractor of a specified rural hospital, as defined in ORS 442.470; and

(C) Under state sponsorship, passes a computed tomography examination by a registry recognized by the board; and

(D) Must have completed and documented vendor-provided applications training specific to any CT machine the waiver applicant will work on; and

(E) Must have completed a minimum of 16 hours in structured CT education requirements within the 24 months prior to applying for the waiver.

(F) Meets clinical experience requirements as specified in the waiver.

(G) Must have completed five supervised diagnostic-quality repetitions of any anatomic area that the waiver recipient will image with computed tomography. The waiver will only cover images of anatomic areas for which the waiver recipient has met this requirement. Supervision must be provided by a licensed technologist with a CT registry credential recognized by the board.

(b) Failure to grant the waiver would result in a substantial shortage in the rural hospital's ability to deliver necessary health services to the community.

(9) The board may prescribe terms of the waiver, including but not limited to time duration of the waiver, supervisory requirements, and clinical experience requirements. The waiver may include deadlines for completing specified requirements included in the waiver. The board may grant a preliminary waiver conditioned upon the waiver applicant's completion of all board-specified waiver requirements within no more than 60 days from the time the applicant submits an initial waiver request to the Board.

Stat. Auth.: ORS 688.555(1)
Stats. Implemented: ORS 688.480
Hist.: BRT 2-2006, f. 12-15-06, cert. ef. 1-1-07; BRT 1-2010, f. & cert. ef. 6-15-10; BMI 2-2014, f. & cert. ef. 10-20-14; BMI 3-2014(Temp), f. & cert. ef. 10-21-14 thru 4-19-15; BMI 1-2015, f. & cert. ef. 3-10-15

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Bureau of Labor and Industries
Chapter 839

Rule Caption: Amends the prevailing rates of wage for the period beginning April 1, 2015
Adm. Order No.: BLI 3-2015
Filed with Sec. of State: 3-13-2015
Certified to be Effective: 4-1-15
Notice Publication Date: 3-1-2015
Rules Amended: 839-025-0700
Subject: The amended rule amends the prevailing rates of wage as determined by the Commissioner of the Bureau of Labor and Industries for the period beginning April 1, 2015.
Rules Coordinator: Marcia Ohlemiller—(971) 673-0784

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

(1) Pursuant to ORS 279C.815, the Commissioner of the Bureau of Labor and Industries has determined that the wage rates stated in the publication of the Bureau of Labor and Industries entitled *Prevailing Wage Rates on Public Works Contracts in Oregon dated January 1, 2015*, are the prevailing rates of wage for workers upon public works in each trade or occupation in the locality where work is performed for the period beginning January 1, 2015, and the effective dates of the applicable special wage determination and rates amendments: Amendments to Oregon Determination 2015-01 (effective April 1, 2015).

(2) Copies of *Prevailing Wage Rates on Public Works Contracts in Oregon dated January 1, 2015*, are available from any office of the Wage and Hour Division of the Bureau of Labor and Industries. The offices are located in Eugene, Portland and Salem. Copies are also available on the bureau's webpage at www.oregon.gov/boli or may be obtained from the Prevailing Wage Rate Coordinator, Prevailing Wage Rate Unit, Wage and Hour Division, Bureau of Labor and Industries, 800 NE Oregon Street #1045, Portland, Oregon 97232; (971) 673-0839.

Stat. Auth.: ORS 279C.815, 651.060
Stats. Implemented: ORS.279C.815
Hist.: BLI 7-1998(Temp), f. & cert. ef. 10-29-98 thru 4-27-99; BLI 1-1999, f. 1-8-99, cert. ef. 1-15-99; BLI 4-1999, f. 6-16-99, cert. ef. 7-1-99; BLI 6-1999, f. & cert. ef. 7-23-99; BLI 9-1999, f. 9-14-99, cert. ef. 10-1-99: BLI 16-1999, f. 12-8-99, cert. ef. 1-1-00; BLI 4-2000, f. & cert. ef. 2-1-00; BLI 9-2000, f. & cert. ef. 3-1-00; BLI 10-2000, f. 3-17-00, cert. ef. 4-1-00; BLI 22-2000, f. 9-25-00, cert. ef. 10-1-00; BLI 26-2000, f. 12-14-00 cert. ef. 1-1-01; BLI 1-2001, f. & cert. ef. 1-5-01; BLI 3-2001, f. & cert. ef. 3-15-01; BLI 4-2001, f. 3-27-01, cert. ef. 4-1-01; BLI 5-2001, f. 6-21-01, cert. ef. 7-1-01; BLI 8-2001, f. & cert. ef. 7-20-01; BLI 14-2001, f. 9-26-01, cert. ef. 10-1-01; BLI 16-2001, f. 12-28-01, cert. ef. 1-1-02; BLI 2-2002, f. 1-16-02, cert. ef. 1-18-02; BLI 8-2002, f. 3-25-02, cert. ef. 4-1-02; BLI 12-2002 f. 6-19-02 cert. ef. 7-1-02; BLI 16-2002, f. 12-24-02 cert. ef. 1-1-03; BLI 1-2003, f. 1-29-03, cert. ef. 2-14-03; BLI 3-2003, f. & cert. ef. 4-1-03; BLI 4-2003, f. 6-26-03, cert. ef. 7-1-03; BLI 5-2003, f. 9-17-03, cert. ef. 10-1-03; BLI 9-2003, f. 12-31-03, cert. ef. 1-5-04; BLI 1-2004, f. 4-9-04, cert. ef. 4-15-04; BLI 6-2004, f. 6-25-04, cert. ef. 7-1-04; BLI 11-2004, f. & cert. ef. 10-1-04; BLI 17-2004, f. 12-10-04 cert. ef. 12-13-04; BLI 18-2004, f. 12-20-04, cert. ef. 1-1-05; Renumbered from 839-016-0700, BLI 7-2005, f. 2-25-05, cert. ef. 3-1-05; BLI 8-2005, f. 3-29-05, cert. ef. 4-1-05; BLI 18-2005, f. 9-19-05, cert. ef. 9-20-05; BLI 19-2005, f. 9-23-05, cert. ef. 10-1-05; BLI 26-2005, f. 12-23-05, cert. ef. 1-1-06; BLI 1-2006, f. 1-24-06, cert. ef. 1-25-06; BLI 2-2006, f. & cert. ef. 2-9-06; BLI 4-2006, f. 2-23-06, cert. ef. 2-24-06; BLI 14-2006, f. 3-30-06, cert. ef. 4-1-06; BLI 20-2006, f. & cert. ef. 6-16-06; BLI 21-2006, f. 6-16-06 cert. ef. 7-1-06; BLI 23-2006, f. 6-27-06 cert. ef. 6-29-06; BLI 25-2006, f. & cert. ef. 7-11-06; BLI 26-2006, f. & cert. ef. 7-13-06; BLI 28-2006, f. 7-21-06, cert. ef. 7-24-06; BLI 29-2006, f. 8-8-06, cert. ef. 8-9-06; BLI 32-2006, f. & cert. ef. 9-13-06; BLI 33-2006, f. 9-28-06, cert. ef. 10-1-06; BLI 36-2006, f. & cert. ef. 10-4-06; BLI 37-2006, f. & cert. ef. 10-19-06; BLI 40-2006, f. 11-17-06, cert. ef. 11-20-06; BLI 43-2006, f. 12-7-06, cert. ef. 12-8-06; BLI 45-2006, f. 12-26-06, cert. ef. 1-1-07; BLI 5-2007, f. 1-30-07, cert. ef. 1-31-07; BLI 6-2007, f. & cert. ef. 3-5-07; BLI 7-2007, f. 3-28-07, cert. ef. 3-30-07; BLI 8-2007, f. 3-29-07, cert. ef. 4-1-07; BLI 9-2007, f. & cert. ef. 4-2-07; BLI 10-2007, f. & cert. ef. 4-30-07; BLI 12-2007, f. & cert. ef. 5-31-07; BLI 13-2007, f. 6-8-07, cert. ef. 6-11-07; BLI 14-2007, f. 6-27-07, cert. ef. 6-28-07; BLI 15-2007, f. & cert. ef. 6-28-07; BLI 16-2007, f. 6-29-07, cert. ef. 7-1-07; BLI 18-2007, f. 7-10-07, cert. ef. 7-12-07; BLI 21-2007, f. 8-3-07, cert. ef. 8-8-07; BLI 22-2007, cert. & ef. 8-30-07; BLI 23-2007, f. 8-31-07, cert. ef. 9-4-07; BLI 24-2007, f. 9-11-07, cert. ef. 9-12-07; BLI 25-2007, f. 9-19-07, cert. ef. 9-20-07; BLI 26-2007, f. 9-25-07 cert. ef. 9-26-07; BLI 27-2007, f. 9-25-07 cert. ef. 10-1-07; BLI 28-2007, f. 9-26-07 cert. ef. 10-1-07; BLI 31-2007, f. 11-20-07, cert. ef. 11-23-07; BLI 34-2007, f. 12-27-07, cert. ef. 1-1-08; BLI 1-2008, f. & cert. ef. 1-4-08; BLI 2-2008, f. & cert. ef. 1-11-08; BLI 3-2008, f. & cert. ef. 2-21-08; BLI 6-2008, f. & cert. ef. 3-13-08; BLI 8-2008, f. 3-31-08, cert. ef. 4-1-08; BLI 9-2008, f. & cert. ef. 4-14-08; BLI 11-2008, f. & cert. ef. 4-24-08; BLI 12-2008, f. & cert. ef. 4-30-08; BLI 16-2008, f. & cert. ef. 6-11-08; BLI 17-2008, f. & cert. ef. 6-18-08; BLI 19-2008, f. & cert. ef. 6-26-08; BLI 20-2008, f. & cert. ef. 7-1-08; BLI 23-2008, f. & cert. ef. 7-10-08; BLI 26-2008, f. & cert. ef. 7-30-08; BLI 28-2008, f. & cert. ef. 9-3-08; BLI 30-2008, f. & cert. ef. 9-25-08; BLI 31-2008, f. 9-29-08, cert. ef. 10-1-08; BLI 32-2008, f. & cert. ef. 10-8-08; BLI 36-2008, f. & cert. ef. 10-29-08; BLI 41-2008, f. & cert. ef. 11-12-08; BLI 42-2008, f. & cert. ef. 12-1-08; BLI 44-2008, f. & cert. ef. 12-29-08; BLI 45-2008, f. 12-31-08, cert. ef. 1-1-09; BLI 1-2009, f. & cert. ef. 1-6-09, BLI 2-2009, f. & cert. ef. 1-12-09; BLI 4-2009, f. & cert. ef. 2-11-09; BLI 6-2009, f. & cert. ef. 3-17-09; BLI 7-2009, f. & cert. ef. 3-24-09; BLI 8-2009, f. 3-31-09, cert. ef. 4-1-09; BLI 10-2009, f. 6-9-09, cert. ef. 6-10-09; BLI 11-2009, f. 6-29-09, cert. ef. 6-30-09; BLI 12-2009, f. 6-29-09, cert. ef. 7-1-09; BLI 13-2009, f. & cert. ef. 7-1-09; BLI 14-2009, f. & cert. ef. 7-10-09; BLI 15-2009, f. & cert. ef. 7-16-09; BLI 16-2009, f. & cert. ef. 7-22-09; BLI 17-2009, f. & cert. ef. 7-29-09; BLI 19-2009, f. & cert. ef. 8-18-09; BLI 20-2009, f. & cert. ef. 9-14-09; BLI 21-2009, f. & cert. ef. 9-21-09; BLI 22-2009, f. 9-30-09, cert. ef. 10-1-09; BLI 23-2009, f. & cert. ef. 10-8-09; BLI 24-2009, f. & cert. ef. 11-12-09; BLI 25-2009, f. & cert. ef. 11-23-09; BLI 29-2009, f. 12-31-09, cert. ef. 1-1-10; BLI 1-2010, f. 1-8-10, cert. ef. 1-12-10; BLI 2-2010, f. 1-11-10, cert. ef. 1-13-10; BLI 3-2010, f. & cert. ef 1-19-10; BLI 4-2010, f. & cert. ef 1-27-10; BLI 13-2010, f. & cert. ef. 4-1-10; BLI 17-2010, f. 6-29-10, cert. ef. 7-1-10; BLI 20-2010, f. & cert. ef. 10-1-10; BLI 24-2010, f. 12-30-10, cert. ef. 1-1-11; BLI 2-2011, f. 3-25-11, cert. ef. 4-1-11; BLI 4-2011, f. 6-30-11, cert. ef. 7-1-11; BLI 7-2011, f. & cert. ef. 10-12-11; BLI 10-2011, f. 12-30-11, cert. ef. 1-1-12; BLI 4-2012, f. & cert. ef. 3-29-12; BLI 6-2012, f. & cert. ef. 7-2-12; BLI 10-2012, f. 9-26-12, cert. ef. 10-1-12; BLI 13-2012, f. 12-28-12, cert. ef. 1-1-13; BLI 1-2013, f. & cert. ef. 3-25-13; BLI 2-2013, f. & cert. ef. 9-20-13; BLI 3-2013, f. 9-30-13, cert. ef. 10-1-13; BLI 5-2013, f. 12-16-13, cert. ef. 1-1-14; BLI 3-2014, f. & cert. ef. 4-2-14; BLI 8-2014, f. 6-13-14, cert. ef. 7-1-14; BLI 11-2014, f. 9-24-14, cert. ef. 10-1-14; BLI 15-2014, f. 12-9-14, cert. ef. 1-1-15; BLI 3-2015, f. 3-13-15, cert. ef. 4-1-15

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Department of Agriculture
Chapter 603

Rule Caption: Amends bovine trichomoniasis rules for clarification and for harmonization with national standards.
Adm. Order No.: DOA 5-2015
Filed with Sec. of State: 2-23-2015
Certified to be Effective: 2-23-15
Notice Publication Date: 1-1-2015

Rules Amended: 603-011-0610, 603-011-0615, 603-011-0620, 603-011-0630

Subject: Bovine Trichomoniasis is a sexually transmitted parasitic infection caused by the microscopic protozoan Tritrichomonas foetus. Primarily, infected bulls that do not exhibit symptoms spread the disease. Infection causes reproductive failure resulting in significant monetary losses to the beef industry. Oregon's bovine trichomoniasis import and disease control rules are included in OAR 603-011-0610 through 0630. There have been advances in laboratory testing technology and a significant increase in knowledge of the disease. Additionally, there is a national effort to harmonize interstate testing requirements on bulls. For these reasons we decided to update definitions, clarify testing procedures, and amend importation requirements.

The quantitative polymerase chain reaction (qPCR) test is the preferred laboratory diagnostic test nationally. It is a particular category of test with multiple companies manufacturing kits, machines, and reagents. The qPCR test will be the defining test for importation purposes, and the status age for virgin bulls has been increased to 18 months of age. Specific references to trade names in the rules have been removed. The rule clarifies that trichomoniasis testing must be performed by a certified veterinarian, instead of the previous language, which referred to a certified person. The final rule harmonizes Oregon's rules with the majority of the states.

Rules Coordinator: Sue Gooch—(503) 986-4583

603-011-0610
Definitions

(1) "Bovine trichomoniasis" is a sexually transmitted disease of cattle caused by the parasitic protozoan organism Tritrichomonas foetus.

(2) "The Department" is the Oregon Department of Agriculture (ODA).

(3) "Virgin bull" is a sexually intact male bovine less than 18 months of age that is certified by the owner/manager as having had no potential breeding contact with females.

(4) "Exposed herds" are cattle herds which have had, within twelve months, direct commingling or cross fence contact with test-positive herd during a time of potential breeding activity.

(5) "Permanent Identification" is a USDA steel alphanumeric ear tag provided as official identification to accredited veterinarians, or breed registry tattoos, or other means of identification established by the Department after review by the Trichomoniasis Advisory Panel.

(6) "Herd" is a group of cattle managed as a separate unit and not mixed with other cattle under the same ownership.

(7) "Test positive herd" is a defined herd of cattle in which a diagnosis of trichomoniasis has been made by a certified, licensed veterinarian.

(8) "Trich-year" is the period from September 1st to August 31st of any given year.

(9) "qPCR Assay" is a laboratory test based on the amplification and quantification of target DNA molecules. The quantitative polymerase chain reaction is also called real-time polymerase chain reaction (qPCR).

Stat. Auth.: ORS 591 & 596
Stats. Implemented: ORS 596.392
Hist.: DOA 9-2000, f. & cert. ef. 4-4-00; DOA 11-2005, f. & cert. ef. 2-17-05; DOA 19-2007, f. & cert. ef. 11-28-07; DOA 15-2008, f. 6-12-08, cert. ef. 9-1-08; DOA 13-2009(Temp), f. 8-28-09 cert. ef. 9-1-09 thru 2-28-10; DOA 9-2010, f. & cert. ef. 2-26-10; DOA 5-2015, f. & cert. ef. 2-23-15

603-011-0615
Importation Requirements

In addition to an import permit and other disease control requirements, the following requirements must be met regarding bovine trichomoniasis.

(1) Any non-virgin bull of any age with known breeding contact with female cattle or each bull 18 months of age and over shall have all of the following:

(a) Individual negative qPCR trichomoniasis test results within 60 days preceding entry into Oregon performed by a certified veterinarian at an official laboratory and

(b) A Certificate of Veterinary Inspection that states:

(A) The bulls represented on this Certificate of Veterinary Inspection have been tested for and found to be negative for trichomoniasis pursuant to subsection (1)(a) above and have been confined and have not had sexual contact with females since their last negative test; and

(B) Trichomoniasis has not been diagnosed in the herd of origin within the past 24 months and

(c) Permanent identification

(2) Any bull originating from a herd in which trichomoniasis has been diagnosed within the past 24 months shall have all of the following:

(a) Three (3) consecutive negative trichomoniasis culture tests conducted at least seven (7) days apart, but not more than 28 days apart, or one (1) negative qPCR Assay with the last test conducted within 60 days preceding entry; and

(b) A Certificate of Veterinary Inspection that states that the requirements, set forth in subsection (2)(a) above, have been met; and

(c) Permanent identification.

(3) All breeding bulls, 18 months of age and over, entering Oregon as part of a herd that has an authorized Out-of-State Grazing permit pursuant to section 603-011-0264, do not require a Certificate of Veterinary Inspection but are required to have one negative qPCR trichomoniasis test within the 12 months preceding entry. However, all bulls from a herd in which trichomoniasis has been diagnosed within the past 24 months must comply with (2)(a) above to qualify the herd for an Out-of-State Grazing permit. All Out-of-State Grazing permits shall include an attached copy of the test record, that includes the permanent identification number of the bull(s) tested and the name and telephone number of the testing certified veterinarian.

(4) Bulls may be exempt from the trichomoniasis test requirements for entry into Oregon under any one or all of the following conditions:

(a) Used solely for exhibition purposes and remain under confinement at the location of the exhibition without having access to or allowed to commingle with sexually mature female cattle; or

(b) Used solely for artificial insemination using semen extension and preservation protocols that meet Certified Semen Services standards; or

(c) Consigned directly to slaughter without unloading before the arrival at the slaughter plant.

Stat. Auth.: ORS 596
Stats. Implemented:
Hist.: DOA 15-2008, f. 6-12-08, cert. ef. 9-1-08; DOA 13-2009(Temp), f. 8-28-09 cert. ef. 9-1-09 thru 2-28-10; DOA 9-2010, f. & cert. ef. 2-26-10; DOA 5-2015, f. & cert. ef. 2-23-15

603-011-0620
Procedures

(1) The Department shall establish a Bovine Trichomoniasis Advisory Panel, whose membership shall be:

(a) Five voting members who are representatives of the cattle industry, recommended by the Animal Health Committee of the Oregon Cattlemen's Association; and

(b) Four non-voting advisory members who are; the OSU Extension Veterinarian, two practicing veterinarians appointed by the Advisory Panel, and one representative of the office of the ODA State Veterinarian.

(2) Duties of the Advisory Board shall be to:

(a) Advise the Department on management of issues related to the program; and

(b) Advise the Department on preferred policies and processes for resolution of disputes related to the program.

(3) Certified veterinarians, as described in 603-011-0630, must report a positive test result of Tritrichomonas foetus to the Department on a form supplied by the Department within 24 hours of determining the result.

(4) In response to a positive bovine trichomoniasis test the Department shall:

(a) Conduct an investigation to identify herds that were potentially exposed to the infected herd.

(b) Require that any further bovine trichomoniasis testing be performed by a certified veterinarian, and accept the results of a retest by a certified veterinarian, if the original test was performed by a non-certified veterinarian; and

(c) Require permanent identification and testing of all bulls, excepting virgin bulls, in the test-positive herd and exposed herds.

(5) All bulls in herds required to be tested must be withdrawn from breeding contact and tested between 14 and 90 days after withdrawal.

(6) All bulls in test-positive herds must each have three consecutive negative culture test results with each test event separated by at least seven days and no more than 28 days, or one (1) negative qPCR Assay result completed at least seven (7) days after initial diagnosis is made. Bulls that have a positive test result shall be considered infected and be handled as described in 603-011-0620(8).

(a) Test-positive herds with valid Out-of–State Permit will have all bulls restricted in place until negative test results are complete as described

in (6) above. Bulls that have a positive test result shall be considered infected and be handled as described in 603-011-0620(8); or

(b) Return all herdmate bulls from Out-of-State Permit affected herds to their state of origin to complete negative trichomoniasis testing as described in (6) above. The Department shall release the herdmate bulls from restriction when the State Veterinarian from the state of origin notifies the Department that the required testing is complete. Test-positive bulls shall not return.

(c) Out-of-State Permit herds exposed to trichomoniasis will have all bulls restricted in place until one negative trichomoniasis qPCR test is complete. Any cattle determined to be infected will be restricted and the herd status will be changed to a test-positive herd and subject to the requirements of subsection (6)(a) or (b); or

(d) Return all herdmate bulls to their state of origin to complete one negative qPCR trichomoniasis test. The Department shall release the herdmate bulls from restriction when the State Veterinarian from the state of origin notifies the Department that the required testing is complete. Any bull that has a positive test result shall cause the herd to be classified as test-positive and treated as in (6)(a) or (b).

(7) All bulls from a test-positive herd must be re-tested every trich-year until every remaining bull tests negative during the same test period.

(a) All bulls from a test-positive herd must be re-tested before February 1 of the following year.

(b) All bulls removed or culled from a test-positive herd are to be tested before removal or culling.

(8) Test-positive bulls shall be held under quarantine separate and apart from other cattle or shall comply with one of the following:

(a) Culture test-positive bulls may be retested and, if found negative on qPCR Assay completed at least seven (7) days after initial diagnosis is made may be considered test-negative and released from quarantine; or

(b) Test-positive bulls moving into feeding channels shall be castrated before moving from the ranch; or

(c) Test-positive bulls moving out of the infected herd into commercial slaughter-marketing channels, including collection points, shall be identified before moving with an "S" brand applied to both sides of the tailhead and shall move only to slaughter under authority of a VS Form 1-27 Permit for Movement of Restricted Animals; or

(d) Test-positive bulls moving out of the infected herd directly to slaughter shall do so with:

(A) A VS Form 1-27 Permit for Movement of Restricted Animals; and

(B) Prior notification of the State Veterinarian; and

(C) Record of their permanent identification on the VS Form 1-27 under which authority they move.

(9) Failure to comply with the above provisions for response to a positive bovine trichomoniasis test shall result in quarantine of all cattle in the non-compliant herd under provisions of ORS 596.392(4).

Stat. Auth.: ORS 591 & 596
Stats. Implemented: ORS 596.392
Hist.: DOA 9-2000, f. & cert. ef. 4-4-00; DOA 11-2005, f. & cert. ef. 2-17-05; DOA 19-2007, f. & cert. ef. 11-28-07; DOA 15-2008, f. 6-12-08, cert. ef. 9-1-08; DOA 13-2009(Temp), f. 8-28-09 cert. ef. 9-1-09 thru 2-28-10; DOA 9-2010, f. & cert. ef. 2-26-10; DOA 5-2015, f. & cert. ef. 2-23-15

603-011-0630
Certification for Testing and Diagnosis

(1) All persons engaged in testing and diagnosis for bovine trichomoniasis shall be certified by the Department after having completed an appropriate training program.

(2) Applicants for certification must meet the following criteria:

(a) All applicants for certification in specimen collection must hold a valid license to practice veterinary medicine in Oregon; and

(b) All applicants for certification in handling, culture, and diagnostic techniques must pass a qualification test which includes laboratory techniques related to trichomoniasis diagnostics and identification of certifications shall be subject to periodic review and check testing at intervals of no more than five years. The Department shall determine time periods between check tests and recertification depending on availability of new diagnostic techniques.

(3) All persons engaged in testing and diagnosis for bovine trichomoniasis shall use only official laboratories approved by the Department for testing trichomoniasis samples. Quantitative polymerase chain reaction (qPCR) is the test method for official tests. Culture testing and pooling of laboratory samples is allowed on a case-by-case basis by permission of the State Veterinarian.

Stat. Auth.: ORS 561 & 596
Stats. Implemented: ORS 596.392
Hist.: DOA 9-2000, f. & cert. ef. 4-4-00; DOA 11-2005, f. & cert. ef. 2-17-05; DOA 5-2015, f. & cert. ef. 2-23-15

Rule Caption: Prohibits the application of four neonicotinoid insecticides, regardless of application method, on linden trees.
Adm. Order No.: DOA 6-2015
Filed with Sec. of State: 2-27-2015
Certified to be Effective: 2-27-15
Notice Publication Date: 1-1-2015
Rules Adopted: 603-057-0388
Subject: It is prohibited to apply any product containing the neonicotinoid insecticides dinotefuran, imidacloprid, thiamethoxam, or clothianidin, regardless of application method to linden, basswood or other Tilia species.
Rules Coordinator: Sue Gooch—(503) 986-4583

603-057-0388
Prohibits the Application of Four Neonicotinoid Insecticides

(1) It is prohibited to apply any product containing dinotefuran, imidacloprid, thiamethoxam, or clothianidin, regardless of application method, to linden trees, basswood trees or other Tilia species.

(2) Failure to comply with section (1) above may result in one or more of the following actions:

(a) Revocation, suspension or refusal to issue or renew the license or certification of an applicant, licensee or certificate holder;

(b) Imposition of a civil penalty;

(c) Any other enforcement action authorized under any law.

Stat. Auth: ORS 561.020, 634.322(6) & 634.900
Stats. Implemented: ORS 634
Hist.: DOA 6-2015, f. & cert. ef. 2-27-15

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Department of Consumer and Business Services, Insurance Division
Chapter 836

Rule Caption: Adoption of Annual and Supplemental Statement Blanks and Instructions for Reporting Year 2014
Adm. Order No.: ID 1-2015
Filed with Sec. of State: 3-10-2015
Certified to be Effective: 3-10-15
Notice Publication Date: 1-1-2015
Rules Amended: 836-011-0000
Subject: This rulemaking prescribes, for reporting year 2014, the required forms for the annual and supplemental financial statements required of insurers, multiple employer welfare arrangements and health care service contractors under ORS 731.574, as well as the necessary instructions for completing the forms.
Rules Coordinator: Jenny Craig—(503) 947-7484

836-011-0000
Annual Statement Blank and Instructions

(1) For the purpose of complying with ORS 731.574, every authorized insurer, including every health care service contractor and multiple employer welfare arrangement, shall file its financial statement required by 731.574 for the 2014 reporting year on the annual statement blank approved for the 2014 reporting year by the National Association of Insurance Commissioners, for the type or types of insurance transacted by the insurer.

(2) Every authorized insurer, including every health care service contractor, shall complete its annual statement blank under section (1) of this rule for the 2014 reporting year, according to the applicable instructions published for that year by the National Association of Insurance Commissioners, for completing the blank, as required by ORS 731.574.

(3) Every authorized insurer, including every health care service contractor, shall file each annual statement supplement for the 2014 reporting year, as required by the applicable instructions published for that year by the National Association of Insurance Commissioners, and shall complete the supplement according to those instructions.

(4) The applicable instructions published by the National Association of Insurance Commissioners referred to in this rules are available for inspection at the Insurance Division of the Department of Consumer and Business Services. Any person interested in inspecting those instructions should contact the Insurance Division at web.inscomp@state.or.us .

(5) This rule is adopted under the authority of ORS 731.244, 731.574 and 733.210 for the purpose of implementing 731.574 and 733.210.

Stat. Auth.: ORS 731.244, 731.574 & 733.210
Stats. Implemented: ORS 731.574 & 733.210

Hist.: ID 8-1993, f. & cert. ef. 9-23-93; ID 10-1994, f. & cert. ef. 12-14-94; ID 7-1995, f. & cert. ef. 11-15-95; Renumbered from 836-013-0000; ID 4-1996, f. 2-28-96, cert. ef. 3-1-96; ID 16 -1996, f. & cert. ef. 12-16-96; ID 11-1997, f. & cert. ef. 10-9-97; ID 16-1998, f. & cert. ef. 11-10-98; ID 5-1999, f. & cert. ef. 11-18-99; ID 1-2001, f. & cert. ef. 2-7-01; ID 4-2002, f. & cert. ef. 1-30-02; ID 6-2003, f. & cert. ef. 12-3-03; ID 1-2006, f. & cert. ef. 1-23-06; ID 9-2007, f. & cert. ef. 11-8-07; ID 1-2009, f. & cert. ef. 1-29-09; ID 11-2009, f. & cert. ef. 12-9-09; ID 22-2010, f. 12-30-10, cert. ef. 1-1-11; ID 2-2012, f. & cert. ef. 2-7-12; ID 2-2013, f. & cert. ef. 2-6-13; ID 3-2014, f. & cert. ef. 2-14-14; ID 1-2015, f. & cert. ef. 3-10-15

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Rule Caption: Limitation on the use of discretionary clauses in insurance contracts.
Adm. Order No.: ID 2-2015
Filed with Sec. of State: 3-12-2015
Certified to be Effective: 3-12-15
Notice Publication Date: 1-1-2015
Rules Adopted: 836-010-0026
Subject: This new rule, OAR 836-010-0026 defines discretionary clause and prohibits an insurer from including a discretionary clause in an insurance policy, contract, or agreement that would grant deference to the insurer in proceedings subsequent to the insurer's decision, denial, or interpretation of terms, coverage, or eligibility for benefits.

This rule is applicable on and after March 12, 2015 to any new or renewal of an insurance policy, contract, or agreement in Oregon.
Rules Coordinator: Jenny Craig—(503) 947-7484

836-010-0026
Prohibition on the Use of Discretionary Clauses

(1)(a) As used in this rule, "discretionary clause" means a policy provision that purports to bind the claimant, or to grant deference to the insurer, in proceedings subsequent to the insurer's decision, denial or interpretation of terms, coverage or eligibility for benefits. "Discretionary clause" includes a policy provision that provides any of the following:

(A) An insured or other claimant may not appeal a denial of a claim;

(B) The insurer's decision to deny coverage is binding upon a policyholder or other claimant or is otherwise entitled to deference upon appeal or review;

(C) On appeal or review the insurer's decision-making power as to coverage is binding or otherwise entitled to deference;

(D) The insurer's interpretation of the terms of a policy is binding upon a policyholder or other claimant or is otherwise entitled to deference;

(E) On appeal the insurer's interpretation of the terms of a policy is binding or is otherwise entitled to deference;

(F) A legal standard of review on appeal that gives deference to the original claim decision, or gives rise to such legal standard of review; or

(G) The insurer has sole discretion to determine whether a claim is compensable or its interpretation of the provisions of the policy is entitled to deference in a subsequent proceeding.

(b) Nothing in this section prohibits a carrier from including a provision in a contract that informs an insured that as part of its routine operations the carrier applies the terms of its contracts for making decisions, including making determination regarding eligibility, receipt of benefits and claims or explaining its policies, procedures and processes.

(2) A policy, contract or agreement offered or issued in this state by an insurer to provide, deliver, arrange for, pay for or reimburse claim costs may not contain a discretionary clause or other language purporting to reserve discretion to the insurer to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

(3) This rule does not prevent a policy provision that addresses alternative dispute resolution as allowed by law.

(4) This rule is self-executing. The rule applies to policies, contracts and agreements issued or renewed on or after the date the rule is adopted. If a policy, contract or agreement is renewed and contains a provision rendered void and unenforceable by this rule, the parties to the policy, contract or agreement and the courts shall treat that provision as void and unenforceable.

Stat. Auth: ORS 731.244
Stats. Implemented: ORS 731.008, 742.003 & 742.005
Hist.: ID 2-2015, f. & cert. ef. 3-12-15

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

Rule Caption: Amendment of rules governing workers' compensation medical billing and payment
Adm. Order No.: WCD 3-2015
Filed with Sec. of State: 3-12-2015
Certified to be Effective: 4-1-15
Notice Publication Date: 2-1-2015
Rules Amended: 436-009-0004, 436-009-0005, 436-009-0008, 436-009-0010, 436-009-0018, 436-009-0020, 436-009-0023, 436-009-0025, 436-009-0030, 436-009-0035, 436-009-0040, 436-009-0060, 436-009-0080, 436-009-0090, 436-009-0110, 436-009-0998
Subject: The agency has amended OAR 436-009, "Oregon Medical Fee and Payment Rules," to:

Adopt updated medical fee schedules (Appendices B, C, D, and E) and resources for the payment of health care providers;

Add definitions of "date stamp" and "patient";

Specify that a medical service provider who conducts independent medical exams may submit bills in any form or format agreed to by the insurer and the medical service provider;

Explain time frames when medical providers must switch from using ICD-9-CM to ICD-10-CM codes for billing;

Require that modifier "81" be used only to identify services of nurse practitioners and physician assistants who were surgical assistants during surgery;

Make workers liable for payment of the difference in cost between a generic and a brand-name drug, if:

- The prescribing provider has not prohibited substitution;
- The insurer previously notified the worker in writing about the liability; and
- The worker insists on receiving a brand-name drug;

Reduce the discounts on payment for certain diagnostic imaging procedures applied to multiple regions of the body;

Require that the insurer replace a prosthetic appliance that is damaged when in use at the time of and in the course of employment with a comparable appliance, but the worker may choose to upgrade the appliance and pay the price difference;

Specify that all bills from pharmacies must include the prescribing provider's NPI (national provider identifier) or license number; and

Clarify that billable mileage for an interpreter's services includes the miles traveled back to the interpreter's starting point.
Rules Coordinator: Fred Bruyns—(503) 947-7717

436-009-0004
Adoption of Standards

(1) The director adopts, by reference, the American Society of Anesthesiologists ASA,

Relative Value Guide 2015 as a supplementary fee schedule for those anesthesia codes not found in Appendix B. To get a copy of the ASA Relative Value Guide 2015, contact the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573, 847-825-5586, or on the Web at: http://www.asahq.org.

(2) The director adopts, by reference, the American Medical Association's (AMA) Current Procedural Terminology (CPT® 2015), Fourth Edition Revised, 2014, for billing by medical providers. The definitions, descriptions, and guidelines found in CPT® must be used as guides governing the descriptions of services, except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(3) The director adopts, by reference, the AMA's CPT® Assistant, Volume 0, Issue 04 1990 through Volume 24, Issue 12, 2014. If there is a conflict between the CPT® manual and CPT® Assistant, the CPT® manual is the controlling resource.

(4) To get a copy of the CPT® 2015 or the CPT® Assistant, contact the American Medical Association, 515 North State Street, Chicago, IL60610, 800-621-8335, or on the Web at: http://www.ama-assn.org.

(5) The director adopts, by reference, only the alphanumeric codes from the CMS Healthcare Common Procedure Coding System (HCPCS).

These codes are to be used when billing for services, but only to identify products, supplies, and services that are not described by CPT® codes or that provide more detail than a CPT® code.

(a) Except as otherwise provided in these rules, the director does not adopt the HCPCS edits, processes, exclusions, color-coding and associated instructions, age and sex edits, notes, status indicators, or other policies of CMS.

(b) To get a copy of the HCPCS, contact the National Technical Information Service, Springfield, VA 22161, 800-621-8335 or on the Web

at: www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

(6) The director adopts, by reference, CDT 2015: Dental Procedure Codes, to be used when billing for dental services. To get a copy, contact the American Dental Association at American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, or on the Web at: www.ada.org.

(7) The director adopts, by reference, the 02/12 1500 Claim Form and Version 1.1 06/13 (for the 02/12 form) 1500 Health Insurance Claim Form Reference Manual published by the National Uniform Claim Committee (NUCC). To get copies, contact the NUCC, American Medical Association, 515 N. State St., Chicago, IL 60654, or on the Web at: www.nucc.org.

(8) The director adopts, by reference, the Official UB-04 Data Specifications Manual 2015 Edition, published by National Uniform Billing Committee (NUBC). To get a copy, contact the NUBC, American Hospital Association, One North Franklin, 29th Floor, Chicago, IL 60606, 312-422-3390, or on the Web at: www.nubc.org.

(9) The director adopts, by reference, the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.3 and the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) Version 1.1 – 5/2009. To get a copy, contact the National Council for Prescription Drug Programs (NCPDP), 9240 East Raintree Drive, Scottsdale, AZ 85260-7518, 480-477-1000, or on the Web at: www.ncpdp.org.

(10) Specific provisions contained in OAR chapter 436, divisions 009, 010, and 015 control over any conflicting provision in ASA Relative Value Guide 2015, CPT® 2015, CPT® Assistant, HCPCS 2015, CDT 2015, Dental Procedure Codes, 1500 Health Insurance Claim Form Reference Instruction Manual, Official UB-04 Data Specifications Manual, or NCPDP Manual Claim Forms Reference Implementation Guide.

(11) Copies of the standards referenced in this rule are also available for review during regular business hours at the Workers' Compensation Division, Medical Resolution Team, 350 Winter Street NE, Salem OR 97301, 503-947-7606.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.248 & 656.726(4)

Stats. Implemented: ORS 656.248

Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 1-2009, f. 5-22-09, cert. ef. 7-1-09; WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 1-2012, f. 2-16-12, cert. ef. 4-1-12; WCD 2-2013, f. 3-11-13, cert. ef. 4-1-13; WCD 7-2013, f. 11-12-13, cert. ef. 1-1-14; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0005
Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made part of these rules.

(2) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:

(a) ANSI means the American National Standards Institute.

(b) ASC means ambulatory surgery center.

(c) CMS means Centers for Medicare & Medicaid Services.

(d) CPT® means Current Procedural Terminology published by the American Medical Association.

(e) DME means durable medical equipment.

(f) DMEPOS means durable medical equipment, prosthetics, orthotics, and supplies.

(g) EDI means electronic data interchange.

(h) HCPCS means Healthcare Common Procedure Coding System published by CMS.

(i) IAIABC means International Association of Industrial Accident Boards and Commissions.

(j) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.

(k) ICD-10-CM means International Classification of Diseases, Tenth Revision, Clinical Modification.

(l) ICD-10-PCS means International Classification of Diseases, Tenth Revision, Procedure Coding System.

(m) MCO means managed care organization certified by the director.

(n) NPI means national provider identifier.

(o) OSC means Oregon specific code.

(p) PCE means physical capacity evaluation.

(q) WCE means work capacity evaluation.

(3) "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.

(4) "Ambulatory surgery center" (ASC) means:

(a) Any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization; or

(b) Any entity outside of Oregon similarly licensed, or certified by Medicare or a nationally recognized agency as an ASC.

(5) "Attending physician" has the same meaning as described in ORS 656.005(12)(b). See Appendix F, "Matrix for Health Care Provider Types".

(6) "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 who has been assigned an authorized nurse practitioner number by the director.

(7) "Board" means the Workers' Compensation Board and includes its Hearings Division.

(8) "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.

(9) "Clinic" means a group practice in which several medical service providers work cooperatively.

(10) "CMS form 2552" (Hospital and Hospital Health Care Complex Cost Report) means the annual report a hospital makes to Medicare.

(11) "Current procedural terminology" or "CPT"® means the Current Procedural

Terminology codes and terminology published by the American Medical

Association unless otherwise specified in these rules.

(12) "Date stamp" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(13) "Days" means calendar days.

(14) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(15) "Enrolled" means an eligible worker has received notification from the insurer that the worker is being required to receive treatment under the provisions of a managed care organization (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 MCO's certified geographical service area.

(16) "Fee discount agreement" means a direct contract entered into between a medical service provider or clinic and an insurer to discount fees to the medical service provider or clinic under OAR 436-009-0018.

(17) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(18) "Hospital" means an institution licensed by the State of Oregon as a hospital.

(a) "Inpatient" means a patient who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(b) "Outpatient" means a patient 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 that do not result in admission are also considered outpatient services.

(19) "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 practi-

tioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(20) "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 and meets the qualifications of a self-insured employer under ORS 656.407.

(21) "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.

(22) "Interpreter" means a person who:

(a) Provides oral or sign language translation; and

(b) Owns, operates, or works for a business that receives income for providing oral or sign language translation. It does not include a medical provider, medical provider's employee, or a family member or friend of the patient.

(23) "Interpreter services" means the act of orally translating between a medical provider and a patient who speak different languages, including sign language. It includes reasonable time spent waiting at the location for the medical provider to examine or treat the patient as well as reasonable time spent on necessary paperwork for the provider's office.

(24) "Mailed or mailing date" 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 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 provider" means a medical service provider, a hospital, a medical clinic, or a vendor of medical services.

(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 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.

(30) "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.

(31) "Patient" means the same as worker as defined in ORS 656.005(30).

(32) "Physical capacity evaluation" means an objective, directly observed, measurement of a patient's ability to perform a variety of physical tasks combined with subjective analyses of abilities by patient and evaluator. Physical tolerance screening, Blankenship's Functional Capacity Evaluation, and Functional Capacity Assessment have the same meaning as Physical Capacity Evaluation.

(33) "Provider network" means a health service intermediary other than an MCO that facilitates transactions between medical providers and insurers through a series of contractual arrangements.

(34) "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.

(35) "Residual functional capacity" means a patient's remaining ability to perform work-related activities. 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 patient can perform each activity.

(36) "Specialist physician" means a licensed physician who qualifies as an attending physician and who examines a patient at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice or an opinion regarding the treatment being rendered, or considered, for a patient's compensable injury.

(37) "Type A attending physician" means an attending physician under ORS 656.005(12)(b)(A). See Appendix F, "Matrix for Health Care Provider Types".

(38) "Type B attending physician" means an attending physician under ORS 656.005(12)(b)(B). See Appendix F. "Matrix for Health Care Provider Types".

(39) "Usual fee" means the medical provider's fee charged to the general public for a given service.

(40) "Work capacity evaluation" 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 has 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 patient participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the patient to a specific job.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.000 et seq., 656.005, 656.726(4)

Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 1-2015, f. 1-29-15, cert. ef. 3-1-15; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0008

Request for Review by the Director

(1) General.

(a) Administrative review before the director:

(A) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all disputes concerning medical fees, nonpayment of compensable medical bills, and medical service and treatment disputes arising under ORS 656.245, 656.247, 656.248, 656.260, 656.325, and 656.327. Disputes about whether a medical service provided after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c), or whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review before the director.

(B) A party does not need to be represented to participate in the administrative review before the director.

(C) Any party may request that the director provide voluntary mediation or alternative dispute resolution after a request for administrative review or hearing is filed.

(b) Except for disputes regarding interim medical benefits under ORS 656.247, when there is a formal denial of the compensability of the underlying claim, or a denial of the causal relationship between the medical service or treatment and the accepted condition or the underlying condition, the parties may file a request for hearing with the Hearings Division of the Workers' Compensation Board to resolve the compensability issue.

(2) Time Frames and Conditions.

(a) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(b) For MCO-enrolled claims, a party that disagrees with an action or decision of the MCO must first use the MCO's dispute resolution process. If the party does not appeal the MCO's decision using the MCO's dispute resolution process, in writing and within 30 days of the mailing date of the decision, the party will lose all rights to further appeal the decision absent a showing of good cause. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 30-day time frame begins when the attorney receives written notice or has actual knowledge of the MCO decision.

(c) For MCO-enrolled claims, if a party disagrees with the final action or decision of the MCO, the aggrieved party must request administrative review before the director within 60 days of the MCO's final decision. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation to the insurer, the 60-day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. If a party has been denied access to the MCO dispute resolution process, or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving a particular type of dispute, the insurer or the MCO must

advise the medical provider or worker that they may request review before the director.

(d) For claims not enrolled in an MCO, or for disputes that do not involve an action or decision of an MCO:

(A) A worker must request administrative review before the director within 90 days of the date the worker knew, or should have known, there was a dispute over the provision of medical services. If the worker is represented, and the worker's attorney has given notice of representation to the insurer, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute.

(B) A medical provider must request administrative review within 90 days of the mailing date of the most recent explanation of benefits or a similar notification the provider received regarding the disputed service or fee. Rebillings without any relevant changes will not provide a new 90 day period to request administrative review.

(C) An insurer must request administrative review within 90 days of the date action on the bill was due under OAR 436-009-0030.

(D) For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, whichever occurs last. A request for administrative review under this rule may also be filed as prescribed in OAR chapter 438, division 005.

(e) Within 180 days of the date a bill is paid, an insurer may request a refund from a provider for any amount it determines was overpaid for a compensable medical service. If the provider does not respond to the request, or disagrees that a service was overpaid, the insurer may request director review within 90 days of requesting the refund.

(f) Medical provider bills for treatment or services that are under review before the director are not payable during the review.

(3) Form and Required Information.

(a) Requests for administrative review before the director should be made on Form 2842 as described in Bulletin 293. When an insurer or a worker's representative submits a request without the required information, the director may dismiss the request or hold initiation of the administrative review until the required information is submitted. Unrepresented workers may ask the director for help in meeting the filing requirements.

(A) The requesting party must simultaneously notify all other interested parties and their representatives, if known, of the dispute. The notice must: identify the worker's name, date of injury, insurer, and claim number; specify the issues in dispute and the relief sought; and provide the specific dates of the unpaid disputed treatment or services.

(B) If the request for review is submitted by either the insurer or the medical provider, it must state specific codes of services in dispute and include enough documentation to support the request, including copies of original bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to review the dispute. The insurer or medical provider requesting review must provide all involved parties a copy of: the request for review; any attached supporting documentation; and if known, an indication of whether or not there is an issue of causation or compensability of the underlying claim or condition.

(b) In addition to medical evidence relating to the dispute, all parties may submit other relevant information, including written factual information, sworn affidavits, or legal argument, for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain additional evidence consistent with statute, such as pertinent medical treatment and payment records. The director may also interview parties to the dispute, or consult with an appropriate committee of the medical provider's peers. When a party receives a written request for additional information from the director, the party must respond within 14 days.

(c) When a request for administrative review is filed under ORS 656.247, the insurer must provide a record packet, at no charge, to the director and all other parties or their representatives as follows:

(A) The packet must include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number must be preceded by the designation "Ex." and pagination of the multiple page documents must be designated by a hyphen followed by the page number. For example, page two of document 10 must be designated "Ex. 10-2." The index must include the document numbers, description of each document, author, number of pages, and date of the document. The packet must include the following notice in bold type:

We hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order that could affect reimbursement for the disputed medical service(s).

(B) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(C) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer must provide the record within 14 days of the director's request as described in this rule.

(D) If the insurer fails to submit the record in the time and format specified in this rule, the director may sanction the insurer under OAR 436-010-0340.

(4) Dispute Resolution by Agreement (Alternative Dispute Resolution).

(a) A dispute may be resolved by agreement between the parties to the dispute. The agreement must be in writing and approved by the director. The director may issue a letter of agreement instead of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement of the dispute.

(b) Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney.

(5) Director Order and Reconsideration.

(a) The director may, on the director's own motion, reconsider or withdraw any order that has not become final by operation of law. A party also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information that could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be mailed to the director before the administrative order becomes final.

(b) During any reconsideration of the administrative order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(c) Any party requesting reconsideration or responding to a reconsideration request must simultaneously notify all other interested parties of its contentions and provide them with copies of all additional information presented.

(d) Attorney fees in administrative review will be awarded as provided in ORS 656.385(1) and OAR 436-001-0400 through 436-001-0440.

(6) Hearings.

(a) Any party that disagrees with an action or administrative order under these rules may obtain review of the action or order by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order under ORS 656.245, 656.248, 656.260, or 656.327, or within 60 days of the mailing date of an order under ORS 656.247. OAR 436-001 applies to the hearing.

(b) In the review of orders issued under ORS 656.245(3) or 656.247, no new medical evidence or issues will be admitted at hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(c) Contested case hearings of sanctions and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the board as follows:

(A) A written request for a hearing must be mailed to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(B) The request must be mailed to the division within 60 days after the mailing date of the order or notice of assessment.

(C) The division will forward the request and other pertinent information to the board.

(7) Other Proceedings.

(a) Director's administrative review of other actions not covered under sections (1) through (6) of this rule: Any party seeking an action or decision by the director, or any party aggrieved by an action taken by another party, may request administrative review before the director. Any party

may request administrative review as follows:

(b) A written request for review must be sent to the administrator of the Workers' Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(c) The division may require and allow such input and information as it deems appropriate to complete the review.

Stat. Auth.: ORS 656.704, 656.726(4)
Stats. Implemented: ORS 656.704
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0901, 5-1-85 WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-89, (Former sections (3), (4), & (7) Renumbered to 436-010-0130); WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90;WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0110; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-00; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0010
Medical Billing and Payment

(1) General.

(a) Only treatment that falls within the scope and field of the medical provider's license to practice will be paid under a workers' compensation claim. Except for emergency services or as otherwise provided for by statute or these rules, treatments and medical services are only payable if approved by the worker's attending physician or authorized nurse practitioner. Fees for services by more than one physician at the same time are payable only when the services are sufficiently different that separate medical skills are needed for proper care.

(b) All billings must include the patient's full name, date of injury, and the employer's name. If available, billings must also include the insurer's claim number and the provider's NPI. If the provider does not have an NPI, then the provider must provide its license number and the billing provider's FEIN. For provider types not licensed by the state, "99999" must be used in place of the state license number. Bills must not contain a combination of ICD-9 and ICD-10 codes.

(c) The medical provider must bill their usual fee charged to the general public. The submission of the bill by the medical provider is a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department may require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law that require providers to bill other than their usual fee.

(d) Medical providers must not submit false or fraudulent billings, including billing for services not provided. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. A request for pre-payment for a deposition is not considered false or fraudulent.

(e) When a provider treats a patient with two or more compensable claims, the provider must bill individual medical services for each claim separately.

(f) When rebilling, medical providers must indicate that the charges have been previously billed.

(g) If a patient requests copies of medical bills in writing, medical providers must provide copies within 30 days of the request, and provide any copies of future bills during the regular billing cycle.

(2) Billing Timelines. (For payment timelines see OAR 436-009-0030.)

(a) Medical providers must bill within:

(A) 60 days of the date of service;

(B) 60 days after the medical provider has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the provider receives written notice of the final litigation from the insurer.

(b) If the provider bills past the timelines outlined in subsection (a) of this section, the provider may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, a medical provider must establish good cause. Good cause may include, but is not limited to, such issues as extenuating circumstances or circumstances considered outside the control of the provider.

(d) When a provider submits a bill within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When a provider submits a bill more than 12 months after the date of service, the bill is not payable, except when a provision of subsection (2)(a) is the reason the billing was submitted after 12 months.

(3) Billing Forms.

(a) All medical providers must submit bills to the insurer unless a contract directs the provider to bill the managed care organization (MCO).

(b) Medical providers must submit bills on a completed current UB-04 (CMS 1450) or

CMS 1500 except for:

(A) Dental billings, which must be submitted on American Dental Association dental claim forms;

(B) Pharmacy billings, which must be submitted on a current National Council for Prescription Drug Programs (NCPDP) form; or

(C) Electronic billing transmissions of medical bills (see OAR 436-008).

(c) Notwithstanding subsection (3)(a) of this rule, a medical service provider doing an IME may submit a bill in the form or format agreed to by the insurer and medical service provider.

(d) Medical providers may use computer-generated reproductions of the appropriate forms.

(e) Unless different instructions are provided in the table below, the provider should use the instructions provided in the National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual. [Table not included. See ED. NOTE.]

(4) Billing Codes.

(a) When billing for medical services, a medical provider must use codes listed in CPT® 2015 or Oregon specific codes (OSC) listed in OAR 436-009-0060 that accurately describe the service. If there is no specific CPT® code or OSC, a medical provider must use the appropriate HCPCS or dental code, if available, to identify the medical supply or service. If there is no specific code for the medical service, the medical provider must use the unlisted code at the end of each medical service section of CPT® 2015 or the appropriate unlisted HCPCS code, and provide a description of the service provided. A medical provider must include the National Drug Code (NDC) to identify the drug or biological when billing for pharmaceuticals.

(b) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(5) Modifiers.

(a) When billing, unless otherwise provided by these rules, medical providers must use the appropriate modifiers found in CPT® 2015, HCPCS' level II national modifiers, or anesthesia modifiers, when applicable.

(b) Modifier 22 identifies a service provided by a medical service provider that requires significantly greater effort than typically required. Modifier 22 may only be reported with surgical procedure codes with a global period of 0, 10, or 90 days as listed in Appendix B. The bill must include documentation describing the additional work. It is not sufficient to simply document the extent of the patient's comorbid condition that caused the additional work. When a medical service provider appropriately bills for an eligible procedure with modifier 22, the payment rate is 125% of the fee published in Appendix B, or the fee billed, whichever is less. For all services identified by modifier 22, two or more of the following factors must be present:

(A) Unusually lengthy procedure;

(B) Excessive blood loss during the procedure;

(C) Presence of an excessively large surgical specimen (especially in abdominal surgery);

(D) Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;

(E) Other pathologies, tumors, malformations (genetic, traumatic, or surgical) that directly interfere with the procedure but are not billed as separate procedure codes; or

(F) The services rendered are significantly more complex than described for the submitted CPT®.

(6) Physician Assistants and Nurse Practitioners.

Physician assistants and nurse practitioners must document in the chart notes that they provided the medical service. If physician assistants or

nurse practitioners provide services as surgical assistants during surgery, they must bill using modifier "81."

(7) Chart Notes.

(a) All original medical provider billings must be accompanied by legible chart notes. The chart notes must document the services that have been billed and identify the person performing the service.

(b) Chart notes must not be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(c) When processing electronic bills, the insurer may waive the requirement that bills be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. Medical providers may submit their chart notes separately or at regular intervals as agreed with the insurer.

(8) Challenging the Provider's Bill.

For services where the fee schedule does not establish a fixed dollar amount, an insurer may challenge the reasonableness of a provider's bill on a case by case basis by asking the director to review the bill under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, fees for similar services in similar geographic regions, or any extenuating circumstances.

(9) Billing the Patient/Patient Liability.

(a) A patient is not liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer according to OAR chapter 436. However, the patient may be liable, and the provider may bill the patient:

(A) If the patient seeks treatment for conditions not related to the accepted compensable injury or illness;

(B) If the patient seeks treatment for a service that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but is not limited to, ongoing treatment by non-attending physicians in excess of the 30-day/12-visit period or by nurse practitioners in excess of the 180-day period, as set forth in ORS 656.245 and OAR 436-010-0210;

(C) If the insurer notifies the patient that he or she is medically stationary and the patient seeks palliative care that is not authorized by the insurer or the director under OAR 436-010-0290;

(D) If an MCO-enrolled patient seeks treatment from the provider outside the provisions of a governing MCO contract; or

(E) If the patient seeks treatment listed in section (12) of this rule after the patient has been notified that such treatment is unscientific, unproven, outmoded, or experimental.

(b) If the director issues an order declaring an already rendered medical service or treatment inappropriate, or otherwise in violation of the statute or administrative rules, the worker is not liable for such services.

(10) Disputed Claim Settlement (DCS).

The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a DCS were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except, if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.

(11) Payment Limitations.

(a) Insurers do not have to pay providers for the following:

(A) Completing forms 827 and 4909;

(B) Providing chart notes with the original bill;

(C) Preparing a written treatment plan;

(D) Supplying progress notes that document the services billed;

(E) Completing a work release form or completion of a PCE form, when no tests are performed;

(F) A missed appointment "no show" (see exceptions below under section (13) Missed Appointment "No Show"); or

(G) More than three mechanical muscle testing sessions per treatment program or when not prescribed and approved by the attending physician or authorized nurse practitioner.

(b) Mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient. Additional mechanical muscle testing may be paid for only when authorized in writing by the insurer prior to the testing.

(c) 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 patient.

(d) Vitamin B-12 injections are not reimbursable unless necessary for a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(12) Excluded Treatment. The following medical treatments (or treatment of side effects) are not compensable and insurers do not have to pay for:

(a) Dimethyl sulfoxide (DMSO), except for treatment of compensable interstitial cystitis;

(b) Intradiscal electrothermal therapy (IDET);

(c) Surface electromyography (EMG) tests;

(d) Rolfing;

(e) Prolotherapy;

(f) Thermography;

(g) Lumbar artificial disc replacement, unless it is a single level replacement with an unconstrained or semi-constrained metal on polymer device and:

(A) The single level artificial disc replacement is between L3 and S1;

(B) The patient is 16 to 60 years old;

(C) The patient underwent a minimum of six months unsuccessful exercise based rehabilitation; and

(D) The procedure is not found inappropriate under OAR 436-010-0230; and

(h) Cervical artificial disc replacement, unless it is a single level replacement with a semi-constrained metal on polymer or a semi-constrained metal on metal device and:

(A) The single level artificial disc replacement is between C3 and C7;

(B) The patient is 16 to 60 years old;

(C) The patient underwent unsuccessful conservative treatment;

(D) There is intraoperative visualization of the surgical implant level; and

(E) The procedure is not found inappropriate under OAR 436-010-0230.

(13) Missed Appointment (No Show). In general, the insurer does not have to pay for "no show" appointments. However, insurers must pay for "no show" appointments for arbiter exams, director required medical exams, independent medical exams, worker requested medical exams, and closing exams. If the patient does not give 48 hours notice, the insurer must pay the provider 50 percent of the exam or testing fee and 100 percent for any review of the file that was completed prior to cancellation or missed appointment.

[ED. NOTE: Tables referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.245, 656.252, 656.254

Stats. Implemented: ORS 656.245, 656.252, 656.254

Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 8-2001, f. 9-13-01, cert. ef. 9-17-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 1-2009, f. 5-22-09, cert. ef. 7-1-09; WCD 3-2009, f. 12-1-09, cert. ef. 1-1-10; WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 1-2012, f. 2-16-12, cert. ef. 4-1-12; WCD 2-2013, f. 3-11-13, cert. ef. 4-1-13; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 4-2014(Temp), f. & cert. ef. 4-15-14 thru 10-11-14; WCD 6-2014, f. 6-13-14, cert. ef. 7-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0018

Discounts and Contracts

(1) Medical Service Providers and Medical Clinics.

For the purpose of this rule:

(a) "Medical Service Provider" means a person duly licensed to practice one or more of the healing arts.

(b)"Clinic" means a group practice in which several medical service providers work cooperatively.

(2) Discounts.

(a) An insurer may only apply the following discounts to a medical service provider's or clinic's fee:

(A) A fee agreed to under a fee discount agreement that conforms to this rule and has been reported to the director; or

(B) A fee agreed to by the medical service provider or clinic under an MCO contract to cover services provided to a worker enrolled in the MCO.

(b) If the insurer has multiple contracts with a medical service provider or clinic, and one of the contracts is through an MCO for services

provided to an enrolled worker, the insurer may only apply the discount under the MCO's contract.

(c) Any discount under a fee discount agreement cannot be more than 10 percent of the fee schedule amount.

(d) An insurer may not apply a fee discount until the medical service provider or clinic and the insurer have signed the fee discount agreement.

(3) Fee Discount Agreements.

(a) The fee discount agreement between the parties must be on the provider's letterhead and contain all the information listed on Form 3659. Bulletin 352 provides further information. The agreement must include the following:

(A) A statement that the medical service provider or clinic understands and voluntarily agrees with the terms of the fee discount agreement;

(B) The effective and end dates of the agreement;

(C) The discount rate or rates under the agreement;

(D) A statement that the insurer or employer may not direct patients to the provider or clinic, and that the insurer or employer may not direct or manage the care a patient receives;

(E) A statement that the agreement only applies to patients who are being treated for Oregon workers' compensation claims;

(F) A statement that the fee discount agreement may not be amended. A new fee discount agreement must be executed to change the terms between the parties;

(G) A statement that either party may terminate the agreement by providing the other party with 30 days written notice;

(H) The name and address of the singular insurer or self-insured employer that will apply the discounts;

(I) The national provider identifier (NPI) for the provider or clinic; and

(J) Other terms and conditions to which the medical service provider or clinic and the insurer agree and that are consistent with these rules.

(b) Once the fee discount agreement has been signed by the insurer and medical service provider or clinic, the insurer must report the fee discount agreement to the director by completing the director's online form. The following information must be included:

(A) The insurer's name that will apply the discounts under the fee discount agreement;

(B) The medical service provider's or clinic's name;

(C) The effective date of the agreement;

(D) The end date of the agreement;

(E) The discount rate under the agreement; and

(F) An indication that all the terms required under section (3)(a) of this rule are included in the signed fee discount agreement.

(4) Fee Discount Agreement Modifications and Terminations.

(a) When the medical service provider or clinic and the insurer agree to modify an existing fee discount agreement, the parties must enter into a new fee discount agreement.

(b) Either party to the fee discount agreement may terminate the agreement by providing 30 days written notice to the other party. The insurer must report the termination to the director prior to the termination taking effect by completing the director's online form. The following information must be reported:

(A) The insurer's name;

(B) The medical service provider's or clinic's name; and

(C) The termination date of the agreement.

(5) Other Medical Providers.

(a) For the purpose of this rule, "other medical providers" means providers such as hospitals, ambulatory surgery centers, or vendors of medical services and does not include medical service providers or clinics.

(b) The insurer may apply a discount to the medical provider's fee if a written or verbal contract exists.

(c) If the insurer and the medical provider have multiple contracts, only one discount may be applied.

(d) If the insurer has multiple contracts with a provider and one of the contracts is through an MCO for services provided to an enrolled worker, the insurer may only apply the discount under the MCO's contract.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 1-2009, f. 5-22-09, cert. ef. 7-1-09; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0020
Hospitals

(1) Inpatient.

(a) For the purposes of this rule, hospital inpatient services are those services that are billed with codes "0111" through "0118" in form locator #4 on the UB-04 billing form.

(b) Hospital inpatient bills must include:

(A) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes;

(B) When applicable, procedural codes;

(C) The hospital's NPI; and

(D) The Medicare Severity Diagnosis Related Group (MS-DRG) code for bills from those hospitals listed in Appendix A.

(c) Unless otherwise provided by contract, the insurer must pay the audited bill for hospital inpatient services by multiplying the amount charged by the hospital's adjusted cost-to-charge ratio (See Bulletin 290). The insurer must pay in-state hospitals not listed in Bulletin 290 at 80 percent of billed charges for inpatient services.

(2) Outpatient.

(a) For the purposes of this rule, hospital outpatient services are those services that are billed with codes "0131" through "0138" in form locator #4 on the UB-04 billing form.

(b) Hospital outpatient bills must, when applicable, include the following:

(A) Revenue codes;

(B) For dates of service prior to Oct. 1, 2015, ICD-9-CM codes, and for dates of service on and after Oct. 1, 2015, ICD-10-CM codes,

(C) CPT® codes and HCPCS codes; and

(D) The hospital's NPI (c) Unless otherwise provided by contract, the insurer must pay for hospital outpatient services as follows: [Table not included. See ED. NOTE.]

(3) Specific Circumstances. When a patient is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission are considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment is considered part of the hospital services subject to the hospital inpatient fee schedule.

(4) Out-of-State Hospitals.

(a) The payment to out-of-state hospitals may be negotiated between the insurer and the hospital.

(b) Any agreement for payment less than the billed amount must be in writing and signed by the hospital and insurer representative.

(c) The agreement must include language that the hospital will not bill the patient any remaining balance and that the negotiated amount is considered payment in full.

(d) If the insurer and the hospital are unable to reach an agreement within 45 days of the insurer's receipt of the bill, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.

(5) Calculation of Cost-to-Charge Ratio Published in Bulletin 290.

(a) Each hospital's CMS 2552 form and financial statement is the basis for determining its adjusted cost-to-charge ratio. If a current form 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost–to-charge ratio is determined from estimated data, the hospital will receive the lower ratio of either the hospital's last published cost-to-charge ratio or the hospital's cost-to-charge ratio based on estimated data.

(b) The basic cost-to-charge ratio is developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (c), by the total patient revenues from Worksheet G-2.

(c) The net expenses for allocation derived from Worksheet A is modified by adding, from Worksheet A-8, the expenses for:

(A) Provider-based physician adjustment;

(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the department to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

(d) The basic cost-to-charge ratio is further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost-to-charge ratio calculated in subsection (5)(b) to obtain the factor for bad debt and charity care.

(e) The basic cost-to-charge ratio is further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the projected growth in a national fixed weight price deflator will be added together to form a growth factor.

This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(f) The factors resulting from subsections (5)(d) and (5)(e) of this rule is added to the ratio calculated in subsection (5)(b) of this rule to obtain the adjusted cost-to-charge ratio. In no event will the adjusted cost-to-charge ratio exceed 1.00.

(g) The adjusted cost-to-charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as described by bulletin. Each hospital must submit a copy of its CMS 2552 and financial statements each year within 150 days of the end of the hospital's fiscal year to the Information Technology and Research Section, Department of Consumer and Business Services. The adjusted cost-to-charge ratio schedule will be published by bulletin twice yearly, effective for the six-month period beginning April 1 and the six-month period beginning October 1.

(h) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division determines an adjusted cost–to-charge ratio for the hospital based upon the adjusted cost to charge ratios of a group of hospitals of similar size or geographic location.

(i) If the financial circumstances of a hospital unexpectedly or dramatically change, the division may revise the hospital's adjusted cost-to-charge ratio to allow equitable payment.

(j) If audit of a hospital's CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost-to-charge ratio to reflect the data developed subsequent to the initial calculation.

(k) Notwithstanding subsections (1)(c), (2)(b), and (2)(c) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost-to-charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index. All rural hospitals having a financial flexibility index at or below the median for critical access hospitals nationwide qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost-to-charge ratio.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4), 656.012, 656.236(5), 656.327(2) & 656.313(4)(d)

Stats. Implemented: ORS 656.248, 656.252 & 656.256

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0701, 5-1-85; WCD 3-1985(Admin)(Temp), f. & ef. 9-4-85; WCD 4-1985(Admin)(Temp), f. & ef. 9-11-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1986(Admin)(Temp), f. 2-5-86, ef. 2-6-86; WCD 2-1986(Admin), f. 3-10-86, ef. 3-17-86; WCD 2-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 6-1988, f. 9-6-88, cert. ef. 9-15-88; WCD 2-1989, f. 8-21-89, cert. ef. 9-1-89; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 15-1990, f. & cert. ef. 8-7-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 18-1995(Temp), f. & cert. ef. 12-4-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0090; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1997, f. 4-21-97, cert. ef. 7-1-97; Administrative correction 6-18-97; WCD 8-1997(Temp), f. & cert. ef. 7-9-97; WCD 16-1997, f. & cert. ef. 12-15-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 3-2008(Temp), f. & cert. ef. 7-7-08 thru 1-2-09; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 1-2009, f. 5-22-09, cert. ef. 7-1-09; WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 2-2013, f. 3-11-13, cert. ef. 4-1-13; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 4-2014(Temp), f. & cert. ef. 4-15-14 thru 10-11-14; WCD 6-2014, f. 6-13-14, cert. ef. 7-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0023

Ambulatory Surgery Center (ASC)

(1) Billing Form.

(a) The ASC must submit bills on a completed, current CMS 1500 form (see OAR 436-009-0010(3)) unless the ASC submits medical bills electronically. Computer-generated reproductions of the CMS 1500 form may also be used.

(b) The ASC must add a modifier "SG" in box 24D of the CMS 1500 form to identify the facility charges.

(2) ASC Facility Fee.

(a) The following services are included in the ASC facility fee and the ASC may not receive separate payment for them:

(A) Nursing, technical, and related services;

(B) Use of the facility where the surgical procedure is performed;

(C) Drugs and biologicals designated as packaged in Appendix D, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure;

(D) Radiology services designated as packaged in Appendix D;

(E) Administrative, record-keeping, and housekeeping items and services;

(F) Materials for anesthesia;

(G) Supervision of the services of an anesthetist by the operating surgeon; and

(H) Packaged services identified in Appendix C or D.

(b) The payment for the surgical procedure (i.e., the ASC facility fee) does not include physician's services, laboratory, X-ray, or diagnostic procedures not directly related to the surgical procedures, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services.

(3) ASC Billing.

(a) The ASC should not bill for packaged codes as separate line-item charges when the payment amount says "packaged" in Appendices C or D.

(b) When the ASC provides packaged services (see Appendices C and D) with a surgical procedure, the billed amount should include the charges for the packaged services.

(c) For the purpose of this rule, an implant is an object or material inserted or grafted into the body. When the ASC's cost for an implant is $100 or more, the ASC may bill for the implant as a separate line item. The ASC must provide the insurer a receipt of sale showing the ASC's cost of the implant.

(4) ASC Payment.

(a) Unless otherwise provided by contract, insurers must pay ASCs for services according to this rule.

(b) Insurers must pay for surgical procedures (i.e., ASC facility fee) and ancillary services the lesser of:

(A) The maximum allowable payment amount for the HCPCS code found in Appendix C for surgical procedures, and in Appendix D for ancillary services integral to a surgical procedure; or

(B) The ASC's usual fee for surgical procedures and ancillary services.

(c) When more than one procedure is performed in a single operative session, insurers must pay the principal procedure at 100 percent of the maximum allowable fee, and the secondary and all subsequent procedures at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure performed preliminary to an open operation is considered a secondary procedure and should be paid accordingly. The multiple surgery discount described in this section does not apply to codes listed in Appendix C with an "N" in the "Subject to Multiple Procedure Discounting" column.

(d) The table below lists packaged surgical codes that ASCs may perform without any other surgical procedure. In this case do not use Appendix C to calculate payment, use the rates listed below instead. [Appendix not included. See ED. NOTE.]

(e) When the ASC's cost of an implant is more than $100, insurers must pay for the implants at 110 percent of the ASC's actual cost documented on a receipt of sale and not according to Appendix D or E.

(f) When the ASC's cost of an implant is less than $100, insurers are not required to pay separately for the implant. An implant may consist of several separately billable components, some of which may cost less than $100. For payment purposes, insurers must add the costs of all the components for the entire implant and use that total amount to calculate payment for the implant.

(g) The insurer does not have to pay the ASC when the ASC provides services to a patient who is enrolled in a managed care organization (MCO) and:

(A) The ASC is not a contracted facility for the MCO;

(B) The MCO has not pre-certified the service provided; or

(C) The surgeon is not an MCO panel provider.

[ED. NOTE: Appendices referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248 & 656.252

Hist.: WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0025

Worker Reimbursement

(1) General.

(a) When the insurer accepts the claim the insurer must notify the worker in writing that:

(A) The insurer will reimburse claim-related services paid by the worker; and

(B) The worker has two years to request reimbursement.

(b) The worker must request reimbursement from the insurer in writing. The insurer may require reasonable documentation such as a sales slip, receipt, or other evidence to support the request. The worker may use Form 3921 — Request for Reimbursement of Expenses.

(c) Insurers must date stamp requests for reimbursement on the date received.

(d) The insurer or its representative must provide a written explanation to the worker for each type of out-of-pocket expense (mileage, lodging, medication, etc.) being paid or denied.

(e) The explanation to the worker must be in 10 point size font or larger and must include:

(A) The amount of reimbursement for each type of out-of-pocket expense requested.

(B) The specific reason for non-payment, reduced payment, or discounted payment for each itemized out-of-pocket expense the worker submitted for reimbursement;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a worker's reimbursement question within 48 hours, excluding weekends and legal holidays;

(D) The following notice, Web link, and phone number: "To access Bulletin 112 with information about reimbursement amounts for travel, food, and lodging costs visit www.oregonwcdoc.info or call 503-947-7606.";

(E) Space for the worker's signature and date; and

(F) A notice of right to administrative review as follows: "If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(f) According to ORS 656.325(1)(f) and OAR 436-060-0095(5)(f), when a worker attends an independent medical examination (IME), the insurer must reimburse the worker for related costs regardless of claim acceptance, deferral, or denial.

(2) Timeframes.

(a) The worker must submit a request for reimbursement of claim-related costs by whichever date is later:

(A) Two years from the date the costs were incurred or

(B) Two years from the date the claim or medical condition is finally determined compensable.

(b) If the worker requests reimbursement after two years as listed in subsection (a), the insurer may disapprove the reimbursement request.

(c) On accepted claims the insurer must, within 30 days of receiving the reimbursement request:

(A) Reimburse the worker if the request shows the costs are related to the accepted claim;

(B) Disapprove the request if unreasonable or if the costs are not related to the accepted claim; or

(C) Request additional information from the worker to determine if costs are related to the accepted claim. If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement.

(d) When the insurer receives a reimbursement request before claim acceptance, and the claim is ultimately accepted, by whichever date is later the insurer must:

(A) Within 30 days of receiving the reimbursement request: reimburse the worker if the request shows the costs are related, disapprove the request if unreasonable or if the costs are not related, or request additional information. If additional information is needed, the time needed to obtain the information is not counted in the 30-day time frame for the insurer to issue reimbursement; or

(B) Within 14 days of claim acceptance: reimburse the worker if the request shows the costs are related, disapprove the request if unreasonable or if the costs are not related, or request additional information. If additional information is needed, the time needed to obtain the information is not counted in the 14-day time frame for the insurer to issue reimbursement.

(e) In a claim for aggravation or a new medical condition, reimbursement requests are not due and payable until the aggravation or new medical condition is accepted.

(f) If the claim is denied, requests for reimbursement must be returned to the worker within 14 days, and the insurer must retain a copy.

(3) Meal and Lodging Reimbursement.

(a) Meal reimbursement is based on whether a meal is reasonably required by necessary travel to a claim-related appointment.

(b) Lodging reimbursement is based on the need for an overnight stay to attend an appointment.

(c) Meals and lodging are reimbursed at the actual cost or the rate published in Bulletin 112, whichever is less. Lodging reimbursement may exceed the maximum rate published in Bulletin 112 when special lodging is required or when the worker is unable to find lodging at or below the maximum rate within 10 miles of the appointment location.

(4) Travel Reimbursement.

(a) Insurers must reimburse workers for actual and reasonable costs for travel to medical providers paid by the worker under ORS 656.245(1)(e), 656.325, and 656.327.

(b) The insurer may limit worker reimbursement for travel to an attending physician if the insurer provides a prior written explanation and a written list of attending physicians that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker. The insurer may limit worker reimbursement for travel to an authorized nurse practitioner if the insurer provides a prior written explanation and a written list of authorized nurse practitioners that are closer for the worker, of the same specialty, and who are able and willing to provide similar medical services to the worker. The insurer must inform the worker that he or she may continue treating with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited to the distance from the worker's home to a provider on the written list.

(c) Within a metropolitan area the insurer may not limit worker reimbursement for travel to an attending physician or authorized nurse practitioner even if there are medical providers closer to the worker.

(d) Travel reimbursement dispute decisions will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

(e) Personal vehicle mileage is the reasonable actual distance based on the beginning and ending addresses. The mileage reimbursement is limited to the rate published in Bulletin 112.

(f) Public transportation or, if required, special transportation will be reimbursed based on actual cost.

(5) Other Reimbursements.

(a) The insurer must reimburse the worker for other claim-related expenses based on actual cost. However, reimbursement for hearing aids is limited to the amounts listed in OAR 436-009-0080.

(b) For prescription medications, the insurer must reimburse the worker based on actual cost. When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. When a worker insists on receiving the brand-name drug, and the prescribing provider has not prohibited substitution, the worker must either pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy. The worker may then request reimbursement from the insurer. However, if the insurer has previously notified the worker in writing that the worker is liable for the difference between the generic and brand-name drug, the insurer only has to reimburse the worker the generic price of the drug.

(c) For IMEs, child care costs are reimbursed at the rate prescribed by the State of Oregon Department of Human Services.

(d) Home health care provided by a worker's family member is not required to be under the direct control and supervision of the attending physician. A worker may receive reimbursement for such home health care services only if the family member demonstrates competency to the satisfaction of the worker's attending physician.

(6) Advancement Request. If necessary to attend a medical appointment, the worker may request an advance for transportation and lodging expenses. Such a request must be made to the insurer in sufficient time to allow the insurer to process the request.

Stat. Auth: ORS 656.245, 656.325, 656.704 & 656.726(4)

Stats. Implemented: ORS 656.245, 656.704 & 656.726(4)

Hist.: WCB 6-1969, f. 10-23-69, ef. 10-29-69; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0270, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 5-1996,

f. 2-6-96, cert. ef. 2-12-96; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02, Renumbered from 436-060-0070; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; WCD 2-2013, f. 3-11-13, cert. ef. 4-1-13; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0030
Insurer's Duties and Responsibilities

(1) General.

(a) The insurer must pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.

(b) The insurer, or its designated agent, may request from the medical provider any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents under OAR 436-009-0060. If the evaluation of the records must be conducted on-site, the provider must furnish a reasonable work-site for the records to be reviewed at no cost. These records must be provided or made available for review within 14 days of a request.

(c) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit must be continuous and must include no fewer than 10 percent of medical bills. The insurer must provide upon the director's request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(2) Bill Processing.

(a) Insurers must date stamp medical bills, chart notes, and other documentation upon receipt. Bills not submitted according to OAR 436-009-0010(1)(b) and (2) must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why the bill was returned and what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of the receipt of the bill. The number of days between the date the insurer returns the bill or requests chart notes and the date the insurer receives the corrected bill or chart notes, does not count toward the 45 days within which the insurer is required to make payment.

(b) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(1)(b) and (3)(a), and insurer action, for any non-payment or fee reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

(c) Any service billed with a code number commanding a higher fee than the services provided must be returned to the medical provider for correction or paid at the value of the service provided.

(3) Payment Requirements.

(a) Insurers must pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the bill is submitted in proper form according to OAR 436-009-0010(1)(b), (3)(a) through (7)(c), and clearly shows that the treatment is related to the accepted compensable injury or disease.

(b) The insurer or its representative must provide a written explanation of benefits (EOB) of the services being paid or denied. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. The insurer or its representative must send the explanation to the medical provider that billed for the services. For the purpose of this rule an EOB has the same meaning as an explanation of review (EOR).

(c) The written EOB must be in 10 point size font or larger. Electronic and written explanations must include:

(A) The amount of payment for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(B) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to a medical provider's payment question within 48 hours, excluding weekends and legal holidays;

(D) The following notice, Web link, and phone number: "To access information about Oregon's Medical Fee and Payment Rules, visit www.oregonwcdoc.info or call 503-947-7606.";

(E) Space for the provider's signature and date; and

(F) A notice of right to administrative review as follows: "If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(d) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(e) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily applies such a service charge to the general public.

(f) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code.

(g) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid within 45 days of receipt by the insurer even if the claim is denied.

(h) If an insurer determines that it has made an overpayment to a provider for medical services, the insurer may request a refund from the provider. The insurer must make the request within 180 days of the payment date. Resolution of overpayment disputes must be made under OAR 436-009-0008.

(4) Communication with Providers.

(a) The insurer or its representative must respond to a medical provider's inquiry about a medical payment within 48 hours, not including weekends or legal holidays. The insurer or its representative may not refer the medical provider to another entity to obtain an answer.

(b) An insurer or its representative and a medical provider may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

(5) EDI Reporting. For medical bill reporting requirements, see OAR 436-160 Electronic Data Interchange Medical Bill Data rules.

[ED. NOTE: Appendices referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260 & 656.264

Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1997, f. 4-21-97, cert. ef. 7-1-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 3-2008(Temp), f. & cert. ef. 7-7-08 thru 1-2-09; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 1-2009, f. 5-22-09, cert. ef. 7-1-09; WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; WCD 6-2010, f. 10-1-10, cert. ef. 1-1-11; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 1-2012, f. 2-16-12, cert. ef. 4-1-12; WCD 2-2013, f. 3-11-13, cert. ef. 4-1-13; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0035
Interim Medical Benefits

(1) General.

(a) Interim medical benefits under ORS 656.247 only apply to initial claims when the patient has a health benefit plan, i.e., the patient's private health insurance. For the purpose of this rule the Oregon Health Plan is not a health benefit plan.

(b) Interim medical benefits are not due on claims:

(A) When the patient is enrolled in an MCO prior to claim acceptance or denial under ORS 656.245(4)(b)(B); or

(B) When the insurer denies the claim within 14 days of the employer's notice of the claim.

(c) Interim medical benefits cover services provided from the date of employer's notice or knowledge of the claim to the date the insurer accepts

or denies the claim. Interim medical benefits do not include treatments excluded under OAR 436-009-0010(12).

(d) When billing for interim medical benefits, the medical provider must bill the workers' compensation insurer according to these rules, and the health benefit plan according to the plan's requirements. The provider may submit a pre-authorization request to the health benefit plan prior to claim acceptance or denial.

(e) If the medical provider knows that the patient filed a work-related claim, the medical provider may not collect any health benefit plan co-pay, co-insurance, or deductible from the patient during the interim period.

(2) Claim Acceptance. If the insurer accepts the claim:

(a) The insurer must pay medical providers for services according to these rules; and

(b) The provider, after receiving payment from the insurer, must reimburse the worker and the health benefit plan for any medical expenses, co-pays, co-insurance, or deductibles, paid by the worker or the health benefit plan.

(3) Claim Denial. If the insurer denies the claim:

(a) The insurer must notify the medical provider as provided in OAR 436-060-0140 that an initial claim has been denied; and

(b) The medical provider must bill the health benefit plan, unless the medical provider has previously billed the health benefit plan. The provider must forward a copy of the workers' compensation denial letter to the health benefit plan.

Stat. Auth.: ORS 656.245, 656.704, 656.726(4)
Stats. Implemented: ORS 656.247
Hist.: WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 11-2014, f. 10-17-14, cert. ef. 1-1-15; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0040
Fee Schedule

(1) Fee Schedule Table.

(a) Unless otherwise provided by contract or fee discount agreement allowed by these rules, insurers must pay according to the following table: [Table not included. See ED. NOTE.]

(b) The global period is listed in the column 'Global Days' of Appendix B.

(2) Anesthesia.

(a) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate anesthesia code. The total anesthesia value is made up of a basic unit value and, when applicable, time and modifying units.

(b) Physicians or certified nurse anesthetists may use basic unit values only when they personally administer the general anesthesia and remain in constant attendance during the procedure for the sole purpose of providing the general anesthesia.

(c) Attending surgeons may not add time units to the basic unit value when administering local or regional block for anesthesia during a procedure. The modifier 'NT' (no time) must be on the bill.

(d) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the payment for the surgical procedure.

(e) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.

(f) The maximum allowable payment amount for anesthesia codes is determined by multiplying the anesthesia value by a conversion factor of $58.00.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, the insurer must pay the lesser of: the maximum allowable payment amount for anesthesia codes; or the provider's usual fee.

(g) When the anesthesia code is designated by IC (individual consideration), unless otherwise provided by a contract or fee discount agreement, the insurer must pay 80 percent of the provider's usual fee.

(3) Surgery.

Unless otherwise provided by contract or fee discount agreement permitted by these rules, insurers must pay multiple surgical procedures performed in the same session according to the following:

(a) One surgeon: [Appendix not included. See ED. NOTE.]

(b) Two or more surgeons: [Appendix not included. See ED. NOTE.]

(c) Assistant surgeons: [Appendix not included. See ED. NOTE.]

(d) Nurse practitioners or physician assistants: [Appendix not included. See ED. NOTE.]

(e) Self-employed surgical assistants who work under the direct control and supervision of a physician: [Appendix not included. See ED. NOTE.]

(f) When a surgeon performs surgery following severe trauma, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. The surgeon must provide written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(g) If the surgery is non-elective, the physician is entitled to payment for the initial evaluation of the patient in addition to the global fee for the surgical procedure(s) performed. However, the pre-operative visit for elective surgery is included in the listed global value of the surgical procedure, even if the pre-operative visit is more than one day before surgery.

(4) Radiology Services.

(a) Insurers only have to pay for X-ray films of diagnostic quality that include a report of the findings. Insurers will not pay for 14" x 36" lateral views.

(b) When multiple contiguous areas are examined by computerized axial tomography (CAT) scan, computerized tomography angiography (CTA), magnetic resonance angiography (MRA), or magnetic resonance imaging (MRI), then the technical component must be paid 100 percent for the first area examined and 75 percent for all subsequent areas. These reductions do not apply to the professional component. The reductions apply to multiple studies done within two days, unless the ordering provider provides a reasonable explanation of why the studies needed to be done on separate days.

(5) Pathology and Laboratory Services.

(a) The payment amounts in Appendix B apply only when there is direct physician involvement.

(b) Laboratory fees must be billed in accordance with ORS 676.310. If a physician submits a bill for laboratory services that were performed in an independent laboratory, the bill must show the amount charged by the laboratory and any service fee that the physician charges.

(6) Physical Medicine and Rehabilitation Services.

(a) Time-based CPT® codes must be billed and paid according to this table: [Table not included. See ED. NOTE.]

(b) Except for CPT® codes 97001, 97002, 97003, or 97004, payment for modalities and therapeutic procedures is limited to a total of three separate CPT®-coded services per day for each provider, identified by their federal tax ID number. An additional unit of time for the same CPT® code does not count as a separate code.

(c) CPT® codes 97032, 97033, 97034, 97035, 97036, and 97039 are time-based codes and require constant attendance. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day or the amount of time spent providing the treatment.

(d) CPT® codes 97010 through 97028 are not payable unless they are performed in conjunction with other procedures or modalities that require constant attendance or knowledge and skill of the licensed medical provider.

(e) When multiple treatments are provided simultaneously by one machine, device, or table there must be a notation on the bill that treatments were provided simultaneously by one machine, device, or table and there must be only one charge.

(7) Reports.

(a) Except as otherwise provided in OAR 436-009-0060, when another medical provider, or an insurer or its representative asks a medical provider to prepare a report, or review records or reports, the medical provider should bill the insurer for their report or review of the records using CPT® codes such as 99080. The bill should include documentation of time spent reviewing the records or reports.

(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider must bill for the time spent reviewing and responding using OSC D0019. The bill should include documentation of time spent.

(8) Nurse Practitioners and Physician Assistants.

Services provided by authorized nurse practitioners, physician assistants, or out-of-state nurse practitioners must be paid at 85 percent of the amount calculated in section (1) of this rule.

[ED. NOTE: Appendices referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 3-2008(Temp), f. & cert. ef. 7-7-08 thru 1-2-09; WCD 5-2008, f. 12-15-08,

cert. ef. 1-1-09; WCD 1-2009, f. 5-22-09, cert. ef. 7-1-09; WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 1-2012, f. 2-16-12, cert. ef. 4-1-12; WCD 2-2013, f. 3-11-13, cert. ef. 4-1-13; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0060
Oregon Specific Codes

(1) Multidisciplinary Services.

(a) Services provided by multidisciplinary programs not otherwise described by CPT® codes must be billed under Oregon specific codes.

(b) When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for a patient, he or she must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(c) Bills using the multidisciplinary codes must include copies of the treatment record that specifies:

(A) The type of service rendered,

(B) The medical provider who provided the service,

(C) Whether treatment was individualized or provided in a group session, and

(D) The amount of time treatment was rendered for each service billed.

(2) Table of all Oregon Specific Codes (For OSC fees, see Appendix B.) [Appendix not included. See ED. NOTE.]

(3) CARF/JCAHO Accredited Programs.

(a) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program will not be paid unless the program is accredited for that purpose by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(b) Organizations that have applied for CARF accreditation, but have not yet received accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. The organizations may provide multidisciplinary services under this section for a period of up to six months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

(c) Notwithstanding OAR 436-009-0010(4)(a), program fees for services within a multidisciplinary program may be used based upon written pre-authorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided. (d) All job site visits and ergonomic consultations must be preauthorized by the insurer.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.248

Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 1-2009, f. 5-22-09, cert. ef. 7-1-09; WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; 2010, f. 5-28-10, cert. ef. 7-1-10; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 2-2013, f. 3-11-13, cert. ef. 4-1-13; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0080
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

(1) Durable medical equipment (DME) is equipment that: is primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients, is appropriate for use in the home, and is not generally useful to a person in the absence of an illness or injury.

Examples: Transcutaneous Electrical Nerve Stimulation (TENS), Microcurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc.

(2) A prosthetic is an artificial substitute for a missing body part or any device aiding performance of a natural function. Examples: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc. The insurer must pay for the repair or replacement of prosthetic appliances damaged as a result of a compensable injury, even if the worker received no other injury. If the appliance is not repairable, the insurer must replace the appliance with a new appliance comparable to the one damaged. If the worker chooses to upgrade the prosthetic appliance, the worker may do so but must pay the difference in price.

(3) An orthosis is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. Examples: brace, splint, shoe insert or modification, etc.

(4) Supplies are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

(5) When billing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), providers must use the following modifiers, when applicable:

(a) NU for purchased, new equipment

(b) UE for purchased, used equipment

(c) RR for rented equipment

(6) Unless otherwise provided by contract or sections (7) through (11) of this rule, insurers must pay for DMEPOS according to the following table: [Table not included. See ED. NOTE.]

(7) Unless a contract establishes a different rate, the table below lists maximum monthly rental rates for the codes listed (do not use Appendix E or section (6) to determine the rental rates for these codes): [Appendix not included. See ED. NOTE.]

(8) For items rented, unless otherwise provided by contract:

(a) The maximum daily rental rate is one thirtieth (1/30) of the monthly rate established in sections (6) and (7) of this rule.

(b) After a rental period of 13 months, the item is considered purchased, if the insurer so chooses.

(c) The insurer may purchase a rental item anytime within the 13-month rental period, with 75 percent of the rental amount paid applied towards the purchase.

(9) For items purchased, unless otherwise provided by contract, the insurer must pay for labor and reasonable expenses at the provider's usual rate for:

(a) Any labor and reasonable expenses directly related to any repairs or modifications subsequent to the initial set-up; or

(b) The provider may offer a service agreement at an additional cost.

(10) Hearing aids must be prescribed by the attending physician, authorized nurse practitioner, or specialist physician. Testing must be done by a licensed audiologist or an otolaryngologist. The preferred types of hearing aids for most patients are programmable behind the ear (BTE), in the ear (ITE), and completely in the canal (CIC) multichannel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner. Unless otherwise provided by contract, insurers must pay the provider's usual fee for hearing services billed with HCPCS codes V5000 through V5999. However, without approval from the insurer or director, the payment for hearing aids may not exceed $5000 for a pair of hearing aids, or $2500 for a single hearing aid.

(11) Unless otherwise provided by contract, insurers must pay the provider's usual fee for vision services billed with HCPCS codes V0000 through V2999.

(12) The worker may select the service provider. For claims enrolled in a managed care organization (MCO) the worker may be required to select a provider from a list specified by the MCO.

(13) Except as provided in section (10) of this rule, the payment amounts established by this rule do not apply to a worker's direct purchase of DMEPOS. Workers are entitled to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(14) DMEPOS dispensed by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

[ED. NOTE: Tables & appendices referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.248

Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 4-2011(Temp) f. 6-30-11, cert. ef. 7-5-11 thru 12-31-11; WCD 5-2011, f. 11-18-11, cert. ef. 1-1-12; WCD 1-2012, f. 2-16-12, cert. ef. 4-1-12; WCD 2-2012(Temp), f. 4-13-12, cert. ef. 4-23-12 thru 10-19-12; WCD 4-2012, f. 9-21-12, cert. ef. 10-20-12; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0090
Pharmaceutical

(1) General.

(a) Unless otherwise provided by an MCO contract, prescription medications do not require prior approval even after the patient is medically stationary.

(b) When a provider prescribes a brand-name drug, pharmacies must dispense the generic drug (if available), according to ORS 689.515. However, a patient may insist on receiving the brand-name drug and either

pay the total cost of the brand-name drug out of pocket or pay the difference between the cost of the brand-name drug and generic to the pharmacy.

(c) Unless otherwise provided by MCO contract, the patient may select the pharmacy.

(2) Pharmaceutical Billing and Payment.

(a) Pharmaceutical billings must contain the National Drug Code (NDC) to identify the drug or biological billed.

(b) All bills from pharmacies must include the prescribing provider's NPI or license number.

(c) Unless otherwise provided by contract, insurers must pay medical providers for prescription medication, including injectable drugs, at the medical provider's usual fee, or the maximum allowable fee, whichever is less. However, drugs provided by a hospital (inpatient or outpatient) must be billed and paid according to OAR 436-009-0020.

(d) Unless directly purchased by the worker (see 009-0025(5)), the maximum allowable fee for pharmaceuticals is calculated according to the following table: [Table not included. See ED. NOTE.]

NOTE: "AWP" means the Average Wholesale Price effective on the date the drug was dispensed.

(e) Insurers must use a nationally published prescription pricing guide for calculating payments to the provider, e.g., First DataBank, RED BOOK, or Medi-Span.

(3) Clinical Justification Form 4909.

(a) The prescribing provider must fill out Form 4909, Pharmaceutical Clinical Justification for Workers' Compensation, and submit it to the insurer when prescribing more than a five day supply of the following drugs:

(A) Celebrex®,

(B) Cymbalta®,

(C) Fentora®,

(D) Kadian®,

(E) Lidoderm®,

(F) Lyrica®, or

(G) OxyContin®.

(b) Insurers may not challenge the adequacy of the clinical justification. However, they may challenge whether or not the medication is excessive, inappropriate, or ineffectual under ORS 656.327.

(c) The prescribing provider is not required to fill out Form 4909 for refills of medications listed on that form.

(d) If a prescribing provider does not submit Form 4909, Pharmaceutical Clinical

Justification for Workers' Compensation, to the insurer, the insurer may file a complaint with the director.

(4) Dispensing by Medical Service Providers.

(a) Except in an emergency, prescription drugs for oral consumption dispensed by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the patient, up to a maximum of 10 days.

(b) For dispensed over-the-counter medications, the insurer must pay the retail-based fee.

[ED. NOTE: Table referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.248

Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 3-2008(Temp), f. & cert. ef. 7-7-08 thru 1-2-09; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; WCD 1-2009, f. 5-22-09, cert. ef. 7-1-09; WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 1-2012, f. 2-16-12, cert. ef. 4-1-12; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0110
Interpreters

(1) Choosing an Interpreter. A patient may choose a person to communicate with a medical provider when the patient and the medical provider speak different languages, including sign language. The patient may choose a family member, a friend, an employee of the medical provider, or an interpreter. The medical provider may disapprove of the patient's choice at any time the medical provider feels the interpreter services are not improving communication with the patient, or feels the interpretation is not complete or accurate.

(2) Billing.

(a) Interpreters must charge the usual fee they charge to the general public for the same service.

(b) Interpreters may only bill an insurer or, if provided by contract, a managed care organization (MCO). However, if the insurer denies the claim, interpreters may bill the patient.

(c) Interpreters may bill for interpreter services and for mileage when the round-trip mileage is 15 or more miles. For the purpose of this rule, "mileage" means the number of miles traveling from the interpreter's starting point to the exam or treatment location and back to the interpreter's starting point.

(d) If the interpreter arrives at the provider's office for an appointment that was required by the insurer or the director, e.g., an independent medical exam, a physician review exam, or an arbiter exam, the interpreter may bill for interpreter services and mileage according to section (2)(c) of this rule even if:

(A) The patient fails to attend the appointment; or

(B) The provider has to cancel or reschedule the appointment.

(e) If interpreters do not know the workers' compensation insurer responsible for the claim, they may contact the Department of Consumer and Business Services', Workers' Compensation Division at 503-947-7814. They may also access insurance policy information at http://www4.cbs.state.or.us/ex/wcd/cov/index.cfm.

(3) Billing and Payment Limitations.

(a) When an appointment was not required by the insurer or director, interpreters may not bill any amount for interpreter services or mileage if:

(A) The patient fails to attend the appointment: or

(B) The provider cancels or reschedules the appointment.

(b) The insurer is not required to pay for interpreter services or mileage when the services are provided by:

(A) A family member or friend of the patient; or

(B) A medical provider's employee.

(4) Billing Timelines.

(a) Interpreters must bill within:

(A) 60 days of the date of service;

(B) 60 days after the interpreter has received notice or knowledge of the responsible workers' compensation insurer or processing agent; or

(C) 60 days after any litigation affecting the compensability of the service is final, if the interpreter receives written notice of the final litigation from the insurer.

(b) If the interpreter bills past the timelines outlined in subsection (a) of this section, the interpreter may be subject to civil penalties as provided in ORS 656.254 and OAR 436-010-0340.

(c) When submitting a bill later than outlined in subsection (a) of this section, an interpreter must establish good cause. Good cause may include, but is not limited to, extenuating circumstances or circumstances considered outside the control of the interpreter.

(d) A bill is considered sent by the date the envelope is post-marked or the date the document is faxed.

(5) Billing Form.

(a) Interpreters must use an invoice when billing for interpreter services and mileage and use Oregon specific code:

(A) D0004 for interpreter services except American Sign Language,

(B) D0005 for American Sign Language interpreter services, and

(C) D0041 for mileage.

(b) An interpreter's invoice must include:

(A) The interpreter's name, the interpreter's company name, if applicable, billing address, and phone number;

(B) The patient's name;

(C) The patient's workers' compensation claim number, if known;

(D) The correct Oregon specific codes for the billed services (D0004, D0005, or D0041);

(E) The workers' compensation insurer's name and address;

(F) The date interpreter services were provided;

(G) The name and address of the medical provider that conducted the exam or provided treatment;

(H) The total amount of time interpreter services were provided; and

(I) The mileage, if the round trip was 15 or more miles.

(6) Payment Calculations.

(a) Unless otherwise provided by contract, insurers must pay the lesser of the maximum allowable payment amount or the interpreter's usual fee.

(b) Insurers must use the following table to calculate the maximum allowable payment for interpreters: [Table not included. See ED. NOTE.]

(7) Payment Requirements.

(a) When the medical exam or treatment is for an accepted claim or condition, the insurer must pay for interpreter services and mileage if the round-trip mileage is 15 or more miles.

(b) When the patient fails to attend or the provider cancels or reschedules a medical exam required by the director or the insurer, the insurer must pay the no-show fee and mileage if the round-trip mileage is 15 or more miles.

(c) The insurer must pay the interpreter within:

(A) 14 days of the date of claim acceptance or any action causing the service to be payable, or 45 days of receiving the invoice, whichever is later; or

(B) 45 days of receiving the invoice for an exam required by the insurer or director.

(d) When an interpreter bills within 12 months of the date of service, the insurer may not reduce payment due to late billing.

(e) When an interpreter bills over 12 months after the date of service, the bill is not payable, except when a provision of subsection (4)(c) of this rule is the reason the billing was submitted after 12 months.

(f) If the insurer does not receive all the information to process the invoice, the insurer must return the invoice to the interpreter within 20 days of receipt. The insurer must provide specific information about what is needed to process the invoice.

(g) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each service billed.

(h) The insurer must provide a written explanation of benefits for services paid or denied and must send the explanation to the interpreter that billed for the services. If the billing is done electronically, the insurer or its representative may provide this explanation electronically. All the information on the written explanation must be in 10 point size font or larger.

(i) Electronic and written explanations must include:

(A) The payment amount for each service billed. When the payment covers multiple patients, the explanation must clearly separate and identify payments for each patient;

(B) The specific reason for non-payment, reduced payment, or discounted payment for each service billed;

(C) An Oregon or toll-free phone number for the insurer or its representative, and a statement that the insurer or its representative must respond to an interpreter's payment questions within 48 hours, excluding weekends and legal holidays;

(D) The following notice, Web link, and phone number:

"To access the information about Oregon's Medical Fee and Payment rules, visit www.oregonwcdoc.info or call 503-947-7606";

(E) Space for a signature and date; and

(F) A notice of the right to administrative review as follows: "If you disagree with this decision about this payment, please contact {the insurer or its representative} first. If you are not satisfied with the response you receive, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of the mailing date of this explanation. To request review, sign and date in the space provided, indicate what you believe is incorrect about the payment, and mail this document with the required supporting documentation to the Workers' Compensation Division, Medical Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-947-7629. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(j) The insurer or its representative must respond to an interpreter's inquiry about payment within 48 hours, not including weekends or legal holidays. The insurer or its representative may not refer the interpreter to another entity to obtain the answer.

(k) The insurer or its representative and an interpreter may agree to send and receive payment information by email or other electronic means. Electronic records sent are subject to the Oregon Consumer Identity Theft Protection Act under ORS 646A.600 to 646A.628 and federal law.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248
Hist.: WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; WCD 1-2012, f. 2-16-12, cert. ef. 4-1-12; WCD 2-2013, f. 3-11-13, cert. ef. 4-1-13; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

436-009-0998
Sanctions and Civil Penalties

(1) The director may impose sanctions upon a medical provider or insurer for violation of these rules in accordance with OAR 436-010-0340.

(2) If an insurer applies a contract or fee discount agreement to a provider's bill that is incorrect, the insurer must pay the provider's bill at the provider's usual fee or according to the fee schedule, whichever is less, and the insurer may be subject to a civil penalty.

(3) Although insurers may contract with provider networks for certain services, the insurer is responsible for their own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provision of these rules, the director may impose a civil penalty against the insurer.

(4) If the director finds a pattern and practice, or an egregious violation of applying incorrect discounts to providers' fees under these rules, by an insurer or someone acting on the insurer's behalf, the director may issue a civil penalty up to the amount allowed under ORS Chapter 656.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.254, 656.745
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09; Renumbered from 436-009-0100 by WCD 3-2010, f. 5-28-10, cert. ef. 7-1-10; Renumbered from 436-009-0199, WCD 1-2011, f. 3-1-11, cert. ef. 4-1-11; WCD 3-2014, f. 3-12-14, cert. ef. 4-1-14; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15; WCD 3-2015, f. 3-12-15, cert. ef. 4-1-15

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Department of Corrections
Chapter 291

Rule Caption: Use of Assessment Tools to Classify Offenders and Assign their Level of Community Supervision
Adm. Order No.: DOC 3-2015
Filed with Sec. of State: 2-25-2015
Certified to be Effective: 2-25-15
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Rules Amended: 291-078-0010, 291-078-0020, 291-078-0026, 291-078-0031
Rules Repealed: 291-078-0010(T), 291-078-0020(T), 291-078-0026(T), 291-078-0031(T)
Subject: These rule amendments are necessary to expressly incorporate by reference and identify by title and file with these rules the risk assessment rules adopted by the department to classify offenders according to risk to assign their level of community supervision. Specifically, these risk assessment tools are the Level of Service/Case Management Inventory, Ontario Domestic Assault Risk Assessment, Public Safety Checklist, Proxy, Static-99R, Stable-2007, and Acute-2007.
Rules Coordinator: Janet R. Worley—(503) 945-0933

291-078-0010
Definitions

(1) Agency: The Department of Corrections or county community corrections agencies.

(2) Case Management: A proactive and collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an offender's risks, needs, and responsivity factors. Case management is the process that links all the elements involved in an offender's management. The process of case management unifies procedures and personnel to balance resources and an offender's needs through their term of community supervision.

(3) Case Plan: A dynamic document created collaboratively with an offender that specifically identifies the offender's evidence-based assessed risk and needs, accompanied by risk reduction strategies and plans of action, with timelines.

(4) Evidence-Based Practices: The body of research and clinical knowledge that describes correctional assessment, programming, and supervision strategies that lead to improved correctional outcomes, such as risk reduction and increased public safety. Such principles not only meet the public's expectations for economical business strategies, efficiency, and effectiveness; but also reflect fairness and accountability.

(5) Intensive Supervision: An enhanced level of supervision exceeding a county's high risk level supervision standards. Intensive supervision may include, but not be limited to, electronic monitoring, house arrest, curfew, day reporting, supervised housing, multiple supervising officers, adjunct surveillance by law enforcement or other specialists, increased face-to-face offender contacts in the community, increased collateral contacts (such as with family, therapist and employer), community notification, geographic restrictions, offender mileage logs, medication monitoring (such as psychotropics, or antabuse), intensive outpatient or residential treatment programming, urinalysis, and polygraph.

(6) Offender: Any person under the supervision of local community corrections who is on probation, parole, or post-prison supervision status.

(7) Risk of Violence: The identified potential of an offender to engage in or threaten to engage in behavior that constitutes physical force and/or the inflicting of injury on another person.

(8) Risk of Recidivism: The likelihood of an offender being convicted of a new felony within three years of release from prison or admission to probation.

(9) Sexually Violent Dangerous Offender (SVDO): A special designation by the Court and/or Board of Parole and Post-Prison Supervision as defined in ORS 144.635 subjecting the offender to intensive supervision for the full period of parole and/or post-prison supervision.

(10) Supervision Intake Date: The date upon which the agency supervisor assigns a new case offender to a supervising/intake officer.

(11) Supervision Period: The period of time an offender is under the supervision of an agency or agencies. The period of supervision may involve multiple cases and is interrupted only by Department of Correction incarceration, transfer of the offender's supervision out of state, case closure due to absconding, or legal termination of the final chronological case.

(12) Supervision Termination Date: The date established by the releasing/sentencing authority when the offender is no longer legally subject to community 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 15-1991, f. & cert. ef. 6-14-91; CD 12-1997, f. 7-23-97, cert. ef. 8-1-97; DOC 9-2012(Temp), f. 8-31-12, cert. ef. 9-1-12 thru 2-28-13; DOC 3-2013, f. & cert. ef. 2-28-13; DOC 19-2014(Temp), f. & cert. ef. 8-29-14 thru 2-25-15; DOC 3-2015, f. & cert. ef. 2-25-15

291-078-0020
Risk Assessment

(1) Proper assessment ensures the classification of offenders according to risk and their assignment to specified levels of community supervision. The following risk assessment tools are utilized by the department and county community corrections agencies for risk assessment of offenders:

(a) Level of Service/Case Management Inventory (LS/CMI) Section 1 General Risk/Need Factors (version Feb. 2013): A validated assessment tool used to determine an offender's risk to recidivate and identify criminogenic risk factors across eight domains Criminal History, Education/Employment, Family/Marital, Leisure/Recreation, Companions, Alcohol/Drug Problem, Procriminal Attitude/Orientation, Antisocial Pattern.

(b) Ontario Domestic Assault Risk Assessment (ODARA) (version June 2004): Actuarial risk assessment tool to assess risk of committing future battering in cases where a man or a woman has assaulted his partner.

(c) Public Safety Checklist (PSC)(version 2005): A statistical calculation developed by the Oregon Criminal Justice Commission in collaboration with the department's research unit to predict an offender's risk to recidivate within three years of release from custody or admission to probation.

(d) Proxy (version 2005): A three question validated risk assessment tool used to identify initial risk for offenders entering probation supervision.

(e) Stable-2007 (version Sept. 2012): Actuarial risk assessment designed to assess risk of sexually recidivating over time using static risk factors used in conjunction Acute-2007.

(f) Acute-2007 (version Aug. 2012): Actuarial risk and needs scale for the assessment of sexual offenders and the probability of sexual and violent recidivism based upon dynamic needs measured at each supervision contact.

(g) Static-99R and Definitions (version 2003, age coding August 2012): A ten item actuarial assessment instrument for use with adult sexual offenders who are at least 18 years of age at the time of admission to supervision.

(h) The risk assessment tools listed in (a) through (g) above are filed with this rule and are available on request from the Department of Corrections or at the Secretary of State's Office.

(2) New Case: Any offender received for community supervision who is not already under community supervision at the time of the admission to supervision shall be considered a new case. A risk assessment must be completed.

(a) The offender shall be considered a new case for a period of up to 30 days commencing with the supervision intake date. Authorization to extend the new case status an additional 30 days may be granted by the supervisor when extenuating circumstances warrant such extension. Approval for the extension may be documented in the case file.

(b) An absconder shall be considered a new case upon return to supervision if he/she has been absent from supervision for a period of six months or longer.

(c) An offender shall be considered a new case upon release from incarceration due to revocation or upon a new felony conviction.

(3) Risk Assessment:

(a) The assessment of risk will involve the use of the PSC, a validated risk assessment tool, which is an objective instrument that groups offenders according to their likelihood to recidivate.

(b) The assessment of risk will rely primarily on automated static risk factors to predict the likelihood to recidivate. The initial risk assessment score will be created as part of new case procedures.

(c) The computer generated score will place the offender in one of three risk levels: high, medium, or low.

(d) If an offender has no in-state arrest history or an extensive out-of-state criminal history, the Proxy risk tool will be used, which is a manual risk assessment tool and will serve as a proxy to the automated risk assessment tool and will determine the initial risk level.

(4) Risk, Needs, and Responsivity Assessment:

(a) The ongoing assessment of offenders risk, needs, and responsivity relies on a combination of both static and dynamic risk factors in order to predict recidivism and identify criminogenic needs and responsivity issues.

(b) The LS/CMI and a case plan, as described in OAR 291-078-0026, will be completed on all offenders determined to be of high or medium risk either by the PSC, Proxy, or by an approved override. The LS/CMI is not required on sexual offenders who are subject to the Stable/Acute and Static-99R.

(c) Offenders will be reassessed using the LS/CMI a minimum of every twelve months, or as circumstances warrant for high and medium level cases.

(d) The LS/CMI is not required on offenders that are assessed at the low level either by the PSC or by an approved override. Low level offenders may be reassessed using the PSC or LS/CMI as circumstances warrant.

(e) Nothing in this rule prevents an agency from completing an LS/CMI on a sexual offender or on a low level offender.

(5) Overrides:

(a) The override feature is intended to address risk factors that may not be included in the objective risk assessment instruments. These factors are based upon:

(A) Dynamic risk factors, which appear to impact the risk the offender poses to the community; or

(B) Policy and/or value statements on the part of the agency regarding the delivery of correctional services.

(b) The override feature provides for either increases or decreases in the level of supervision from that determined through the initial risk assessment score.

(c) All overrides must be based upon static and/or dynamic risk factors identified by one of the following tools, special offender designation, or the offender's availability for supervision:

(A) LS/CMI;
(B) Stable/Acute
(C) ODARA;
(D) SVDO;
(E) Policy; or
(F) Unavailable status, which includes
(i) In custody;
(ii) Warrant/Abscond;
(iii) Residential Treatment;
(iv) CMPO, Compacted Out of State; or
(v) Medical (Hospice, State Hospital, etc.)

(d) The assessing officer must indicate the single most appropriate category on the override screen.

(e) Approval of override requests by the officer's supervisor is not required; however, an agency may require this level of approval.

(f) All overrides must include a comment or a reason for the override.

(g) Supervision level changes due to override shall remain in effect until:

(A) A change in circumstances warrants a reassessment and subsequent adjustment in the level of supervision;

(B) The removal of the override is warranted and consistent with public safety and the reformation of the offender.

(6) In order to ensure a baseline of statewide consistency in the supervision of offenders, three basic levels of supervision have been established: high, medium, and low. The risk instrument shall, in most cases, determine which supervision level is appropriate. The county community corrections manager will establish minimum contact standards for each of the three supervision levels for new cases.

(a) Standards will be in writing with the policies and procedures of the agency.

(b) The county will notify the Department of Corrections of the contact standards so that they can be coded into the Corrections Information System (CIS). The management reports generated by CIS will reflect the actual standards set in the county.

(7) An offender found to be a SVDO, as defined in ORS 144.635, shall be subject to intensive supervision for the full period of the offender's parole and post-prison supervision.

(8) Intensive supervision for the purposes of this rule means an enhanced level of supervision exceeding a county's high risk level supervision standards. Intensive supervision may include, but not be limited to, electronic monitoring, house arrest, curfew, day reporting, supervised housing, multiple supervising officers, adjunct surveillance by law enforcement or other specialists, increased face-to-face offender contacts in the community, increased collateral contacts (such as with family, therapist and employer), community notification, geographic restrictions, offender mileage logs, medication monitoring (such as depo provera, psychotropics, antabuse), intensive outpatient or residential treatment programming, urinalysis, and polygraph.

Stat. Auth.: ORS 144.637, 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 144.637, 179.040, 423.020, 423.030 & 423.075
Hist.: CD 15-1991, f. & cert. ef. 6-14-91; CD 12-1997, f. 7-23-97, cert. ef. 8-1-97; DOC 4-2001, f. & cert. ef. 2-7-01; DOC 9-2012(Temp), f. 8-31-12, cert. ef. 9-1-12 thru 2-28-13; DOC 3-2013, f. & cert. ef. 2-28-13; DOC 19-2014(Temp), f. & cert. ef. 8-29-14 thru 2-25-15; DOC 3-2015, f. & cert. ef. 2-25-15

291-078-0026
Community Case Management and Planning

(1) Community case management and planning is comprised of the following principles:

(a) When all community corrections staff and community stakeholders share appropriate information and assist in the case planning for offenders, both the quality of change and the safety of the community improve. Mutual respect, proper training, and on-going communication and cooperation provide the foundation for community case management;

(b) Case planning begins in the institution for those offenders releasing on parole or post-prison supervision. An effective community case management system will build upon the case planning that occurred in the institution;

(c) Each offender is treated as an individual rather than as a part of a group;

(d) Case management programs and interventions are structured around an individual's risk, need, and responsivity factors;

(e) Case plan programs and interventions contain clear and achievable goals where goal achievement is rewarded;

(f) Positive behaviors and personal accountability are expected in order to achieve goals;

(g) Each offender has the ability to provide input into their case plan;

(h) Quality pro-social interaction between all agency staff and offenders is the expectation and is an evidence-based practice that can be consistently offered throughout the correctional process;

(i) Offenders receive support in various ways, including education, employment, programs, and treatment services;

(j) The emphasis is on being proactive rather than waiting for problems to develop;

(k) Accurate record keeping for monitoring progress is a vital and on-going part of successful community case planning and case management;

(l) Feedback to the offender about case planning and progress is a vital and on-going part of successful community case management; and

(m) Quality assurance measures are utilized to ensure consistency and reliability of community case management techniques, as well as a consistent statewide case management approach.

(2) Individualized case plans shall be prepared on all high and medium risk offenders. Case plans may be prepared on all other offenders.

(a) The case plan will identify interventions, supervision strategies, programming, treatment, and educational/employment activities that are appropriate to the offender's strengths and needs;

(b) The case plan will promote positive change and assist in developing pro-social behaviors;

(c) The case plan process is intended to be collaborative in nature;

(d) The automated case plan in the Case Management Module shall be used when creating a case plan;

(e) Components of each case plan should contain or identify:

(A) Prioritized goals based upon assessments such as the LS/CMI, Stable/Acute and Static 99R, ODARA, (as referenced in this rule division) mental health status, or any other instruments assessing need or risk to recidivate;

(B) Desired outcomes for each goal;

(C) Action steps or tasks linking the offender to the appropriate services;

(i) Are time sensitive, measurable, achievable, and specific;

(ii) Are time specific and should not be identified as a range (e.g. 30-60 days) or as an unspecified period of time, (e.g. as needed);

(iii) Should identify who is responsible for accomplishing the action steps/tasks; and

(iv) Should prioritize completion dates.

(3) Officers should routinely review the case plan with the offender and modifications should be made as indicated by the offender's behavior, compliance with the plan, and responsivity to change.

(a) Progress should be outcome oriented, measurable, and recorded in case plan;

(b) When goals and action steps are completed, they should be replaced by the next prioritized risk/need areas identified.

(4) Reentry and release planning are part of the case planning process.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: DOC 9-2012(Temp), f. 8-31-12, cert. ef. 9-1-12 thru 2-28-13; DOC 3-2013, f. & cert. ef. 2-28-13; DOC 19-2014(Temp), f. & cert. ef. 8-29-14 thru 2-25-15; DOC 3-2015, f. & cert. ef. 2-25-15

291-078-0031
Validation/Evaluation

(1) The Department of Corrections will subject the PSC to periodic validation in order to ensure that the tool is predicting risk within acceptable ranges.

(2) Evaluation of the community case management system will occur through:

(a) The ongoing assessment of operations through the operational review system;

(b) The ongoing informal feedback of users and recommendations of the Oregon Association of Community Corrections Directors Risk Assessment Workgroup; and

(c) The formal written evaluation of the system to determine operational effectiveness and accomplishments of identified purposes.

(3) A formal evaluation will occur at no more than five-year intervals.

(4) Each agency is responsible for quality assurances measures within their county.

(a) Case plans should be reviewed a minimum of every six months for high and medium cases and as needed for all other cases;

(b) Internal quality assurance measures such as peer review and supervisor audits should be used to maximize consistency and reliability of case management tasks. These reviews should be conducted on a regular basis as determined by the agency.

(c) Internal quality assurance may include:

(A) Spot checks of assessments, which may include the LS/CMI and Stable/Acute and Static 99R (as referenced in this rule division);

(B) Review of case plan development and maintenance;

(C) Observation, review, and feedback of LS/CMI (as referenced in this rule division) interviews or motivational interviews;

(D) Proper use of supervision overrides;

(E) Accurate and appropriate case documentation; and/or

(F) Adherence to case plan policies and procedures.

(d) External quality assurance measures, including peer review and formal audits, may be used to ensure a statewide case management practice.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: DOC 9-2012(Temp), f. 8-31-12, cert. ef. 9-1-12 thru 2-28-13; DOC 3-2013, f. & cert. ef. 2-28-13; DOC 19-2014(Temp), f. & cert. ef. 8-29-14 thru 2-25-15; DOC 3-2015, f. & cert. ef. 2-25-15

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Department of Fish and Wildlife
Chapter 635

Rule Caption: Treaty Indian Winter Commercial Fisheries in Zone 6 of the Columbia River Modified.
Adm. Order No.: DFW 13-2015(Temp)
Filed with Sec. of State: 2-19-2015
Certified to be Effective: 2-20-15 thru 3-31-15
Notice Publication Date:
Rules Amended: 635-041-0065
Rules Suspended: 635-041-0065(T)

Subject: This amended rule modifies the Treaty Indian winter gill net commercial season. These modifications extend the period for commercial sales, in Oregon, of white sturgeon caught The Dalles, and John Day pools by tribal fishers from 6:00 p.m. Friday, February 20 to 6:00 p.m. Tuesday, February 24, 2015. Modifications are consistent with action taken February 19, 2015 by the Oregon and Washington Departments of Fish and Wildlife, in cooperation with the Columbia River Treaty Tribes, in a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-041-0065
Winter Salmon Season

(1) Salmon, steelhead, shad, walleye, catfish, bass, yellow perch, and carp may be taken for commercial purposes in the Columbia River Treaty Indian platform and hook-and-line fisheries from:

(a) The Dalles and John Day pools in the Columbia River Treaty Indian hook-and-line fisheries 6:00 a.m. Monday, February 2 through 6:00 p.m. Friday, February 20, 2015; and

(b) The Bonneville Pool, 6:00 a.m. Monday, February 2 through 5:59 a.m. Monday, February 23, 2015.

(c) Gear used in the fisheries described above is restricted to subsistence fishing gear which includes hoopnets, dipnets, and rod and reel with hook-and-line.

(d) Salmon, steelhead, shad, yellow perch, bass, walleye, catfish and carp landed during any open fishing period may be sold at any time or retained for subsistence purposes. White sturgeon between 43 and 54 inches in fork length taken from The Dalles and John Day pools during any open period may be sold at any time or kept for subsistence purposes. White sturgeon between 38 and 54 inches in fork length taken from the Bonneville Pool may not be sold but may be kept for subsistence purposes. Live release of all undersize or oversize white sturgeon is required.

(2) Salmon, steelhead, shad, walleye, catfish, bass, yellow perch, carp and white sturgeon may be taken for commercial purposes in the Columbia River Treaty Indian gill net fisheries from:

(a) The Dalles and John Day pools beginning 6:00 a.m. Monday, February 2 through 6:00 p.m. Tuesday, February 24, 2015; and

(b) The Bonneville Pool beginning 6:00 a.m. Monday, February 23 through 6:00 p.m. Saturday, March 21, 2015.

(c) Gear is restricted to gill nets. There are no mesh size restrictions.

(d) Salmon, steelhead, shad, yellow perch, bass, walleye, catfish and carp landed during any open fishing period may be sold at any time or retained for subsistence purposes. White sturgeon between 43 and 54 inches in fork length from The Dalles and John Day pools and white sturgeon between 38 and 54 inches in fork length from the Bonneville Pool that are taken during any open period may be sold at any time or kept for subsistence purposes. Live release of all undersize or oversize white sturgeon is required.

(3) Closed areas as set forth in OAR 635-041-0045 are in effect.

Stat. Auth.: ORS 496.118 & 506.119
Stats. Implemented: ORS 506.109, 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79; FWC 13-1979(Temp), f. & ef. 3-30-1979, Renumbered from 635-035-0065; FWC 6-1980, f. & ef. 1-28-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 2-1983, f. 1-21-83, ef. 2-1-83; FWC 4-1984, f. & ef. 1-31-84; FWC 2-1985, f. & ef. l-30-85; FWC 4-1986(Temp), f. & ef. 1-28-86; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 3-1988(Temp), f. & cert. ef. 1-29-88; FWC 10-1988, f. & cert. ef. 3-4-88; FWC 5-1989, f. 2-6-89, cert. ef. 2-7-89; FWC 13-1989(Temp), f. & cert. ef. 3-21-89; FWC 15-1990(Temp), f. 2-8-90, cert. ef. 2-9-90; FWC 20-1990, f. 3-6-90, cert. ef. 3-15-90; FWC 13-1992(Temp), f. & cert. ef. 3-5-92; FWC 7-1993, f. & cert. ef. 2-1-93; FWC 12-1993(Temp), f. & cert. ef. 2-22-93; FWC 18-1993(Temp), f. & cert. ef. 3-2-93; FWC 7-1994, f. & cert. ef. 2-1-94; FWC 11-1994(Temp), f. & cert. ef. 2-28-94; FWC 9-1995, f. & cert. ef. 2-1-95; FWC 19-1995(Temp), f. & cert. ef. 3-3-95; FWC 5-1996, f. & cert. ef. 2-7-96; FWC 4-1997, f. & cert. ef. 1-30-97; DFW 8-1998(Temp), f. & cert. ef. 2-5-98 thru 2-28-98; DFW 14-1998, f. & cert. ef. 3-3-98; DFW 20-1998(Temp), f. & cert. ef. 3-13-98 thru 3-20-98; DFW 23-1998(Temp), f. & cert. ef. 3-20-98 thru 6-30-98; DFW 2-1999(Temp), f. & cert. ef. 2-1-99 through 2-19-99; DFW 9-1999, f. & cert. ef. 2-26-99; DFW 14-1999(Temp), f. 3-5-99, cert. ef. 3-6-99 thru 3-20-99; Administrative correction 11-17-99; DFW 6-2000(Temp), f. & cert. ef. 2-1-00 thru 2-29-00; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 19-2000, f. 3-18-00, cert. ef. 3-18-00 thru 3-21-00; DFW 26-2000(Temp), f. 5-4-00, cert. ef. 5-6-00 thru 5-28-00; Administrative correction 5-22-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 14-2001(Temp), f. 3-12-01, cert. ef. 3-14-01 thru 3-21-01; Administrative correction 6-20-01; DFW 9-2002, f. & cert. ef. 2-1-02; DFW 11-2002(Temp), f. & cert. ef. 2-8-02 thru 8-7-02; DFW 17-2002(Temp), f. 3-7-02, cert. ef. 3-8-02 thru 9-1-02; DFW 18-2002(Temp), f. 3-13-02, cert. ef. 3-15-02 thru 9-11-02; DFW 134-2002(Temp), f. & cert. ef. 12-19-02 thru 4-1-03; DFW 20-2003(Temp), f. 3-12-03, cert. ef. 3-13-03 thru 4-1-03; DFW 131-2003(Temp), f. 12-26-03, cert. ef. 1-1-04 thru 4-1-04; DFW 5-2004(Temp), f. 1-26-04, cert. ef. 2-2-04 thru 4-1-04; DFW 15-2004(Temp), f. 3-8-04, cert. ef. 3-10-04 thru 4-1-04; DFW 130-2004(Temp), f. 12-23-04, cert. ef. 1-1-05 thru 4-1-05; DFW 4-2005(Temp), f. & cert. ef 1-31-05 thru 4-1-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 3-2006(Temp), f. & cert. ef. 1-27-06 thru 3-31-06; Administrative correction 4-19-06; DFW 7-2007(Temp), f. 1-31-07, cert. ef. 2-1-07 thru 7-30-07; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 14-2007(Temp), f. & cert. ef. 3-9-07 thru 9-4-07; DFW 15-2007(Temp), f. & cert. ef. 3-14-07 thru 9-9-07; Administrative correction 9-16-07; DFW 6-2008(Temp), f. 1-29-08, cert. ef. 1-31-08 thru 7-28-08; DFW 20-2008(Temp), f. 2-28-08, cert. ef. 2-29-08 thru 7-28-08; DFW 21-2008(Temp), f. & cert. ef. 3-5-08 thru 7-28-08; DFW 22-2008(Temp), f. 3-7-08, cert. ef. 3-10-08 thru 7-28-08; Administrative correction 8-21-08; DFW 142-2008, f. & cert. ef. 11-21-08; DFW 6-2009(Temp), f. 1-30-09, cert. ef. 2-2-09 thru 8-1-09; DFW 11-2009(Temp), f. 2-13-09, cert. ef. 2-16-09 thru 7-31-09; DFW 22-2009(Temp), f. 3-5-09, cert. ef. 3-6-09 thru 7-31-09; Administrative correction 8-21-09; DFW 9-2010(Temp), f. & cert. ef. 2-3-10 thru 8-1-10; DFW 12-2010(Temp), f. 2-10-10, cert. ef. 2-11-10 thru 8-1-10; DFW 18-2010(Temp), f. 2-24-10, cert. ef. 2-26-10 thru 4-1-10; DFW 24-2010(Temp), f. 3-2-10, cert. ef. 3-3-10 thru 4-1-10; Administrative correction 4-21-10; DFW 8-2011(Temp), f. 1-31-11, cert. ef. 2-1-11 thru 4-1-11; DFW 9-2011(Temp), f. 2-9-11, cert. ef. 2-10-11 thru 4-1-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 5-2012(Temp), f. 1-30-12, cert. ef. 2-1-12 thru 3-31-12; DFW 18-2012(Temp), f. 2-28-12, cert. ef. 2-29-12 thru 6-15-12; DFW 19-2012(Temp), f. 3-2-12, cert. ef. 3-5-12 thru 6-15-12; DFW 20-2012(Temp), f. & cert. ef. 3-5-12 thru 6-15-12; DFW 46-2012(Temp), f. 5-14-12, cert. ef. 5-15-12 thru 6-30-12; Administrative correction, 8-1-12; DFW 9-2013(Temp), f. 1-31-13, cert. ef. 2-1-13 thru 3-31-13; DFW 15-2013(Temp), f. 2-22-13, cert. ef. 2-27-13 thru 6-15-13; DFW 18-2013(Temp), f. 3-5-13, cert. ef. 3-6-13 thru 6-15-13; DFW 35-2013(Temp), f. & cert. ef. 5-21-13 thru 6-30-13; DFW 48-2013(Temp), f. 6-7-13, cert. ef. 6-8-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 6-2014(Temp), f. 1-30-14, cert. ef. 2-1-14 thru 7-30-14; DFW 15-2014(Temp), f. 2-25-14, cert. ef. 2-26-14 thru 7-30-14; DFW 17-2014(Temp), f. 2-28-14, cert. ef. 3-1-14 thru 7-30-14; DFW 23-2014(Temp), f. 3-11-14, cert. ef. 3-12-14 thru 7-31-14; DFW 37-2014(Temp), f. & cert. ef. 5-6-14 thru 7-31-14; DFW 46-2014(Temp), f. 5-19-14, cert. ef. 5-20-14 thru 7-31-14; DFW 48-2014(Temp), f. 5-27-14, cert. ef. 5-28-14 thru 7-31-13; DFW 54-2014(Temp), f. 6-2-14, cert. ef. 6-3-14 thru 7-31-14; DFW 59-2014(Temp), f. 6-9-14, cert. ef. 6-10-14 thru 7-31-14; Administrative correction, 8-28-14; DFW 9-2015(Temp), f. 1-29-15, cert. ef. 2-2-15 thru 3-31-15; DFW 13-2015(Temp), f. 2-19-15, cert. ef. 2-20-15 thru 3-31-15

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Rule Caption: Oregon Department of Fish and Wildlife Art Contests
Adm. Order No.: DFW 14-2015
Filed with Sec. of State: 2-25-2015
Certified to be Effective: 2-25-15
Notice Publication Date: 1-1-2015
Rules Amended: 635-095-0100, 635-095-0105, 635-095-0111, 635-095-0125
Rules Repealed: 635-053-0100, 635-053-0105, 635-053-0111, 635-053-0125
Subject: Amend rules to consolidate and streamline the three ODFW art contests (Habitat Conservation Stamp, Upland Game Bird Stamp and Waterfowl Stamp.)
Rules Coordinator: Michelle Tate—(503) 947-6044

635-095-0100
Purpose

The purpose of these rules is to describe the procedures and necessary accompanying information for submission of artwork for the Habitat Conservation, Upland Game Bird, and Waterfowl Stamp art competitions, selection of the winning entries, obligations of the winning artists, and sales provisions pursuant to ORS Chapter 496.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.303, 496.550, 496.555, 496.558, 496.562, 496.566, 496.571, 497.151, 497.153, 497
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.303, 496.550, 496.555, 496.558, 496.562, 496.566, 496.571, 497.151, 497.153
Hist.: DFW 13-2012, f. & cert. ef. 2-10-12; DFW 65-2014, f. 6-11-14, cert. ef. 7-4-14; DFW 14-2015, f. & cert. ef. 2-25-15

635-095-0105
Submission of Artwork: Requirements

(1) Applicants shall submit artwork for the Habitat Conservation, Upland Game Bird, and

Waterfowl Stamp art competitions to the Department headquarters office (4034 Fairview Industrial Drive SE, Salem, OR 97302) between the last Friday of August and 5:00 p.m. on the last Friday of September preceding the respective stamp year.

(2) Artwork shall feature eligible species. A list of eligible species for each contest will be provided on the respective Art Competition Entry Form for the corresponding stamp year.

(3) Artist depictions must be identifiable as an eligible species or will be disqualified from the competition.

(4) Image size of each entry shall measure 13 inches by 18 inches (horizontal or vertical) and shall be in any full color medium.

(5) No photographs, sculptures, fabric art, computer-generated or computer-enhanced art, or carvings will be accepted.

(6) The artwork shall be the artist's original creation. A direct copy of another person's artwork or photograph is not acceptable.

(7) The artwork shall be unsigned by the artist. Any signed artwork will be disqualified.

(8) Artwork previously used in production or entered into any state or federal stamp competition, including Oregon, will be disqualified.

(9) The artwork shall be completely dry. The Department is not responsible for damage to any artwork submitted wet or uncured.

(10) The entry shall be mounted and/or matted (white only), but it shall not be framed or under glass.

(11) All entries must be submitted in sturdy reusable containers. Artwork will be returned to the artist in the same packaging as originally submitted. The Department will not be liable for loss or damage during shipment to or from the Department's office.

(12) It is the responsibility of each entrant to obtain adequate property insurance coverage for their contest submission. The Department assumes no liability for damage, loss, or theft of any entry.

(13) Artists may submit more than one entry meeting the requirements herein.

(14) Each artist shall submit with each entry a completed Art Competition Entry Form provided by the Department. The Department reserves the right to use this information for publicity should the work be selected.

(15) Department employees are not eligible to participate in the contests.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.303, 496.550, 496.555, 496.558, 496.562, 496.566, 496.571, 497.151, 497.153, 497.156
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.303, 496.550, 496.555, 496.558, 496.562, 496.566, 496.571, 497.151, 497.153
Hist.: DFW 13-2012, f. & cert. ef. 2-10-12; DFW 57-2012, f. & cert. ef. 6-11-12; DFW 65-2014, f. 6-11-14, cert. ef. 7-4-14; DFW 14-2015, f. & cert. ef. 2-25-15

635-095-0111
Selection Process and Criteria

(1) Winning entries shall be selected by a five-member panel including one Fish and Wildlife Commission member and four citizens appointed by the Director or their designee. Panel members may include representatives from the art community, wildlife profession, news media and conservation organizations.

(2) The selection panel shall choose winning artwork based on:

(a) Artistic composition;

(b) Anatomical accuracy;

(c) Habitat accuracy;

(d) General rendering;

(e) Background; and

(f) General appeal.

(3) All artwork submissions shall be made available for public viewing following selection of the winning entries.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.303, 496.550, 496.555, 496.571, 497.151, 497.153, 497.156
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.303, 496.550, 496.555, 496.571, 497.151, 497.153
Stat. Auth.: ORS 496.012, 496.138 & HB 2127 (2011) (2011 OL Ch. 50)ter 50)
Stats. Implemented: ORS 496 & HB 2127 (2011) (2011 OL Ch. 50)
Hist.: DFW 13-2012, f. & cert. ef. 2-10-12; DFW 14-2015, f. & cert. ef. 2-25-15

635-095-0125
Other Provisions

(1) The fee for the Habitat Conservation Stamp is $18.00 (plus $2.00 agent fee).

(2) Sale of Habitat Conservation Stamps by the Department shall end at the close of business on December 31, of the respective year

(3) Sale of Upland Game Bird and Waterfowl Stamps by the Department shall end at the close of business on June 30, of the respective year.

(4) If prints of winning entries are produced, up to 200 stamps with numbers corresponding with the prints signed by the artist will be retained past the sales deadlines specified above. These stamps will only be sold with the sale of the corresponding prints.

(5) The Department shall award two thousand dollars ($2,000) to the winning artist of each of the stamp contests.

(6) The winning entries shall become the exclusive property of the Department.

(7) The Department shall retain all reproduction rights of winning entries.

(8) The winning artist for each contest shall sign, at no charge, up to two hundred fifty (250) prints and/or stamps for sale by the Department

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.303, 496.550, 496.555, 496.558, 496.562, 496.566, 496.571, 497.151, 497.153, 497
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.303, 496.550, 496.555, 496.558, 496.562, 496.566, 496.571, 497.151, 497.153
Stat. Auth.: ORS 496.012, 496.138, HB 2127, 2011 OL Ch. 50
Stats. Implemented: ORS 496, HB 2127, 2011 OL Ch. 50
Hist.: DFW 13-2012, f. & cert. ef. 2-10-12; DFW 57-2012, f. & cert. ef. 6-11-12; DFW 156-2012(Temp), f. & cert. ef. 12-31-12 thru 6-28-13; DFW 51-2013, f. & cert. ef. 6-10-13; DFW 65-2014, f. 6-11-14, cert. ef. 7-4-14; DFW 88-2014(Temp), f. & cert. ef. 7-7-14 thru 12-31-14; Administrative correction, 1-27-15; DFW 14-2015, f. & cert. ef. 2-25-15

Rule Caption: Establish 2015 Seasons and Regulations for Game Mammals
Adm. Order No.: DFW 15-2015
Filed with Sec. of State: 2-26-2015
Certified to be Effective: 2-26-15
Notice Publication Date: 9-1-2014
Rules Amended: 635-068-0000, 635-069-0000, 635-073-0000, 635-073-0015
Subject: Establish 2015 hunting regulations for game mammals, including season dates, bag limits, areas, methods and other restrictions.
Rules Coordinator: Michelle Tate—(503) 947-6044

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 2014 are listed in Tables 1 and 2 and are adopted and incorporated into OAR chapter 635, division 68 by reference.

(3) OAR chapter 635, division 68 incorporates, by reference, the requirements for hunting western Oregon deer set out in the document entitled "2015 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the "2015 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.

(4) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

[ED. NOTE: Tables & 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; DFW 125-2006, f. 12-4-06, cert. ef. 3-1-07; DFW 42-2007, f. & cert. ef. 6-14-07; DFW 116-2007, f. 10-31-07, cert. ef. 3-1-08; DFW 60-2008, f. & cert. 6-12-08; DFW 13-2009, f. 2-19-09, cert. ef. 3-1-09; DFW 66-2009, f. & cert. ef. 6-10-09; DFW 14-2010, f. 2-16-10, cert. ef. 3-1-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 14-2011, f. 2-15-11, cert. ef. 3-1-11; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 15-2012, f. 2-10-12, cert. ef. 3-1-12; DFW 58-2012, f. & cert. ef. 6-11-12; DFW 14-2013, f. 2-15-13, cert. ef. 3-1-13; DFW 53-2013, f. & cert. ef. 6-10-13; DFW 122-2013, f. & cert. ef. 10-25-13; DFW 16-2014, f. & cert. ef. 2-27-14; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 15-2015, f. & cert. ef. 2-26-15

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 2014 are listed in Tables 1 and 2 and are adopted and incorporated into OAR Chapter 635, Division 69 by reference.

(3) OAR Chapter 635, Division 69 incorporates, by reference, the requirements for hunting eastern Oregon deer set out in the document entitled "2015 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the "2015 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 and website of the Oregon Department of Fish and Wildlife.

(4) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

[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; DFW 124-2006, f. 12-7-06, cert. ef. 2-1-07; DFW 42-2007, f. & cert. ef. 6-14-07; DFW 117-2007, f. 10-31-07, cert. ef. 2-1-08; DFW 60-2008, f. & cert. 6-12-08; DFW 8-2009, f. & cert. ef. 2-3-09; DFW 66-2009, f. & cert. ef. 6-10-09; DFW 4-2010, f. 1-12-10, cert. ef. 2-1-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 7-2011, f. 1-31-11, cert. ef. 2-1-11; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 3-2012, f. 1-13-12, cert. ef. 2-1-12; DFW 58-2012, f. & cert. ef. 6-11-12; DFW 4-2013, f. 1-15-13, cert. ef. 2-1-13; DFW 53-2013, f. & cert. ef. 6-10-13; DFW 3-2014, f. & cert. ef. 1-22-14; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 15-2015, f. & cert. ef. 2-26-15

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 2014 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 73 by reference.

(3) OAR chapter 73 incorporates, by reference, the requirements for bow and muzzleloader hunting and controlled deer and elk youth hunts set out in the document entitled "2015 Oregon Big Game Regulations," into Oregon Administrative Rules. Therefore, persons must consult the "2015 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 and website of the Oregon Department of Fish and Wildlife.

(4) Additional regulation information is available on the Oregon Department of Fish and Wildlife website at www.odfw.com.

[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; DFW 124-2006, f. 12-7-06, cert. ef. 2-1-07; DFW 42-2007, f. & cert. ef. 6-14-07; DFW 117-2007, f. 10-31-07, cert. ef. 2-1-08; DFW 60-2008, f. & cert. 6-12-08; DFW 8-2009, f. & cert. ef. 2-3-09; DFW 66-2009, f. & cert. ef. 6-10-09; DFW 4-2010, f. 1-12-10, cert. ef. 2-1-10; DFW 83-2010, f. & cert. ef. 6-15-10; DFW 7-2011, f. 1-31-11, cert. ef. 2-1-11; DFW 62-2011, f. & cert. ef. 6-3-11; DFW 3-2012, f. 1-13-12, cert. ef. 2-1-12; DFW 58-2012, f. & cert. ef. 6-11-12; DFW 4-2013, f. 1-15-13, cert. ef. 2-1-13; DFW 53-2013, f. & cert. ef. 6-10-13; DFW 3-2014, f. & cert. ef. 1-22-14; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 89-2014(Temp), f. & cert. ef. 7-7-14 thru 11-1-14; Administrative correction 11-24-14; DFW 15-2015, f. & cert. ef. 2-26-15

635-073-0015
Late Eastern Oregon Deer Bowhunting Seasons

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 123, f. & ef. 6-9-77; FWC 33-1978, f. & ef. 6-30-78; FWC 28-1979, f. & ef. 8-2-79; FWC 33-1980, f. & ef. 6-30-80; FWC 6-1981, f. & ef. 1-23-81; FWC 11-1981, f. & ef. 3-31-81; FWC 20-1981, f. & ef. 6-19-81; FWC 37-1982, f. & ef. 6-25-82, Renumbered from 635-065-0525; 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 35-1986, f. & ef. 8-7-86; FWC 63-1986, f. & ef. 10-2-86; FWC 47-1987, f. & ef. 7-6-87; FWC 44-1988, f. & cert. ef. 6-13-88; FWC 71-1989, f. & cert. ef. 8-15-89; FWC 63-1990, f. & cert. ef. 6-21-90; FWC 66-1991, f. & cert. ef. 6-24-91; FWC 116-1991, f. & cert. ef. 9-30-91; FWC 51-1992, f. & cert. ef. 7-15-92; FWC 36-1993, f. & cert. ef. 6-14-93; FWC 18-1994, f. 3-30-94, cert. ef. 5-1-94; FWC 6-1995, f. 1-23-95, cert. ef. 4-1-95; FWC 9-1997, f. & cert. ef. 2-27-97; DFW 63-2014, f. & cert. ef. 6-10-14; DFW 15-2015, f. & cert. ef. 2-26-15

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Rule Caption: Columbia River Recreational Seasons for Salmon and Steelhead Modified.
Adm. Order No.: DFW 16-2015(Temp)
Filed with Sec. of State: 3-5-2015
Certified to be Effective: 3-5-15 thru 6-15-15
Notice Publication Date:
Rules Amended: 635-023-0125
Rules Suspended: 635-023-0125(T)
Subject: This amended rule modifies regulations for Columbia River recreational spring Chinook and steelhead seasons with descriptions of areas, dates, and bag limits for harvest of adipose fin-clipped Chinook salmon and adipose fin-clipped steelhead. Revisions are consistent with action previously taken by the Washington Department of Fish and Wildlife.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-023-0125
Spring Sport Fishery

(1) The **2015 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 **2015 Oregon Sport Fishing Regulations**.

(2) The Columbia River recreational salmon and steelhead fishery downstream of Bonneville Dam is open from the mouth at Buoy 10 upstream to Beacon Rock (boat and bank) plus bank angling only from Beacon Rock upstream to the Bonneville Dam deadline from Sunday, March 1 through Friday, April 10, 2015, except closed Tuesday, March 24, Tuesday, March 31, and Tuesday, April 7, 2015 (38 retention days) with the following restrictions:

(a) No more than two adult adipose fin-clipped salmonids, of which only one may be a Chinook, may be retained per day. All non-adipose fin-clipped salmon and non-adipose fin-clipped steelhead must be released immediately unharmed.

(b) All other permanent **2015 Oregon Sport Fishing Regulations**.

(c) The upstream boat boundary at Beacon Rock is defined as: "a deadline marker on the Oregon bank (approximately four miles downstream from Bonneville Dam Powerhouse One) in a straight line through the western tip of Pierce Island to a deadline marker on the Washington bank at Beacon Rock."

(3) The Columbia River recreational steelhead fishery upstream of Bonneville Dam to the Oregon/Washington border is open for retention of adipose fin-clipped steelhead from Sunday, March 1 through Sunday, March 15, 2015. All other permanent **2015 Oregon Sport Fishing Regulations** apply.

(4) The Columbia River recreational salmon and steelhead fishery upstream of the Tower Island power lines (approximately 6 miles below The Dalles Dam) to the Oregon/Washington border, plus the Oregon and Washington banks between Bonneville Dam and the Tower Island power lines is open for retention of adipose fin-clipped Chinook and adipose fin-clipped steelhead from Monday, March 16 through Wednesday, May 6, 2015 (52 retention days) with the following restrictions:

(a) No more than two adult adipose fin-clipped salmonids, of which only one may be a Chinook, may be retained per day. All non-adipose fin-clipped salmon and non-adipose fin-clipped steelhead must be released immediately unharmed.

(b) All other permanent **2015 Oregon Sport Fishing Regulations** apply.

(5) The Columbia River Select Area recreational salmon and steelhead fisheries are open from March 1 through June 15 with the following restrictions:

(a) On days when the recreational fishery below Bonneville Dam is open to retention of Chinook, the salmonid daily bag limit in Select Areas will be the same as mainstem Columbia River bag limits; and

(b) On days when the mainstem Columbia River fishery is closed to Chinook retention, the permanent salmonid bag limit regulations for Select Areas apply.

(6) The mainstem Columbia River will be open March 1 through May 15, 2015 for retention of adipose fin-clipped steelhead and shad only during days and in areas open for retention of adipose fin-clipped spring Chinook.

(7) Oregon tributary recreational smelt fishery in the Sandy River (bank only) is open from 6:00 a.m. to noon Saturday, March 7 and 6:00 a.m. to noon Sunday, March 15, 2015 with the following restrictions:

(a) Only dip net gear may be used.

(b) The daily limit is 10 pounds per person.

[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; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 7-2007(Temp), f. 1-31-07, cert. ef. 2-1-07 thru 7-30-07; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 28-2007(Temp), f. & cert. ef. 4-26-07 thru 7-26-07; DFW 33-2007(Temp), f. 5-15-07, cert. ef. 5-16-07 thru 7-30-07; DFW 37-2007(Temp), f. & cert. ef. 5-31-07 thru 7-30-07; DFW 39-2007(Temp), f. 6-5-07, cert. ef. 6-6-07 thru 7-31-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 13-2008(Temp), f. 2-21-08, cert. ef. 2-25-08 thru 8-22-08; DFW 17-2008(Temp), f. & cert. ef. 2-27-08 thru 8-22-08; DFW 35-2008(Temp), f. 4-17-08, cert. ef. 4-21-08 thru 8-22-08; DFW 49-2008(Temp), f. & cert. ef. 5-13-08 thru 6-15-08; Administrative correction 7-22-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 10-2009(Temp), f. 2-13-09, cert. ef. 3-1-09 thru 6-15-09; DFW 18-2009, f. & cert. ef. 2-26-09; DFW 48-2009(Temp), f. 5-14-09, cert. ef. 5-15-09 thru 6-16-09; DFW 68-2009(Temp), f. 6-11-09, cert. ef. 6-12-09 thru 6-16-09; Administrative correction 7-21-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 19-2010(Temp), f. 2-26-10, cert. ef. 3-1-10 thru 8-27-10; DFW 23-2010(Temp), f. & cert. ef. 3-2-10 thru 8-27-10; DFW 45-2010(Temp), f. 4-21-10, cert. ef. 4-24-10 thru 7-31-10; DFW 49-2010(Temp), f. 4-27-10, cert. ef. 4-29-10 thru 7-31-10; DFW 55-2010(Temp), f. 5-7-10, cert. ef. 5-8-10 thru 7-31-10; Suspended by DFW 88-2010(Temp), f. 6-25-10, cert. ef. 6-26-10 thru 7-31-10; Administrative correction 8-18-10; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 13-2011(Temp), f. & cert. ef. 2-14-11 thru 6-15-11; DFW 28-2011(Temp), f. 4-7-11, cert. ef. 4-8-11 thru 6-15-11; DFW 30-2011(Temp), f. 4-15-11, cert. ef. 4-16-11 thru 6-15-11; DFW 33-2011(Temp), f. & cert. ef. 4-21-11 thru 6-15-11; DFW 39-2011(Temp), f. 5-5-11, cert. ef. 5-7-11 thru 6-15-11; DFW 48-2011(Temp), f. 5-13-11, cert. ef. 5-15-11 thru 6-15-11; DFW 55-2011(Temp), f. 5-25-11, cert. ef. 5-27-11 thru 6-15-11; DFW 59-2011(Temp), f. & cert. ef. 6-2-11 thru 6-15-11; Administrative correction 6-28-11; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 8-2012(Temp), f. 2-6-12, cert. ef. 2-15-12 thru 6-15-12; DFW 31-2012(Temp), f. 4-5-12, cert. ef. 4-6-12 thru 6-15-12; DFW 33-2012(Temp), f. 4-12-12, cert. ef. 4-14-12 thru 6-15-12; DFW 45-2012(Temp), f. 5-1-12, cert. ef. 5-2-12 thru 7-31-12; DFW 47-2012(Temp), f. 5-15-12, cert. ef. 5-16-12 thru 7-31-12; DFW 49-2012(Temp), f. 5-18-12, cert. ef. 5-19-12 thru 7-31-12; DFW 51-2012(Temp), f. 5-23-12, cert. ef. 5-26-12 thru 7-31-12; Suspended by DFW 85-2012(Temp), f. 7-6-12, cert. ef. 7-9-12 thru 8-31-12; DFW 149-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 12-2013(Temp), f. 2-12-13, cert. ef. 2-28-13 thru 7-31-13; DFW 26-2013(Temp), f. 4-4-13, cert. ef. 4-5-13 thru 7-1-13; DFW 38-2013(Temp), f. 5-22-13, cert. ef. 5-25-13 thru 7-1-13; DFW 49-2013(Temp), f. 6-7-13, cert. ef. 6-8-13 thru 6-30-13; Administrative correction, 7-18-13; DFW 137-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 12-2014(Temp), f. 2-13-14, cert. ef. 3-1-14 thru 6-15-14; DFW 29-2014(Temp), f. 4-3-14, cert. ef. 4-4-14 thru 6-15-14; DFW 31-2014(Temp), f. 4-17-14, cert. ef. 4-19-14 thru 7-31-14; DFW 40-2014(Temp), f. 5-7-14, cert. ef. 5-9-14 thru 6-30-14; DFW 44-2014(Temp), f. 5-14-14, cert. ef. 5-15-14 thru 6-15-14; DFW 52-2014(Temp), f. 5-28-14, cert. ef. 5-31-14 thru 6-30-14; Administrative correction, 7-24-14; DFW 165-2014, f. 12-18-14, cert. ef. 1-1-15; DFW 12-2015(Temp), f. 2-3-15, cert. ef. 3-1-15 thru 6-15-15; DFW 16-2015(Temp), f. & cert. ef. 3-5-15 thru 6-15-15

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Rule Caption: Commercial Winter Fisheries for Youngs Bay Select Area of the Columbia River Modified.
Adm. Order No.: DFW 17-2015(Temp)
Filed with Sec. of State: 3-5-2015
Certified to be Effective: 3-9-15 thru 7-30-15
Notice Publication Date:
Rules Amended: 635-042-0145
Rules Suspended: 635-042-0145(T)
Subject: This amended rule modifies seasons for the winter commercial fisheries for Chinook salmon and shad in the Youngs Bay Select Area of the Columbia River that begins March 9, 2015.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-042-0145
Youngs Bay Salmon Season

(1) Salmon and shad may be taken for commercial purposes during open 2015 fishing periods in waters of Youngs Bay as described below. Retention and sale of white sturgeon is prohibited.

(a) The 2015 open fishing periods are established in three segments categorized as the winter fishery, subsection (1)(a)(A); the spring fishery, subsection (1)(a)(B); and summer fishery, subsection (1)(a)(C), as follows:

(A) Winter Season: Open Mondays, Wednesdays, and Thursdays from February 9 through March 9 (13 days). Open hours are from 6:00 a.m. to midnight (18 hours) on Mondays and Thursdays, and 6:00 a.m. to 6:00 p.m. (12 hours) on Wednesdays. Beginning March 11 the following open periods apply:

Wednesday — March 11, 8:00 a.m.–4:00 p.m. (8 hrs.);
Thursday — March 12, 8:00 a.m. –4:00 p.m. (8 hrs.);
Monday — March 16, noon–8:00 p.m. (8 hrs.);
Wednesday — March 18, 6:00 p.m. –10:00 p.m. (4 hrs.);
Thursday — March 19, 7:00 p.m. –11:00 p.m. (4 hrs.);
Monday — March 23, 9:00 a.m. –1:00 p.m. (4 hrs.);
Wednesday — March 25, 11:00a.m. –3:00 p.m. (4 hrs.);
Thursday — March 26, 12:00 p.m. –4:00 p.m. (4 hrs.);
Monday — March 30, 10:00 a.m. –2:00 p.m. (4 hrs.).

(B) Spring Season: Open during the following periods:

Tuesday — April 21, 8:00 p.m. –Midnight (4 hrs.);
Thursday — April 23, 9:00 p.m. –3:00 a.m. Friday, April 24 (6 hrs.);
Tuesday — April 28, 7:00 p.m. –7:00 a.m. Wednesday, April 29 (12 hrs.);
Thursday — April 30, 7:00 p.m. –7:00 a.m. Friday, May 1 (12 hrs.);
Monday — May 4, 9:00 a.m. –3:00 a.m. Tuesday, May 5 (18 hrs.);
Wednesday — May 6, 9:00 a.m. –9:00 p.m. (12 hrs.);
Thursday — May 7 9:00 a.m. –3:00 a.m. Friday, May 8 (18 hrs.); and
Noon Monday through Noon Friday (4 days/week) from May 11 through June 12 (20 days).

(C) Summer Season: Beginning June 16 the following open periods apply:

Noon Tuesday, June 16 through Noon Friday, June 19 (3 days);
Noon Mondays through Noon Fridays, June 22-July 3 (8 days);
Noon Monday, July 6 through Noon Thursday, July 9 (3 days); and
Noon Tuesdays through Noon Thursdays, July 14 through July 30 (6 days).

(b) For the winter fisheries, 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 including the lower Walluski River upstream to the Highway 202 Bridge are open. Those waters southerly of the alternate Highway 101 Bridge (Lewis and Clark River) are closed. For the spring and summer fisheries 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 and includes th lower Walluski River upstream to Highway 202 Bridge and the lower Lewis and Clark River upstream to the overhead power lines immediately upstream of Barrett Slough.

(2) Gill nets may not exceed 1,500 feet (250 fathoms) in length and weight may not exceed two pounds per any fathom except the use of additional weights and/or anchors attached directly to the leadline is allowed upstream of markers located approximately 200 yards upstream of the mouth of the Walluski River during all Youngs Bay commercial fisheries and upstream of the alternate Highway 101 Bridge in the Lewis and Clark River during the spring and summer seasons. 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.

(a) It is *unlawful* to use a gill net having a mesh size that is less than 7 inches during the winter season. It is *unlawful* to use a gill net having a mesh size that is more than 9.75 inches during the spring and summer seasons.

(b) Nets not specifically authorized for use in these areas may be onboard a vessel if properly stored. A properly stored net is defined as a net on a drum that is fully covered by a tarp (canvas or plastic) and bound with a minimum of ten revolutions of rope with a diameter of 3/8 (0.375) inches or greater.

(3) Non-resident commercial fishing and boat licenses are not required for Washington fishers participating in Youngs Bay commercial fisheries. A valid fishing and boat license issued by the state of Washington is considered adequate for participation in this fishery. The open area for non-resident commercial fishers includes all areas open for commercial fishing.

Stat. Auth.: ORS 183.325, 506.109 & 506.119
Stats. Implemented: ORS 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; DFW 52-2006(Temp), f. & cert. ef. 6-28-06 thru 7-27-06; DFW 73-2006(Temp), f. 8-1-06, cert. ef. 8-2-06 thru 12-31-06; DFW 103-2006(Temp), f. 9-15-06, cert. ef. 9-18-06 thru 12-31-06; DFW 119-2006(Temp), f. & cert. ef. 10-18-06 thru 12-31-06; Administrative correction 1-16-07; DFW 7-2007(Temp), f. 1-31-07, cert. ef. 2-1-07 thru 7-30-07; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 13-2007(Temp), f. & cert. ef. 3-6-07 thru 9-1-07; DFW 16-2007(Temp), f. & cert. ef. 3-14-07 thru 9-9-07; DFW 25-2007(Temp), f. 4-17-07, cert. ef. 4-18-07 thru 7-26-07; DFW 45-2007(Temp), f. 6-15-07, cert. ef. 6-25-07 thru 7-31-07; DFW 50-2007(Temp), f. 6-29-07, cert. ef. 7-4-07 thru 7-31-07; DFW 61-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 10-31-07; DFW 108-2007(Temp), f. 10-12-07, cert. ef. 10-14-07 thru 12-31-07; Administrative correction 1-24-08; DFW 6-2008(Temp), f. 1-29-08, cert. ef. 1-31-08 thru 7-28-08; DFW 16-2008(Temp), f. 2-26-08, cert. ef. 3-2-08 thru 8-28-08; DFW 30-2008(Temp), f. 3-27-08, cert. ef. 3-30-08 thru 8-28-08; DFW 48-2008(Temp), f. & cert. ef. 5-12-08 thru 8-28-08; DFW 58-2008(Temp), f. & cert. ef. 6-4-08 thru 8-31-08; DFW 85-2008(Temp), f. 7-24-08, cert. ef. 8-1-08 thru 12-31-08; DFW 108-2008(Temp), f. 9-8-08, cert. ef. 9-9-08 thru 12-31-08; Administrative correction 1-23-09; DFW 12-2009(Temp), f. 2-13-09, cert. ef. 2-15-09 thru 7-31-09; DFW 24-2009(Temp), f. 3-10-09, cert. ef. 3-11-09 thru 7-31-09; DFW 49-2009(Temp), f. 5-14-09, cert. ef 5-17-09 thru 7-31-09; DFW 89-2009(Temp), f. 8-3-09, cert. ef. 8-4-09 thru 12-31-09; DFW 107-2009(Temp), f. 9-2-09, cert. ef. 9-5-09 thru 10-31-09; Administrative correction 11-19-09; DFW 17-2010(Temp), f. & cert. ef. 2-22-10 thru 7-31-10; DFW 20-2010(Temp), f. & cert. ef. 2-26-10 thru 7-31-10; DFW 30-2010(Temp), f. 3-11-10, cert. ef. 3-14-10 thru 7-31-10; DFW 35-2010(Temp), f. 3-23-10, cert. ef. 3-24-10 thru 7-31-10; DFW 40-2010(Temp), f. & cert. ef. 4-1-10 thru 7-31-10; DFW 46-2010(Temp), f. & cert. ef. 4-21-10 thru 7-31-10; DFW 53-2010(Temp), f. & cert. ef. 5-4-10 thru 7-31-10; DFW 57-2010(Temp), f. & cert. ef. 5-11-10 thru 7-31-10; DFW 69-2010(Temp), f. & cert. ef. 5-18-10 thru 7-31-10; DFW 113-2010(Temp), f. 8-2-10, cert. ef. 8-4-10 thru 10-31-10; DFW 129-2010(Temp), f. & cert. ef. 9-10-10 thru 10-31-10; Administrative correction 11-23-10; DFW 12-2011(Temp), f. 2-10-11, cert. ef. 2-13-11 thru 7-29-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 32-2011(Temp), f. 4-20-11, cert. ef. 4-21-11 thru 7-29-11; DFW 35-2011(Temp), f. & cert. ef. 4-28-11 thru 7-29-11; DFW 46-2011(Temp), f. & cert. ef. 5-12-11 thru 7-29-11; DFW 52-2011(Temp), f. & cert. ef. 5-18-11 thru 7-29-11; DFW 76-2011(Temp), f. 6-24-11, cert. ef. 6-27-11 thru 7-29-11; DFW 106-2011(Temp), f. 8-2-11, cert. ef. 8-3-11 thru 10-31-11; DFW 121-2011(Temp), f. 8-29-11, cert. ef. 9-5-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 12-2012(Temp), f. 2-8-12, cert. ef. 2-12-12 thru 7-31-12; DFW 24-2012(Temp), f. 3-15-12, cert. ef. 3-18-12 thru 7-31-12; DFW 26-2012(Temp), f. 3-20-12, cert. ef. 3-21-12 thru 7-31-12; DFW 27-2012(Temp), f. 3-27-12, cert. ef. 3-29-12 thru 7-31-12; DFW 28-2012(Temp), f. 3-30-12, cert. ef. 4-1-12 thru 7-31-12; DFW 30-2012(Temp), f. 4-4-12, cert. ef. 4-5-12 thru 7-31-12; DFW 36-2012(Temp), f. 4-16-12, cert. ef. 4-19-12 thru 7-31-12; DFW 82-2012(Temp), f. 6-29-12, cert. ef. 7-2-12 thru 7-31-12; DFW 96-2012(Temp), f. 7-30-12, cert. ef. 8-1-12 thru 10-31-12; Administrative correction 11-23-12; DFW 11-2013(Temp), f. 2-8-13, cert. ef. 2-11-13 thru 7-31-13; DFW 22-2013(Temp), f. 3-12-13, cert. ef. 3-13-13 thru 7-31-13; DFW 34-2013(Temp), f. 5-14-13, cert. ef. 5-15-13 thru 7-31-13; DFW 36-2013(Temp), f. & cert. ef. 5-22-13 thru 7-31-13; DFW 44-2013(Temp), f. & cert. ef. 5-29-13 thru 7-31-13; DFW 82-2013(Temp), f. 7-29-13, cert. ef. 7-31-13 thru 10-31-13; DFW 87-2013(Temp), f. & cert. ef. 8-9-13 thru 10-31-13; DFW 109-2013(Temp), f. 9-27-13, cert. ef. 9-30-13 thru 10-31-13; Administrative correction, 11-22-13; DFW 8-2014(Temp), f. & cert. ef. 2-10-14 thru 7-31-14; DFW 18-2014(Temp), f. 3-7-14, cert. ef. 3-10-14 thru 7-30-14; DFW 25-2014(Temp), f. 3-13-14, cert. ef. 3-17-14 thru 7-31-14; DFW 32-2014(Temp), f. 4-21-14, cert. ef. 4-22-14 thru 7-31-14; DFW 35-2014(Temp), f. & cert. ef. 4-24-14 thru 7-31-14; DFW 39-2014(Temp), f. 5-7-14, cert. ef. 5-8-14 thru 7-31-14; DFW 45-2014(Temp), f. 5-14-14, cert. ef. 5-20-14 thru 7-31-14; DFW 51-2014(Temp), f. & cert. ef. 5-28-14 thru 7-31-14; DFW 55-2014(Temp), f. 6-3-14, cert. ef. 6-4-14 thru 7-31-14; DFW 104-2014(Temp), f. 8-4-14, cert. ef. 8-5-14 thru 10-31-14; Administrative correction 11-24-14; DFW 10-2015(Temp), f. 2-3-15, cert. ef. 2-9-15 thru 7-30-15; DFW 17-2015(Temp), f. 3-5-15, cert. ef. 3-9-15 thru 7-30-15

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Rule Caption: Amendments to Rules for Commercial and Recreational Groundfish Fisheries.
Adm. Order No.: DFW 18-2015
Filed with Sec. of State: 3-10-2015
Certified to be Effective: 3-10-15
Notice Publication Date: 12-1-2014
Rules Amended: 635-004-0275, 635-039-0080
Rules Repealed: 635-004-0275(T), 635-039-0090(T)
Subject: These amended rules define the purpose and scope of groundfish management measures for commercial and sport groundfish fisheries in 2015. Housekeeping and technical corrections to the regulations were made to ensure rule consistency.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-004-0275
Scope, Inclusion, and Modification of Rules

(1) The commercial groundfish fishery in the Pacific Ocean off Oregon is jointly managed by the state of Oregon and the federal government through the Pacific Fishery Management Council process. The Code of Federal Regulations provides federal requirements for this fishery, including but not limited to the time, place, and manner of taking groundfish. However, additional regulations may be promulgated subsequently by publication in the Federal Register, and these supersede, to the extent of any inconsistency, the Code of Federal Regulations. Therefore, the following publications are incorporated into Oregon Administrative Rule by reference:

(a) Code of Federal Regulations, Part 660, Subparts C, D, E and F (October 1, 2014 ed.);

(b) Federal Register Vol. 80, No. 46, dated March 10, 2015 (80 FR 12567);

(c) Federal Register Vol. 79, No. 231, dated December 2, 2014 (79 FR 71340).

(2) Persons must consult the federal regulations in addition to Division 004 to determine all applicable groundfish fishing requirements. Where federal regulations refer to the fishery management area, that area is extended from shore to three nautical miles from shore coterminous with the Exclusive Economic Zone.

(3) The Commission may adopt additional or modified regulations that are more conservative than federal regulations, in which case Oregon Administrative Rule takes precedence. See OAR 635-004-0205 through 635-004-0235 and 635-004-0280 through 635-004-0365 for additions or modifications to federal groundfish regulations.

Stat. Auth.: ORS 496.138, 496.162, 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 496.162, 506.109 & 506.129
Hist.: DFW 75-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 78-2012(Temp), f. 6-28-12, cert. ef. 7-1-12 thru 10-27-12; DFW 106-2012(Temp), f. 8-15-12, cert. ef. 9-1-12 thru 12-31-12; DFW 1-2013, f. & cert. ef. 1-3-13; DFW 96-2013(Temp), f. 8-27-13, cert. ef. 9-1-13 thru 12-31-13; DFW 132-2013(Temp), f. & cert. ef. 12-9-13 thru 6-7-14; DFW 136-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 34-2014(Temp), f. & cert. ef. 4-23-14 thru 9-30-14; DFW 109-2014(Temp), f. & cert. ef. 8-4-14 thru 12-31-14; DFW 163-2014(Temp), f. 12-15-14, cert. ef. 1-1-15 thru 6-29-15; DFW18-2015, f. & cert. ef. 3-10-15

635-039-0080
Purpose and Scope

(1) The purpose of division 39 is to provide for management of sport fisheries for marine fish, shellfish, and marine invertebrates in the Pacific Ocean, coastal bays, and beaches over which the State has jurisdiction.

(2) Division 39 incorporates into Oregon Administrative Rules, by reference:

(a) The sport fishing regulations of the State, included in the document entitled 2015 Oregon Sport Fishing Regulations;

(b) Title 50 of the Code of Federal Regulations, Part 300, Subpart E (October 1, 2014 ed.), as amended;

(c) Title 50 of the Code of Federal Regulations, Part 660, Subpart G (October 1, 2014 ed.), as amended;

(d) Federal Register Vol. 80, No. 46, dated March 10, 2015 (80 FR 12567);

(e) Federal Register Vol. 79. No. 48, dated March 12, 2014 (79 FR 3906); and

(f) Federal Register Vol. 79. No. 65, dated April 4, 2014 (79 FR 18827).

(3) Therefore, persons must consult all publications referenced in this rule in addition to Division 011 and Division 39 to determine all applicable sport fishing requirements for marine fish, shellfish and marine invertebrates.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.146, 506.119
Stats. Implemented: ORS 496.162 & 506.129
Hist.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; Renumbered from 635-39-105 - 635-39-135; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 25-1997, f. 4-22-97, cert. ef. 5-1-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 91-1998, f. & cert. ef. 11-25-98; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 98-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 81-2000, f. 12-22-00, cert. ef. 1-1-01; DFW 118-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; 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 120-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 33-2005(Temp), f. 4-29-05, cert. ef. 5-1-05 thru 10-27-05; DFW 54-2005(Temp), f. 6-10-05, cert. ef. 6-12-05 thru 11-30-05; DFW 56-2005, f. 6-21-05, cert. ef. 7-1-05; DFW 71-2005(Temp), f. & cert. ef. 7-7-05 thru 11-30-05; DFW 89-2005(Temp), f. & cert. ef. 8-12-05 thru 12-12-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 138-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 134-2006(Temp), f. 12-21-06, cert. ef. 1-1-07 thru 6-29-07; DFW 3-2007, f. & cert. ef. 1-12-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 39-2009, f. & cert. ef. 4-27-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 32-2010, f. & cert. ef. 3-15-10; DFW 37-2010, f. 3-30-10, cert. ef. 4-1-10; DFW 157-2010, f. 12-6-10, cert. ef. 1-1-11; DFW 24-2011, f. & cert. ef. 3-22-11; DFW 164-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 39-2012, f. & cert. ef. 4-24-12; DFW 1-2013, f. & cert. ef. 1-3-13; DFW 25-2013(Temp), f. 4-2-13, cert. ef. 5-1-13 thru 5-31-13; DFW 32-2013, f. & cert. ef. 5-14-13; DFW 136-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 36-2014, f. 4-29-14, cert. ef. 5-1-14; DFW 165-2014, f. 12-18-14, cert. ef. 1-1-15; DFW18-2015, f. & cert. ef. 3-10-15

635-039-0090
Inclusions and Modifications

(1) The **2015 Oregon Sport Fishing Regulations** provide requirements for sport fisheries for marine fish, shellfish, and marine invertebrates in the Pacific Ocean, coastal bays, and beaches, commonly referred to as the Marine 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 **2015 Oregon Sport Fishing Regulations**.

(2) For the purposes of this rule, a "sport harvest guideline" is defined as a specified numerical harvest objective that is not a quota. Attainment of a harvest guideline does not automatically close a fishery. Upon attainment of a sport harvest guideline, the Department shall initiate consultation to determine if additional regulatory actions are necessary to achieve management objectives.

(a) The following sport harvest guidelines include the combined landings and other fishery related mortalit by the Oregon sport fishery in a single calendar year:

(A) Black rockfish, 440.8 metric tons.

(B) Cabezon, 16.8 metric tons.

(C) Blue rockfish and other nearshore rockfish combined, 26 metric tons.

(b) The following sport harvest guidelines include total landings in the Oregon sport ocean boat fishery in a single calendar year: Greenling, 5.2 metric tons.

(3) For the purposes of this rule, "Other nearshore rockfish" means the following rockfish species: black and yellow (Sebastes chrysolmelas); brown (S. auriculatus); calico (S. dalli); China (S. nebulosus); copper (S. caurinus); gopher (S. carnatus); grass (S. rastelliger); kelp (S. atrovirens); olive (S. serranoides); quillback (S. maliger); and treefish (S. serriceps).

(4) In addition to the regulations for Marine Fish in the **2015 Oregon Sport Fishing Regulations**, the following apply for the sport fishery in the Marine Zone in 2015:

(a) Lingcod (including green colored lingcod): 2 fish daily bag limit.

(b) All rockfish ("sea bass" "snapper"), greenling ("sea trout"), cabezon, skates, and other marine fish species not listed in the **2015 Oregon Sport Fishing Regulations** in the Marine Zone, located under the category of Species Name, Marine Fish: 7 fish daily bag limit in aggregate (total sum or number), of which no more than three may be blue rockfish and no more than one may be a cabezon. Retention of the following species is prohibited:

(A) Yelloweye rockfish;

(B) China rockfish;

(C) Copper rockfish;

(D) Quillback rockfish;

(E) Cabezon from January 1 through June 30; and

(F) Canary rockfish.

(c) Flatfish (flounder, sole, sanddabs, turbot, and all halibut species except Pacific halibut): 25 fish daily bag limit in aggregate (total sum or number).

(d) Retention of all marine fish listed under the category of Species Name, Marine Fish, except Pacific cod, sablefish, herring, anchovy, smelt, sardine, striped bass, hybrid bass, and offshore pelagic species (excluding leopard shark and soupfin shark), is prohibited when Pacific halibut is retained on the vessel during open days for the all-depth sport fishery for Pacific halibut north of Humbug Mountain. Persons must also consult all publications referenced in OAR 635-039-0080 to determine all rules applicable to the taking of Pacific halibut.

(e) Harvest methods and other specifications for marine fish in subsections (4)(a), (4)(b) and (4)(c) including the following:

(A) Minimum length for lingcod, 22 inches.

(B) Minimum length for cabezon, 16 inches.

(C) Minimum length for greenling, 10 inches.

(D) May be taken by angling, hand, bow and arrow, spear, gaff hook, snag hook and herring jigs.

(E) Mutilating the fish so the size or species cannot be determined prior to landing or transporting mutilated fish across state waters is prohibited.

(f) Sport fisheries for species in subsections (4)(a), (4)(b) and (4)(c) and including leopard shark and soupfin shark are open January 1 through December 31, twenty-four hours per day, except as provided in subsections (4)(a) and (4)(d), and ocean waters are closed for these species during April 1 through September 30, outside of the 30-fathom curve (defined by latitude and longitude) as shown on Title 50 Code of Federal Regulations Part 660 Section 71. A 20-fathom, 25-fathom, or 30-fathom curve, as shown on Title 50 Code of Federal Regulations Part 660 Section 71 may be implemented as the management line as in-season modifications necessitate. In addition, the following management lines may be used to set area specific regulations for inseason action only:

(A) Cape Lookout (45°20'30" N latitude); and

(B) Cape Blanco (42°50'20" N latitude).

(g) The Stonewall Bank Yelloweye Rockfish Conservation Area (YRCA) is defined by coordinates specified in Title 50 Code of Federal Regulations Part 660 Section 70 (October 1, 2014 ed.). Within the YRCA, it is unlawful to fish for, take, or retain species listed in subsections (4)(a), (4)(b) and (4)(c) of this rule, leopard shark, soupfin shark, and Pacific halibut using recreational fishing gear. A vessel engaged in recreational fishing within the YRCA is prohibited from possessing any species listed in subsections (4)(a), (4)(b) and (4)(c) of this rule, leopard shark, soupfin shark, and Pacific halibut. Recreational fishing vessels in possession of species listed in subsections (4)(a), (4)(b) and (4)(c) and including leopard shark, soupfin shark, and Pacific halibut may transit the YRCA without fishing gear in the water.

[ED. NOTE: Tables 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 22-1994, f. 4-29-94, cert. ef. 5-2-94; FWC 29-1994(Temp), f. 5-20-94, cert. ef. 5-21-94; FWC 31-1994, f. 5-26-94, cert. ef. 6-20-94; FWC 43-1994(Temp), f. & cert. ef. 7-19-94; FWC 83-1994(Temp), f. 10-28-94, cert. ef. 11-1-94; FWC 95-1994, f. 12-28-94, cert. ef. 1-1-95; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 25-1995, f. 3-29-95, cert. ef. 4-1-95; FWC 26-1995, 3-29-95, cert. ef. 4-2-95; FWC 36-1995, f. 5-3-95, cert. ef. 5-5-95; FWC 43-1995(Temp), f. 5-26-95, cert. ef. 5-28-95; FWC 46-1995(Temp), f. & cert. ef. 6-2-95; FWC 58-1995(Temp), f. 7-3-95, cert. ef. 7-5-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 28-1996(Temp) , f. 5-24-96, cert. ef. 5-26-96; FWC 30-1996(Temp), f. 5-31-96, cert. ef. 6-2-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 68-1999(Temp), f. & cert. ef. 9-17-99 thru 9-30-99; administrative correction 11-17-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 118-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 35-2003, f. 4-30-03, cert. ef. 5-1-03; DFW 114-2003(Temp), f. 11-18-03, cert. ef. 11-21-03 thru 12-31-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 128-2003, f. 12-15-03, cert. ef. 1-1-04; DFW 83-2004(Temp), f. 8-17-04, cert. ef. 8-18-04 thru 12-31-04; DFW 91-2004(Temp), f. 8-31-04, cert. ef. 9-2-04 thru 12-31-04; DFW 97-2004(Temp), f. 9-22-04, cert. ef. 9-30-04 thru 12-31-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 34-2005(Temp), f. 4-29-05, cert. ef. 5-1-05 thru 10-27-05; DFW 75-2005(Temp), f. 7-13-05, cert. ef. 7-16-05 thru 12-31-05; DFW 87-2005(Temp), f. 8-8-05, cert. ef. 8-11-05 thru 12-31-05; DFW 121-2005(Temp), f. 10-12-05, cert. ef. 10-18-05 thru 12-31-05; DFW 129-2005(Temp), f. & cert. ef. 11-29-05 thru 12-31-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 138-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 141-2005(Temp), f. 12-12-05, cert. ef. 12-30-05 thru 12-31-05; Administrative correction 1-19-06; DFW 61-2006, f. 7-13-06, cert. ef. 10-1-06; DFW 65-2006(Temp), f. 7-21-06, cert. ef. 7-24-06 thru 12-31-06; DFW 105-2006(Temp), f. 9-21-06, cert. ef. 9-22-06 thru 12-31-06; DFW 134-2006(Temp), f. 12-21-06, cert. ef. 1-1-07 thru 6-29-07; DFW 3-2007, f. & cert. ef. 1-12-07; DFW 10-2007, f. & cert. ef. 2-14-07; DFW 66-2007(Temp), f. 8-6-07, cert. ef. 8-11-07 thru 12-31-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 73-2008(Temp), f. 6-30-08, cert. ef. 7-7-08 thru 12-31-08; DFW 97-2008(Temp), f. 8-18-08, cert. ef. 8-21-08 thru 12-31-08; DFW 105-2008(Temp), f. 9-4-08, cert. ef. 9-7-08 thru 12-31-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 7-2009(Temp), f. & cert. ef. 2-2-09 thru 7-31-09; DFW 39-2009, f. & cert. ef. 4-27-09; DFW 110-2009(Temp), f. 9-10-09, cert. ef. 9-13-09 thru 12-31-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 103-2010(Temp), f. 7-21-10, cert. ef. 7-23-10 thru 12-31-10; DFW 157-2010, f. 12-6-10, cert. ef. 1-1-11; DFW 24-2011, f. & cert. ef. 3-22-11; DFW 97-2011(Temp), f. & cert. ef. 7-20-11 thru 12-31-11; DFW 135-2011(Temp), f. 9-21-11, cert. ef. 10-1-11 thru 12-31-11; DFW 155-2011(Temp), f. 11-18-11, cert. ef. 12-1-11 thru 12-31-11; DFW 156-2011(Temp), f. 12-9-11, cert. ef. 12-15-11 thru 1-31-12; DFW 164-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 90-2012(Temp), f. 7-17-12, cert. ef. 9-20-12 thru 12-31-12; DFW 151-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 155-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-29-13; DFW 23-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-27-13; DFW 32-2013, f. & cert. ef. 5-14-13; DFW 112-2013(Temp), f. & cert. ef. 9-27-13 thru 12-31-13; DFW 136-2013, f. 12-19-13, cert. ef. 1-1-14; DFW 165-2014, f. 12-18-14, cert. ef. 1-1-15; DFW 4-2015, f. 1-13-15, cert. ef. 1-15-15; [DFW 5-2015(Temp), f. 1-13-15, cert. ef. 1-15-15 thru 7-13-15; Temporary suspended by DFW18-2015, f. & cert. ef. 3-10-15]

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Rule Caption: Treaty Indian Commercial Winter Gill Net Fisheries in the Bonneville Pool Modified.
Adm. Order No.: DFW 19-2015(Temp)
Filed with Sec. of State: 3-11-2015
Certified to be Effective: 3-12-15 thru 3-31-15
Notice Publication Date:
Rules Amended: 635-041-0065
Rules Suspended: 635-041-0065(T)
Subject: This amended rule modifies the Treaty Indian commercial winter gill net season in the Bonneville Pool of the Columbia River. These modifications close sales of Chinook salmon caught in the Tribal commercial winter gill net fishery in the Bonneville Pool at 6:00 p.m. Thursday, March 12, 2015. Modifications are consistent with action taken March 10, 2015 by the Oregon and Washington Departments of Fish and Wildlife, in cooperation with the

Columbia River Treaty Tribes, in a meeting of the Columbia River Compact.
Rules Coordinator: Michelle Tate—(503) 947-6044

635-041-0065
Winter Salmon Season

(1) Salmon, steelhead, shad, walleye, catfish, bass, yellow perch, and carp may be taken for commercial purposes in the Columbia River Treaty Indian platform and hook-and-line fisheries from:

(a) The Dalles and John Day pools in the Columbia River Treaty Indian hook-and-line fisheries 6:00 a.m. Monday, February 2 through 6:00 p.m. Friday, February 20, 2015; and

(b) The Bonneville Pool, 6:00 a.m. Monday, February 2 through 5:59 a.m. Monday, February 23, 2015.

(c) Gear used in the fisheries described above is restricted to subsistence fishing gear which includes hoopnets, dipnets, and rod and reel with hook-and-line.

(d) Salmon, steelhead, shad, yellow perch, bass, walleye, catfish and carp landed during any open fishing period may be sold at any time or retained for subsistence purposes. White sturgeon between 43 and 54 inches in fork length taken from The Dalles and John Day pools during any open period may be sold at any time or kept for subsistence purposes. White sturgeon between 38 and 54 inches in fork length taken from the Bonneville Pool may not be sold but may be kept for subsistence purposes. Live release of all undersize or oversize white sturgeon is required.

(2) Salmon, steelhead, shad, walleye, catfish, bass, yellow perch, carp and white sturgeon may be taken for commercial purposes in the Columbia River Treaty Indian gill net fisheries from:

(a) The Dalles and John Day pools beginning 6:00 a.m. Monday, February 2 through 6:00 p.m. Tuesday, February 24, 2015; and

(b) The Bonneville Pool beginning 6:00 a.m. Monday, February 23 through 6:00 p.m. Saturday, March 21, except that salmon may not be sold after 6:00 p.m. Thursday, March 12, 2015.

(c) Gear is restricted to gill nets. There are no mesh size restrictions.

(d) Salmon, steelhead, shad, yellow perch, bass, walleye, catfish and carp landed during any open fishing period may be sold at any time or retained for subsistence purposes. White sturgeon between 43 and 54 inches in fork length from The Dalles and John Day pools and white sturgeon between 38 and 54 inches in fork length from the Bonneville Pool that are taken during any open period may be sold at any time or kept for subsistence purposes. Live release of all undersize or oversize white sturgeon is required.

(3) Closed areas as set forth in OAR 635-041-0045 are in effect.

Stat. Auth.: ORS 496.118 & 506.119
Stats. Implemented: ORS 506.109, 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79; FWC 13-1979(Temp), f. & ef. 3-30-1979, Renumbered from 635-035-0065; FWC 6-1980, f. & ef. 1-28-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 2-1983, f. 1-21-83, ef. 2-1-83; FWC 4-1984, f. & ef. 1-31-84; FWC 2-1985, f. & ef. l-30-85; FWC 4-1986(Temp), f. & ef. 1-28-86; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 3-1988(Temp), f. & cert. ef. 1-29-88; FWC 10-1988, f. & cert. ef. 3-4-88; FWC 5-1989, f. 2-6-89, cert. ef. 2-7-89; FWC 13-1989(Temp), f. & cert. ef. 3-21-89; FWC 15-1990(Temp), f. 2-8-90, cert. ef. 2-9-90; FWC 20-1990, f. 3-6-90, cert. ef. 3-15-90; FWC 13-1992(Temp), f. & cert. ef. 3-5-92; FWC 7-1993, f. & cert. ef. 2-1-93; FWC 12-1993(Temp), f. & cert. ef. 2-22-93; FWC 18-1993(Temp), f. & cert. ef. 3-2-93; FWC 7-1994, f. & cert. ef. 2-1-94; FWC 11-1994(Temp), f. & cert. ef. 2-28-94; FWC 9-1995, f. & cert. ef. 2-1-95; FWC 19-1995(Temp), f. & cert. ef. 3-3-95; FWC 5-1996, f. & cert. ef. 2-7-96; FWC 4-1997, f. & cert. ef. 1-30-97; DFW 8-1998(Temp), f. & cert. ef. 2-5-98 thru 2-28-98; DFW 14-1998, f. & cert. ef. 3-3-98; DFW 20-1998(Temp), f. & cert. ef. 3-13-98 thru 3-20-98; DFW 23-1998(Temp), f. & cert. ef. 3-20-98 thru 6-30-98; DFW 2-1999(Temp), f. & cert. ef. 2-1-99 through 2-19-99; DFW 9-1999, f. & cert. ef. 2-26-99; DFW 14-1999(Temp), f. 3-5-99, cert. ef. 3-6-99 thru 3-20-99; Administrative correction 11-17-99; DFW 6-2000(Temp), f. & cert. ef. 2-1-00 thru 2-29-00; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 19-2000, f. 3-18-00, cert. ef. 3-18-00 thru 3-21-00; DFW 26-2000(Temp), f. 5-4-00, cert. ef. 5-6-00 thru 5-28-00; Administrative correction 5-22-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 14-2001(Temp), f. 3-12-01, cert. ef. 3-14-01 thru 3-21-01; Administrative correction 6-20-01; DFW 9-2002, f. & cert. ef. 2-1-02; DFW 11-2002(Temp), f. & cert. ef. 2-8-02 thru 8-7-02; DFW 17-2002(Temp), f. 3-7-02, cert. ef. 3-8-02 thru 9-1-02; DFW 18-2002(Temp), f. 3-13-02, cert. ef. 3-15-02 thru 9-11-02; DFW 134-2002(Temp), f. & cert. ef. 12-19-02 thru 4-1-03; DFW 20-2003(Temp), f. 3-12-03, cert. ef. 3-13-03 thru 4-1-03; DFW 131-2003(Temp), f. 12-26-03, cert. ef. 1-1-04 thru 4-1-04; DFW 5-2004(Temp), f. 1-26-04, cert. ef. 2-2-04 thru 4-1-04; DFW 15-2004(Temp), f. 3-8-04, cert. ef. 3-10-04 thru 4-1-04; DFW 130-2004(Temp), f. 12-23-04, cert. ef. 1-1-05 thru 4-1-05; DFW 4-2005(Temp), f. & cert. ef 1-31-05 thru 4-1-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 3-2006(Temp), f. & cert. ef. 1-27-06 thru 3-31-06; Administrative correction 4-19-06; DFW 7-2007(Temp), f. 1-31-07, cert. ef. 2-1-07 thru 7-30-07; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 14-2007(Temp), f. & cert. ef. 3-9-07 thru 9-4-07; DFW 15-2007(Temp), f. & cert. ef. 3-14-07 thru 9-9-07; Administrative correction 9-16-07; DFW 6-2008(Temp), f. 1-29-08, cert. ef. 1-31-08 thru 7-28-08; DFW 20-2008(Temp), f. 2-28-08, cert. ef. 2-29-08 thru 7-28-08; DFW 21-2008(Temp), f. & cert. ef. 3-5-08 thru 7-28-08; DFW 22-2008(Temp), f. 3-7-08, cert. ef. 3-10-08 thru 7-28-08; Administrative correction 8-21-08; DFW 142-2008, f. & cert. ef. 11-21-08; DFW 6-2009(Temp), f. 1-30-09, cert. ef. 2-2-09 thru 8-1-09; DFW 11-2009(Temp), f. 2-13-09, cert. ef. 2-16-09 thru 7-31-09; DFW 22-2009(Temp), f. 3-5-09, cert. ef. 3-6-09 thru 7-31-09; Administrative correction 8-21-09; DFW 9-2010(Temp), f. & cert. ef. 2-3-10 thru 8-1-10; DFW 12-2010(Temp), f. 2-10-10, cert. ef. 2-11-10 thru 8-1-10; DFW 18-2010(Temp), f. 2-24-10, cert. ef. 2-26-10 thru 4-1-10; DFW 24-2010(Temp), f. 3-2-10, cert. ef. 3-3-10 thru 4-1-10; Administrative correction 4-21-10; DFW 8-2011(Temp), f. 1-31-11, cert. ef. 2-1-11 thru 4-1-11; DFW 9-2011(Temp), f. 2-9-11, cert. ef. 2-10-11 thru 4-1-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 5-2012(Temp), f. 1-30-12, cert. ef. 2-1-12 thru 3-31-12; DFW 18-2012(Temp), f. 2-28-12, cert. ef. 2-29-12 thru 6-15-12; DFW 19-2012(Temp), f. 3-2-12, cert. ef. 3-5-12 thru 6-15-12; DFW 20-2012(Temp), f. & cert. ef. 3-5-12 thru 6-15-12; DFW 46-2012(Temp), f. 5-14-12, cert. ef. 5-15-12 thru 6-30-12; Administrative correction, 8-1-12; DFW 9-2013(Temp), f. 1-31-13, cert. ef. 2-1-13 thru 3-31-13; DFW 15-2013(Temp), f. 2-22-13, cert. ef. 2-27-13 thru 6-15-13; DFW 18-2013(Temp), f. 3-5-13, cert. ef. 3-6-13 thru 6-15-13; DFW 35-2013(Temp), f. & cert. ef. 5-21-13 thru 6-30-13; DFW 48-2013(Temp), f. 6-7-13, cert. ef. 6-8-13 thru 7-31-13; Administrative correction, 8-21-13; DFW 6-2014(Temp), f. 1-30-14, cert. ef. 2-1-14 thru 7-30-14; DFW 15-2014(Temp), f. 2-25-14, cert. ef. 2-26-14 thru 7-30-14; DFW 17-2014(Temp), f. 2-28-14, cert. ef. 3-1-14 thru 7-30-14; DFW 23-2014(Temp), f. 3-11-14, cert. ef. 3-12-14 thru 7-31-14; DFW 37-2014(Temp), f. & cert. ef. 5-6-14 thru 7-31-14; DFW 46-2014(Temp), f. 5-19-14, cert. ef. 5-20-14 thru 7-31-14; DFW 48-2014(Temp), f. 5-27-14, cert. ef. 5-28-14 thru 7-31-13; DFW 54-2014(Temp), f. 6-2-14, cert. ef. 6-3-14 thru 7-31-14; DFW 59-2014(Temp), f. 6-9-14, cert. ef. 6-10-14 thru 7-31-14; Administrative correction, 8-28-14; DFW 9-2015(Temp), f. 1-29-15, cert. ef. 2-2-15 thru 3-31-15; DFW 13-2015(Temp), f. 2-19-15, cert. ef. 2-20-15 thru 3-31-15; DFW 19-2015(Temp), f. 3-11-15, cert. ef. 3-12-15 thru 3-31-15

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Department of Human Services, Aging and People with Disabilities and Developmental Disabilities
Chapter 411

Rule Caption: Nursing Facilities/Licensing — Transfers
Adm. Order No.: APD 5-2015(Temp)
Filed with Sec. of State: 2-27-2015
Certified to be Effective: 3-2-15 thru 8-28-15
Notice Publication Date:
Rules Amended: 411-088-0050, 411-088-0060
Subject: To meet the requirements of 411-088-0070, the Department is immediately amending 411-088-0050 and 411-088-0060 to provide the correct citation for a form that is named in both rules, and delete the outdated form that is currently included as an exhibit at the end of the rule division. Minor wording, grammar, formatting, and punctuation changes will be made to the rules as well to improve clarity.
Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-088-0050
Right to Return from Hospital

(1) If a resident is transferred to a hospital, the facility may not fill the resident's bed with another person if the resident or the resident's legal representative offers payment, or reimbursement is available from the Department, for the period of the hospital stay. If payment or reimbursement is offered or available, from or on behalf of the resident, the Department, or a combination thereof, or if the facility has not complied in full with section (2) of this rule, the resident shall have the right of return to his or her bed immediately after the period of hospital stay.

(2) The Administrator, or his or her designee, is responsible for notifying the resident or legal representative and any agency responsible for the welfare or support of the resident of the option to offer payment to hold the bed prior to filling the bed with another person. This notification shall be documented in the resident's record by either the resident's or legal representative's written agreement to pay or rejection of the option to pay.

(3) If the resident is unable, due to physical or mental incapacity, to enter such agreement and there is no legal representative known to the facility, this fact shall be documented in the resident's record and the resident's bed may thereafter be filled upon issuance of the notice (SDS 0510).

(4) If the resident's bed has been given to another person because payment was not offered, the resident shall have priority for readmission over all other persons with a right to readmission and over any waiting list.

(5) If a former resident or his or her legal representative requests right of return and the facility denies right of return, then the facility shall give written notice (SDS 0510).

(6) Persons with right of return have priority over all persons with right of readmission.

(7) Residents with a right of return are entitled to return to the facility immediately upon discharge from the hospital unless the resident's bed has been filled in compliance with this rule and there is no available bed in the facility.

Stat. Auth.: ORS 410 & 441.055
Stats. Implemented: ORS 441.055, 441.600 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93; APD 5-2015(Temp), f. 2-27-15, cert. ef. 3-2-15 thru 8-28-15

411-088-0060
Right to Readmission

(1) Any person transferred from a facility voluntarily or involuntarily shall have the right of readmission to the facility from which the person was transferred, provided that:

(a) A request for readmission is made within 180 days of the date of transfer;

(b) The person is eligible by means of payment and requires nursing facility care; and

(c) No determination was made at informal conference or hearing that the person shall not have the right of readmission.

(2) Section (1) of this rule does not require a facility to accept a person in a bed located in a room which is occupied by a resident of the opposite sex at the time of the request.

EXCEPTION: A facility is required to accept a person to a room occupied by a resident of the opposite sex if the respective resident previously shared a room in the facility and if neither resident objects to the admission.

(3) Section (1) of this rule does not require a facility to accept a person who voluntarily transferred from the facility directly to another nursing facility.

(4) If a person or his or her legal representative request readmission, and the facility denies readmission, then the facility shall give written notice (SDS 0510).

(5) A former resident who receives Medicaid does not have the right to be readmitted to a facility which is not Medicaid certified unless reimbursement is available pursuant to OAR 411-070-0010.

(6) If more than one person has a right of readmission, priority in allocation of vacancies shall be determined by the earliest date of application for readmission.

(7) A person whose stay in the facility totals 30 or fewer days and was transferred pursuant to OAR 411-088-0070(1)(d) (post-hospital extended care services or specialized services) may not have a right of readmission.

Stat. Auth.: ORS 441.055 & 441.605
Stats. Implemented: ORS 441.055, 441.600 & 441.615
Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93; SSD 2-1995, f. & cert. ef. 2-15-95; APD 5-2015(Temp), f. 2-27-15, cert. ef. 3-2-15 thru 8-28-15

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Rule Caption: Nursing Facilities — Complex Medical Add-On
Adm. Order No.: APD 6-2015
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Rules Amended: 411-070-0005, 411-070-0027, 411-070-0035, 411-070-0043, 411-070-0091
Subject: The Department of Human Services (Department), Aging and People with Disabilities (APD) is permanently updating the rules for Nursing Facilities located in OAR chapter 411, division 070 to update the process in regards to complex medical add-on documentation. Definitions, along with the amended rules, were updated to reflect current Department terminology. The amendments also fix minor grammar, formatting, punctuation, and housekeeping issues in the rules.
Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-070-0005
Definitions

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-085-0005 apply to the rules in OAR chapter 411, division 070:

(1) "Accrual Method of Accounting" means a method of accounting where revenues are reported in the period they are earned, regardless of when they are collected, and expenses are reported in the period they are incurred, regardless of when they are paid.

(2) "Active Treatment" means the implementation of an individualized care plan developed under and supervised by a physician and other qualified mental health professionals that prescribes specific therapies and activities.

(3) "Activities of Daily Living" means activities usually performed in the course of a normal day in an individual's life such as eating, dressing, grooming, bathing, personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition and behavior.

(4) "Addictions and Mental Health (AMH)" means the Division, within the Oregon Health Authority, responsible for addictions and mental health services.

(5) "Aging and People with Disabilities" means the program area of Aging and People with Disabilities, within the Department of Human Services.

(6) "APD" means "Aging and People with Disabilities."

(7) "Alternative Services" mean individuals or organizations offering services to persons living in a community other than a nursing facility or hospital.

(8) "Area Agency on Aging (AAA)" means the Department of Human Services designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors and individuals with disabilities in a planning and service area. For the purpose of these rules, the term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in 410.210 to 410.300.

(9) "Augmented Rate" means the additional compensation to a nursing facility who qualifies for the Quality and Efficiency Incentive Program described in OAR 411-070-0437. The augmented rate is a daily rate of $9.75 and is in addition to the rate a nursing facility would otherwise receive. The Department may pay the augmented rate to a qualifying facility for a period not to exceed four years from the date the facility purchases bed capacity under the Quality and Efficiency Incentive Program.

(10) "Basic Flat Rate Payment" and "Basic Rate" means the statewide standard payment rate for all long term services provided to a Medicaid resident of a nursing facility, except for services reimbursed through another Medicaid payment source. The "Basic Rate" is the bundled payment rate, unless the resident qualifies for the complex medical add-on rate (in addition to the basic rate) or the bundled pediatric rate (instead of the basic rate).

(11) "Capacity" means licensed nursing beds multiplied by number of days in operation.

(12) "Case Manager" means a Department of Human Services or Area Agency on Aging 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.

(13) "Cash Method of Accounting" means a method of accounting where revenues are recognized only when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for them.

(14) "Categorical Determinations" mean the provisions in the Code of Federal Regulations (42 CFR 483.130) for creating categories that describe certain diagnoses, severity of illness, or the need for a particular service that clearly indicates that admission to a nursing facility is normally needed or that the provision of specialized services is not normally needed.

(a) Membership in a category may be made by the evaluator only if existing data on the individual is current, accurate, and of sufficient scope.

(b) An individual with mental illness or developmental disabilities may enter a nursing facility without a PASRR Level II evaluation if criteria of a categorical determination are met as described in OAR 411-070-0043(2)(a)–(2)(c).

(15) "Certification" and "Certification for the Categorical Determination of Exempted Hospital Discharge" means the attending physician has written orders for the individual to receive skilled services at the nursing facility.

(16) "Certified Program" means a hospital, private agency, or an Area Agency on Aging certified by the Department of Human Services to conduct private admission assessments in accordance with ORS 410.505 through 410.530.

(17) "Change of Ownership" means a change in the individual or legal organization that is responsible for the operation of a nursing facility. Change of ownership does not include changes in personnel, e.g., a change of administrators. Events that change ownership include, but are not limited to, the following:

(a) The form of legal organization of the owner is changed (e.g., a sole proprietor forms a partnership or corporation);

(b) The title to the nursing facility enterprise is transferred to another party;

(c) The nursing facility enterprise is leased or an existing lease is terminated;

(d) Where the owner is a partnership, any event occurs which dissolves the partnership;

(e) Where the owner is a corporation, it is dissolved, merges with another corporation that is the survivor, or consolidates with one or more other corporations to form a new corporation; or

(f) The facility changes management via a management contract.

(18) "Compensation" means the total of all benefits and remuneration, exclusive of payroll taxes and regardless of the form, provided to or claimed by an owner, administrator, or other employee. Compensation includes, but is not limited to:

(a) Salaries paid or accrued;

(b) Supplies and services provided for personal use;

(c) Compensation paid by the facility to employees for the sole benefit of the owner;

(d) Fees for consultants, directors, or any other fees paid regardless of the label;

(e) Key man life insurance;

(f) Living expenses, including those paid for related persons; or

(g) Gifts for employees in excess of federal Internal Revenue Service reporting guidelines.

(19) "Complex Medical Add-On Payment" and "Medical Add-On" means the statewide standard supplemental payment rate for a Medicaid resident of a nursing facility whose service is reimbursed at the basic rate if the resident needs one or more of the medication procedures, treatment procedures, or rehabilitation services listed in OAR 411-070-0091, for the additional licensed nursing services needed to meet the resident's increased needs.

(20) "Continuous" means more than once per day, seven days per week. Exception: If only skilled rehabilitative services and no skilled nursing services are required, "continuous" means at least once per day, five days per week.

(21) "Costs Not Related to Resident Services" means costs that are not appropriate or necessary and proper in developing and maintaining the operation of a nursing facility. Such costs are not allowable in computing reimbursable costs. Costs not related to resident services include, for example, cost of meals sold to visitors, cost of drugs sold to individuals who are not residents, cost of operation of a gift shop, and similar items.

(22) "Costs Related to Resident Services" mean all necessary costs incurred in furnishing nursing facility services, subject to the specific provisions and limitations set out in these rules. Examples of costs related to resident services include nursing costs, administrative costs, costs of employee pension plans, and interest expenses.

(23) "CPI" means the consumer price index for all items and all urban consumers.

(24) "Day of Admission" means an individual being admitted, determined as of 12:01 a.m. of each day, for all days in the calendar period for which an assessment is being reported and paid. If an individual is admitted and discharged on the same day, the individual is deemed present on 12:01 a.m. of that day.

(25) "Department" or "DHS" means the Department of Human Services.

(26) "Developmental Disability" means "developmental disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(27) "Direct Costs" mean costs incurred to provide services required to directly meet all the resident nursing and activity of daily living service needs. Direct costs are further defined in OAR 411-070-0359 and 411-070-0465. Examples: The person who feeds food to the resident is directly meeting the resident's needs, but the person who cooks the food is not. The person who is trained to meet the resident's needs incurs direct costs whereas the person providing the training is not. Costs for items that are capitalized or depreciated are excluded from this definition.

(28) "Division of Medical Assistance Programs (DMAP)" means a Division, within the Oregon Health Authority, responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan Medicaid demonstration, the State Children's Health Insurance Program, and several other programs.

(29) "DRI Index" means the "HCFA or CMS Nursing Home Without Capital Market Basket" index, which is published quarterly by DRI/McGraw — Hill in the publication, "Global Insight Health Care Cost Review".

(30) "Essential Nursing Facility" means a nursing facility that serves predominantly rural and frontier communities as designated by the Office of Rural Health that is located more than 32 miles from another nursing facility or from a hospital that has received a formal notice of Critical Access Hospital (CAH) designation from the Centers for Medicare and Medicaid Services and that is currently contracted to provide swing bed services for Medicaid-eligible individuals.

(31) "Exempted Hospital Discharge" for PASRR means an individual seeking temporary admission to a nursing facility from a hospital as described in OAR 411-070-0043(2)(a).

(32) "Facility" or "Nursing Facility" means an establishment that is licensed and certified by the Department of Human Services as a nursing facility. A nursing facility also means a Medicaid certified nursing facility only if identified as such.

(33) "Fair Market Value" means the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

(34) "Generally Accepted Accounting Principles" mean the accounting principles approved by the American Institute of Certified Public Accountants.

(35) "Goodwill" means the excess of the price paid for a business over the fair market value of all other identifiable, tangible, and intangible assets acquired, or the excess of the price paid for an asset over its fair market value.

(36) "Historical Cost" means the actual cost incurred in acquiring and preparing a fixed asset for use. Historical cost includes such planning costs as feasibility studies, architects' fees, and engineering studies. Historical cost does not include "start-up costs" as defined in this rule.

(37) "Hospital-Based Facility" means a nursing facility that is physically connected and operated by a licensed general hospital.

(38) "Indirect Costs" mean the costs associated with property, administration, and other operating support (real property taxes, insurance, utilities, maintenance, dietary (excluding food), laundry, and housekeeping). Indirect costs are further described in OAR 411-070-0359 and 411-070-0465.

(39) "Individual" means a person who receives or expected to receive nursing facility services.

(40) "Intellectual Disability" means "intellectual disability" as defined in OAR 411-320-0020 and described in 411-320-0080.

(41) "Interrupted-Service Facility" means an established facility recertified by the Department of Human Services following decertification.

(42) "Level I" means a component of the federal PASRR requirement. Level I refers to the identification of individuals who are potential nursing facility admissions who have indicators of mental illness or developmental disabilities (42 CFR 483.128(a)).

(43) "Level II" means a component of the federal PASRR requirement. Level II refers to the evaluation and determination of whether nursing facility services and specialized services are needed for individuals with mental illness or developmental disability who are potential nursing facility admissions, regardless of the source of payment for the nursing facility service (42 CFR 483.128(a)). Level II evaluations include assessment of the individual's physical, mental, and functional status (42 CFR 483.132).

(44) "Level of Care Determination" means an evaluation of the intensity of a person's health service needs. The level of care determination may not be used to require that the person receive services in a nursing facility.

(45) "Medicaid Occupancy Percentage" means the total Medicaid bed days divided by total resident days.

(46) "Medical Add-On" or "Complex Medical Add-On Payment" has the meaning provided in section (19) of this rule.

(47) "Mental Illness" means a major mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV-TR) limited to schizophrenic, paranoid and schizoaffective disorders, bipolar (manic-depressive), and atypical psychosis. "Mental Illness" for pre-admission screening means having both a primary diagnosis of a major mental disorder (schizophrenic, paranoid, major affective and schizoaffective disorders, or atypical psychosis) and treatment related to the diagnosis in the past two years. Diagnoses of dementia or Alzheimer's are excluded.

(48) "Necessary Costs" mean costs that are appropriate and helpful in developing and maintaining the operation of resident facilities and activities. Necessary costs are usually costs that are common and accepted occurrences in the field of long term nursing services.

(49) "New Admission" for PASRR purposes means an individual admitted to any nursing facility for the first time. It does not include individuals moving within a nursing facility, transferring to a different nursing facility, or individuals who have returned to a hospital for treatment and are being admitted back to the nursing facility. New admissions are subject to the PASRR process (42 CFR 483.106(b)(1), (3), (4)).

(50) "New Facility" means a nursing facility commencing to provide services to individuals.

(51) "Nursing Aide Training and Competency Evaluation Program (NATCEP)" means a nursing assistant training and competency evaluation

program approved by the Oregon State Board of Nursing pursuant to ORS chapter 678 and the rules adopted pursuant thereto.

(52) "Nursing Facility Financial Statement (NFFS)" means Form DHS 35, or Form DHS 35A (for hospital-based facilities), and includes an account number listing of all costs to be used by all nursing facility providers in reporting to the Department of Human Services for reimbursement.

(53) "Occupancy Rate" means total resident days divided by capacity.

(54) "Official Bed Count Measurement" means the number of licensed nursing facility beds as of October 7, 2013 and the beds being developed by facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December 1, 2012 or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013.

(55) "Ordinary Costs" mean costs incurred that are customary for the normal operation.

(56) "Oregon Medical Professional Review Organization (OMPRO)" means the organization that determines level of services, need for services, and quality of services.

(57) "Pediatric Rate" means the statewide standard payment rate for all long term services provided to a Medicaid resident under the age of 21 who is served in a pediatric nursing facility or a self-contained pediatric unit.

(58) "Perquisites" mean privileges incidental to regular wages.

(59) "Personal Incidental Funds" mean resident funds held or managed by the licensee or other person designated by the resident on behalf of a resident.

(60) "Placement" means the location of a specific place where health services can be adequately provided to meet the service needs.

(61) "Pre-Admission Screening (PAS)" means the assessment and determination of a potential Medicaid-eligible individual's need for nursing facility services, including the identification of individuals who can transition to community-based service settings and the provision of information about community-based alternatives. This assessment and determination is required when potentially Medicaid-eligible individuals are at risk for admission to nursing facility services. PAS may include the completion of the federal PASRR Level I requirement (42 CFR, Part 483, (C)-(E)), to identify individuals with mental illness or intellectual or developmental disabilities.

(62) "Pre-Admission Screening and Resident Review (PASRR)" means the federal requirement, (42 CFR, Part 483, (C)-(E)), to identify individuals who have mental illness or developmental disabilities and determine if nursing facility service is required and if specialized services are required. PASRR includes Level I and Level II functions.

(63) "Prior Authorization" means the local Aging and People with Disabilities or Area Agency on Aging office participates in the development of proposed nursing facility care plans to assure the facility is the most suitable service setting for the individual. Nursing facility reimbursement is contingent upon prior-authorization.

(64) "Private Admission Assessment (PAA)" means the assessment that is conducted for non-Medicaid residents as established by ORS 410.505 to 410.545 and OAR chapter 411, division 071, who are potential admissions to a Medicaid-certified nursing facility. Service needs are evaluated and information is provided about long-term service choices. A component of private admission assessment is the federal PASRR Level I requirement, (42 CFR, Part 483.128(a)), to identify individuals with mental illness or developmental disabilities.

(65) "Provider" means an entity, licensed by Aging and People with Disabilities, responsible for the direct delivery of nursing facility services.

(66) "Provider Preventable Condition (PPC)" means a condition listed below caused by the provider:

(a) Foreign object retained after treatment;

(b) Stage III and IV pressure ulcers;

(c) Falls and trauma;

(d) Manifestations of poor glycemic control;

(e) Catheter-associated urinary tract infection;

(f) Medication error; or

(g) Surgical site or wound site infection.

(67) "Quality and Efficiency Incentive Program" means the program described in OAR 411-070-0437 designed to reimburse quality nursing facilities that voluntarily reduce bed capacity that increases occupancy levels and enhances efficiency with the goal of slowing the growth of system-wide costs.

(68) "Reasonable Consideration" means an inducement that is equivalent to the amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.

(69) "Related Organization" means an entity that is under common ownership or control with, or has control of, or is controlled by the contractor. An entity is deemed to be related if it has 5 percent or more ownership interest in the other. An entity is deemed to be related if it has capacity derived from any financial or other relationship, whether or not exercised, to influence directly or indirectly the activities of the other.

(70) "Resident" means a person who receives nursing facility services.

(71) "Resident Days" mean the number of occupied bed days.

(72) "Resident Review" means a review conducted by the Addictions and Mental Health Division for individuals with mental illness or by the Aging and People with Disabilities Division for individuals with developmental disabilities who are residents of nursing facilities. The findings of the resident review may result in referral to PASRR Level II (42 CFR 483.114).

(73) "Restricted Fund" means a fund in which the use of the principal or principal and income is restricted by agreement with, or direction by, the donor to a specific purpose. Restricted fund does not include a fund over which the owner has complete control. The owner is deemed to have complete control over a fund that is to be used for general operating or building purposes.

(74) "Specialized Services for Mental Illness" means mental health services delivered by an interdisciplinary team in an inpatient psychiatric hospital for treatment of acute mental illness.

(75) "Specialized Services for Intellectual or Developmental Disabilities" means:

(a) For individuals with intellectual or developmental disabilities under age 21, specialized services are equal to school services; and

(b) For individuals with t intellectual or developmental disabilities over age 21, specialized services mean:

(A) A consistent and ongoing program that includes participation by the individual in continuous, aggressive training and support to prevent loss of current optimal function;

(B) Promotes the acquisition of function, skills, and behaviors necessary to increase independence and productivity; and

(C) Is delivered in community-based or vocational settings at a minimum of 25 hours a week.

(76) "Start-Up Costs" mean one-time costs incurred prior to the first resident being admitted. Start-up costs include, but are not limited to, administrative and nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs. Start-up costs do not include such costs as feasibility studies, engineering studies, architect's fees, or other fees that are part of the historical cost of the facility.

(77) "Supervision" means initial direction and periodic monitoring of performance. Supervision does not mean the supervisor is physically present when the work is performed.

(78) "These Rules" mean the rules in OAR chapter 411, division 070.

(79) "Title XVIII" and "Medicare" means Title XVIII of the Social Security Act.

(80) "Title XIX," "Medicaid," and "Medical Assistance" means Title XIX of the Social Security Act.

(81) "Uniform Chart of Accounts (Form DHS 35)" means a list of account titles identified by code numbers established by the Department of Human Services for providers to use in reporting their costs.

[ED. NOTE: Forms referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070 & 414.065

Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; PWC 866(Temp), f. 12-30-77, ef. 1-1-78; AFS 19-1978, f. & ef. 5-1-78; AFS 58-1981, f. & ef. 9-1-81; Renumbered from 461-017-0010, AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 6-1985, f. 5-31-85, ef. 6-1-85; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 12-2007, f. 8-30-07, cert. ef. 9-1-07; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 6-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09; SPD 12-2012(Temp), f. 8-31-12, cert. ef. 9-1-12 thru 2-28-13; SPD 2-2013, f. & cert. ef. 3-1-13; SPD 37-2013(Temp), f. 10-4-13, cert. ef. 10-7-13 thru 4-5-14; APD 2-2014, f. 3-13-14, cert. ef. 4-1-14; APD 6-2015, f. 3-4-15, cert. ef. 3-9-15

411-070-0027

Complex Medical Add-On Payment Authorization

(1) PAYMENT. APD may provide payment for a complex medical add-on (in addition to the basic rate) when the resident requires one or more of the treatments, procedures, and services listed in OAR 411-070-0091, for

the additional licensed nursing services needed to meet the resident's increased needs.

(2) APD may pay the complex medical add-on only as long as the resident's needs meet one or more of the treatments, procedures, and services listed in OAR 411-070-0091 and the facility maintains the required documentation.

(3) DOCUMENTATION. The licensed nursing staff of the nursing facility must keep sufficient documentation pertinent to the qualified complex medical add-on procedure codes in the resident's clinical record to justify the complex medical add-on payment determination in accordance with these rules (refer to OAR 411-070-0091) and must make it available to APD upon request.

(4) COMPLEX MEDICAL ADD-ONS PROHIBITED. APD may not provide complex medical add-on payments for a facility with a waiver that allows a reduction of eight or more hours per week from required licensed nurse staffing hours.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070 & 414.065

Hist.: SSD 20-1990, f. & cert. ef. 10-4-90; SSD 21-1990(Temp), f. & cert. ef. 10-5-90; SSD 6-1991, f. & cert. ef. 3-25-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09; APD 6-2015, f. 3-4-15, cert. ef. 3-9-15

411-070-0035

Complex Medical Add-On Effective Start and End Dates and Administrative Review

(1) Effective Complex Medical Add-On Start and End Dates

(a) Complex Medical Add-On Start Date:

(A) Admission of any Medicaid resident whose condition or service needs meet the criteria for a complex medical add-on procedure code; or

(B) A current Medicaid resident whose condition or service needs change and now meets the criteria for a complex medical add-on procedure code. This includes a readmission or return of a Medicaid resident following a leave of absence from the nursing facility whose needs meet add-on criteria.

(b) Complex Medical Add-On End date — For a resident whose condition or service needs meet a complex medical add-on procedure code, the complex medical add-on is effective only until the last date the resident's condition or need continues to meet complex medical add-on procedure code criteria.

(2) ADMINISTRATIVE REVIEW. If a provider disagrees with the decision of APD's Complex Medical Add-On Coordinator to make or deny an adjustment in the complex medical add-on payment for a Medicaid resident, the provider may request from APD an administrative review of the decision. The provider must submit its request for review in writing within 30 days of receipt of the notice to make or deny the adjustment. The provider must submit documentation, as requested by APD, to substantiate its position. APD shall notify the provider in writing of its informal decision within 45 days of APD's receipt of the provider's request for review. APD's informal decision shall be an order in other than a contested case and subject to review pursuant to ORS 183.484.

(3) OVERPAYMENT FOR COMPLEX MEDICAL ADD-ONS. APD shall collect monies that were overpaid to a facility for any period APD determines the resident's condition or service needs did not meet the criteria for the complex medical add-on, or determines the facility did not maintain the required documentation.

Stat. Auth.: ORS 414.070

Stats. Implemented: ORS 410.070 & 414.065

Hist.: PWC 847(Temp), f. & ef. 7-1-77; PWC 859, f. 10-31-77, ef. 11-1-77; AFS 40-1979, f. 10-31-79, ef. 11-1-79; AFS 58-1981, f. & ef. 9-1-81; Renumbered from 461-017-0050 by Ch. 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 10-1983, f. 10-19-83, ef. 11-1-83; SSD 8-1985, f. 6-13-85, ef. 6-15-85; SSD 20-1990, f. & cert. ef. 10-4-90; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 8-1994, f. & cert. ef. 12-1-94; SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09; APD 6-2015, f. 3-4-15, cert. ef. 3-9-15

411-070-0043

Pre-Admission Screening and Resident Review (PASRR)

(1) INTRODUCTION. PASRR was mandated by Congress as part of the Omnibus Budget Reconciliation Act of 1987 and is codified in Section 1919(e)(7) of the Social Security Act. Final regulations are contained in 42 CFR, Part 483, subparts C through E. The purpose of PASRR is to prevent the placement of individuals with mental illness or intellectual or developmental disabilities in a nursing facility unless their medical needs clearly indicate that they require the level of service provided by a nursing facility. Categorical determination, as described in section (2) of this rule, are groupings of individuals with mental illness or intellectual or developmental disabilities who may be admitted to a nursing facility without a PASRR Level II evaluation.

(2) CATEGORICAL DETERMINATIONS.

(a) Exempted hospital discharge:

(A) The individual is admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; or

(B) The individual is admitted to the nursing facility directly from a hospital after receiving care as an observation-status; and

(C) The individual requires nursing facility services for the condition for which he or she received care in the hospital; and

(D) The individual's attending physician has certified before admission to the facility that the individual is likely to require nursing facility services for 30 days or less.

(b) End of life care for terminal illness. The individual is admitted to the nursing facility to receive end of life care and the individual has a life expectancy of six months or less.

(c) Emergency situations with nursing facility admission not to exceed seven days unless authorized by AAA or APD staff.

(A) The individual requires nursing facility level of service; and

(B) The emergency is due to unscheduled absence or illness of the regular caregiver; or

(C) Nursing facility admission is the result of protective services action.

(3) PASRR includes three components.

(a) PASRR LEVEL I. PASRR Level I is a screening process that is conducted prior to nursing facility admission for all individuals applying as new admissions to a Medicaid certified nursing facility regardless of the individual's source of payment. The purpose of the screening is to identify indicators of mental illness or intellectual or developmental disabilities that may require further evaluation {42 CFR 483.128} or if categorical determinations, as described in section (2) of this rule, which verify that the nursing facility service is required.

(A) PASRR Level I screening is performed by AAA or APD authorized staff, private admission assessment (PAA) programs, professional medical staff working directly under the supervision of the attending physician, or by organizations designated by DHS.

(B) Documentation of PASRR Level I screening is completed using a APD-designated form.

(C) If there are no indicators of mental illness or intellectual or developmental disabilities or if the individual belongs to a categorically determined group, the individual may be admitted to a nursing facility subject to all other relevant rules and requirements.

(D) If PASRR Level I screening determines that an individual has indicators of mental illness and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact AMH and request a PASRR Level II evaluation.

(E) If PASRR Level I screening determines that an individual has indicators of intellectual or developmental disabilities and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact APD and request a PASRR Level II evaluation.

(F) Except as provided in section (3)(a)(F)(ii) of this rule, nursing facilities must not admit an individual without a completed and signed PASRR Level I screening form in the individual's resident record.

(i) Completion of the PASRR Level I form under sections (3)(a)(A) through (3)(a)(F) of this rule does not constitute prior authorization of payment. Nursing facilities must still obtain prior authorization from the local AAA or APD office as required in OAR 411-070-0035.

(ii) A nursing facility may admit an individual without a completed and signed PASRR Level I form in the resident record provided the facility has received verbal confirmation from the Level I assessor that the screening has been completed and a copy of the PASRR Level I form will be sent to the facility as soon as is reasonably possible.

(iii) The original or a copy of the PASRR Level I form must be retained as a permanent part of the resident's clinical record and must accompany the individual if he or she transfers to another nursing facility.

(b) PASRR LEVEL II. PASRR Level II is an evaluation and determination of whether nursing facility service and specialized services are needed for an individual who has been identified through the PASRR Level I screening process with indicators of mental illness or intellectual or developmental disabilities who does not meet categorical determination criteria (42 CFR 483.128).

(A) Individual's identified with indicators or mental illness or intellectual or developmental disabilities as a result of PASRR Level I screening are referred for PASRR Level II evaluation and determination.

(B) PASRR Level II evaluations and determinations are conducted by AMH for individuals with mental illness or by APD for individuals with intellectual or developmental disabilities.

(C) PASRR Level II evaluations result in a determination of an individual's need for nursing facility services and specialized services (42 CFR 483.128-136) consistent with federal regulations established by the Social Security Act, Section 1919(e)(7)(C).

(D) Pursuant to 42 CFR 483.130(l), the written determination must include the following findings:

(i) Whether a nursing facility level of services is needed;

(ii) Whether specialized services are needed;

(iii) The placement options that are available to the individual consistent with these determinations; and

(iv) The rights of the individual to appeal the determination.

(E) The PASRR Level II evaluation report must be sent to the individual or their legal representative, the individuals attending physician, and the admitting or retaining nursing facility. In the case of an individual being discharged from the hospital, the discharging hospital must receive a copy of the PASRR evaluation report as well (42 CFR 483.128(l)(1)–(3)).

(F) Denials of nursing facility service are subject to appeal (OAR 137-003, OAR 461-025 & 42 CFR Subpart E).

(c) RESIDENT REVIEW. Resident reviews are conducted by AMH for individuals with indicators of mental illness or APD for individuals with intellectual or developmental disabilities who are residents of nursing facilities. Based on the findings of the resident review, a PASRR Level II may be requested. {42 CFR 483.114}.

(A) All residents of a Medicaid certified nursing facility may be referred for resident review when symptoms of mental illness develop.

(i) Resident review for individuals with indicators of mental illness that require further evaluation must be referred to the local Community Mental Health Program who shall determine eligibility for PASRR Level II evaluations.

(ii) The resident review form, part A, must be completed by the nursing facility. The resident review must be performed in conjunction with the comprehensive assessment specified by the AMH, in accordance with OAR 411-086-0060.

(B) All individuals identified as having intellectual or developmental disabilities through the PASRR Level I screening process that are admitted to a nursing facility must receive a resident review. A resident review must be conducted within seven days if the nursing facility admission is due to an emergency situation (OAR 411-070-0043(2)(c)(A)–(C)), within 20 days if the nursing facility admission is due to other categorical determinations (OAR 411-070-0043(2)(a)–(b)), and annually, or as dictated by changes in resident's needs or desires.

(i) The resident review must be completed by APD or designee.

(ii) The resident review must be completed using forms designated by APD.

(4) SPECIALIZED SERVICES.

(a) Specialized services for individuals with mental illness are not provided in nursing facilities. Individuals with mental illness who are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

(b) Specialized services for individuals with intellectual or developmental disabilities under age 21 are equal to school services and must be based on the Individualized Education Plan.

(c) Specialized services for individuals with intellectual or developmental disabilities over age 21 are not provided in nursing facilities. Individuals with intellectual or developmental disabilities over age 21 that are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

(5) RESPITE CARE. Respite care in nursing facilities for individuals with mental illness, intellectual, or developmental disabilities is approved under the following conditions:

(a) For individuals with mental illness, a nursing facility admission for respite care must be authorized by AMH and for individuals with intellectual or developmental disabilities, a nursing facility admission for respite care must be authorized by APD Central Office;

(b) Nursing facility respite stay must be limited to no more than a total of 56 respite days within a calendar year although APD may grant exceptions to this limit at its discretion;

(c) Nursing facility level of service must be required to meet a severe medical condition that excludes care needs due to mental illness or intellectual or developmental disabilities; and

(d) There must not be a viable community care setting available that is appropriate to meet the individual's respite care needs as determined by section (5)(a) of this rule.

[ED. NOTE: Forms referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070, 535 & 414.065

Hist.: SSD 5-1989(Temp), f. & cert. ef. 4-20-89; SSD 15-1989, f. & cert. ef. 10-20-89; SSD 3-1994, f. 4-29-94, cert. ef. 5-1-94; SDSD 1-1998, f. 1-30-98, cert. ef. 2-1-98; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 12-2007, f. 8-30-07, cert. ef. 9-1-07; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09; APD 6-2015, f. 3-4-15, cert. ef. 3-9-15

411-070-0091
Complex Medical Add-On Services

(1) LICENSED NURSING SERVICES. If a Medicaid resident qualifies for payment at the basic rate and if the resident's condition or service needs are determined to meet one or more of the procedures, routines, or services listed in this rule, and the nursing facility maintains documentation per OAR 411-070-0027, APD may pay a complex medical add-on payment (in addition to the basic rate) for the additional licensed nursing services needed to meet the resident's increased needs.

(a) Medication Procedures.

(A) M-1 — Administration of medication, at least daily, requiring skilled observation and judgment for necessity, dosage, and effect, for example new anticoagulants. (This category is limited to non-routine subcutaneous injections and does not include insulin, or the infrequent adjustments of current medications). The facility must maintain a daily nursing note.

(B) M-2 — Intravenous injections or infusions, heparin locks used daily or continuously for hydration or medication. The facility must maintain a daily nursing note. For total parenteral nutrition (TPN) the facility must maintain daily documentation on a flow sheet and must maintain a weekly nursing note.

(C) M-4 — Intramuscular medications for unstable condition used at least daily. The facility must maintain a daily nursing note.

(D) M-5 — External infusion pumps used at least daily. This does not include external infusion pumps when the resident is able to self bolus. The facility must maintain a daily nursing note.

(E) M-6 — Hypodermoclysis - daily or continuous use. The facility must maintain a daily nursing note.

(F) M-7 — Peritoneal dialysis, daily. This does not include residents who can do their own exchanges. The facility must maintain a daily nursing note.

(b) Treatment Procedures.

(A) T-1 — Nasogastric, Gastrostomy or Jejunostomy tubes used daily for feedings. The facility must maintain daily information on a flow sheet and a weekly nursing note.

(B) T-2 — Nasopharyngeal suctioning, twice a day or more. Tracheal suctioning, as required, for a resident who is dependent on nursing staff to maintain airway. The facility must maintain a daily nursing note.

(C) T-3 — Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more. The facility must maintain a daily nursing note.

(D) T-4 — Ventilator dependence. Services for a resident who is dependent on nursing staff for initiation, monitoring, and maintenance. The facility must maintain a daily nursing note.

(c) Skin or Wound.

(A) S-1 — Is limited to visible Stage III or IV pressure ulcers that require aggressive treatment with documented expectation of ulcer resolution. The facility must maintain a weekly wound assessment and a weekly nursing note. A healing Stage III or IV pressure ulcer that has the visual appearance of a Stage II pressure ulcer cannot be considered eligible for purposes of complex medical criteria.

The pressure ulcer is eligible for add-on until the last day the ulcer is visibly a Stage III pressure ulcer. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident's needs meet or continue to meet complex medical add-on criteria.

(i) Pressure ulcer means any skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include decubitus ulcers.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

(B) S-2 — Open wounds as defined by dehisced surgical wounds or surgical wounds not closed primarily that require aggressive treatment and are expected to resolve. The facility must maintain a weekly wound assessment and a weekly nursing note.

(C) S-3 — Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III. The facility must maintain a weekly wound assessment and a weekly nursing note. The stasis ulcer is eligible for add-on until the last day the ulcer is visually equivalent to a Stage III, or if the stasis ulcer is an infected, chronic Stage III or IV, it is eligible for add-on until it is no longer infected and returns to previous chronic Stage III or IV state. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident's needs meet or continue to meet complex medical add-on criteria.

(i) Stasis ulcer means a skin ulcer, usually in the lower extremities, caused by altered blood flow from chronic vascular insufficiency, also referred to as venous insufficiency, lymphedema, arterial insufficiency, or peripheral vascular disease.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

(v) A healing Stage III or IV stasis ulcer that has the visual appearance of a Stage II stasis ulcer cannot be considered eligible for purposes of complex medical criteria.

(vi) A chronic Stage III or IV stasis ulcer that is no longer infected and has returned to previous chronic Stage III or IV status cannot be considered eligible for purposes of complex medical criteria.

(d) O-4— Insulin Dependent Diabetes Mellitus (IDDM).

(A) Unstable IDDM in a resident who requires sliding scale insulin; and

(i) Exhibits signs or symptoms of hypoglycemia or hyperglycemia, or both;

(ii) Requires nursing or medical interventions such as extra feeding, glucagon, or additional insulin, and transfer to emergency room; and

(iii) Is having insulin dosage adjustments.

(B) The facility must maintain a daily nursing note. A Medication Administration Record is required when sliding scale insulin or other medication related to the IDDM has been administered. While all three criteria do not need to be present on a daily basis, the resident must be considered unstable. A resident with erratic blood sugars, without a need for further interventions, does not meet this criteria.

(e) Other.

(A) O-1 — Professional Teaching. Short term, daily teaching pursuant to discharge or a self-care plan. The facility must maintain a teaching plan and a weekly nursing note.

(B) O-2 — Emergent medical or surgical problems, requiring short term licensed nursing observation and assessment. Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical or surgical problem. The facility must maintain a nursing note every shift.

(C) O-3 — Emergent Behavior Problems — Emergent behavior is a sudden, generally unexpected change or escalation in behavior of a resident that poses a serious threat to the safety of self or others and requires immediate intervention, consultation, and a care plan. Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical problem. The facility must maintain a nursing note every shift.

(f) Effective September 1, 2012, the Department shall no longer provide the complex medical add-on for Provider Preventable Conditions (PPC).

(A) Nursing facilities may not receive complex medical add-on if the need for the complex medical add-on was caused by a PPC and the need for complex medical add-on did not exist prior to treatment or intervention.

(B) No reduction in payment for a PPC shall be imposed on a provider when the condition defined as a PPC for a particular individual occurred outside of the nursing facility or prior to admission.

(C) Regardless of payment requests, a nursing facility must report each PPC event to the Department through a Department approved reporting system.

(2) R-1 — REHABILITATION SERVICES.

(a) Physical Therapy — At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(b) Speech Therapy — At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(c) Occupational Therapy — At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(d) Any combination of physical therapy, occupational therapy, and speech therapy at least five days every week qualifies. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(e) Respiratory Therapy — At least five days every week by a respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan, or a third party payor. The facility must maintain the therapist's notes and a weekly nursing progress note.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 414.065
Hist.: SSD 1-1997, f. 6-30-97, cert. ef. 7-1-97; SDSD 5-1998, f. 6-25-98, cert. ef. 7-1-98; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 12-2012(Temp) , f. 8-31-12, cert. ef. 9-1-12 thru 2-28-13; SPD 2-2013, f. & cert. ef. 3-1-13; APD 6-2015, f. 3-4-15, cert. ef. 3-9-15

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Rule Caption: K-Plan Services
Adm. Order No.: APD 7-2015
Filed with Sec. of State: 3-4-2015
Certified to be Effective: 3-9-15
Notice Publication Date: 2-1-2015
Rules Amended: 411-035-0010
Rules Repealed: 411-035-0010(T)
Subject: The Department of Human Services (Department) is permanently updating the rules for the K-State Plan in OAR chapter 411, division 035 to make permanent temporary changes that became effective on November 10, 2014. The Department needs to amend OAR 411-035-0010 to be less restrictive in the definitions for Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), and any other related definitions. This needs to be done because the K-State Plan approved by the Center for Medicare and Medicaid Services (CMS) did not apply the limitations from OAR 411-015-0006 and 411-015-0007 to the ADL and IADL definitions and services provided for in this rule. This will be accomplished by removing the references to OAR 411-015-0006 and 411-015-0007 in the definitions for ADL, IADL, and any other related definitions in this rule.
Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-035-0010
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 035:

(1) "AAA" means "Area Agency on Aging" as defined in this rule.

(2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by an individual for continued well-being, which are essential for health and safety. Activities include, but are not limited to, eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition/behavior.

(3) "ADL" means "activities of daily living" as defined in this rule.

(4) "Alert Systems" means a unit that is worn by the individual or is located in the individual's home for the purpose of generating notification that an emergency has or may occur.

(5) "Area Agency on Aging (AAA)" means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to older adults or individuals with disabilities in a planning and service area. The term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300.

(6) "Assistive Technology" means equipment that provides additional security and support to an individual and replaces the need for human interventions. Assistive technologies enable an individual to self-direct their care and maximize their independence.

(7) "Back-up systems", for the purpose of these rules, mean devices or electronic systems, which secure help in emergencies, safety in the community, or are other reminders that help an individual with activities, including, but not limited to, medication management, eating, or other types of monitoring.

(8) "Case Manager" means an employee of the Department or Area Agency on Aging who assesses the service needs of an individual, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements an individual's service plan, and monitors the services delivered as described in OAR chapter 411, division 28.

(9) "Chore Services" means specific services intended to ensure the individual's home is safe and allows for independent living.

(10) "Consumer" or "Consumer-Employer" means the person applying for or eligible for Medicaid home or community-based services.

(11) "Cost Effective" means being responsible and accountable with Department resources by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Less costly alternatives may include other programs available from the Department, the utilization of assistive devices, natural supports, architectural modifications, and alternative service resources (defined in OAR 411-015-0005). Less costly alternatives may include resources not paid for by the Department.

(12) "Department" means the Department of Human Services (DHS).

(13) "Durable Medical Equipment", is an apparatus, such as a walker, which is primarily used to serve a medical purpose and is appropriate to use in the individual's home.

(14) "Environmental Modifications" means the changes made to adapt living spaces to meet specific service needs of eligible individuals with physical limitations to maintain their health, safety, and independence.

(15) "Exception" means the individual has service needs above the limits described in this rule, and documented in the assessment and service plan that warrant an exception for payment.

(16) "IADL" means "instrumental activities of daily living" as defined in this rule.

(17) "Individual" means the person applying for or eligible for services.

(18) "In-Home Services" mean the activities of daily living and instrumental activities of daily living that assist an individual to stay in his or her own home or the home of a relative.

(19) "Instrumental Activities of Daily Living (IADL)" means those activities that include, but are not limited to, activities other than the activities of daily living, required by an individual to continue independent living. Activities include, but are not limited to, housekeeping, laundry, meal preparation, medication management, shopping, and transportation.

(20) "Long-Term Care" means the Medicaid system through which the Department provides nursing facility, community-based, and in-home services to eligible adults who are aged, blind, or have physical disabilities.

(21) "Medication Reminders" are devices used for the purpose of prompting an individual to take their medication.

(22) "Natural Supports" means resources and supports (e.g. relatives, friends, neighbors, significant others, roommates, or the community) who are willing to voluntarily provide services to an individual without the expectation of compensation. Natural supports are identified in collaboration with the individual and the potential "natural support". The natural support is required to have the skills, knowledge, and ability to provide the needed services and supports.

(23) "Person-centered Assessment and Service Plans" means:

(a) A process, either formal or informal, for gathering and organizing information that helps an individual:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with individual needs and preferences.

(24) "Personal Emergency Response Systems" mean a type of electronic back-up system that:

(a) Secures help for individuals in an emergency;

(b) Ensures a consumer's safety in the community; and

(c) Includes other reminders that help an individual with their activities of daily living and instrumental activities of daily living.

(25) "Rate Schedule" means the rate schedule maintained by the Department at http://www.dhs.state.or.us/spd/tools/program/osip/rateschedule.pdf. Printed copies may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Aging and People with Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301.

(26) "Representative" means a person with longstanding involvement in assuring the individual's health, safety, and welfare that is appointed by an individual to participate in service planning on the individual's behalf. In all cases, unless the individual is incapable, the individual's consent is obtained before designating a representative on the individual's behalf. When feasible, the individual's authorization of a representative is made in writing or by another method that clearly indicates the individual's free choice. An individual's representative is not a paid provider to an individual receiving services and supports.

(27) "Service Need" means the assistance an individual requires from another person, or equipment that replaces the need for another person, for those functions or activities.

(28) "Transition Services" means those services and supports necessary for an individual to transition from a nursing facility or the Oregon State Hospital to a community-based care or in-home setting.

(29) "Voluntary Consumer Training Services" means activities to empower and inform individuals receiving in-home services regarding their rights, role, and responsibilities as employers of care providers.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 409.050, 410.040, 410.090, 410.210 - 410.300 & 441.520
Hist.: APD 16-2014, f. & cert. ef. 6-4-14; APD 36-2014(Temp), f. & cert. ef. 11-10-14 thru 5-8-15; APD 7-2015, f. 3-4-15, cert. ef. 3-9-15

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Rule Caption: ODDS — Children's Intensive In-Home Services (Behavior Program and Medically Fragile Children's Services)
Adm. Order No.: APD 8-2015
Filed with Sec. of State: 3-12-2015
Certified to be Effective: 3-12-15
Notice Publication Date: 1-1-2015
Rules Amended: 411-300-0120, 411-350-0030, 411-350-0050
Subject: The Department of Human Services, Office of Developmental Disability Services, needs to refile 411-300-0120, 411-350-0030, and 411-350-0050 from the February 16, 2015 permanent rulemaking to correct language in the rules that was inadvertently left out or incorrectly changed. The refiling of the rules fixes the errors.
Rules Coordinator: Kimberly Colkitt-Hallman—(503) 945-6398

411-300-0120
Eligibility for CIIS

(1) ELIGIBILITY. In order to be eligible for CIIS, a child must:

(a) Be under the age of 18;

(b) Be an Oregon resident who meets the citizenship and alien status requirements of OAR 461-120-0110;

(c) Be receiving Medicaid Title XIX benefits under OSIPM or OHP Plus. This does not include CHIP Title XXI benefits;

(d) For a child with excess income, contribute to the cost of services pursuant to OAR 461-160-0610 and OAR 461-160-0620;

(e) Be determined eligible for developmental disability services by the CDDP of the county of origin as described in OAR 411-320-0080;

(f) Meet the level of care as defined in OAR 411-320-0020;

(g) Be accepted by the Department by scoring greater than 200 on the behavior criteria within two months prior to starting services and maintain a score above 150 as determined by reassessment annually.

(h) Reside in the family home; and

(i) Be safely served in the family home. This includes, but is not limited to, a qualified primary caregiver demonstrating the willingness, skills, and ability to provide direct care as outlined in an ISP in a cost effective manner, as determined by a services coordinator within the limitations of OAR 411-300-0150, and participate in planning, monitoring, and evaluation of the CIIS provided.

(2) TRANSFER OF ASSETS.

(a) As of October 1, 2014, a child receiving medical benefits under OAR chapter 410, division 200 requesting Medicaid coverage for services in a nonstandard living arrangement (see OAR 461-001-0000) is subject to the requirements of the rules regarding transfer of assets (see OAR 461-140-0210 to 461-140-0300) in the same manner as if the child was requesting these services under OSIPM. This includes, but is not limited to, the following assets:

(A) An annuity evaluated according to OAR 461-145-0022;

(B) A transfer of property when a child retains a life estate evaluated according to OAR 461-145-0310;

(C) A loan evaluated according to OAR 461-145-0330; or

(D) An irrevocable trust evaluated according to OAR 461-145-0540.

(b) When a child is considered ineligible for CIIS due to a disqualifying transfer of assets, the parent or guardian and child must receive a notice meeting the requirements of OAR 461-175-0310 in the same manner as if the child was requesting services under OSIPM.

(3) INELIGIBILITY. A child is not eligible for CIIS if the child:

(a) Resides in a medical hospital, psychiatric hospital, school, subacute facility, nursing facility, intermediate care facility for individuals with intellectual or developmental disabilities, foster home, or other 24-hour residential setting;

(b) Does not require waiver services or Community First Choice state plan services as evidenced by a functional needs assessment;

(c) Has sufficient family, government, or community resources available to provide for his or her care; or

(d) Is not safely served in the family home as described in section (1)(i) of this rule.

(4) TRANSITION. A child whose reassessment score on the behavior criteria is less than 150 is transitioned out of CIIS within 90 days. The child must exit from CIIS at the end of the 90 day transition period.

(a) When possible and agreed upon by the parent or guardian and the services coordinator, CIIS may be incrementally reduced during the 90 day transition period.

(b) The services coordinator must coordinate and attend a transition planning meeting at least 30 days prior to the end of the transition period. The transition planning meeting must include a CDDP representative, the parent or guardian, and any other person at the request of the parent or guardian.

(5) EXIT.

(a) CIIS may be terminated:

(A) At the oral or written request of a parent or guardian to end the service relationship; or

(B) In any of the following circumstances:

(i) The child no longer meets the eligibility criteria in section (1) of this rule;

(ii) The child does not require waiver services or Community First Choice state plan services;

(iii) There are sufficient family, government, community, or alternative resources available to provide for the care of the child;

(iv) The child may not be safely served in the family home as described in section (1)(i) of this rule;

(v) The parent or guardian either cannot be located or has not responded after 30 days of repeated attempts by a services coordinator to complete ISP development and monitoring activities and does not respond to a notice of intent to terminate;

(vi) The services coordinator has sufficient evidence that the parent or guardian has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the ISP, refused to cooperate with documenting expenses of CIIS funds, or otherwise knowingly misused public funds associated with CIIS.

(vii) The child is incarcerated or admitted to a medical hospital, psychiatric hospital, sub-acute facility, nursing facility, intermediate care facility for individuals with intellectual or developmental disabilities, foster home, or other 24-hour residential setting and it is determined that the child is not returning to the family home or is not returning to the family home after 90 consecutive days; or

(viii) The child does not reside in Oregon.

(b) In the event CIIS are terminated, a written Notification of Planned Action must be provided as described in OAR chapter 411, division 318.

(6) WAIT LIST. If the maximum number of children allowed on the ICF/ID Behavioral Model Waiver are enrolled and being served, the Department may place a child eligible for CIIS on a wait list. A child on the wait list may access other Medicaid-funded services or General Fund services for which the child is determined eligible through the CDDP.

(a) The date of the initial completed application for CIIS determines the order on the wait list. A child, who previously received CIIS that currently meets the criteria for eligibility as described in section (1) of this rule, is put on the wait list as of the date the original application for CIIS was complete.

(b) The date the application for CIIS is complete is the date that the Department has the required demographic data for the child and a statement of eligibility for developmental disability services.

(c) Children on the wait list are served on a first come, first served basis as space on the ICF/ID Behavioral Model Waiver allows. A re-evaluation is completed prior to entry to determine current eligibility.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007 & 430.215

Hist.: SDSD 12-2002, f. 12-26-02, cert. ef. 12-28-02; SPD 11-2009, f. 7-31-09, cert. ef. 8-1-09; SPD 20-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13; SPD 53-2013, f. 12-27-13. cert. ef. 12-28-13; APD 31-2014(Temp), f. & cert. ef. 8-20-14 thru 2-16-15; APD 4-2015, f. 2-13-15, cert. ef. 2-16-15; APD 8-2015, f. & cert. ef. 3-12-15

411-350-0030
Eligibility for MFC Services

(1) ELIGIBILITY.

(a) In order to be eligible for MFC services, a child must:

(A) Be under the age of 18;

(B) Be an Oregon resident who meets the citizenship and alien status requirements of OAR 461-120-0110;

(C) Be receiving Medicaid Title XIX benefits under OSIPM or OHP Plus. This does not include CHIP Title XXI benefits;

(D) For a child with excess income, contribute to the cost of services pursuant to OAR 461-160-0610 and OAR 461-160-0620;

(E) Meet the level of care as defined in OAR 411-350-0020;

(F) Be accepted by the Department by scoring 50 or greater on the clinical criteria prior to starting services and have a status of medical need that is likely to last for more than two months;

(G) Reside in the family home; and

(H) Be safely served in the family home This includes, but is not limited to, a qualified primary caregiver demonstrating the willingness, skills, and ability to provide direct care as outlined in an ISP in a cost effective manner, as determined by a services coordinator within the limitations of OAR 411-300-0150, and participate in planning, monitoring, and evaluation of the MFC services provided.

(b) A child that resides in a foster home that meets the eligibility criteria in subsection (a)(A) to (E) of this section is eligible for private duty nursing as described in OAR 411-350-0050.

(c) A child that resides in a foster home is eligible for only private duty nursing as described in OAR 411-350-0050;

(d) TRANSFER OF ASSETS.

(A) As of October 1, 2014, a child receiving medical benefits under OAR chapter 410, division 200 requesting Medicaid coverage for services in a nonstandard living arrangement (see OAR 461-001-0000) is subject to the requirements of the rules regarding transfer of assets (see OAR 461-140-0210 to 461-140-0300) in the same manner as if the child was requesting these services under OSIPM. This includes, but is not limited to, the following assets:

(i) An annuity evaluated according to OAR 461-145-0022;

(ii) A transfer of property when a child retains a life estate evaluated according to OAR 461-145-0310;

(iii) A loan evaluated according to OAR 461-145-0330; or

(iv) An irrevocable trust evaluated according to OAR 461-145-0540.

(B) When a child is considered ineligible for MFC services due to a disqualifying transfer of assets, the parent or guardian and child must receive a notice meeting the requirements of OAR 461-175-0310 in the same manner as if the child was requesting services under OSIPM.

(2) INELIGIBILITY. A child is not eligible for MFC services if the child:

(a) Resides in a medical hospital, psychiatric hospital, school, subacute facility, nursing facility, intermediate care facility for individuals with intellectual or developmental disabilities, residential facility, or other 24-hour residential setting;

(b) Does not require waiver services or Community First Choice state plan services as evidenced by a functional needs assessment;

(c) Has sufficient family, government, or community resources available to provide for his or her care; or

(d) Is not safely served in the family home as described in section (1)(a)(G) of this rule.

(3) REDETERMINATION. The Department redetermines the eligibility of a child for MFC services using the clinical criteria at least every six months, or as the status of the child changes.

(4) TRANSITION. A child whose reassessment score on the clinical criteria is less than 35 is transitioned out of MFC services within 60 days. The child must exit from MFC services at the end of the 60 day transition period.

(a) When possible and agreed upon by the parent or guardian and the services coordinator, MFC services may be incrementally reduced during the 60 day transition period.

(b) The services coordinator must coordinate and attend a transition planning meeting at least 30 days prior to the end of the transition period. The transition planning meeting must include a CDDP representative if eligible for developmental disability services, the parent or guardian, and any other person at the request of the parent or guardian.

(5) EXIT.

(a) MFC services may be terminated:

(A) At the oral or written request of a parent or legal guardian to end the service relationship; or

(B) In any of the following circumstances:

(i) The child no longer meets the eligibility criteria in section (1) of this rule;

(ii) The child does not require waiver services or Community First Choice state plan services;

(iii) There are sufficient family, government, community, or alternative resources available to provide for the care of the child;

(iv) The child may not able to be safely served in the family home as described in section (1)(a)(G) of this rule;

(v) The parent or guardian either cannot be located or has not responded after 30 days of repeated attempts by a services coordinator to complete ISP development and monitoring activities and does not respond to a notice of intent to terminate;

(vi) The services coordinator has sufficient evidence that the parent or guardian has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the ISP, refused to cooperate with documenting expenses of MFC funds, or otherwise knowingly misused public funds associated with MFC services;

(vii) The child is incarcerated or admitted to a medical hospital, psychiatric hospital, sub-acute facility, nursing facility, intermediate care facility for individuals with intellectual or developmental disabilities, or other 24-hour residential setting and it is determined that the child is not returning to the family home or is not returning to the family home after 90 consecutive days; or

(viii) The child does not reside in Oregon.

(b) In the event MFC services are terminated, a written Notification of Planned Action must be provided as described in OAR chapter 411, division 318.

(6) WAIT LIST. If the maximum number of children allowed on the Hospital Model Waiver are enrolled and being served, the Department may place a child eligible for MFC services on a wait list. A child on the wait list may access other Medicaid-funded services or General Fund services for which the child is determined eligible through the CDDP.

(a) The date of the initial completed application for MFC services determines the order on the wait list. A child who previously received MFC services that currently meets the criteria for eligibility as described in section (1) of this rule is put on the wait list as of the date the original application for MFC services was complete.

(b) Children on the wait list are served on a first come, first served basis as space on the Hospital Model Waiver allows. A re-evaluation is completed prior to entry to determine current eligibility.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, 430.215

Hist.: MHD 21-1998(Temp), f. 11-25-98, cert. ef. 12-1-98 thru 5-29-99; MHD 3-1999, f. 5-17-99, cert. ef. 5-28-99; MHD 8-2003(Temp) f. & cert. ef. 12-11-03 thru 6-7-04; Renumbered from 309-044-0120, SPD 14-2004, f. & cert. ef. 6-1-04; SPD 1-2009, f. 2-24-09, cert. ef. 3-1-09; SPD 28-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13; SPD 55-2013, f. 12-27-13, cert. ef. 12-28-13; APD 31-2014(Temp), f. & cert. ef. 8-20-14 thru 2-16-15; APD 4-2015, f. 2-13-15, cert. ef. 2-16-15; APD 8-2015, f. & cert. ef. 3-12-15

411-350-0050

Scope of MFC Services and Limitations

(1) MFC services are intended to support, not supplant, the naturally occurring services provided by a legally responsible primary caregiver and enable the primary caregiver to meet the needs of caring for a child on the Hospital Model Waiver. MFC services are not meant to replace other available governmental or community services and supports. All services funded by the Department must be provided in accordance with the Expenditure Guidelines and based on the actual and customary costs related to best practice standards of care for children with similar disabilities.

(2) The use of MFC funds to purchase supports is limited to:

(a) The service level for a child as determined by a functional needs assessment and clinical criteria. The functional needs assessment determines the total number of hours needed to meet the identified needs of the child. The total number of hours may not be exceeded without prior approval from the Department. The types of services that contribute to the total number of hours used include attendant care, skills training, hourly relief care, and private duty nursing.

(b) Other services and supports determined by a services coordinator to be necessary to meet the support needs identified through a person-centered planning process and consistent with the Expenditure Guidelines.

(3) To be authorized and eligible for payment by the Department, all MFC services and supports must be:

(a) Directly related to the disability of a child;

(b) Required to maintain the health and safety of a child;

(c) Cost effective;

(d) Considered not typical for a parent or guardian to provide to a child of the same age;

(e) Required to help the parent or guardian to continue to meet the needs of caring for the child;

(f) Included in an approved ISP;

(g) Provided in accordance with the Expenditure Guidelines; and

(h) Based on the actual and customary costs related to best practice standards of care for children with similar disabilities.

(4) When conditions of purchase are met and provided purchases are not prohibited under section (27) of this rule, MFC funds may be used to purchase a combination of the following supports based upon the needs of a child as determined by a services coordinator and consistent with a functional needs assessment, clinical criteria, initial or annual ISP, and the OSIPM or OHP Plus benefits the child qualifies for:

(a) Community First Choice state plan services:

(A) Behavior support services as described in section (5) of this rule;

(B) Community nursing services as described in section (6) of this rule;

(C) Environmental modifications as described in section (7) of this rule;

(D) Attendant care as described in section (8) of this rule;

(E) Skills training as described in section (9) of this rule;

(F) Relief care as described in section (10) of this rule;

(G) Assistive devices as described in section (11) of this rule;

(H) Assistive technology as described in section (12) of this rule;

(I) Chore services as described in section (13) of this rule;

(J) Community transportation as described in section (14) of this rule; and

(K) Transition costs as described in section (15).

(b) Home and community based waiver services:

(A) Case management as defined in OAR 411-350-0020;

(B) Family training as described in section (16) of this rule;

(C) Environmental safety modifications as described in section (17) of this rule;

(D) Vehicle modifications as described in section (18) of this rule;

(E) Specialized medical supplies as described in section (19) of this rule;

(F) Special diet as described in section (20) of this rule; and

(G) Individual-directed goods and services as described in section (21) of this rule.

(c) State plan services, including private duty nursing as described in section (23) of this rule, and personal care services as described in OAR chapter 411, division 034.

(5) BEHAVIOR SUPPORT SERVICES. Behavior support services may be authorized to support a primary caregiver in their caregiving role and to respond to specific problems identified by a child, primary caregiver, or a services coordinator. Positive behavior support services are used to enable a child to develop, maintain, or enhance skills to accomplish ADLs, IADLs, and health-related tasks.

(a) A behavior consultant must:

(A) Work with the child and primary caregiver to identify:

(i) Areas of the family home life that are of most concern for the child and the parent or guardian;

(ii) The formal or informal responses the family or the provider has used in those areas; and

(iii) The unique characteristics of the child and family that may influence the responses that may work with the child.

(B) Assess the child. The assessment must include:

(i) Specific identification of the behaviors or areas of concern;

(ii) Identification of the settings or events likely to be associated with, or to trigger, the behavior;

(iii) Identification of early warning signs of the behavior;

(iv) Identification of the probable reasons that are causing the behavior and the needs of the child that are met by the behavior, including the possibility that the behavior is:

(I) An effort to communicate;

(II) The result of a medical condition;

(III) The result of an environmental cause; or

(IV) The symptom of an emotional or psychiatric disorder.

(v) Evaluation and identification of the impact of disabilities (i.e. autism, blindness, deafness, etc.) that impact the development of strategies and affect the child and the area of concern; and

(vi) An assessment of current communication strategies.

(C) Develop a variety of positive strategies that assist the primary caregiver and the provider to help the child use acceptable, alternative actions to meet the needs of the child in the safest, most positive, and cost effective manner. These strategies may include changes in the physical and social environment, developing effective communication, and appropriate responses by the primary caregiver.

(i) When interventions in behavior are necessary, the interventions must be performed in accordance with positive behavioral theory and practice as defined in OAR 411-350-0020.

(ii) The least intrusive intervention possible to keep the child and others safe must be used.

(iii) Abusive or demeaning interventions must never be used.

(iv) The strategies must be adapted to the specific disabilities of the child and the style or culture of the family.

(D) Develop a written Behavior Support Plan using clear, concrete language that is understandable to the primary caregiver and the provider that describes the assessment, strategies, and procedures to be used;

(E) Develop emergency and crisis procedures to be used to keep the child, primary caregiver, and the provider safe. When interventions in the behavior of the child are necessary, positive, preventative, non-aversive interventions that conform to OIS must be utilized. The use of protective physical intervention must be part of the Behavior Support Plan for the child. When protective physical intervention is required, the protective physical intervention must only be used as a last resort and the provider must be appropriately trained in OIS;

(F) Teach the primary caregiver and the provider the strategies and procedures to be used; and

(G) Monitor and revise the Behavior Support Plan as needed.

(b) Behavior support services may include:

(A) Training a primary caregiver or provider of a child;

(B) Developing a visual communication system as a strategy for behavior support; and

(C) Communicating, as authorized by a parent or guardian through a release of information, with other professionals about the strategies and outcomes of the Behavior Support Plan as written in the Behavior Support Plan within authorized consultation hours only.

(c) Behavior support services exclude:

(A) Mental health therapy or counseling;

(B) Health or mental health plan coverage;

(C) Educational services including, but not limited to, consultation and training for classroom staff;

(D) Adaptations to meet the needs of a child at school;

(E) An assessment in a school setting;

(F) Attendant care;

(G) Relief care; or

(H) Communication or activities not directly related to the development, implementation, or revision of the Behavior Support Plan.

(6) COMMUNITY NURSING SERVICES.

(a) Community nursing services include:

(A) Nursing assessments, including medication reviews;

(B) Care coordination;

(C) Monitoring;

(D) Development of a Nursing Service Plan;

(E) Delegation and training of nursing tasks to a provider and primary caregiver;

(F) Teaching and education of a primary caregiver and provider and identifying supports that minimize health risks while promoting the autonomy of a child and self-management of healthcare; and

(G) Collateral contact with a services coordinator regarding the community health status of a child to assist in monitoring safety and well-being and to address needed changes to the ISP for the child.

(b) Community nursing services exclude private duty nursing care.

(c) A Nursing Service Plan must be present when MFC funds are used for community nursing services. A services coordinator must authorize the provision of community nursing services as identified in an ISP.

(d) After an initial nursing assessment, a nursing reassessment must be completed very six months or sooner if a change in a medical condition requires an update to the Nursing Service Plan.

(7) ENVIRONMENTAL MODIFICATIONS.

(a) Environmental modifications include, but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke alarms, light fixtures, and appliances;

(G) Installation of ramps, grab-bars, and electric door openers;

(H) Adaptation of kitchen cabinets and sinks;

(I) Widening of doorways;

(J) Handrails;

(K) Modification of bathroom facilities;

(L) Individual room air conditioners for a child whose temperature sensitivity issues create behaviors or medical conditions that put the child or others at risk;

(M) Installation of non-skid surfaces;

(N) Overhead track systems to assist with lifting or transferring;

(O) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the child; and

(P) Adaptations to control lights, heat, stove, etc.

(b) Environmental modifications exclude:

(A) Adaptations or improvements to the family home that are of general utility, such as carpeting, roof repair, and central air conditioning, unless directly related to the health and safety needs of the child and identified in the ISP for the child;

(B) Adaptations that add to the total square footage of the family home except for ramps that attach to the home for the purpose of entry or exit;

(C) Adaptations outside of the family home; and

(D) General repair or maintenance and upkeep required for the family home.

(c) Environmental modifications must be tied to supporting assessed ADL, IADL, and health-related tasks as identified in the ISP for the child.

(d) Environmental modifications are limited to $5,000 per modification. A services coordinator must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the child and the determination by the Department of appropriateness and cost effectiveness. In addition, separate environmental modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.

(e) Environmental modifications must be completed by a state licensed contractor with a minimum of $1,000,000 liability insurance. Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. Certification of compliance must be filed in the file for the contractor prior to payment.

(f) Environmental modifications must be made within the existing square footage of the family home, except for external ramps, and may not add to the square footage of the family home.

(g) Payment to the contractor is to be withheld until the work meets specifications.

(h) A scope of work as defined in OAR 411-350-0020 must be completed for each identified environmental modification project. All contractors submitting bids must be given the same scope of work.

(i) A services coordinator must follow the processes outlined in the Expenditure Guidelines for contractor bids and the awarding of work.

(j) All dwellings must be in good repair and have the appearance of sound structure.

(k) The identified home may not be in foreclosure or the subject of legal proceedings regarding ownership.

(l) Environmental modifications must only be completed to the family home.

(m) Upgrades in materials that are not directly related to the health and safety needs of the child are not paid for or permitted.

(n) Environmental modifications are subject to Department requirements regarding material and construction practices based on industry standards for safety, liability, and durability, as referenced in building codes, materials manuals, and industry and risk management publications.

(o) RENTAL PROPERTY.

(A) Environmental modifications to rental property may not substitute or duplicate services otherwise the responsibility of the landlord under the landlord tenant laws, the Americans with Disabilities Act, or the Fair Housing Act.

(B) Environmental modifications made to a rental structure must have written authorization from the owner of the rental property prior to the start of the work.

(C) The Department does not fund work to restore the rental structure to the former condition of the rental structure.

(8) ATTENDANT CARE. Attendant care services include direct support provided to a child in the family home or community by a qualified personal support worker or provider organization. ADL and IADL services provided through attendant care must support the child to live as independently as appropriate for the age of the child, support the family in their primary caregiver role, and be based on the identified goals, preferences, and needs of the child. The primary caregiver is expected to be present or available during the provision of attendant care.

(a) ADL services include, but are not limited to:

(A) Basic personal hygiene — providing or assisting with needs, such as bathing (tub, bed, bath, shower), hair care, grooming, shaving, nail care, foot care, dressing, skin care, or oral hygiene;

(B) Toileting, bowel, and bladder care - assisting to and from the bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, managing menses, cleansing a child or adjusting clothing related to toileting, emptying a catheter, drainage bag, or assistive device, ostomy care, or bowel care;

(C) Mobility, transfers, and repositioning — assisting with ambulation or transfers with or without assistive devices, turning a child or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(D) Nutrition — assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with adaptive utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(E) Delegated nursing tasks;

(F) First aid and handling emergencies — addressing medical incidents related to the conditions of a child, such as seizure, aspiration, constipation, or dehydration, responding to the call of the child for help during an emergent situation, or for unscheduled needs requiring immediate response;

(G) Assistance with necessary medical appointments — help scheduling appointments, arranging medical transportation services, accompaniment to appointments, follow up from appointments, or assistance with mobility, transfers, or cognition in getting to and from appointments; and

(H) Observation of the status of a child and reporting of significant changes to a physician, health care provider, or other appropriate person.

(b) IADL services include, but are not limited to, the following services provided solely for the benefit of the child:

(A) Light housekeeping tasks necessary to maintain the child in a healthy and safe environment — cleaning surfaces and floors, making the child's bed, cleaning dishes, taking out the garbage, dusting, and laundry;

(B) Grocery and other shopping necessary for the completion of other ADL and IADL tasks;

(C) Meal preparation and special diets;

(D) Cognitive assistance or emotional support provided to a child due to an intellectual or developmental disability - helping the child cope with change and assisting the child with decision-making, reassurance, orientation, memory, or other cognitive functions;

(E) Medication and medical equipment — assisting with ordering, organizing, and administering medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring a child for choking while taking medications, assisting with the administration of medications, maintaining equipment, or monitoring for adequate medication supply; and

(F) Support in the community around socialization and participation in the community:

(i) Support with socialization — assisting a child in acquiring, retaining, and improving self-awareness and self-control, social responsiveness, social amenities, and interpersonal skills;

(ii) Support with community participation — assisting a child in acquiring, retaining, and improving skills to use available community resources, facilities, or businesses; and

(iii) Support with communication — assisting a child in acquiring, retaining, and improving expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(c) Assistance with ADLs, IADLs, and health-related tasks may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may be provided through human assistance or the use of electronic devices or other assistive devices. Assistance may also require verbal reminding to complete any of the IADL tasks described in subsection (b) of this section.

(A) "Cueing" means giving verbal, audio, or visual clues during an activity to help a child complete the activity without hands-on assistance.

(B) "Hands-on" means a provider physically performs all or parts of an activity because a child is unable to do so.

(C) "Monitoring" means a provider observes a child to determine if assistance is needed.

(D) "Reassurance" means to offer a child encouragement and support.

(E) "Redirection" means to divert a child to another more appropriate activity.

(F) "Set-up" means the preparation, cleaning, and maintenance of personal effects, supplies, assistive devices, or equipment so that a child may perform an activity.

(G) "Stand-by" means a provider is at the side of a child ready to step in and take over the task if the child is unable to complete the task independently.

(d) Attendant care services must:

(A) Be prior authorized by the services coordinator before services begin;

(B) Be delivered through the most cost effective method as determined by the services coordinator; and

(C) Only be provided when the child is present to receive services.

(e) Attendant care services exclude:

(A) Hours that supplant parental responsibilities or other natural supports and services as defined in this rule available from the family, community, other government or public services, insurance plans, schools, philanthropic organizations, friends, or relatives;

(B) Hours solely to allow the primary caregiver to work or attend school;

(C) Hours that exceed what is necessary to support the child based on the functional needs assessment and clinical criteria;

(D) Support generally provided for a child of similar age without disabilities by the parent or guardian or other family members;

(E) Supports and services in the family home that are funded by Child Welfare;

(F) Educational and supportive services provided by schools as part of a free and appropriate public education for children and young adults under the Individuals with Disabilities Education Act;

(G) Services provided by the family; and

(H) Home schooling.

(f) Attendant care services may not be provided on a 24-hour shift-staffing basis.

(9) SKILLS TRAINING. Skills training is specifically tied to accomplishing ADL, IADL, and other health-related tasks as identified by the functional needs assessment and ISP and is a means for a child to acquire, maintain, or enhance independence.

(a) Skills training may be applied to the use and care of assistive devices and technologies.

(b) Skills training is authorized when:

(A) The anticipated outcome of the skills training, as documented in the ISP, is measurable;

(B) Timelines for measuring progress towards the anticipated outcome are established in the ISP; and

(C) Progress towards the anticipated outcome are measured and the measurements are evaluated by a services coordinator no less frequently than every six months, based on the start date of the initiation of the skills training.

(c) When anticipated outcomes are not achieved within the timeframe outline in the ISP, the services coordinator must reassess or redefine the use of skills training with the child for that particular goal.

(d) Skills training does not replace the responsibilities of the school system.

(10) RELIEF CARE.

(a) Relief care may not be characterized as daily or periodic services provided solely to allow the primary caregiver to attend school or work. Daily relief care may be provided in segments that are sequential but may not exceed seven consecutive days without permission from the Department. No more than 14 days of relief care in a plan year are allowed without approval from the Department.

(b) Relief care may include both day and overnight services that may be provided in:

(A) The family home;

(B) A licensed or certified setting;

(C) The home of a qualified provider, chosen by the parent or guardian, as a safe setting for the child; or

(D) The community, during the provision of ADL, IADL, health-related tasks, and other supports identified in the ISP for the child.

(c) Relief care services are not authorized for the following:

(A) Solely to allow the primary caregiver of the child to attend school or work;

(B) For more than seven consecutive overnight stays without permission from the Department;

(C) For more than 10 days per individual plan year when provided at a camp that meets provider qualifications;

(D) For vacation, travel, and lodging expenses; or

(E) To pay for room and board.

(11) ASSISTIVE DEVICES. Assistive devices are primarily and customarily used to meet an ADL, IADL, or health-related support need. The purchase, rental, or repair of an assistive device must be limited to the types of equipment that are not excluded under OAR 410-122-0080.

(a) Assistive devices may be purchased with MFC funds when the intellectual or developmental disability of a child otherwise prevents or limits the independence of the child to assist in areas identified in a functional needs assessment.

(b) Assistive devices that may be purchased for the purpose described in subsection (a) of this section must be of direct benefit to the child and may include:

(A) Devices to secure assistance in an emergency in the community and other reminders, such as medication minders, alert systems for ADL or IADL supports, or mobile electronic devices.

(B) Assistive devices not provided by any other funding source to assist and enhance the independence of a child in performing ADLs or IADLs, such as durable medical equipment, mechanical apparatus, or electronic devices.

(c) Expenditures for assistive devices are limited to $5,000 per plan year without Department approval. Any single purchase costing more than $500 must be approved by the Department prior to expenditure. Approval is based on the service and support needs and goals of the child and a determination by the Department of appropriateness and cost-effectiveness.

(d) Devices must be limited to the least costly option necessary to meet the assessed need of a child.

(e) To be authorized by a services coordinator, assistive devices must be:

(A) In addition to any assistive devices, medical equipment, or supplies furnished under OHP, private insurance, or alternative resources;

(B) Determined necessary to the daily functions of a child; and

(C) Directly related to the disability of a child.

(f) Assistive devices exclude:

(A) Items that are not necessary or of direct medical or remedial benefit to the child or do not address the underlying need for the device;

(B) Items intended to supplant similar items furnished under OHP, private insurance, or alternative resources;

(C) Items that are considered unsafe for a child;

(D) Toys or outdoor play equipment; and

(E) Equipment and furnishings of general household use.

(12) ASSISTIVE TECHNOLOGY. Assistive technology is primarily and customarily used to provide additional safety and support and replace the need for direct interventions, to enable self-direction of care, and maximize independence. Assistive technology includes, but is not limited to, motion or sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinence and fall sensors, or other electronic backup systems.

(a) Expenditures for assistive technology are limited to $5,000 per plan year without Department approval. Any single purchase costing more than $500 must be approved by the Department prior to expenditure. A services coordinator must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the child and a determination by the Department of appropriateness and cost-effectiveness.

(b) Payment for ongoing electronic back-up systems or assistive technology costs must be paid to providers each month after services are received.

(A) Ongoing costs do not include electricity or batteries.

(B) Ongoing costs may include minimally necessary data plans and the services of a company to monitor emergency response systems.

(13) CHORE SERVICES. Chore services may be provided only in situations where no one else is responsible or able to perform or pay for the services.

(a) Chore services include heavy household chores, such as:

(A) Washing floors, windows, and walls;

(B) Tacking down loose rugs and tiles; and

(C) Moving heavy items of furniture for safe access and egress.

(b) Chore services may include yard hazard abatement to ensure the outside of the family home is safe for the child to traverse and enter and exit the home.

(14) COMMUNITY TRANSPORTATION.

(a) Community transportation includes, but is not limited to:

(A) Community transportation provided by a common carrier or bus in accordance with standards established for these entities;

(B) Reimbursement on a per-mile basis for transporting a child; or

(C) Assistance with the purchase of a bus pass.

(b) Community transportation may only be authorized when natural supports or volunteer services are not available and one of the following is identified in the ISP for the child:

(A) The child has an assessed need for ADL, IADL, or a health-related task during transportation; or

(B) The child has either an assessed need for ADL, IADL, or a health-related task at the destination or a need for waiver funded services at the destination.

(c) Community transportation must be provided in the most cost-effective manner which meets the needs identified in the ISP for the child.

(d) Community transportation expenses exceeding $500 per month must be approved by the Department.

(e) Community transportation must be prior authorized by a services coordinator and documented in an ISP. The Department does not pay any provider under any circumstances for more than the total number of hours, miles, or rides prior authorized by the services coordinator and documented in the ISP. Personal support workers who use their own personal vehicles for community transportation are reimbursed as described in OAR chapter 411, division 375.

(f) Community transportation excludes:

(A) Medical transportation;

(B) Purchase or lease of a vehicle;

(C) Routine vehicle maintenance and repair, insurance, and fuel;

(D) Ambulance services;

(E) Costs for transporting a person other than the child.

(F) Transportation for a provider to travel to and from the workplace of the provider;

(G) Transportation that is not for the sole benefit of the child;

(H) Transportation to vacation destinations or trips for relaxation purposes;

(I) Transportation provided by family members;

(J) Transportation normally provided by schools;

(K) Transportation used for behavioral intervention or calming;

(L) Transportation normally provided by a primary caregiver for a child of similar age without disabilities;

(M) Reimbursement for out-of-state travel expenses; and

(N) Transportation services that may be obtained through other means, such as OHP or other alternative resources available to the child.

(15) TRANSITION COSTS.

(a) Transition costs are limited to a child transitioning to the family home from a nursing facility, intermediate care facility for individuals with intellectual or developmental disabilities, or acute care hospital.

(b) Transition costs are based on the assessed need of a child determined during the person-centered service planning process and must support the desires and goals of the child receiving services and supports. Final approval for transition costs must be through the Department prior to expenditure. The approval of the Department is based on the need of the child and the determination by the Department of appropriateness and cost-effectiveness.

(c) Financial assistance for transition costs is limited to:

(A) Moving and move-in costs including movers, cleaning and security deposits, payment for background or credit checks (related to housing), or initial deposits for heating, lighting, and phone;

(B) Payment of previous utility bills that may prevent the child from receiving utility services and basic household furnishings such as a bed; and

(C) Other items necessary to re-establish a home.

(d) Transition costs are provided no more than twice annually.

(e) Transitions costs for basic household furnishings and other items are limited to one time per year.

(f) Transition costs may not supplant the legal responsibility of the parent or guardian. In this context, the term parent or guardian does not include a designated representative.

(16) FAMILY TRAINING. Family training services are provided to the family of a child to increase the abilities of the family to care for, support, and maintain the child in the family home.

(a) Family training services include:

(A) Instruction about treatment regimens and use of equipment specified in an ISP;

(B) Information, education, and training about the disability, medical, and behavioral conditions of a child; and

(C) Registration fees for organized conferences and workshops specifically related to the intellectual or developmental disability of the child or the identified, specialized, medical, or behavioral support needs of the child.

(i) Conferences and workshops must be prior authorized by a services coordinator, directly relate to the intellectual or developmental disability or medical condition of a child, and increase the knowledge and skills of the family to care for and maintain the child in the family home.

(ii) Conference and workshop, costs exclude:

(I) Travel, food, and lodging expenses;

(II) Services otherwise provided under OHP or available through other resources; or

(III) Costs for individual family members who are employed to care for the child.

(b) Family training services exclude:

(A) Mental health counseling, treatment, or therapy;

(B) Training for a paid provider;

(C) Legal fees;

(D) Training for a family to carry out educational activities in lieu of school;

(E) Vocational training for family members; and

(F) Paying for training to carry out activities that constitute abuse of a child.

(17) ENVIRONMENTAL SAFETY MODIFICATIONS.

(a) Environmental safety modifications must be made from materials of the most cost effective type and may not include decorative additions.

(b) Fencing may not exceed 200 linear feet without approval from the Department.

(c) Environmental safety modifications exclude:

(A) Large gates such as automobile gates;

(B) Costs for paint and stain;

(C) Adaptations or improvements to the family home that are of general utility and are not for the direct safety or long-term benefit to the child or do not address the underlying environmental need for the modification; and

(D) Adaptations that add to the total square footage of the family home.

(d) Environmental safety modifications must be tied to supporting ADL, IADL, and health-related tasks as identified in the ISP for the child.

(e) Environmental safety modifications are limited to $5,000 per modification. A services coordinator must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the child and a determination by the Department of appropriateness and cost-effectiveness.

(f) In addition, separate environmental safety modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.

(g) Environmental safety modifications must be completed by a state licensed contractor with a minimum of $1,000,000 liability insurance. Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. Certification of compliance must be filed in the file for the contractor prior to payment.

(h) Environmental safety modifications must be made within the existing square footage of the family home and may not add to the square footage of the family home.

(i) Payment to the contractor is to be withheld until the work meets specifications.

(j) A scope of work as defined in OAR 411-350-0020 must be completed for each identified environmental modification project. All contractors submitting bids must be given the same scope of work.

(k) A services coordinator must follow the processes outlined in the Expenditure Guidelines for contractor bids and the awarding of work.

(l) All dwellings must be in good repair and have the appearance of sound structure.

(m) The identified home may not be in foreclosure or the subject of legal proceedings regarding ownership.

(n) Environmental modifications must only be completed to the family home.

(o) Upgrades in materials that are not directly related to the health and safety needs of the child are not paid for or permitted.

(p) Environmental modifications are subject to Department requirements regarding material and construction practices based on industry standards for safety, liability, and durability, as referenced in building codes, materials manuals, and industry and risk management publications.

(q) RENTAL PROPERTY.

(A) Environmental modifications to rental property may not substitute or duplicate services otherwise the responsibility of the landlord under the landlord tenant laws, the Americans with Disabilities Act, or the Fair Housing Act.

(B) Environmental modifications made to a rental structure must have written authorization from the owner of the rental property prior to the start of the work.

(C) The Department does not fund work to restore the rental structure to the former condition of the rental structure.

(18) VEHICLE MODIFICATIONS.

(a) Vehicle modifications may only be made to the vehicle primarily used by a child to meet the unique needs of the child. Vehicle modifications may include a lift, interior alterations to seats, head and leg rests, belts, special safety harnesses, other unique modifications to keep the child safe in the vehicle, and the upkeep and maintenance of a modification made to the vehicle.

(b) Vehicle modifications exclude:

(A) Adaptations or improvements to a vehicle that are of general utility and are not of direct medical benefit to a child or do not address the underlying need for the modification;

(B) The purchase or lease of a vehicle; or

(C) Routine vehicle maintenance and repair.

(c) Vehicle modifications are limited to $5,000 per modification. A services coordinator must request approval for additional expenditures through the Department prior to expenditure. Approval is based on the service and support needs and goals of the child and a determination by the Department of appropriateness and cost-effectiveness. In addition, separate vehicle modification projects that cumulatively total up to over $5,000 in a plan year must be submitted to the Department for review.

(d) Vehicle modifications must meet applicable standards of manufacture, design, and installation.

(19) SPECIALIZED MEDICAL SUPPLIES. Specialized medical supplies do not cover services which are otherwise available to a child under Vocational Rehabilitation and Other Rehabilitation Services, 29 U.S.C. 701-796l, as amended, or the Individuals with Disabilities Education Act, 20 U.S.C. 1400 as amended. Specialized medical supplies may not overlap with, supplant, or duplicate other services provided through a waiver, OHP, or Medicaid state plan services.

(20) SPECIAL DIET.

(a) A special diet is a supplement and is not intended to meet the complete, daily nutritional requirements for a child.

(b) A special diet must be ordered at least annually by a physician licensed by the Oregon Board of Medical Examiners and periodically monitored by a dietician or physician.

(c) The maximum monthly purchase for special diet supplies may not exceed $100 per month.

(d) Special diet supplies must be in support of an evidence-based treatment regimen.

(e) A special diet excludes restaurant and prepared foods, perishables vitamins, and supplements.

(21) INDIVIDUAL-DIRECTED GOODS AND SERVICES.

(a) Individual-directed goods and services provide equipment and supplies that are not otherwise available through another source, such as waiver services or state plan services.

(b) Individual-directed goods and services are therapeutic in nature and must be recommended in writing by at least one licensed health professional or by a behavior consultant.

(c) Individual-directed goods and services must directly address an identified disability related need of a child in the ISP.

(d) Individual-directed goods and services must:

(A) Decrease the need for other Medicaid services;

(B) Promote inclusion of a child in the community; or

(C) Increase the safety of a child in the family home.

(e) Individual-directed goods and services may not be:

(A) Otherwise available through another source, such as waiver services or state plan services;

(B) Experimental or prohibited treatment; or

(C) Goods or services that are normally purchased by a family for a typically developing child of the same age.

(f) Individual-directed goods and services purchased must be the most cost effective option available to meet the needs of the child.

(22) PRIVATE DUTY NURSING. If the service needs of a child require the presence of an RN or LPN on an ongoing basis as determined medically necessary based on the assessed needs of the child, private duty nursing services may be allocated to ensure medically necessary supports are provided.

(a) Private duty nursing may be provided on a shift staffing basis as necessary.

(b) Private duty nursing must be delivered by a licensed RN or LPN, as determined by the service needs of the child and documented in the ISP and Nursing Service Plan.

(c) The amount of private duty nursing available to a child is based on the acuity level of the child as measured by the clinical criteria as follows:

(A) Level 1. Score of 75 or above and on a ventilator for 20 hours or more per day = up to a maximum of 554 nursing hours per month;

(B) Level 2. Score of 70 or above = up to a maximum of 462 nursing hours per month;

(C) Level 3. Score of 65 to 69 = up to a maximum of 385 nursing hours per month;

(D) Level 4. Score of 60 to 64 = up to a maximum of 339 nursing hours per month;

(E) Level 5. Score of 50 to 59 or if a child requires ventilation for sleeping hours = up to a maximum of 293 nursing hours per month; and

(F) Level 6. Score of less than 50 = up to a maximum of 140 nursing hours per month.

(23) All MFC services authorized by the Department must be included in a written ISP in order to be eligible for payment. The ISP must use the most cost effective services for safely and appropriately meeting the service needs of a child as determined by a services coordinator. Any goods purchased with MFC funds that are not used according to an ISP may be immediately recovered by the Department.

(24) All requests for General Fund expenditures and expenditures exceeding limitations in the Expenditure Guidelines must be authorized by the Department. The approval of the Department is limited to 90 days unless re-authorized. Exceptions associated with criteria hours may be approved for up to six months to align with the criteria redetermination. A request for a General Fund expenditure or an expenditure exceeding limitations in the Expenditure Guidelines is only authorized in the following circumstances:

(a) To prevent the hospitalization of a child;

(b) To provide initial teaching of new service needs;

(c) The child is not safely served in the family home without the expenditure;

(d) The expenditure provides supports for the emerging or changing service needs or behaviors of the child;

(e) A significant medical condition or event, as documented by a primary care provider, prevents or seriously impedes the primary caregiver from providing services; or

(f) The services coordinator determines, with a behavior consultant, that the child needs two staff present at one time to ensure the safety of the child and others. Prior to approval, the services coordinator must determine that a caregiver, including the parent or guardian, has been trained in behavior management and that all other feasible recommendations from the behavior consultant and the services coordinator have been implemented.

(25) Payment for MFC services is made in accordance with the Expenditure Guidelines.

(26) The Department may expend funds through contract, purchase order, use of credit card, payment directly to the vendor, or any other legal payment mechanism. No payments are made to families for reimbursement or to pay for services.

(27) The Department does not pay for MFC services that are:

(a) Illegal, experimental, or determined unsafe for the general public by a recognized child or consumer safety agency;

(b) Notwithstanding abuse as defined in ORS 419B.005, abusive, aversive, or demeaning;

(c) Not necessary, not in accordance with the Expenditure Guidelines, not cost effective, or do not meet the definition of support or social benefit as defined in OAR 411-350-0020;

(d) Educational services for school-age children, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills;

(e) Services or activities that the legislative or executive branch of Oregon government has prohibited use of public funds;

(f) Medical treatments; or

(g) Provided by private health insurance, OHP, or alternative resources.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007 & 430.215

Hist.: MHD 21-1998(Temp), f. 11-25-98, cert. ef. 12-1-98 thru 5-29-99; MHD 3-1999, f. 5-17-99, cert. ef. 5-28-99; MHD 8-2003(Temp) f. & cert. ef. 12-11-03 thru 6-7-04; Renumbered from 309-044-0140, SPD 14-2004, f. & cert. ef. 6-1-04; SPD 1-2009, f. 2-24-09, cert. ef. 3-1-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 28-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13; SPD 55-2013, f. 12-27-13, cert. ef. 12-28-13; APD 31-2014(Temp), f. & cert. ef. 8-20-14 thru 2-16-15; APD 4-2015, f. 2-13-15, cert. ef. 2-16-15; APD 8-2015, f. & cert. ef. 3-12-15

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Department of Human Services, Child Welfare Programs
Chapter 413

Rule Caption: Repealing obsolete Child Welfare rules relating to Child Abuse Multidisciplinary Intervention (CAMI)
Adm. Order No.: CWP 9-2015
Filed with Sec. of State: 2-26-2015
Certified to be Effective: 3-6-15
Notice Publication Date: 2-1-2015
Rules Repealed: 413-300-0200, 413-300-0210, 413-300-0220, 413-300-0230, 413-300-0240, 413-300-0250, 413-300-0260, 413-300-0270, 413-300-0280
Subject: The Department of Human Services, Office of Child Welfare Programs, is permanently repealing its rules on Child Abuse Multidisciplinary Intervention (CAMI), OAR 413-300-0200 to 413-300-0280. The rules implement the CAMI account and set forth eligibility criteria for county multidisciplinary teams to access the funds. Per ORS 418.746, the CAMI Program in the Department of Justice has authority to adopt rules regarding the CAMI account. Department of Justice administrative rules implement the account and set forth eligibility criteria to qualify for funds at OAR 137-082-0200 to 137-082-0280. The Department of Human Services' rules on this topic are obsolete.
Rules Coordinator: Kris Skaro—(503) 945-6067

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Department of Human Services, Self-Sufficiency Programs
Chapter 461

Rule Caption: Updating Qualified Medicare Beneficiaries (QMB) rules to reflect annual Federal Poverty Level (FPL) Adjustments
Adm. Order No.: SSP 8-2015
Filed with Sec. of State: 2-27-2015
Certified to be Effective: 3-1-15
Notice Publication Date: 11-1-2014
Rules Amended: 461-155-0290, 461-155-0291, 461-155-0295
Subject: OAR 461-155-0290 about income standards for QMB-BAS, 461-155-0291 about income standards for QMB-DW, and 461-155-0295 about income standards for QMB-SMB and QMB-SMF are being amended to reflect the annual Federal Poverty Level (FPL) adjustments. The poverty guidelines are updated annually by the US Department of Health and Human Services based on the Consumer Price Index for All Urban Consumers (CPI-U). The poverty guidelines are then used to determine financial eligibility for public assistance programs.
Rules Coordinator: Kris Skaro—(503) 945-6067

461-155-0290
Income Standard; QMB-BAS

The adjusted income standard for the QMB-BAS program is 100 percent of the 2015 federal poverty level. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 411.060 & 411.070
Stats. Implemented: ORS 411.060 & 411.070
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 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 9-1991, f. 3-29-91, cert. ef. 4-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 5-1993, f. & cert. ef. 4-1-93; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 16-1996, f. 4-29-96, cert. ef. 5-1-96; 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 7-2003, f. & cert. ef. 4-1-03; SSP 8-2004, f. & cert. ef. 4-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 4-2006, f. & cert. ef. 3-1-06; SSP 2-2007(Temp), f.& cert. ef. 3-1-07 thru 3-31-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 6-2008(Temp), f. 2-29-08, cert. ef. 3-1-08 thru 8-28-08; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 6-2009(Temp), f. & cert. ef. 4-1-09 thru 9-28-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 8-2011(Temp), f. & cert. ef. 3-1-11 thru 8-28-11; SSP 17-2011, f. & cert. ef. 7-1-11; SSP 8-2012, f. & cert. ef. 3-1-12; SSP 6-2013, f. & cert. ef. 3-1-13; SSP 4-2014(Temp), f. 2-4-14, cert. ef. 3-1-14 thru 8-28-14; SSP 7-2014, f. & cert. ef. 3-7-14; SSP 8-2015, f. 2-27-15, cert. ef. 3-1-15

461-155-0291
Income Standard; QMB-DW

The adjusted income standard for the QMB-DW program is 200 percent of the 2015 federal poverty level (see OAR 461-155-0290).. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 411.060 & 411.070
Stats. Implemented: ORS 411.060 & 411.070
Hist.: AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 9-1991, f. 3-29-91, cert. ef. 4-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 5-1993, f. & cert. ef. 4-1-93; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 16-1996, f. 4-29-96, cert. ef. 5-1-96; 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 7-2003, f. & cert. ef. 4-1-03; SSP 8-2004, f. & cert. ef. 4-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 4-2006, f. & cert. ef. 3-1-06; SSP 2-2007(Temp), f.& cert. ef. 3-1-07 thru 3-31-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 6-2008(Temp), f. 2-29-08, cert. ef. 3-1-08 thru 8-28-08; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 6-2009(Temp), f. & cert. ef. 4-1-09 thru 9-28-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 8-2011(Temp), f. & cert. ef. 3-1-11 thru 8-28-11; SSP 17-2011, f. & cert. ef. 7-1-11; SSP 8-2012, f. & cert. ef. 3-1-12; SSP 6-2013, f. & cert. ef. 3-1-13; SSP 4-2014(Temp), f. 2-4-14, cert. ef. 3-1-14 thru 8-28-14; SSP 7-2014, f. & cert. ef. 3-7-14; SSP 8-2015, f. 2-27-15, cert. ef. 3-1-15

461-155-0295
Income Standard; QMB-SMB, QMB-SMF

(1) Eligibility for QMB-SMB requires income greater than 100 percent (see OAR 461-155-0290) but less than 120 percent of the federal poverty level. The adjusted income standard for QMB-SMB is 120 percent of the 2015 federal poverty level. [Table not included. See ED. NOTE.]

(2) Eligibility for QMB-SMF requires income equal to or greater than 120 percent (see section (1) of this rule) but less than 135 percent of the federal poverty level. The adjusted income standard for QMB-SMF is 135 percent of the 2015 federal poverty level. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 411.060 & 411.070
Stats. Implemented: ORS 411.060 & 411.070
Hist.: AFS 35-1992, f. 12-31-92, cert. ef. 1-1-93; AFS 5-1993, f. & cert. ef. 4-1-93; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 16-1996, f. 4-29-96, cert. ef. 5-1-96; AFS 5-1997, f. 4-30-97, cert. ef. 5-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; 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; AFS 19-2002(Temp), f. 12-10-02, cert. ef. 1-1-03 thru 5-31-03; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 8-2004, f. & cert. ef. 4-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 4-2006, f. & cert. ef. 3-1-06; SSP 2-2007(Temp), f.& cert. ef. 3-1-07 thru 3-31-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 6-2008(Temp), f. 2-29-08, cert. ef. 3-1-08 thru 8-28-08; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 6-2009(Temp), f. & cert. ef. 4-1-09 thru 9-28-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 8-2011(Temp), f. & cert. ef. 3-1-11 thru 8-28-11; SSP 17-2011, f. & cert. ef. 7-1-11; SSP 8-2012, f. & cert. ef. 3-1-12; SSP 6-2013, f. & cert. ef. 3-1-13; SSP 4-2014(Temp), f. 2-4-14, cert. ef. 3-1-14 thru 8-28-14; SSP 7-2014, f. & cert. ef. 3-7-14; SSP 8-2015, f. 2-27-15, cert. ef. 3-1-15

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Rule Caption: Clarifying that some medical costs are not deductible in the Supplemental Nutrition Assistance Program (SNAP)
Adm. Order No.: SSP 9-2015(Temp)
Filed with Sec. of State: 3-10-2015
Certified to be Effective: 3-10-15 thru 9-5-15
Notice Publication Date:
Rules Amended: 461-160-0055
Subject: OAR 461-160-0055 about medical deductions allowed in the GA, GAM, OSIP, OSIPM, and SNAP programs is being amended to add a provision that for the SNAP Program, costs for items which can be purchased with SNAP benefits, including but not limited to special diets, nutritional drinks, or organic foods, are not allowable medical deductions, even if prescribed by a medical professional.
Rules Coordinator: Kris Skaro—(503) 945-6067

461-160-0055
Medical Costs That are Deductible; GA, GAM, OSIP, OSIPM, SNAP

(1) This rule applies only to SNAP filing group (see OAR 461-110-0370) members who are elderly (see OAR 461-001-0015) or who have a disability (see OAR 461-001-0015), and to clients in the GA, GAM, OSIP, and OSIPM programs.

(2) Medical costs are deductible to the extent a deduction is authorized in OAR 461-160-0415 and 461-160-0430 and in this rule.

(3) Health and hospitalization insurance premiums and coinsurance are deductible. In the OSIPM and SNAP programs, health insurance premiums paid less frequently than monthly may be prorated over the period covered by the premium.

(4) In the OSIPM and SNAP programs:

(a) Long-term care insurance premiums are deductible if the insurance pays for services while an individual is:

(A) Receiving home and community-based care (see OAR 461-001-0030);

(B) Receiving nursing facility services; or

(C) In an intermediate care facility for the mentally retarded (ICF/MR).

(b) A policy that is set up to pay a lump sum, similar to life insurance, is not deductible.

(5) The cost of a medical service is deductible if it is:

(a) Provided by, prescribed by, or used under the direction of a licensed medical practitioner; or

(b) Except in the SNAP program, a medical necessity approved by the Department.

(6) Medical deductions are also allowed for, among other things, the cost of:

(a) Medical and dental care, including psychotherapy, rehabilitation services, hospitalization, and outpatient treatment.

(b) Prescription drugs and over-the-counter medications prescribed by a licensed practitioner, the annual fee for a drug prescription card, medical supplies and equipment, dentures, hearing aids, prostheses, and prescribed eyeglasses.

(c) In the SNAP program, such items as the following:

(A) Nursing care, nursing home care, and hospitalization, including payments for an individual who was a member of the filing group immediately prior to entering a hospital or a nursing home certified by the state. Deduction of these payments is also allowed for an individual who was a member of the filing group immediately prior to death if the remaining filing group members are legally responsible for payment of the expenses.

(B) Services of an attendant, home health aid, housekeeper, or provider of dependent care necessary due to the client's age or illness, including an amount equal to a one-person SNAP benefit group (see OAR 461-110-0750) if the client furnishes the majority of an attendant's meals.

(C) Prescribed assistance animals (such as a Seeing Eye Dog, Hearing Dog, or Housekeeper Monkey) that have received special training to provide a service to the client. This deduction includes the cost of acquiring these animals, their training, food, and veterinarian bills.

(D) Reasonable costs for transportation and lodging needed to obtain medical treatment or services.

(E) Installment plan arrangements made before a bill becomes past due. The expense is not deducted if the client defaults and makes a second agreement.

(7) In the SNAP program, the following costs, even if prescribed by a medical practitioner, are not allowable medical deductions:

(a) Costs for and related to medical use of marijuana, including registry identification cards.

(b) Costs for items which can be purchased with SNAP benefits including, but not limited to, special diets, nutritional drinks, or organic foods.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404 & 411.816
Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.404 & 411.816
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 20-2004(Temp), f. & cert. ef. 9-7-04 thru 12-31-04; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 23-2004(Temp), f. & cert. ef. 10-1-04 thru 12-31-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 15-2006,

f. 12-29-06, cert. ef. 1-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 27-2012(Temp), f. & cert. ef. 7-12-12 thru 1-8-13; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 9-2015(Temp), f. & cert. ef. 3-10-15 thru 9-5-15

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Rule Caption: Exempts some clients eligible for Temporary Assistance for Domestic Violence Survivors from ERDC reservation list
Adm. Order No.: SSP 10-2015
Filed with Sec. of State: 3-12-2015
Certified to be Effective: 3-31-15
Notice Publication Date: 2-1-2015
Rules Amended: 461-115-0016
Subject: OAR 461-115-0016 about the application process and reservation list for the Employment Related Day Care (ERDC) program is being amended to make permanent a temporary rule adopted on October 1, 2014, that added an additional exemption under which otherwise eligible ERDC families would not be placed on the reservation list. Under the amendment, new ERDC applicants that include a filing group member who is determined eligible for Temporary Assistance for Domestic Violence Survivors (TA-DVS) program benefits from the State of Oregon in the current month or at least one of the preceding three months will meet an exception to the ERDC reservation list.
Rules Coordinator: Kris Skaro—(503) 945-6067

461-115-0016
Application Process; Reservation List for ERDC

Notwithstanding any other rule in chapter 461 of the Oregon Administrative Rules, in the ERDC program:

(1) Eligibility (see OAR 461-001-0000) is subject to the availability of funds. The Department may implement a Child Care Reservation List whenever the Department determines that sufficient funding is not available to sustain benefits for all of the applicants requesting assistance.

(2) Except as provided in section (3) of this rule, the following applicants are subject to placement on the Child Care Reservation List when the Child Care Reservation List is in effect:

(a) New applicants for ERDC when no member of the ERDC filing group (see OAR 461-110-0350) meets the requirements of one or more of the following paragraphs:

(A) Received a partial or full month of REF, SFPSS, or TANF program cash benefits from the State of Oregon in at least one of the preceding three months; and no member of the ERDC program filing group may be concurrently receiving TANF program benefits except as allowed under OAR 461-165-0030.

(B) Is eligible for and being placed in a current opening in a Head Start program contracted slot under OAR 461-135-0405 or an Oregon Program of Quality contracted slot under OAR 461-135-0407.

(C) The caretaker (see OAR 461-001-0000) is currently working with Child Welfare as part of a CPS assessment or open case, an ongoing safety plan is in place, and Child Welfare has determined the use of child care as part of an ongoing safety plan will:

(i) Prevent removal of the child (see OAR 461-001-0000) from their home;

(ii) Allow a child to be returned home; or

(iii) Allow for placement of the child with a relative or with an adult whom the child or the family of the child has an established relationship.

(D) Determined eligible for TA-DVS program benefits (see OAR 461-135-1225) from the State of Oregon in the current month or at least one of the preceding three months.

(b) Individuals who are reapplying for ERDC after a break in ERDC benefits of two consecutive, calendar months or more.

(3) Except as allowed under OAR 461-165-0030, no member of an ERDC program filing group may be concurrently receiving TANF program benefits. When concurrent benefits are not allowed, the Department sends a decision notice (see OAR 461-001-0000) of ineligibility for the ERDC program and the filing group is not placed on the Child Care Reservation List.

(4) When the Child Care Reservation List is in effect, the Department must place all applicants who are subject to the Child Care Reservation List under section (2) of this rule on the Child Care Reservation List for future selection. The Department sends these applicants a decision notice of ineligibility for the ERDC program.

(5) Each month, on the basis of an estimate of available funds, an appropriate number of individuals from the Child Care Reservation List are randomly selected and invited to apply for ERDC.

(6) After an individual is selected from the Child Care Reservation List, the individual must contact the Department to establish a date of request (see OAR 461-115-0030) no later than 30 days after the date on the selection letter. The individual may request child care benefits from the Department:

(a) Without completing a new application, when the previous application is within 45 days of its date of request; or

(b) By submitting a new application for child care benefits to the Department.

(7) The processing time frame for the ERDC application is the same as that specified in OAR 461-115-0190, except that:

(a) An individual who requests benefits after the 30 day deadline to apply (see section (6) of this rule) will be returned to the Child Care Reservation List.

(b) If the Department does not receive a request for benefits within the deadline to apply, the individual is dropped from the Child Care Reservation List.

Stat. Auth.: ORS 409.050, 411.060 & 411.116
Stats. Implemented: ORS 409.010, 409.050, 409.610, 411.060, 411.116, 411.121, 411.122 & 411.135
Hist.: SSP 23-2011(Temp), f. & cert. ef. 8-1-11 thru 1-27-12; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 29-2012(Temp), f. 8-31-12, cert. ef. 9-1-12 thru 2-28-13; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; SSP 39-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 25-2014(Temp), f. & cert. ef 10-1-14 thur 3-30-15; SSP 10-2015, f. 3-12-15, cert. ef. 3-31-15

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Rule Caption: Amending rules relating to the Refugee and Refugee Medical programs
Adm. Order No.: SSP 11-2015
Filed with Sec. of State: 3-13-2015
Certified to be Effective: 4-1-15
Notice Publication Date: 2-1-2015
Rules Amended: 461-001-0000, 461-101-0010, 461-110-0210, 461-110-0430, 461-145-0050, 461-145-0088, 461-145-0130, 461-145-0910, 461-145-0930, 461-193-0031
Subject: OAR 461-001-0000 about definitions for rules in chapter 461 is being amended to: remove reference to the REF (Refugee) program from the definition of 'caretaker relative'; remove reference to the REF and REFM (Refugee — Medical) programs from the definitions of 'dependent child' and 'minor parent'; and clarify that the 'primary person' for the REF and REFM programs is the client or the client's spouse.

OAR 461-101-0010 about program acronyms used in chapter 461 is being amended to remove the reference to the REF and REFM programs in the description of the JOBS program.

OAR 461-110-0210 about household groups is being amended to clarify when an individual who is absent from the household for longer than 30 days remains part of the household group in the REF and REFM programs.

OAR 461-110-0430 about filing groups in the REF and REFM programs and 461-193-0031 about eligibility requirements for Refugee Case Services Project (RCSP) are being amended to restrict newly arrived refugees who are being reunited with a spouse who is currently residing in the U.S. from forming a separate filing group that excludes the previously arrived spouse.

OAR 461-145-0050 about how burial spaces and merchandise are treated when determining income and resources is being amended to include REFM as a program to which this rule applies.

OAR 461-145-0088 about how corporations and business entities are treated when determining income and resources is being amended to include REF and REFM as programs to which the rule applies. The rule is also being amended to remove an unnecessary reference

to the Oregon Health Plan (OHP). OHP rules are in chapter 410 of the Oregon Administrative Rules.

OAR 461-145-0130 about earned income is being amended to remove an inapplicable reference to dependent children as it relates to how earned income is treated in the REF and REFM programs.

OAR 461-145-0910 about self-employment income is being amended to specify how self-employment income is counted in the REFM program.

OAR 461-145-0930 about determination of countable self-employment income is being amended to include REFM as a program to which this rule applies, specifically that in the REFM program, all costs permitted under 461-145-0920 (Self-Employment; Costs That Are Excluded To Determine Countable Income) are excluded.

In addition, the above rules are being amended to accurately reflect Department terminology, correct formatting and punctuation, and update statutory and rule references.

Rules Coordinator: Kris Skaro—(503) 945-6067

461-001-0000
Definitions for Chapter 461

Defined terms are often italicized throughout this chapter of rules. If a defined term is accompanied by a cross-reference to a rule defining the term, subsequent usages of that term in the same rule refer to the same definition cross-referenced earlier in the rule. In this chapter of rules, unless the context indicates otherwise:

(1) A reference to Division, Adult and Family Services Division (or AFS), Senior and Disabled Services Division (or SDSD), or any other agency formerly part of the Department of Human Services means the Department of Human Services (DHS), except:

(a) The rule in which reference occurs only regulates programs covered by chapter 461 of the Oregon Administrative Rules.

(b) OCCS medical program eligibility rules are in division 410-200 of Oregon Administrative Rules.

(2) "Address Confidentiality Program" (ACP) means a program of the Oregon Department of Justice, which provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence (see section (25) of this rule), sexual assault, or stalking.

(3) "Adjusted income" means the amount determined by subtracting income deductions from countable (see section (18) of this rule) income (see OAR 461-140-0010). Specific rules on the deductions are in division 461-160 of Oregon Administrative Rules.

(4) "Adoption assistance" means financial assistance provided to families adopting children with special needs. "Adoption assistance" may be state or federally funded. Federal adoption assistance is authorized by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. No. 96-272, 94 Stat. 500 (1980)). State adoption assistance is authorized by ORS 418.330 to 418.335.

(5) "Assets" mean income and resources.

(6) "Basic decision notice" means a decision notice (see section (21) of this rule) mailed no later than the date of action given in the notice.

(7) "Branch office" means any Department or AAA (Area Agency on Aging) office serving a program covered by this chapter of rules.

(8) "Budgeting" means the process of calculating the benefit level.

(9) "Budget month" means the calendar month from which nonfinancial and financial information is used to determine eligibility (see section (28) of this rule) and benefit level for the payment month (see section (50) of this rule).

(10) "Cafeteria plan" means a written benefit plan offered by an employer in which:

(a) All participants are employees; and

(b) Participants may choose, cafeteria-style, from a menu of two or more cash or qualified benefits. In this context, qualified benefits are benefits other than cash that the Internal Revenue Service does not consider part of an employee's gross income. Qualified benefits include, but are not limited to:

(A) Accident and health plans (including medical plans, vision plans, dental plans, accident and disability insurance);

(B) Group term life insurance plans (up to $50,000);

(C) Dependent care assistance plans; and

(D) Certain stock bonus plans under section 401(k)(2) of the Internal Revenue Code (but not 401(k)(1) plans).

(11) "Capital asset" means property that contributes toward earning self-employment income, including self-employment income from a microenterprise (see section (43) of this rule), either directly or indirectly. A "capital asset" generally has a useful life of over one year and a value, alone or in combination, of $100 or more.

(12) "Caretaker" means an individual who is responsible for the care, control, and supervision of a child (see section (15) of this rule). The status of "caretaker" ends once the individual no longer exercises care, control, and supervision of the child for 30 days.

(13) "Caretaker relative" means:

(a) In the Pre-TANF, SFPSS, and TANF programs, a dependent child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece who lives in a residence maintained by one or more of the relatives as the child's or the relative's own home.

(b) In all programs not covered under subsection (a) of this section, a caretaker (see section (12) of this rule) who meets the requirements of one of the following paragraphs:

(A) Is one of the following relatives of the dependent child (see section (23) of this rule):

(i) Any blood relative, including those of half-blood, and including first cousins, nephews, or nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.

(ii) Stepfather, stepmother, stepbrother, and stepsister.

(iii) An individual who legally adopts the child and any individual related to the individual adopting the child, either naturally or through adoption.

(B) Is or was a spouse (see section (62) of this rule) of an individual listed in paragraph (A) of this subsection.

(C) Met the definition of "caretaker relative" under paragraph (A) or (B) of this subsection before the child was adopted (notwithstanding the subsequent adoption of the child).

(14) "Certification period" means the period for which an individual is certified eligible for a program.

(15) "Child" includes natural, step, and adoptive children. The term "child" does not include an unborn.

(a) In the ERDC program, a "child" need not have a biological or legal relationship to the caretaker but must be in the care and custody of the caretaker, must meet the citizenship or alien status requirements of OAR 461-120-0110, and must be:

(A) Under the age of 18; or

(B) Under the age of 19 and in secondary school or vocational training at least half time.

(b) In the GA, GAM, and OSIP programs, a "child" is an individual under the age of 18.

(c) In the OSIPM and QMB programs, "child" means an unmarried individual living with a parent (see section (49) of this rule) who is:

(A) Under the age of 18; or

(B) Under the age of 22 and attending full-time secondary, postsecondary or vocational-technical training designed to prepare the individual for employment.

(d) In the REF and REFM programs, a "child" is:

(A) An individual under the age of 18; or

(B) An individual who is 18 years of age and attending secondary school full-time or pursuing a GED full-time.

(16) "Community based care" is any of the following:

(a) Adult foster care — Room and board and 24 hour care and services for the elderly or for people with disabilities 18 years of age or older. The care is contracted to be provided in a home for five or fewer clients.

(b) Assisted living facility — A program approach, within a physical structure, which provides or coordinates a range of services, available on a 24-hour basis, for support of resident independence in a residential setting.

(c) In-home Services — Individuals living in their home receiving services determined necessary by the Department.

(d) Residential care facility — A facility that provides residential care in one or more buildings on contiguous property for six or more individuals who have physical disabilities or are socially dependent.

(e) Specialized living facility — Identifiable services designed to meet the needs of individuals in specific target groups which exist as the result of a problem, condition, or dysfunction resulting from a physical disability or a behavioral disorder and require more than basic services of other established programs.

(f) Independent choices — In-Home Services program wherein the participant is given cash benefits to purchase self-directed personal assis-

tance services or goods and services provided pursuant to a written service plan (see OAR 411-030-0020).

(17) "Continuing benefit decision notice" means a decision notice that informs the client of the right to continued benefits and is mailed in time to be received by the date benefits are, or would be, received.

(18) "Countable" means that an available asset (either income or a resource) is not excluded and may be considered by some programs to determine eligibility.

(19) "Cover Oregon" means Oregon Health Insurance Exchange Corporation.

(20) "Custodial parents" mean parents who have physical custody of a child. "Custodial parents" may be receiving benefits as dependent children or as caretaker relatives for their own children.

(21) "Decision notice" means a written notice of a decision by the Department regarding an individual's eligibility for benefits in a program.

(22) "Department" means the Department of Human Services (DHS).

(23) "Dependent child" in the TANF program means the following:

(a) An individual who is not a caretaker relative (see section (13) of this rule) of a child in the household, is unmarried or married but separated, and is under the age of 18, or 18 years of age and a full time student in secondary school or the equivalent level of vocational or technical training; or

(b) A minor parent (see section (44) of this rule) whose parents have chosen to apply for benefits for the minor parent. This does not apply to a minor parent who is married and living with his or her spouse.

(24) "Disability" means:

(a) In the SNAP program, see OAR 461-001-0015.

(b) In the REF, SFPSS, TA-DVS, and TANF programs, for purposes other than determining eligibility:

(A) An individual with a physical or mental impairment that substantially limits the individual's ability to meet the requirements of the program; or

(B) An individual with a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or who is regarded as having such an impairment as defined by the Americans with Disabilities Act (42 USC 12102; 28 CFR 35.104).

(25) "Domestic violence" means the occurrence of one or more of the acts described in subsections (a) to (d) of this section between family members, intimate partners, or household members:

(a) Attempting to cause or intentionally, knowingly, or recklessly causing physical injury or emotional, mental, or verbal abuse.

(b) Intentionally, knowingly, or recklessly placing another in fear of imminent serious physical injury.

(c) Committing sexual abuse in any degree as defined in ORS 163.415, 163.425 and 163.427.

(d) Using coercive or controlling behavior.

(e) As used in this section, "family members" and "household members" mean any of the following:

(A) Spouse;

(B) Former spouse;

(C) Individuals related by blood, marriage (see section (42) of this rule), or adoption;

(D) Individuals who are cohabitating or have cohabited with each other;

(E) Individuals who have been involved in a sexually intimate or dating relationship; or

(F) Unmarried parents of a child.

(26) "Domestic violence shelters" are public or private nonprofit residential facilities providing services to victims of domestic violence. If the facility serves other people, a portion must be used solely for victims of domestic violence.

(27) "Electronic application" is an application electronically signed and submitted through the Internet.

(28) "Eligibility" means the decision as to whether an individual qualifies, under financial and nonfinancial requirements, to receive program benefits.

(29) "Equity value" means fair market value (see section (30) of this rule) minus encumbrances.

(30) "Fair market value" means the amount an item is worth on the open market.

(31) "Family stability" in the JOBS, Pre-TANF, Post-TANF, SFPSS, TA-DVS, and TANF programs means the characteristics of a family that support healthy child development, including parental mental health, drug and alcohol free environment, stable relationships, and a supportive, flexible, and nurturing home environment.

(32) "Family stability activity" in the JOBS, Pre-TANF, Post-TANF, SFPSS, TA-DVS, and TANF programs means an action or set of actions taken by an individual, as specified in a case plan, intended to promote the ability of one or both parents to achieve or maintain family stability (see section (31) of this rule).

(33) "Financial institution" means a bank, credit union, savings and loan association, investment trust, or other organization held out to the public as a place receiving funds for deposit, savings, checking, or investment.

(34) "Income producing property" means any real or personal property that generates income for the financial group (see OAR 461-110-0530). Examples of "income producing property" are:

(a) Livestock, poultry, and other animals.

(b) Farmland, rental homes (including a room or other space in the home or on the property of a member of the financial group), vacation homes, condominiums.

(35) "Initial month" of eligibility means any of the following:

(a) In all programs, the first month a benefit group (see OAR 461-110-0750) is eligible for a program benefit in Oregon after a period during which the group is not eligible.

(b) In all programs except the SNAP program, the first month a benefit group is eligible for a program benefit after there has been a break in the program benefit of at least one full calendar month. If benefits are suspended for one month, that is not considered a break.

(c) In the SNAP program:

(A) The first month for which the benefit group is certified following any period during which they were not certified to participate, except for migrant and seasonal farm workers (see OAR 461-001-0015).

(B) For migrant and seasonal farmworkers, the first month for which the benefit group is certified following any period of one month or more during which they were not certified to participate.

(d) For a new applicant to the GA, GAM, OSIP, or OSIPM program applying for care in a nonstandard living arrangement (see section (45) of this rule), for the purposes of calculating the correct divisor in OAR 461-140-0296, the month in which the individual would have been eligible had it not been for the disqualifying transfer of assets (see section (5) of this rule).

(e) For a current recipient of the GA, GAM, OSIP, or OSIPM program receiving or applying for care in a nonstandard living arrangement, for the purpose of calculating the correct divisor in OAR 461-140-0296, the later of the following:

(A) The month the disqualifying transfer occurred.

(B) The month of application for long-term care (see section (40) of this rule) services if the individual would have been eligible had it not been for the disqualifying transfer of assets.

(36) "In-kind income" means income in a form other than money (such as food, clothing, cars, furniture, and payments made to a third party).

(37) "Legally married" means a marriage uniting two individuals according to:

(a) The statutes of the state where the marriage occurred;

(b) Except in the SNAP program, the common law of the state in which the two individuals previously resided while meeting the requirements for common law marriage in that state; or

(c) The laws of a country in which the two individuals previously resided while meeting the requirements for legal or cultural marriage in that country.

(38) "Life estate" means the right to property limited to the lifetime of the individual holding it or the lifetime of some other individual. In general, a "life estate" enables the owner of the "life estate" to possess, use, and obtain profits from property during the lifetime of a designated individual while actual ownership of the property is held by another individual. A "life estate" is created when an individual owns property and then transfers ownership to another individual while retaining, for the rest of the individual's life, certain rights to that property. In addition, a "life estate" is established when a member of the financial group purchases a "life estate" interest in the home of another individual.

(39) "Lodger" means a member of the household group (see OAR 461-110-0210) who:

(a) Is not a member of the filing group (see OAR 461-110-0310); and

(b) Pays the filing group:

(A) In all programs except the GA, GAM, OSIP, OSIPM, and QMB programs, for room and board.

(B) In the GA, GAM, OSIP, OSIPM, and QMB programs, for room with or without board.

(40) "Long term care" means the system through which the Department provides a broad range of social and health services to eligible

adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and state hospitals (Eastern Oregon and Oregon State Hospitals).

(41) "Lump-sum income" means income received too infrequently or irregularly to be reasonably anticipated, or received as a one-time payment. "Lump-sum income" includes:

(a) Retroactive benefits covering more than one month, whether received in a single payment or several payments.

(b) Income from inheritance, gifts, winnings, and personal injury claims.

(42) "Marriage" means the union of two individuals who are legally married (see section (37) of this rule).

(43) "Microenterprise" means a sole proprietorship, partnership, or family business with fewer than five employees and capital needs no greater than $35,000.

(44) "Minor parent" in the ERDC and TANF programs means a parent under the age of 18.

(45) "Nonstandard living arrangement" is defined as follows:

(a) In the GA, GAM, OSIP, OSIPM, and QMB programs, an individual is considered to be in a "nonstandard living arrangement" when the individual is applying for or receiving services in any of the following locations:

(A) A nursing facility in which the individual receives long-term care services paid with Medicaid funding, except this subsection does not apply to a Medicare client in a skilled-stay nursing facility.

(B) An intermediate care facility for the mentally retarded (ICF/MR).

(C) A psychiatric institution, if the individual is not yet 21 years of age or has reached the age of 65.

(D) A community based care (see section (16) of this rule) setting, except a State Plan Personal Care (SPPC) setting is not considered a "nonstandard living arrangement".

(b) In all programs except GA, GAM, OSIP, OSIPM, and QMB, "nonstandard living arrangement" means each of the following locations:

(A) Foster care.

(B) Residential Care facility.

(C) Drug or alcohol residential treatment facility.

(D) Homeless or domestic violence shelter.

(E) Lodging house if paying for room and board.

(F) Correctional facility.

(G) Medical institution.

(46) "OCCS" is the Office of Client and Community Services, part of the Medical Assistance Programs under the Oregon Health Authority responsible for OCCS medical program eligibility policy, community outreach, OCCS Medical Program eligibility determinations, and the OHA Customer Service Call Center.

(47) "OCCS Medical Programs" refers to programs for which eligibility policy can be found in division 410-200 of Oregon Administrative Rules, and includes CEC, CEM, MAA, MAF, EXT, OHP, Substitute Care, BCCTP, and MAGI Medicaid/CHIP programs, including:

(a) MAGI Adult;

(b) MAGI Child;

(c) MAGI Parent or Other Caretaker Relative;

(d) MAGI Pregnant Woman; and

(e) MAGI CHIP.

(48) "Ongoing month" means one of the following:

(a) For all programs except the SNAP program, any month following the initial month (see section (35) of this rule) of eligibility, if there is no break in the program benefit of one or more calendar months.

(b) For the SNAP program, any month in the certification period (see section (14) of this rule) following the initial month of eligibility.

(49) "Parent" for all programs except the JPI and SNAP programs, means the biological or legal mother or father of an individual or unborn child. For the SNAP program, a "parent" means the biological or legal mother or father of an individual. For the JPI program, a "parent" means the biological or legal mother or father of a child under the age of 18.

(a) If the mother lives with a male and either she or the male claims that he is the father of the child or unborn, and no one else claims to be the father, he is treated as the father even if paternity has not been legally established.

(b) A stepparent relationship exists if:

(A) The individual is legally married to the child's biological or adoptive parent; and

(B) The marriage has not been terminated by legal separation, divorce, or death.

(c) A legal adoption erases all prior legal and blood relationships and establishes the adoptive parent as the legal parent. However, the biological parent is also considered a "parent" if both of the following are true:

(A) The child lives with the biological parent; and

(B) The legal parent has given up care, control, and supervision of the child.

(50) "Payment month" means, for all programs except EA, the calendar month for which benefits are issued.

(51) "Payment period" means, for EA, the 30-day period starting with the date the first payment is issued and ending on the 30th day after the date the payment is issued.

(52) "Periodic income" means income received on a regular basis less often than monthly.

(53) "Primary person" for all programs except the SNAP program, means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits. The "primary person" for individual programs is as follows:

(a) For the TANF program, the parent or caretaker relative.

(b) For the ERDC program, the caretaker.

(c) For SNAP, see OAR 461-001-0015.

(d) For the GA, GAM, OSIP, OSIPM, QMB, REF, and REFM programs: the client or client's spouse.

(54) "Qualified Partnership Policy" means a long-term care insurance policy meeting the requirements of OAR 836-052-0531 that was either:

(a) Issued while the individual was a resident in Oregon on January 1, 2008 or later; or

(b) Issued in another state while the individual was a resident of that state on or after the effective date of that state's federally approved State Plan Amendment to issue qualified partnership policies.

(55) "Real property" means land, buildings, and whatever is erected on or affixed to the land and taxed as "real property".

(56) "Reimbursement" means money or in-kind compensation provided specifically for an identified expense.

(57) "Safe homes" mean private homes that provide a few nights lodging to victims of domestic violence. The homes must be recognized as such by the local domestic violence agency, such as crisis hot lines and shelters.

(58) "Shelter costs" mean, in all programs except the SNAP program, housing costs (rent or mortgage payments, property taxes) and utility costs, not including cable TV or non-basic telephone charges. In the SNAP program, see OAR 461-160-0420.

(59) "Shelter-in-kind" means an agency or individual outside the financial group provides the shelter of the financial group, or makes a payment to a third party for some or all of the shelter costs (see section (58) of this rule) of the financial group. "Shelter-in-kind" does not include temporary shelter provided by a domestic violence shelter, homeless shelter, or residential alcohol and drug treatment facilities or situations where no shelter is being provided, such as sleeping in a doorway, park, or bus station.

(60) "Sibling" means the brother or sister of an individual. "Blood related" means they share at least one biological or adoptive parent. "Step" means they are not related by blood, but are related by the marriage of their parents.

(61) "Spousal support" means income paid (voluntarily, per court order, or per administrative order) by a separated or divorced spouse to a member of the financial group.

(62) "Spouse" means an individual who is legally married to another individual.

(63) "Stable income" means income that is the same amount each time it is received.

(64) "Standard living arrangement" means a location that does not qualify as a nonstandard living arrangement.

(65) "Teen parent" means, for TANF and JOBS, a parent under the age of 20 who has not completed a high school diploma or GED.

(66) "Timely continuing benefit decision notice" means a decision notice that informs the individual of the right to continued benefits and is mailed no later than the time requirements in OAR 461-175-0050.

(67) "Trust funds" mean money, securities, or similar property held by an individual or institution for the benefit of another individual.

(68) "USDA meal reimbursements" mean cash reimbursements made by the Oregon Department of Education for family day-care providers who serve snacks and meals to children in their care.

(69) "Variable income" means earned or unearned income that is not always received in the same amount each month.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.816, 412.006, 412.014 & 412.049

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.816, 412.001, 412.006, 412.014 & 412.049

Hist.: AFS 28-1978, f. & ef. 7-13-78; AFS 54-1984, f. 12-28-84, ef. 1-1-85; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 15-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 3-29-08; SSP 5-2008, f. 2-29-08, cert. ef. 3-1-08; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; Administrative correction 4-21-10; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 17-2012(Temp), f. & cert. ef. 5-1-12 thru 10-28-12; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 22-2013(Temp), f. & cert. ef. 8-23-13 thru 2-19-14; SSP 24-2013, f. & cert. ef. 10-1-13; SSP 29-2013(Temp), f. & cert. ef. 10-1-13 thru 2-19-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 39-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; SSP 9-2014, f. & cert. ef. 4-1-14; SSP 14-2014(Temp), f. & cert. ef. 6-26-14 thru 12-23-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 18-2014(Temp), f. & cert. ef. 7-1-14 thru 12-23-14; SSP 24-2014, f. & cert. ef. 10-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

461-101-0010
Program Acronyms and Overview

(1) Acronyms are frequently used when referring to a program. There is an acronym for each umbrella program and acronyms for each subprogram.

(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.

(4) CAWEM; Citizen/Alien-Waived Emergent Medical. Medicaid coverage of emergent medical needs for individuals who are not eligible for other medical programs solely because they do not meet citizenship and alien status requirements.

(5) DSNAP; Disaster Supplemental Nutrition Assistance Program. Following a presidential declaration of a major disaster in Oregon, DSNAP provides emergency DSNAP program benefits to victims. OAR 461-135-0491 to 461-135-0497 cover DSNAP eligibility and benefits.

(6) EA; Emergency Assistance. Emergency cash to families without the resources to meet emergent needs.

(7) ERDC or ERDC-BAS; Employment Related Day Care-Basic. Helps low-income working families pay the cost of child care.

(8) GA; General Assistance. Cash assistance to low-income individuals with disabilities who do not have dependent children.

(9) GAM; General Assistance Medical. Medical assistance to individuals who are eligible for the GA program but have not been found eligible for OSIPM benefits.

(10) 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 461-135-1335) were repealed July 1, 2001.

(11) JOBS; Job Opportunity and Basic Skills. An employment program for TANF clients. JOBS helps these clients attain self-sufficiency through training and employment. The program is part of Welfare Reform.

(12) JOBS Plus. Provides subsidized jobs rather than SNAP or TANF benefits. For TANF clients, JOBS Plus is a component of the JOBS Program; for SNAP clients and noncustodial parents of children receiving TANF, it is a separate employment program. Eligibility for TANF clients, SNAP 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) TANF-PLS; Clients eligible for JOBS Plus based on TANF.

(b) SNAP-PLS; Clients eligible for JOBS Plus based on SNAP.

(c) NCP-PLS; Noncustodial parents of children receiving TANF.

(13) JPI; Job Participation Incentive. An additional $10 food benefit to help increase the ability of parents with children, who meet federal TANF participation rate, to meet the nutritional needs of their families.

(14) 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.

(15) OFSET. The Oregon Food Stamp Employment Transition Program, which helps SNAP program benefit recipients find employment. This program is mandatory for some SNAP program benefit recipients.

(16) OSIP; Oregon Supplemental Income Program. Cash supplements and special need payments to individuals 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.

(17) 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

(18) The Post-TANF program provides a monthly transitional payment to employed clients who are no longer eligible for the Pre-TANF or TANF programs due to earnings, and meet the other eligibility requirements.

(19) The Pre-TANF program is an up-front assessment and resource-search program for TANF applicant families. The intent of the program is to assess the individual's employment potential; determine any barriers to employment or family stability; develop an individualized case plan that promotes family stability and financial independence; help individuals find employment or other alternatives; and provide basic living expenses immediately to families in need.

(20) QMB; Qualified Medicare Beneficiaries. Programs providing payment of Medicare premiums and one program also providing additional medical coverage for Medicare recipients. Each of these programs also is considered to be a Medicare Savings Program (MSP). When used alone in a rule, QMB refers to all MSP. 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 individuals 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 — Specified Limited Medicare Beneficiary. Payment of the Medicare Part B premium only. There are no medical benefits available through QMB-SMB.

(d) QMB-SMF; Qualified Medicare Beneficiaries — Qualified Individuals. Payment of the Medicare Part B premium only. There are no medical benefits available through QMB-SMF. This program has a 100-percent federal match, but also has an allocation that, if reached, results in the closure of the program.

(21) REF; Refugee Assistance. Cash assistance to low-income refugee singles or married couples without children.

(22) REFM; Refugee Assistance Medical. Medical coverage for low-income refugees.

(23) The Repatriate Program helps Americans resettle in the United States if they have left a foreign land because of an emergency situation.

(24) SFDNP; Senior Farm Direct Nutrition Program. Food vouchers for low-income seniors. Funded by a grant from the United States Department of Agriculture.

(25) SFPSS; State Family Pre-SSI/SSDI Program. A voluntary program providing cash assistance and case management services to families when at least one TANF eligible adult in the household has an impairment (see OAR 461-125-0260) and is or will be applying for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

(26) SNAP; Supplemental Nutrition Assistance Program. Helps low-income households maintain proper nutrition by giving them the means to purchase food. SNAP used to be known as FS or Food Stamps; any reference to SNAP also includes FS and Food Stamps.

(27) TA-DVS; Temporary Assistance for Domestic Violence Survivors. Addresses the needs of individuals threatened by domestic violence.

(28) 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.

Stat. Auth.: ORS 411.060, 411.404, 411.706, 411.816, 412.014, 412.049, 414.025 & 414.826
Stats. Implemented: ORS 411.060, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049, 414.025, 414.826 & 414.839
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; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 5-2008, f. 2-29-08, cert. ef. 3-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 39-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 25-2010(Temp), f. & cert. ef. 8-16-10 thru 2-12-11; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 22-2013(Temp), f. & cert. ef. 8-23-13 thru 2-19-14; SSP 29-2013(Temp), f. & cert. ef. 10-1-13 thru 2-19-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 14-2014(Temp), f. & cert. ef. 6-26-14 thru 12-23-14; SSP 16-2014, f. & cert. ef. 7-1-1; SSP 18-2014(Temp), f. & cert. ef. 7-1-14 thru 12-23-14; SSP 24-2014, f. & cert. ef. 10-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

461-110-0210
Household Group

(1) This rule describes who is included in the household group. The household group generally consists of the individuals who live together with or without the benefit of a dwelling. For homeless individuals, the household group consists of the individuals who consider themselves living together.

(2) A separate dwelling is not recognized for the purpose of determining the members of a household group unless the living space has, separate from any other dwelling, an access to the outside that does not pass through another dwelling, a functional sleeping area, bathroom, and kitchen facility.

(3) Each individual in the household group who applies for benefits is an applicant. The household group and applicants form the basis for determining who is in the remaining eligibility groups.

(4) For all programs except the SNAP program, a separate household group is established for individuals who live in the same dwelling as another household group, if all the following subsections are true:

(a) There is a landlord-tenant relationship between the two household groups in which the tenant is billed by the landlord at fair market value (see OAR 461-001-0000) for housing.

(b) The tenant lives independently from the landlord.

(c) The tenant:

(A) Has and uses sleeping, bathroom, and kitchen facilities separate from the landlord; or

(B) Shares bathroom or kitchen facilities with the landlord, but the facilities are in a commercial establishment that provides room or board or both for compensation at fair market value.

(5) Individuals who live with more than one household group during a calendar month are members of the household group in which they spend more than half of their time, except as follows:

(a) In the ERDC program, if a child (see OAR 461-001-0000) lives with different caretakers during the month, the child is considered a member of both household groups.

(b) In the TANF program:

(A) If a parent (see OAR 461-001-0000) sleeps at least 30 percent of the time during the calendar month in the home of the dependent child (see OAR 461-001-0000), the parent is in the same household group as the dependent child.

(B) A dependent child is included in the household group with the caretaker relative (see OAR 461-001-0000), who usually has the major responsibility for care and control of the dependent child, if the dependent child lives with two household groups in the same calendar month for at least one of the following reasons:

(i) Education.

(ii) The usual caretaker relative is gone from the household for part of the month because of illness.

(iii) A family emergency.

(c) In the SNAP program:

(A) The individual is a member of the household group that provides the individual more than half of his or her 21 weekly meals. If the individual is a child, the child is a member of the household group credited with providing the child more than half of his or her 21 weekly meals. A household group is credited with providing breakfast and lunch for each day the child departs that group's home for school, even if the child eats no breakfast or lunch at that home.

(B) During the month in which a resident of a domestic violence shelter (see OAR 461-001-0000) enters the domestic violence shelter, the resident may be included both in the household group he or she left and in a household group in the domestic violence shelter.

(6) In the OSIPM program, individuals receiving or applying for home and community-based care (see OAR 461-001-0030) or nursing facility care are each an individual household group regardless of others living in the individual's dwelling or facility.

(7) Individuals absent from the household for 30 days or more are no longer part of the household group, except for the following:

(a) In all programs except the SNAP program, an individual in an acute care medical facility remains in the household group unless the individual enters long-term care (see OAR 461-001-0000).

(b) In the ERDC and TANF programs:

(A) A caretaker relative who is absent for up to 90 days while in a residential alcohol or drug treatment facility is in the household group.

(B) A child who is absent for 30 days or more is in the household group if the child is:

(i) Absent for illness (unless the child is in a long-term care Title XIX facility), social service, or educational reasons;

(ii) In foster care, but expected to return to the household within the next 30 days.

(c) In the ERDC, REF, and REFM programs, an individual in the household group who is:

(A) Absent because of education, training, or employment, including long-haul truck driving, fishing, or active duty in the U.S. armed forces;

(B) Absent to care for an emergent need of an individual related to illness, injury, or death; or

(C) Absent but reasonably anticipated to return within 90 days.

(d) In the TANF program when a filing group (see OAR 461-110-0330) includes more than one caretaker relative, a caretaker relative in the household group who is absent because of education, training, or employment — including absence while working or looking for work outside the area of his or her residence, such as long-haul truck driving, fishing, or active duty in the U.S. armed forces.

(8) In the OSIP-EPD and OSIPM-EPD programs, the household group consists only of the individual applying for or receiving benefits.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706, 411.816 & 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 411.816, 412.001, 412.049, 414.025, 414.826 & 414.839
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 1-1999(Temp), f. & cert. ef. 2-1-99 thru 7-31-99; AFS 3-1999, f. 3-31-99, cert. ef. 4-1-99; AFS 5-1999(Temp), f. & cert. ef. 4-1-99 thru 6-30-99; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 39-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 10-2011, f. 3-31-11, cert. ef. 4-1-11; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13; SSP 26-2013, f. & cert. ef. 10-1-13; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 37-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 15-2014, f. & cert. ef. 7-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

461-110-0430
Filing Group; REF, REFM

In the REF and REFM programs:

(1) The filing group consists of:

(a) A single adult (see section (2) of this rule) who has no spouse (see OAR 461-001-0000) or dependent child (see 461-001-0000) in the household group (see 461-110-0210); or

(b) A legally married (see OAR 461-001-0000) couple who is in the same household group and has no dependent child in the household group.

(2) For purposes of this rule, an "adult" means an individual 18 years of age or older who is not attending secondary school full-time or pursuing a GED full-time.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.116, 412.006 & 412.049
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.116, 412.006 & 412.049
Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.116, 412.006 & 412.049
Hist.: AFS 9-1997, f. & cert. ef. 7-1-97; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 10-2011, f. 3-31-11, cert. ef. 4-1-11; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 9-2013(Temp), f. & cert. ef. 4-10-13 thru 10-7-13; SSP 24-2013, f. & cert. ef. 10-1-13; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

461-145-0050
Burial Space and Merchandise

(1) Burial spaces include conventional grave sites, crypts, mausoleums, urns, and other repositories that are traditionally used for the remains of deceased individuals. Burial spaces also include headstones and the opening and closing of the grave.

(a) In the ERDC, REF, REFM, SNAP, and TANF programs, the equity value (see OAR 461-001-0000) of one burial space is excluded as a resource for each member of the financial group (see OAR 461-110-0530).

(b) In the GA, GAM, OSIP, OSIPM, and QMB programs, the equity value of a burial space is excluded as a resource if owned by the client and designated for the client, the spouse (see OAR 461-001-0000) of the client, minor and adult children, siblings, parents, and the spouse of any of these individuals.

(2) Burial merchandise includes, but is not limited to, caskets, liners, burial vaults, markers, and foundations. The equity value of burial merchandise is excluded as a resource if owned by the client and designated for:

(a) In the ERDC, REF, REFM, SNAP, and TANF programs, a member of the financial group.

(b) In the GA, GAM, OSIP, OSIPM, and QMB programs, the client, the spouse of the client, minor and adult children, siblings, parents, and the spouse of any of these individuals.

Stat. Auth.: ORS 411.060, 411.404, 411.816 & 412.014
Stats. Implemented: ORS 411.060, 411.404, 411.816 & 412.014
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; 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 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

461-145-0088
Corporations and Business Entities; Income and Resources

(1) The value of stocks or other ownership interest in a corporation is a resource.

(2) Assets of the corporation essential to the employment of an individual are excluded. For instance, if the corporation owns equipment used by the individual to produce income for the corporation, the equipment is an excluded resource. If an individual must own stock in the corporation as a condition of working for the corporation, the stock is an excluded resource.

(3) Except as provided in OAR 461-140-0040(2) and section (4) of this rule, income of a corporation is not income of an individual with an ownership interest in the corporation until the income is distributed to the individual.

(4) In the OSIP, OSIPM, QMB, REF, REFM, and SNAP programs:

(a) An expenditure by a business entity or corporation that benefits a principal (see subsection (b) of this section):such as a car or housing payment — is considered available when the expenditure is made.

(b) For purposes of this rule, a "principal" means an individual with significant authority in a business entity or corporation, including a sole proprietor, a self-employed person (see OAR 461-145-0910), a partner in a partnership, a member or manager of a limited liability company, and an officer or principal stockholder of a closely held corporation.

(c) See OAR 461-145-0130, 461-145-0280, and 461-145-0470 for the treatment of earned in-kind income.

(5) In the SNAP program:

(a) Income from business entities and corporations is treated as follows:

(A) If an individual is actively working in a corporation, the income is treated as earned income.

(B) If an individual is actively working in an unincorporated business entity, refer to OAR 461-145-0910 to determine if the income is treated as earned or as self-employment.

(C) If an individual is no longer actively working to produce the income, the income is treated as unearned.

(b) Income from a limited liability company is treated as follows:

(A) If an individual is a member or a manager member, the income is treated as self-employment income.

(B) If an individual is a manager but not a member, the income is treated as earned income.

Stat. Auth.: ORS 411.060, 411.404, 411.816 & 412.049
Stats. Implemented: ORS 411.060, 411.404, 411.706, 411.816 & 412.049
Hist.: AFS 11-1999, f. & cert. ef. 10-1-99; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

461-145-0130
Earned Income; Treatment

(1) Earned income (see OAR 461-145-0120) is countable in determining eligibility for programs, subject to sections (2) to (8) of this rule.

(2) JOBS Plus income is earned income and is treated as follows:

(a) In the SNAP program:

(A) JOBS Plus income earned by a TANF-PLS client:

(i) Is counted in determining initial SNAP program eligibility.

(ii) Is excluded in determining ongoing eligibility.

(B) JOBS Plus wages received after the client's last month of work under a TANF-PLS JOBS Plus agreement are counted.

(b) In the TANF program:

(A) JOBS Plus income earned by an NCP-PLS (see OAR 461-101-0010(20)(c)) client is counted in determining initial TANF eligibility.

(B) When determining the need for a TANF supplement for a TANF-PLS client, the income is treated as follows:

(i) It is excluded in determining the countable income limit and in calculating the benefit equivalency standards.

(ii) It is counted in calculating the wage supplement.

(C) JOBS Plus wages received after the client's last month of work under a JOBS Plus agreement are counted.

(c) In the OSIPM, QMB, and REFM programs:

(A) For JOBS Plus income earned by a TANF-PLS program client who is also in the REFM program, the income is excluded when determining initial and ongoing program eligibility.

(B) JOBS Plus wages received after the client's last month of work under a TANF-PLS JOBS Plus agreement are counted.

(d) In all programs not covered under subsections (a) to (c) of this section, TANF-PLS income is counted as earned income.

(e) In all programs other than the TANF program, NCP-PLS income is counted as earned income.

(f) In all programs, client wages received under the Tribal TANF JOBS programs are counted as earned income.

(3) Welfare-to-Work work experience income is treated as follows:

(a) In the REF, REFM, and TANF programs, the income is earned income, and the first $260 is excluded each month.

(b) In the SNAP program, the income is earned income.

(4) In the ERDC program, earned income of a child is excluded.

(5) In the REF, REFM, and TANF programs:

(a) Earned income of the following children is excluded:

(A) Dependent children under the age of 19 years, and minor parents under the age of 18 years, who are full-time students in grade 12 or below (or the equivalent level of vocational training, in GED courses), or in home schooling approved by the local school district.

(B) Dependent children under the age of 18 years who are attending school part-time (as defined by the institution) and are not employed full-time.

(C) Dependent children too young to be in school.

(b) Income remaining after the month of receipt is a resource.

(c) In-kind earned income is excluded (see OAR 461-145-0280 and 461-145-0470).

(6) In the SNAP program:

(a) If a cafeteria plan (see OAR 461-001-0000) benefit that the employee cannot elect to receive as a cash payment is designated and used to pay for child care, medical care, or health insurance, the benefit is excluded unless it is reimbursed by the Department. If reimbursed, the Department counts it as earned income.

(b) The following types of income are excluded:

(A) The earned income of an individual under the age of 18 years who is under the parental control of another member of the household and is:

(i) Attending elementary or high school;

(ii) Attending GED classes recognized by the local school district;

(iii) Completing home-school elementary or high school classes recognized by the local school district; or

(iv) Too young to attend elementary school.

(B) In-kind earned income, except as provided in section (7) of this rule.

(C) Deductions from base pay for future educational costs under Pub. L. No. 99-576, 100 Stat. 3248 (1986), for clients on active military duty.

(D) Income remaining after the month of receipt is a resource.

(7) In the SNAP program, earned in-kind income (see OAR 461-145-0280) is excluded unless it is an expenditure by a business entity that benefits a principal (see OAR 461-145-0088).

(8) In all programs except in the OSIPM program for a client in nonstandard living arrangement (see OAR 461-001-0000), the income of a temporary employee of the U.S. Census Bureau employed to assist in taking the census is excluded.

Stat. Auth.: ORS 411.060, 411.070, 411.083, 411.400, 411.404, 411.706, 411.816, 411.892, 412.014, 412.049, 414.231, 414.712 & 414.826

Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.400, 411.404, 411.706, 411.816, 411.892, 412.014, 412.049, 414.231, 414.712 & 414.826

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 9-1990, f. & cert. ef. 3-2-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 17-1992, f. & cert. ef. 7-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 1-1993, f. & cert. ef. 2-1-93; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 19-1994, f. & cert. ef. 9-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 17-1996, f. 4-29-96, cert. ef. 5-1-96; AFS 27-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 32-1996(Temp), f. & cert. ef. 9-23-96; 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 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 11-1999, f. & cert. ef. 10-1-99; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 7-2000(Temp), f. 3-10-00, cert. ef. 3-10-00 thru 9-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 12-2001, 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; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 31-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 39-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 14-2010(Temp), f. & cert. ef. 5-19-10 thru 11-15-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

461-145-0910
Self-Employment; General

(1) Self-employment income is income resulting from an individual's business, trade, or profession, rather than from a salary or wage paid by an employer. An individual is considered self-employed if the individual meets the criteria in sections (2) or (3) of this rule. Except as noted in section (3) of this rule, for all programs except SNAP, when an individual has established a corporation, determine if the individual is self-employed according to section (2) of this rule. If the individual has more than one self-employment business, trade, or profession, the income from each is determined separately.

(2) Except as provided in OAR 461-145-0250(1), an individual is self-employed for the purposes of this division of rules if the individual:

(a) Is considered an independent contractor by the business that employs the individual; or

(b) Meets at least four of the following criteria:

(A) Is engaged in an enterprise for the purpose of producing income.

(B) Is responsible for obtaining or providing a service or product by retaining control over the means and manner of providing the work or services offered.

(C) Has principal responsibility for the success or failure of the business operation by assuming the necessary business expenses and profit or loss risks connected with the operation of the business, and has the authority to hire and fire employees to perform the labor or services.

(D) Is not required to complete an IRS W-4 form for an employer and is not required to have federal income tax or FICA payments withheld from a pay check.

(E) Is not covered under an employer's liability or workers' compensation insurance policy.

(3) Notwithstanding section (2) of this rule:

(a) Homecare Workers (see OAR 411-031-0020) paid by the Department are not self-employed.

(b) Child care providers (see OAR 461-165-0180) paid by the Department, adult foster home providers (see 411-050-0602) paid by the Department, realty agents, and individuals who sell plasma, redeem beverage containers, pick mushrooms for sale, or engage in similar enterprises are considered to be self-employed.

(4) In the ERDC, REF, SNAP, and TANF programs, self-employment income, including income from a microenterprise (see OAR 461-001-0000), is counted prospectively to determine eligibility (see OAR 461-001-0000) as follows:

(a) Self-employment income is annualized when it is:

(A) Received during less than a 12-month period but is intended as a full year's income.

(B) From a business that has operated for a full year and the previous year is representative of what the income and costs will be during the budget month.

(b) Self-employment income is treated as anticipated income when a financial group (see OAR 461-110-0530) begins self-employment and is unable to determine what the income and costs will be during the budget month.

(5) In the GA, OSIP, OSIPM, and QMB programs, self-employment income is considered available upon receipt by a member of the financial group, except it is prorated over the period of work if the duration of the work exceeds one month.

(6) In the REFM program:

(a) Self-employment income is counted only if received in the month of application.

(b) If self-employment income counted in the month of application puts the applicant over the income limits for REFM, the income is calculated according to section (4) of this rule.

(7) When determining the amount of countable (see OAR 461-001-0000) self-employment income, use gross receipts and sales, including mileage reimbursements, before costs.

Stat. Auth.: ORS 411.060, 411.404, 411.816, 412.006 & 412.049

Stats. Implemented: ORS 411.060, 411.404, 411.816, 412.006 & 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 1-2005(Temp), f. & cert. ef. 2-1-05 thru 6-30-05; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 5-2005(Temp), f. & cert. ef. 4-1-05 thru 6-30-05; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

461-145-0930
Self-Employment; Determination of Countable Income

(1) The Department initially determines gross sales and receipts minus any returns and allowances (before excluding or deducting any costs). This rule explains how different programs exclude and deduct costs from self-employment gross sales and receipts.

(2) In the ERDC program, if an individual claims an excludable cost permitted under OAR 461-145-0920, at least 50 percent of gross self-employment income is excluded. The maximum exclusion is the total excludable cost under OAR 461-145-0920.

(3) In the GA, OSIP, OSIPM, QMB, and REFM programs, all costs permitted under OAR 461-145-0920 are excluded.

(4) In the REF program, no costs are excluded.

(5) In the SNAP program, if there are any costs permitted under OAR 461-145-0920, there is a deduction of 50 percent of gross self-employment income.

(6) In the TANF program:

(a) For an individual participating in the microenterprise (see OAR 461-001-0000) component of the JOBS program, costs are excluded according to 461-145-0920 and general accounting principles, as applied by a certified public accountant, bookkeeping firm, or other entity approved by the Department.

(b) For all other individuals, no costs are subtracted (excluded).

Stat. Auth.: ORS 409.050, 411.060, 411.083, 411.404, 411.706, 411.816, 412.006, 412.009, 412.049 & 414.826

Stats. Implemented: ORS 409.050, 411.060, 411.083, 411.404, 411.706, 411.816, 412.006, 412.009, 412.049 & 414.826

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 5-1998(Temp), f. & cert. ef. 3-11-98 thru 5-31-98; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 24-1998(Temp), f. 11-30-98, cert. ef. 12-1-98 thru 3-31-99; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 30-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; SSP 38-2013, f. 12-31-13, cert. ef. 1-1-14; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

461-193-0031
Eligibility Requirements; Refugee Case Services Project (RCSP)

In the RCSP program, to be eligible an applicant must meet the requirements of sections (1) to (6) of this rule, and section (7) if section (7) applies:

(1) Meet all REF or TANF program eligibility (see OAR 461-001-0000) requirements.

(2) Meet the alien status requirements under OAR 461-120-0125.

(3) Reside in Clackamas, Multnomah, or Washington County.

(4) Have resided in the U.S. for eight months or less. The first month is, for an individual meeting the alien status requirements of OAR 461-120-0125:

(a) Subsections (8)(a), (c), (d), or (e), the month the individual entered the United States.

(b) Subsections (8)(b), (f), or (g), the month the individual was granted the individual's immigration status.

(c) Subsection (8)(h):

(A) If the individual entered the U.S. with special immigrant status, the month the individual entered the United States.

(B) If the individual is granted special immigrant status after entering the U.S., the month in which the special immigrant status was granted.

(d) Each month in the U.S. is counted as a whole month; there is no prorating of any month.

(5) Be 64 years old or younger.

(6) Not be enrolled as a full-time student or intending to enroll as a full-time student within six months of RCSP program intake.

(7) For a newborn, a parent (see OAR 461-001-0000) must provide verification of the child's birth, including the date of birth. The newborn child's U.S. arrival date and eligibility period are the same as those for the child's mother.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.116, 412.006 & 412.049
Stats. Implemented: ORS 409.010, 409.050, 411.060, 411.070, 411.116, 412.006 & 412.049
Hist.: AFS 9-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 24-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 34-1996, f. 9-26-96, cert. ef. 10-1-96; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 13-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 7-2009, f. & cert. ef. 4-1-09; SSP 9-2009(Temp), f. & cert. ef. 5-1-09 thru 10-28-09; SSP 28-2009, f. & cert. ef. 10-1-09; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 11-2015, f. 3-13-15, cert. ef. 4-1-15

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Department of Justice
Chapter 137

Rule Caption: Qualifications of mediators and schedule of fees for an Environmental Claims Mediation Program.
Adm. Order No.: DOJ 4-2015
Filed with Sec. of State: 2-23-2015
Certified to be Effective: 2-23-15
Notice Publication Date: 1-1-2015
Rules Adopted: 137-130-0001, 137-130-0005, 137-130-0010, 137-130-0110, 137-130-0210
Rules Repealed: 137-130-0001(T), 137-130-0005(T), 137-130-0010(T), 137-130-0110(T), 137-130-0210(T)
Subject: SB 814 (2013) establishes an environmental claims mediation program that requires, in certain circumstances, participation in mediation by an insurance company when requested by their insured (policyholder.) These rules do not address environmental claims mediation generally but only the qualifications and training of program mediators and the mediation fees paid by the insured and their insurers. The rules list various combinations of subject matter expertise (i.e. expertise in environmental and insurance issues) and process expertise (i.e. experience and training as a mediator) that a mediator must have to participate in the program. The rules also allow a mediator to serve if agreed to by the parties in a specific case. The rules require the mediator's fees to be published on the Department of Justice website and that the fees will be split among the parties to the mediation.
Rules Coordinator: Carol Riches—(503) 947-4700

137-130-0001
Purpose

These division 130 rules govern the Environmental Claims Mediation Program created by Oregon Laws 2013, chapter 350.

Stat. Auth.: ORS 465.484(2)(e)
Stats. Implemented: ORS 465.484(2), ORS 465.483(3)(b)
Hist.: DOJ 14-2014(Temp), f. & cert. ef. 10-31-14 thru 4-28-15; DOJ 4-2015, f. & cert. ef. 2-23-15

137-130-0005
Application

These division 130 rules apply to any Mediation resulting from a request for Environmental Claim Mediation pursuant to Oregon laws 2013, ch 350.

Stat. Auth.: ORS 465.484(2)(e)
Stats. Implemented: ORS 465.484(2), ORS 465.483(3)(b)
Hist.: DOJ 14-2014(Temp), f. & cert. ef. 10-31-14 thru 4-28-15; DOJ 4-2015, f. & cert. ef. 2-23-15

137-130-0010
Definitions

As used in these division 130 rules:

(1) "Environmental Claims Mediation Program" means the Mediation program established under Oregon Laws 2013, chapter 350.

(2) "Environmental Claims Mediation" means a Mediation conducted pursuant to Oregon Laws 2013 Chapter 350 Section 6.

(3) "Environmental Claims Mediator Roster" means the roster of qualified Mediators established by the Mediation Service Provider pursuant to these rules.

(4) "Mediation" is defined in ORS 36.110(5).

(5) "Mediation Communications" is defined in ORS 36.110(7).

(6) "Mediation Service Provider" ("MSP") means the entity appointed by the Attorney General pursuant to Oregon Laws 2013, chapter 350, section 6.

(7) "Mediation Session" means a meeting involving the mediator, the insured and the insurer.

(8) "Mediator" is defined in ORS 36.110(9).

(9) "Party" is defined in ORS 36.234.

Stat. Auth.: ORS 465.484(2)(e)
Stats. Implemented: ORS 465.484(2), ORS 465.483(3)(b)
Hist.: DOJ 14-2014(Temp), f. & cert. ef. 10-31-14 thru 4-28-15; DOJ 4-2015, f. & cert. ef. 2-23-15

137-130-0110
Mediator Qualifications, Training and Experience

(1) The Mediation Service Provider shall publish, in writing and on its website, an Environmental Claims Mediator Roster composed of those Mediators who meet or exceed the minimum qualifications set forth below, and who have entered into an agreement with the Mediation Service Provider for the provision of Environmental Claims Mediation.

(2) To be included on the Environmental Claim Mediation Roster a mediator must:

(a) Provide the MSP with the mediator's experience and education, including but not limited to:

(A) The number of mediations conducted, approximate number of hours of mediation experience, and approximate number of hours dealing with cases or matters related to environmental matters or insurance claims;

(B) General mediator training;

(C) Specific subject training;

(D) Education level; and

(E) Continuing education.

(b) Provide to the MSP the Mediator's:

(A) Professional standards of mediation practice to which the mediator adheres;

(B) Contact information;

(C) Languages spoken;

(D) Website links, if applicable;

(E) Counties of Oregon where they are willing to serve and the counties they are able to serve without charging travel expenses; and

(F) Fee information.

(c) Certify to the MSP that the Mediator has:

(A) The equivalent of at least 5 (five) years of full-time experience in the environmental or insurance fields in their professional capacity. This professional role may have included, but is not limited to, the role of attorney, insurance or environmental professional, judge, hearing officer or mediator;

(B) Conducted at least 20 Mediations of any type or subject matter and have over 200 hours of experience as a Mediator; or

(C) Conducted 5 (five) mediations involving environmental insurance claims.

(d) Certify to the MSP that the Mediator has participated in or conducted 30 hours of basic mediator training meeting the standards in Section 3.2 of the Oregon Judicial Department Court Connected Mediator Qualification Rules effective August 1, 2005, or a comparable, integrated training;

(e) Certify to the MSP that the Mediator has, within five years prior to the date of application to join the Roster, participated in a total 16 hours of training in the following areas:

(A) Program orientation approved by the MSP; and

(B) Subject-matter training related to environmental matters or insurance claims, including but not limited to:

(i) Environmental cleanup;

(ii) Key cases and substantive law related to environmental insurance claims;

(iii) Court procedures, laws and rules relevant to environmental insurance claims; or

(iv) Role playing exercises involving the negotiated or mediated resolution of environmental insurance claims.

(f) Certify to the MSP that the Mediator will, if included on the Roster, complete 6 (six) hours of continuing education every two years on topics related to environmental matters or insurance claims in a course approved for continuing education by the MSP, a state or national professional accrediting organization or bar association.

(3) A Mediator who meets the minimum qualifications as a Mediator under these rules and is added to the Environmental Claims Mediator Roster may not represent that fact as license or certification of their competency for anything other than their role in the Environmental Claims Mediation Program.

(4) Notwithstanding any other provision of these rules:

(a) If all the parties to an Environmental Claims Mediation agree in writing to the use of a mediator who is not on the Environmental Claims Mediator Roster, and that Mediator enters into an agreement with the MSP as provided in Section (1) of this rule, that Mediator may serve as the Mediator in that specific matter.

(b) A mediator who enters into an agreement under section 4(a) of this rule may be included on the Environmental Claims Mediator Roster upon satisfaction of the requirements of (2)(a), (2)(b), (2)(d) and certification that the Mediator has completed the program orientation referred to in section (2)(e)(A) of this rule.

(5) Notwithstanding any other provision of these rules, if a Mediator is eligible for inclusion on the Environmental Claims Mediator Roster on the basis that they have conducted 5 (five) or more mediations involving environmental insurance claims, the Mediator shall be excused from compliance with the requirements of (2)(d), (2)(e)(B) and (2)(f) above.

(6) Upon becoming aware that a mediator does not meet the requirements of this rule or has performed in a manner inconsistent with the mediator's professional standards identified in section 2(b)(i) of this rule, the MSP shall remove that mediator from the Roster.

Stat. Auth.: ORS 465.484(2)(e)
Stats. Implemented: ORS 465.484(2), ORS 465.483(3)(b)
Hist.: DOJ 14-2014(Temp), f. & cert. ef. 10-31-14 thru 4-28-15; DOJ 4-2015, f. & cert. ef. 2-23-15

137-130-0210
Mediation Fees

(1) The fees for each Mediator on the Environmental Claims Mediator Roster, and any other fees that may be charged to the parties to an Environmental Claims Mediation shall be provided by the Mediation Service Provider to the Department of Justice and published on the Mediation Service Provider's website and at the Department of Justice website at http://www.doj.state.or.us/adr/pages/environmental_claims.aspx.

(2) Unless agreed otherwise by the parties in writing, the Mediation Service Provider shall ensure that the fees and costs of the Mediation are billed equally to the parties to the Mediation.

(3) The Mediation Service Provider shall ensure that the parties are billed for the Mediator's services consistent with the published fee schedule.

(4) The Mediation Service Provider shall provide to the Department of Justice a schedule for any additional fees charged for mediation services that are not included in the Mediator's hourly rate. This fee schedule shall be published on the Mediation Service Provider's website and at the Department of Justice website at http://www.doj.state.or.us/adr/pages/environmental_claims.aspx .

Stat. Auth.: ORS 465.484(2)(e)
Stats. Implemented: ORS 465.484(2), ORS 465.483(3)(b)
Hist.: DOJ 14-2014(Temp), f. & cert. ef. 10-31-14 thru 4-28-15; DOJ 4-2015, f. & cert. ef. 2-23-15

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Occupational Therapy Licensing Board
Chapter 339

Rule Caption: CE rule modified to allow maintenance of NBCOT certification as fulfilling the requirements of CE.
Adm. Order No.: OTLB 1-2015
Filed with Sec. of State: 3-6-2015
Certified to be Effective: 3-6-15
Notice Publication Date: 1-1-2015
Rules Amended: 339-020-0010
Subject: 339-020-0010 CE Requirements for Current Licensees

(1) All current licensees shall obtain a minimum of 30 points of CE from Board approved categories during the two years immediately preceding the date of the license renewal; or

(2) The Board recognizes the maintenance of continuous professional development hours as evidenced by current NBCOT Certification (National Board of Certification in Occupational Therapy) as fulfilling the requirements for CE under (1).

(3) Exceptions:

(a) Current licensees who have their first NBCOT certification do not need CE for their first year.

(b) Current licensees who have their second year of NBCOT certification shall obtain a minimum of 15 points of CE from Board approved categories.

Rules Coordinator: Felicia Holgate—(971) 673-0198

339-020-0010
CE Requirements for Current Licensees

(1) All current licensees shall obtain a minimum of 30 points of CE from Board approved categories during the two years immediately preceding the date of the license renewal; or

(2) The Board recognizes the maintenance of continuous professional development hours as evidenced by current NBCOT Certification (National Board of Certification in Occupational Therapy) as fulfilling the requirements for CE under (1).

(3) Exceptions:

(a) Current licensees who have their first NBCOT certification do not need CE for their first year.

(b) Current licensees who have their second year of NBCOT certification shall obtain a minimum of 15 points of CE from Board approved categories.

Stat. Auth.: ORS 675.320(11) & (12)
Stats. Implemented:
Hist.: OTLB 2-1994, f. 4-11-94, cert. ef. 6-1-94; OTLB 1-2005, f. & cert. ef. 8-11-05; OTLB 1-2015, f. & cert. ef. 3-6-15

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Oregon Business Development Department
Chapter 123

Rule Caption: This division of rules relates to the Beginning and Expanding Farmer Loan Program.
Adm. Order No.: OBDD 3-2015
Filed with Sec. of State: 2-24-2015
Certified to be Effective: 2-24-15
Notice Publication Date: 11-1-2014
Rules Adopted: 123-052-1000, 123-052-1100, 123-052-1200, 123-052-1300, 123-052-1400, 123-052-1500, 123-052-1600, 123-052-1700, 123-052-1800, 123-052-1900, 123-052-2000, 123-052-2100, 123-052-2200, 123-052-2300, 123-052-2400
Subject: In the 2013 regular legislative session, HB 2700 was passed creating the Beginning and Expanding Farmer Loan Program, otherwise known as "Aggie Bonds". This program lowers the interest cost on loans made by private parties to beginning farmers for the acquisition of agricultural land and improvements as well as depreciable agricultural property. These rules provide for the administration of the program, requirements of the farmers, requirements for lenders and the bonds and costs.
Rules Coordinator: Mindee Sublette—(503) 986-0036

123-052-1000
Purpose

(1) The purpose of these rules is to assist Applicants in applying for the benefits available under the Beginning and Expanding Farmer Loan Program (aka "Aggie Bonds Program") authorized by ORS 285A.420 to 285A.435 and to describe the procedures to be used by the Oregon Business Development Department in administering that Program.

(2) The Program lowers the interest cost on loans made by private parties to Beginning Farmers for the acquisition of Agricultural Land and Agricultural Improvements and Depreciable Agricultural Property. This is accomplished by Beginning Farmers arranging loans through Eligible Lenders in compliance with the rules in this Division, so that the Eligible Lender may exclude interest from gross income under Section 147(c)(2) of

the United States Internal Revenue Code and may exempt interest from Oregon personal income taxes.

(3) Section 147(c)(2) of the United States Internal Revenue Code, its regulations and ORS 285A.420 to 285A.435 impose very substantial restrictions on the Program; the administrative rules in this Division outline those restrictions to assist Applicants in determining whether they may qualify for the Program. The administrative rules in this Division also describe a simplified Aggie Bond option that reduces the Applicant's non-Department related costs for participating in the Program.

(4) The Program does not provide any state or federal money to repay Beginning and Expanding Farmer loans, to guarantee these loans, or to repay any Aggie Bonds that are issued under the Program. Those loans and the related Aggie Bonds are secured only by the resources that eligible Beginning Farmers provide to lenders.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-1100
Definitions

For the purposes of these rules, the following terms shall have the following meanings, unless the context clearly indicates otherwise:

(1) "Aggie Bonds" means conduit revenue bonds issued by the State of Oregon pursuant to ORS 285A.420 to 285A.435 and these rules.

(2) "Agricultural Improvements" means any improvements, buildings, structures or fixtures suitable for use in farming that are located on Agricultural Land. "Agricultural Improvements" do not include personal residences.

(3) "Agricultural Land" means land located in the State of Oregon that is:

(a) Suitable for use in farming and that is or will be operated as a farm; and

(b) That will be acquired by a Beginning Farmer.

(4) "Applicant" means any person who submits an Application for Aggie Bond financing.

(5) "Application" means an Application for Aggie Bonds that is submitted to the Department on a form provided by the Department.

(6) "Beginning Farmer" means an individual who meets the requirements of OAR 123-052-1300 and is therefore eligible to be a Borrower under the Program.

(7) "Bond Counsel" means the bond counsel firm(s) under contract with Oregon Business Development Department to represent the State of Oregon as issuer of Aggie Bonds.

(8) "Borrower" means a Beginning Farmer who has received Aggie Bond financing under the Program.

(9) "Code" means the United States Internal Revenue Code of 1986, as amended, and all rules, regulations, and notices and releases issued under it.

(10) "Department" means the Oregon Business Development Department, or its designee.

(11) "Depreciable Agricultural Property" means personal property suitable for use in farming for which an income tax deduction for depreciation is allowable in computing federal income tax under the Code, including but not limited to farm machinery and trucks but not including feeder livestock, seed, feed, fertilizer and other types of inventory or supplies.

(12) "Depreciable Farm Property" means property of a character subject to the allowance for depreciation in computing federal income tax under the Code which is to be used in a trade or business of farming.

(13) "Eligible Lender" means a lender who meets the requirements of OAR 123-052-1500.

(14) "Eligible Revenue" means the revenue or assets that are provided as security for a loan to a Beginning Farmer participating in the Program.

(15) "Federal Maximum" means the maximum amount of a loan that federal law allows to be financed under the Program. For calendar year 2015 the Federal Maximum is $517,700. This amount may be adjusted for inflation in future calendar years as provided for in Section 147(c)(2)(H) of the Code.

(16) "Financed Property" means property described in OAR 123-052-1400(1)(a) which is financed through the Program.

(17) "Financing Agreement" means an agreement, in substantially the form and with the substance acceptable to the Department, which describes the requirements for an Eligible Lender making a loan to a Beginning Farmer that is eligible for financing under the Program.

(18) "Lender Documents" means the Financing Agreement between the Department and the Eligible Lender and the Loan Agreement and related documents between an Eligible Lender and a Beginning Farmer, including but not limited to any related security documents such as mortgages, deeds of trust and security agreements.

(19) "Permitted Costs" means any costs of property described in OAR 123-052-1400(1)(a).

(20) "Program" means the Beginning and Expanding Farmer Loan Program authorized by ORS 285A.420 to 285A.435 and described in these rules.

(21) "Related Person" means a person other than the Borrower if:

(a) The relationship between the Borrower and that person would result in a disallowance of losses under section 267 or 707(b) of the Code, or

(b) The Borrower and that person are members of the same controlled group of corporations (as defined in section 1563(a), except that "more than 50 percent" shall be substituted for "at least 80 percent" each place it appears therein). For example, a Related Person includes a grandparent, parent, sibling (whether whole or half-blood), child, grandchild, or spouse, as well as certain corporations and partnerships.

(22) "State" means the State of Oregon, any department, agency, or political subdivision of the State of Oregon, or any designee thereof.

(23) "Substantial Farmland" means any parcel of land unless the parcel is smaller than 30 percent of the median size of a farm in the county where the agricultural project is located. However, Substantial Farmland does not include farmland which was previously owned by the individual seeking to qualify as a Beginning Farmer if the farmland was disposed of while the individual was insolvent and Code section 108 applied to indebtedness with respect to that farmland.

(24) "Tax-exempt" means excludable from gross income under the Code, and exempt from Oregon personal income taxation.

(25) "State Treasurer" means the Treasurer of the State of Oregon or the Treasurer's designee.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-1200
Application

(1) An Applicant must apply for qualification to the Program on a form provided by the Department.

(2) Each Application shall:

(a) Contain a representation that the Applicant is an individual who has reviewed the Program rules and determined that the Applicant qualifies as a Beginning Farmer as described in OAR 123-052-1300.

(b) Contain a description of the costs to be financed through the Program, together with a representation that those costs are Permitted Costs as described in OAR 123-052-1400.

(c) Contain a statement of whether the Applicant desires the simplified Aggie Bond option described in OAR 123-052-1800.

(d) Be accompanied by a commitment, letter of interest or similar document satisfactory to the department, from the proposed lender that:

(A) Outlines the terms of the proposed loan;

(B) Expresses the lender's interest in making that loan through the Program;

(C) States that the lender is qualified to make an aggie bond loan under OAR 123-052-1500, and identifies the lender as:

(i) An insured institution as described in OAR 123-052-1500(1)(a);

(ii) An "Accredited Investor" as described in OAR 123-052-1500(1)(b);

(iii) A "Qualified Institutional Buyer" as described in OAR 123-052-1500(1)(c); or,

(iv) A "Sophisticated Investor" (SI) as described in OAR 123-052-1500(1)(d).

(D) States whether the Lender will require that the Applicant receive training in farm management.

(E) States that the Lender has reviewed, and is willing to execute, a Financing Agreement in substantially the form provided by the Department, and is willing to make the proposed loan under a Loan Agreement substantially in the form and with the substance of the form of Loan Agreement provided by the Department.

(e) States that the Applicant has reviewed the form of Loan Agreement provided by the Department and is willing and able to make the certifications and promises, including the federal tax certifications, provided in that form.

(f) Be accompanied by an application fee of $250. This fee is not refundable.

(g) Unless the Financed Property will consist exclusively of new Depreciable Agricultural Property, be accompanied by an appraisal that is satisfactory to the Department. The Lender should contact the Department to determine the Department's requirements for appraisals before the Lender orders an appraisal.

(h) Contain any other information or documents specified in the Application form provided by the Department.

(3) The Department shall review each completed Application and notify the Applicant within Thirty days indicating whether the Applicant, the proposed project and the proposed lender appear eligible for the Program.

(4) Expenditures made by the Borrower more than sixty days before the Aggie Bonds are issued generally are not eligible for financing with Aggie Bonds unless the Department has signed a Reimbursement Declaration. If the Department signs a reimbursement declaration, expenditures made more than sixty days before the reimbursement declaration is signed are generally not eligible for financing with Aggie Bonds. If the Department determines that the Applicant, the proposed project and the proposed lender appear eligible for the Program, the Department shall sign a reimbursement declaration that complies with the requirements of Section 1.150-2 of the Code. Execution of the reimbursement declaration by the Department permits the Borrower to use the Program to finance certain expenditures made no earlier than sixty days before such reimbursement declaration is signed, but does not assure the Applicant that any Aggie Bond will be issued. The Department shall notify the Applicant promptly upon execution of the reimbursement declaration.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-1300
Requirements for Beginning Farmers

(1) As required by federal law, a Beginning Farmer must:

(a) Be a "first-time farmer" within the meaning of Section 147(c)(2) of the Code. That section of the Code generally provides that a first-time farmer is an individual who has not at any time had any direct or indirect ownership interest in Substantial Farmland in the operation of which the individual has materially participated. However, in certain cases land that was disposed of while the individual was insolvent may be disregarded for this purpose. Dispositions of land while the individual was insolvent should be listed in the Application for Program financing.

(b) Be the principal user of the Financed Property.

(c) Materially and substantially participate in the operation of the farm of which the Financed Property is a part.

(d) Not have received Tax-exempt financing under Section 147(c)(2) of the Code in an aggregate amount that, when added to the amount financed through the Program, exceeds the Federal Maximum.

(2) A Beginning Farmer must be a resident of the State of Oregon.

(3) Any property owned by an individual's spouse or minor children will be treated as owned by the individual. Any material participation in the operation of a farm by an individual's spouse or minor children will be treated as operation of that farm by the individual. Any receipt of Tax-exempt financing by an individual's spouse or minor children will be treated as receipt by the individual.

(4) A Beginning Farmer and Applicant's spouse must have total combined personal net worth of no more than $750,000, as evidenced by a signed, dated personal financial statement on a form satisfactory to the Department.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-1400
Requirements for Property Financed through the Program

(1) Federal law requires that:

(a) Property financed through the Program consist only of:

(A) Agricultural Land as defined in OAR 123-052-1100(3).

(B) Agricultural Improvements as defined in OAR 123-052-1100(2).

(C) New Depreciable Agricultural Property, as defined in OAR 123-052-1100(11), that is used for farming on Agricultural Land.

(D) Used Depreciable Agricultural Property may not exceed the maximum amount permitted by federal law, as defined in OAR 123-052-1100(11), that is used for farming on Agricultural Land, including for purposes of compliance with the $62,500 limit, financing received by an individual's spouse or minor children. The Applicant must provide the Department with an appraisal or other method of determining the value of any used Depreciable Agricultural Property that will be financed through the Program. The appraisal or other method of determining the value of any used Depreciable Agricultural Property must be satisfactory to the Department. On the date these rules are adopted, the maximum amount permitted by federal law for this purpose is $62,500.

(E) No more than the maximum amount permitted by federal law of Depreciable Farm Property, as defined in OAR 123-052-1100(12), including for purposes of compliance with this $250,000 limit, Depreciable Farm Property with respect to which the principal user is or will be the same person or 2 or more Related Persons as defined in 123-052-1100(20). On the date these rules are adopted, the maximum amount permitted by federal law for this purpose is $250,000.

(b) No more than two percent of the borrowed funds are used to pay costs related to obtaining the loan or participating in the Program.

(c) Except as provided in 123-052-1400(1)(d), below, the Borrower cannot use Aggie Bond proceeds to acquire property from a Related Person, within the meaning of OAR 123-052-1100(20).

(d) Property may be acquired from a Related Person only if:

(A) The acquisition price is the fair market value of the property, as shown in an independent, professional appraisal that is performed to qualify the property for financing with the Program and is acceptable to the Department; and

(B) The Related Person will not have a financial interest in the farming operation in which the Financed Property is used.

(2) The Financed Property is located, or will be used, in the State of Oregon.

(3) The Financed Property will only be used for farming by the Beginning Farmer or by the Beginning Farmer and the Beginning Farmer's family.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-1500
Requirements for Lenders

(1) A lender must either be:

(a) An insured institution, as defined by ORS 706.008, that is authorized to do business in Oregon and that regularly makes loans to persons engaging in farming or similar operations;

(b) An "Accredited Investor" (AI) as defined under Section 3(a)(2) of the Securities Act of 1933;

(c) A "Qualified Institutional Buyer" (QIB) as defined under Rule 144A of the Securities Act of 1933; or

(d) A "Sophisticated Investor" (SI) as defined in Rule 501 of Regulation D under the Securities Act of 1933 and as further described in 17 CFR 230.506(b)(2)(ii) as one who has such knowledge and experience in financial and business matters that he is capable of evaluating the merits and risks of the prospective investment.

(2) The lender must represent in writing that it is an insured institution, AI, QIB, or SI, pursuant to 123-052-1500(1), that the aggie bonds are being acquired for investment, and that the lender intends to hold the aggie bonds for the lender's own account and not with a view to, or for resale.

(3) Under no circumstances can a lender be a substantial user of the Financed Property or related to a substantial user of that property. For this purpose "related" means a Related Person within the meaning of OAR 123-052-1100(20) but shall also include a partnership and any of its partners (and their spouses and minor children), and an S corporation and each of its shareholders (and their spouses and minor children).

(4) The Lender must execute a Financing Agreement in substantially the form and with the substance of the form of Financing Agreement provided by the Department, or must use a form that is specifically approved in advance and in writing by the Department. The Lender must make loans under Loan Agreements that are substantially in the form and with the substance of the form of Loan Agreement provided by the Department, or must use a form that is specifically approved in advance and in writing by the Department.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-1600
Additional Requirements for Aggie Bonds

(1) The expenditures financed under the Program cannot exceed the Federal Maximum, reduced by the total amount of Tax-exempt financing under Section 147(c)(2) of the Code that the Borrower, the Borrower's spouse or minor children have received.

(2) The Department must obtain an allocation of private activity bond volume cap for each Aggie Bond from the Department's legislative alloca-

tion or the private activity bond committee. If an adequate allocation is not available for any reason, the Aggie Bond will not be issued until such allocation is made to the Program.

(3) The Department must hold a "TEFRA hearing" and the State Treasurer must approve the issuance of each Aggie Bond.

(4) The Loan Documents must provide that loan proceeds may only be spent on costs of property described in OAR 123-052-1400.

(5) The Lender Documents must not secure the loan with any stock, other equity securities, any debt securities or any other "investment property" (within the meaning of Treasury Regulation section 1.148 1(b), or require that the Borrower maintain continuing balances of specified amounts in accounts in financial institutions.

(6) To obtain the approving opinion of the Program's Bond Counsel:

(a) The Borrower must complete a tax and arbitrage certificate, in form and substance satisfactory to the Department and the Program's bond counsel, certifying the accuracy of facts that are necessary for Program Bond Counsel to issue its approving opinion and stating that the Borrower shall be solely responsible for compliance with Federal arbitrage restrictions.

(b) The lender must represent that it complies with sections (2) and (3) of OAR 123-052-1500.

(c) The State, the Borrower and the lender must execute any other documents required by the Program's Bond Counsel in order to deliver its approving tax and legal opinions.

(7) At closing, the Borrower shall execute a post-issuance tax compliance agreement satisfactory to the Program's Bond Counsel.

(8) The Borrower and lender shall be responsible for reviewing disbursement requests to confirm eligible uses of bond proceeds.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-1700
Procedure after Preliminary Eligibility Determination

(1) If the Department notifies the Applicant pursuant to OAR 123-052-1200(3) that the Applicant, the proposed project and the proposed lender appear eligible for the Program, the Borrower may file a request for a final eligibility determination with the Department. The request for final eligibility determination shall be filed on a form provided by the Department, and shall contain:

(a) A detailed description of the costs to be financed;

(b) A statement, signed by the Borrower and in substantially the form provided by the Department:

(A) That the Borrower is a Beginning Farmer who meets the requirements of OAR 123-052-1400, that the Aggie Bond proceeds will be spent only on costs described in 123-052-1400, and that the requested loan complies with 123-052-1700; and

(B) Whether the Borrower is electing the simplified Aggie Bond option under OAR 123-052-1800.

(c) A statement, signed by the lender and in substantially the form provided by the Department:

(A) Attaching drafts of the Financing Agreement and other Lender Documents, in substantially final form;

(B) Describing the principal amount of the requested Aggie Bonds, whether lender's loan is a line of credit, and the interest rate and other material loan terms , including but not limited to all fees and points being charged by the lender (if not stated in the Lender Documents).

(C) That the lender is eligible to purchase Aggie Bonds under OAR 123-052-1600, and providing facts supporting this statement.

(D) That the lender has completed its credit review and is prepared to make the loan under the Lenders Documents provided to the Department, and that no significant contingencies remain.

(d) A signed, completed final tax questionnaire on a form provided by the Department.

(e) Any other information specified in the form of request for final eligibility determination provided by the Department.

(2) The Department shall review the request for final eligibility determination when the completed request has been filed with the Department and make a final eligibility determination. The final eligibility determination may be favorable or unfavorable.

(a) The Department shall notify the Applicant of a favorable final eligibility determination no later than five business days after Program Bond Counsel notifies the Department that it expects to be able to issue an approving opinion. The notice of a favorable final eligibility determination shall state that that financing described in the Application and request for final eligibility determination is eligible for Aggie Bond financing, and that the Applicant is authorized to proceed to closing, subject to any conditions imposed by the Department in the final eligibility determination.

(b) The Department shall notify the Applicant of an unfavorable final eligibility determination no later than five business days after either one of the following occurs first:

(A) The Department determines that the financing does not qualify under Oregon law or these rules for Aggie Bond financing; or

(B) Program Bond Counsel notifies the Department that it does not expect to be able to issue an approving opinion.

(c) The notice of an unfavorable final eligibility determination shall state that that financing described in the Application and request for final eligibility determination is not eligible for Aggie Bond financing. Unless appealed, an unfavorable final eligibility determination shall become final on the eleventh day after the Department notifies the Applicant of that determination.

(d) The Applicant is entitled to appeal the unfavorable final eligibility determination to the Finance Committee of the Oregon Business Development Commission by filing a notice of appeal with the Department no later than ten business days after the Department notifies the Applicant of the unfavorable final eligibility determination. Any decision by the Finance Committee of the Oregon Business Development Commission on an appeal is final when it is made.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-1800
Simplified Aggie Bond Option

(1) The Code has many complex requirements for Tax-exempt loans. The cost to the Borrower of participating in the Program may be reduced if the facts associated with the Applicant's financing do not raise complex tax issues.

(2) An Applicant may elect the simplified Aggie Bond option if:

(a) All Depreciable Agricultural Property financed under the Program is new property with a useful life that is at least equal to the term of the Aggie Bond;

(b) All land financed under the program is land that will be used exclusively for farming purposes, that has no houses or other structures of significant value on it, for which the Borrower has provided the Department with an appraisal of the land, exclusive of the value of any structures on the land.

(c) The amount of the loan and the aggie bonds does not exceed the sum of: the cost of new, Depreciable Agricultural Property described in OAR 123-052-1800(2)(a), plus the lesser of the cost or appraised value of the land described in OAR 123-052-1800(2)(b).

(d) The Borrower is acquiring all the Financed Property from people or entities that are not Related Persons as defined in OAR 123-052-1100(20).

(e) The lender is an insured institution described in OAR 123-052-1500.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-1900
Bond Counsel Opinion

(1) The state requires the Applicant and its lender obtain a traditional approving opinion from the Program's Bond Counsel concluding that the Aggie Bond issued for the Applicant is a valid and binding obligation of the State, and that interest on the Aggie Bond is Tax-exempt.

(2) If the Department determines that the financing described in the Application and request for final eligibility determination, filed by the Applicant pursuant to OAR 123-052-1500, is eligible for participation in the Program, the Department shall forward the request for final eligibility determination to the Program's Bond Counsel. Program Bond Counsel shall:

(a) Conduct tax due diligence, determine whether it will be able to issue approving opinions on the proposed Aggie Bonds, and notify the Department of that determination.

(b) Assuming Bond Counsel determines it will be able to issue approving opinions on the proposed Aggie Bonds:

(A) Review the draft Financing Agreement and Loan Agreement provided by the lender and send required changes to the Borrower and lender for review;

(B) Provide forms of tax and arbitrage certificates, and other necessary documents, for the Borrower and lender to execute

(3) If Bond Counsel determines it will be able to issue an approving opinion on a proposed Aggie Bond, the Department will forward the Aggie Bond documents to the Treasurer with a request that the Treasurer approve the issuance of the Aggie Bond. The Treasurer, an independent, elected official of the State of Oregon, has no legal obligation to approve any Aggie Bond issue. If the Treasurer approves issuance of an Aggie Bond, the Department will coordinate the closing with the Borrower, the lender, the State Treasurer, and Bond Counsel.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-2000
Fees and Costs

(1) The Applicant shall pay the Department the nonrefundable $250 application fee.

(2) At closing, the Borrower shall pay the Department or appropriate party the following costs or fees:

(a) A bond closing fee of 1.5% of the total Aggie bonds issued for the project, with a minimum of $1,500, payable to the Department.

(b) Out of pocket costs or fees of the State, including but not limited to any indirect costs charged to the Department or Treasurer by Oregon Department of Justice for complex transactions.

(c) State Treasurer's costs or fees related to the review, approval and processing of each Aggie Bond issuance request and issuance.

(d) Any State Private Activity Bond Committee costs or fees.

(e) Bond Counsel costs or fees

(3) Applicants or beneficiaries of Aggie Bond financing shall pay the Department or appropriate party any costs or fees related to issuance, refunding, modifications, or restructuring of Aggie Bonds including but not limited to Bond Counsel's legal fees and direct expenses.

(4) If the Department issues an unfavorable final eligibility determination, or the Department's Bond Counsel determines it is not able to issue an approving opinion, or the Treasurer does not approve issuance of Aggie Bonds, or the requested Aggie Bonds are not issued for any other reason, the Applicant's Application will terminate and the Borrower shall not be entitled to the return of the application fee it has paid, or entitled to recover any costs it may have incurred in the preparation and submission of the Application or any damages it may have suffered as a result of the failure of such Application.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-2100
Security for Aggie Bonds

(1) Each Aggie Bond will be a special, limited obligation of the State of Oregon that is payable solely from the Eligible Revenue paid to the lender as provided in the Lender Documents

(2) As required by ORS 285A.420 to 285A.435, the Aggie Bonds are not:

(a) Secured by, payable from or chargeable to moneys other than the Eligible Revenue that is committed to pay the Aggie Bonds;

(b) A liability of the State of Oregon. No lender or other owner of an Aggie Bond may: compel an exercise of the taxing power of the State of Oregon to pay any Aggie Bonds or the interest on any Aggie Bonds or enforce payment of any Aggie Bonds against any property of the State of Oregon except the Eligible Revenue that is committed to pay the Aggie Bond.

(c) A charge lien or encumbrance, legal or equitable, upon any property of the State of Oregon, except the Eligible Revenue that is committed to pay an Aggie Bond.

(3) No Aggie Bond shall be a general obligation of the Department, the State of Oregon, or any department, agency, or political subdivision of the State of Oregon.

(4) The full faith and credit of the Department or the State of Oregon or any department, agency, or political subdivision of the State of Oregon shall not be pledged for the payment of any Aggie Bond.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-2200
Waiver

The Department may, in its discretion, waive any of the requirements of these administrative rules to the extent such requirements are not otherwise imposed by law.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-2300
Authority to Manage the Program

The Program shall be managed by the Department or its designee, and is not a Program of the Business Development Commission.

Stat. Auth.: ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

123-052-2400
Confidential Records

(1) Upon written request and within a reasonable time, the Department shall provide program records for inspection in accordance with ORS Chapter 192.

(2) The person requesting records will be charged for preparing and mailing such records. Costs may include but not be limited to costs incurred in locating records, separating exempt and nonexempt records, having a custodian present during the inspection, preparing lists of data, making photocopies and telefaxing materials. Fees to be collected shall be set forth in the Department's schedule of fees and may be amended from time to time as the Department may determine.

(3) Except as otherwise provided in ORS 192.410-192.595, records exempt from disclosure include but are not limited to:

(a) Reports and analyses of reports which bear on the Applicant's character, finances, management ability and reliability, and which were obtained in confidence from persons or firms not required by law to submit them and the Department has obliged itself in good faith not to disclose the information;

(b) Financial statements, tax returns, business records, employment history and other personal data submitted by or for Applicants, or analysis of such data;

(c) Intra-departmental advisory memoranda preliminary to a decision;

(d) Formulas, plans, designs and related information that constitute trade secrets under ORS 192;

(e) Personal financial statement;

(f) Financial statements of Applicants;

(g) Customer lists;

(h) Information of an Applicant pertaining to litigation to which the Applicant is a party if the complaint has been filed, or if the complaint has not been filed, if the Applicant shows that such litigation is reasonably likely to occur. This exemption does not apply to conclude litigation and nothing in this section shall limit any right or opportunity granted by law to a party involved in litigation;

(i) Production, sales or cost data; and

(j) Marketing strategy information that relates to an Applicant's plan to address specific markets and Applicant's strategy regarding specific competitors.

Stat. Auth.: ORS 192.410 – 192.595, ORS 285A.420 - 285A.435, ch. 742 OL 2013
Stats. Implemented: ORS 192.410 -192.595, ORS 285A.420.420 - 285A.435, ch. 742 OL 2013
Hist.: OBDD 3-2015, f. & cert. ef. 2-24-15

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Oregon Department of Education
Chapter 581

Rule Caption: Corporal Punishment defined
Adm. Order No.: ODE 5-2015
Filed with Sec. of State: 3-11-2015
Certified to be Effective: 3-11-15
Notice Publication Date: 2-1-2015
Rules Amended: 581-021-0061
Subject: Aligns Oregon Administrative Rule definition of corporal punishment to be consistent with current statute/regulations for restraint and seclusion.
Rules Coordinator: Cindy Hunt—(503) 947-5651

581-021-0061
Corporal Punishment

(1) Corporal punishment is any act which willfully inflicts or willfully causes the infliction of physical pain on a student.

(2) Corporal punishment does not include physical pain or discomfort resulting from or caused by:

(a) Training for or participation in athletic competition voluntarily engaged in by a student;

(b) Recreational activity voluntarily engaged in by a student;

(c) Physical exertion shared by all students in a teacher directed class activity, which may include, but is not limited to, physical education exercises, field trips, or vocational education projects; or

(d) Physical restraint or seclusion when used as provided in ORS 339.291 and OAR 581-021-0553.

Stat. Auth.: ORS 339
Stats. Implemented: ORS 339.250
Hist.: ED 25-1989(Temp), f. & cert. ef. 9-8-89; EB 20-1990, f. & cert. ef. 4-5-90; ODE 17-2006, f. 12-11-06, cert. ef. 12-12-06; ODE 5-2015, f. & cert. ef. 3-11-15

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Rule Caption: Surrogate Parents
Adm. Order No.: ODE 6-2015
Filed with Sec. of State: 3-11-2015
Certified to be Effective: 3-11-15
Notice Publication Date: 7-1-2014
Rules Amended: 581-015-2320
Subject: Modify rule to fully comply with federal requirements in respect to state supervision of surrogacy; update state rule citation.
Rules Coordinator: Cindy Hunt—(503) 947-5651

581-015-2320
Surrogate Parents

(1) Each public agency must ensure that the rights of a child are protected by determining the need for, and when appropriate assigning, a surrogate parent when no parent (as defined in OAR 581-015-2000) with legal rights in respect to a student's educational decision making can be identified or located after reasonable efforts and additionally:

(a) The child is a ward of the state and there is reasonable cause to believe that the child has a disability; or

(b) The child is an unaccompanied homeless youth.

(2) The school district may not appoint a surrogate solely because the parent or adult student to whom rights have transferred is uncooperative or unresponsive to special education needs.

(3) Each school district must have a method for determining whether a child needs a surrogate parent and for assigning a surrogate parent to the child. The school district must ensure that each person approved to serve as a surrogate:

(a) Is not an employee of the school district or the Department or any other agency that is involved in the education or care of the child;

(b) Is free of any personal or professional interest that conflicts with representing the child's special education interests; and

(c) Has knowledge and skills that ensure adequate representation of the child in special education decisions.

(4) For an unaccompanied homeless youth, appropriate staff of emergency shelters, independent living programs and street outreach programs may be appointed as a temporary surrogate parent without regard to subsection (3)(a) until a surrogate can be appointed that meets all of the requirements of subsection (3).

(5) An appointed surrogate parent has all of the special education rights and procedural safeguards available to the parent.

(6) A surrogate is not considered an employee of a school district solely on the basis that the surrogate is compensated from public funds.

(7) The duties of the surrogate parent are to:

(a) Protect the special education rights of the child;

(b) Be acquainted with the child's disability and the child's special education needs;

(c) Represent the child in all matters relating to the identification, evaluation, IEP and educational placement of the child; and

(d) Represent the child in all matters relating to the provision of a free appropriate public education to the child.

(8) A surrogate has the same rights granted to a parent in a hearing under OAR 581-015-2360, and the procedures regarding hearings in OAR 581-015-2340 through 581-015-2385 apply.

(9) A parent, or an adult student to whom rights have transferred, may give written consent for a surrogate to be appointed.

(a) When a parent or an adult student requests that a surrogate be appointed:

(A) The parent or adult student retains all parental rights to receive notice under OAR 581-015-2190, 581-015-2195, 581-015-2310, and 581-015-2315 and all of the information provided to the surrogate.

(B) The surrogate, alone, is responsible for all matters relating to the special education of the child unless the parent or adult student revokes consent for the surrogate's appointment.

(b) The parent or adult student may revoke consent at any time by providing a written request to revoke the surrogate's appointment.

(10) The school district may change or terminate the appointment of a surrogate when:

(a) The person appointed as surrogate is no longer willing to serve;

(b) Rights transfer to the adult student or the child graduates with a regular diploma;

(c) The child is no longer eligible for special education services;

(d) The legal guardianship of the child is transferred to a person who is able to carry out the role of the parent;

(e) A foster parent is identified who can carry out the role of parent under OAR 581-015-2000(20);

(f) The parent, who previously could not be identified or located, is now identified or located;

(g) The appointed surrogate is no longer eligible;

(h) The child moves to another school district; or

(i) The child is no longer a ward of the state or an unaccompanied homeless youth.

(11) A person appointed as surrogate will not be held liable for actions taken in good faith on behalf of the parent in protecting the special education rights of the child.

(12) When it is determined that a surrogate parent is needed to protect the rights of a student with a disability as outlined above, the surrogate must be appointed not more than 30 days after the determination that the student needs a surrogate.

Stat. Auth.: ORS 343.041, 343.045, 343.055, 343.155
Stats. Implemented: ORS 343.155, 34 CFR 300.519
Hist.: 1EB 18-1979(Temp), f. & ef. 11-15-79; 1EB 5-1980, f. 2-22-80, ef. 2-23-80; EB 9-1992, f. & cert. ef. 4-7-92; EB 11-1995, f. & cert. ef. 5-25-95; ODE 23-1999, f. & cert. ef. 9-24-99; ODE 2-2003, f. & cert. ef. 3-10-03; Renumbered from 581-015-0099, ODE 10-2007, f. & cert. ef. 4-25-07; ODE 6-2015, f. & cert. ef 3-11-15

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Oregon Health Authority, Division of Medical Assistance Programs
Chapter 410

Rule Caption: Update Reference to Current Covered and Non-Covered Dental Services Document, Incorporate Changes to Prioritized List
Adm. Order No.: DMAP 7-2015(Temp)
Filed with Sec. of State: 2-17-2015
Certified to be Effective: 2-17-15 thru 8-15-15
Notice Publication Date:
Rules Amended: 410-123-1220, 410-123-1260
Subject: Effective January 1, 2015, the Health Evidence Review Commission (HERC) added four oral health codes to funded lines of the Prioritized List of Health Services (Prioritized List). These codes are 99188, D1535, D9219, and D9931.The Authority is amending OAR 410-123-1220 and OAR 410-123-1260 to reflect these changes.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-123-1220
Coverage According to the Prioritized List of Health Services

(1) This rule incorporates by reference the "Covered and Non-Covered Dental Services" document, dated January 1, 2015, and located on the Division of Medical Assistance Programs' (Division) website at: http://www.oregon.gov/oha/healthplan/Pages/dental.aspx.

(a) The "Covered and Non-Covered Dental Services" document lists coverage of Current Dental Terminology (CDT) procedure codes according to the Oregon Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) and the client's specific Oregon Health Plan benefit package;

(b) This document is subject to change if there are funding changes to the Prioritized List.

(2) Changes to services funded on the Prioritized List are effective on the date of the Prioritized List change:

(a) The Division administrative rules (chapter 410, division 123) will not reflect the most current Prioritized List changes until they have gone through the Division rule filing process;

(b) For the most current Prioritized List, refer to the HERC website at http://www.oregon.gov/oha/OHPR/Pages/herc/Current-Prioritized-List.aspx;

(c) In the event of an alleged variation between a Division-listed code and a national code, the Division shall apply the national code in effect on the date of request or date of service.

(3) Refer to OAR 410-123-1260 for information about limitations on procedures funded according to the Prioritized List. Examples of limitations include frequency and client's age.

(4) The Prioritized List does not include or fund the following general categories of dental services, and the Division does not cover them for any client. Several of these services are considered elective or "cosmetic" in nature (i.e., done for the sake of appearance):

(a) Desensitization;

(b) Implant and implant services;

(c) Mastique or veneer procedure;

(d) Orthodontia (except when it is treatment for cleft palate);

(e) Overhang removal;

(f) Procedures, appliances, or restorations solely for aesthetic or cosmetic purposes;

(g) Temporomandibular joint dysfunction treatment; and

(h) Tooth bleaching.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 21-1994(Temp), f. 4-29-94, cert. ef. 5-1-94; HR 32-1994, f. & cert. ef. 11-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; HR 9-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 31-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 17-2011, f. & cert. ef. 7-12-11; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 7-2015(Temp), f. & cert. ef. 2-17-15 thru 8-15-15

410-123-1260
OHP Plus Dental Benefits

(1) GENERAL:

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

(A) Refer to Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the EPSDT program, eligible clients, and related services. EPSDT dental services include, but are not limited to:

(i) Dental screening services for eligible EPSDT individuals; and

(ii) Dental diagnosis and treatment that is indicated by screening at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health;

(B) Providers shall provide EPSDT services for eligible Division of Medical Assistance Programs (Division) clients according to the following documents:

(i) The Dental Services Program administrative rules (OAR chapter 410, division 123), for dentally appropriate services funded on the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List); and

(ii) The "Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at www.oregon.gov/oha/healthplan/Pages/dental.aspx;

(b) Restorative, periodontal, and prosthetic treatments:

(A) Documentation shall be included in the client's charts to support the treatment. Treatments shall be consistent with the prevailing standard of care and may be limited as follows:

(i) When prognosis is unfavorable;

(ii) When treatment is impractical;

(iii) A lesser-cost procedure would achieve the same ultimate result; or

(iv) The treatment has specific limitations outlined in this rule;

(B) Prosthetic treatment, including porcelain fused to metal crowns, are limited until rampant progression of caries is arrested and a period of adequate oral hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic.

(2) ENHANCED ORAL HEALTH SERVICES IN PRIMARY CARE SETTINGS:

(a) Topical fluoride treatment:

(A) For children under 19 years of age, topical fluoride varnish may be applied by a licensed medical practitioner during a medical visit. Providers must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with either the appropriate Current Dental Terminology (CDT) code (D1206-Topical Fluoride Varnish) or the appropriate Current Procedural Terminology (CPT) code (99188 - Application of topical fluoride varnish by a physician or other qualified health care professional);

(B) Topical fluoride treatment from a medical practitioner counts toward the overall maximum number of fluoride treatments, as described in subsection (4) of this rule;

(b) Assessment of a patient:

(A) For children under six years of age, CDT code D0191-Assessment of a Patient is covered as an enhanced oral health service in medical settings;

(B) For reimbursement in a medical setting, D0191-Assessment of a patient must include all of the following components:

(i) Caries risk assessment using a standardized tool endorsed by Oregon Oral Health Coalition, the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics;

(ii) Anticipatory guidance and counseling with the client's caregiver on good oral hygiene practices and nutrition;

(iii) Referral to a dentist in order to establish a dental home;

(iv) Documentation in medical chart of risk assessment findings and service components provided;

(C) For reimbursement, the performing provider must meet all of the following criteria:

(i) Be a physician (MD or DO), an advance practice nurse, or a licensed physician assistant; and

(ii) Hold a certificate of completion from one of the following approved training programs within the previous three years:

(I) Smiles for Life; or

(II) First Tooth through the Oregon Oral Health Coalition;

(D) For reimbursement, the medical practitioners must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with the appropriate CDT code (D0191-Assessment of a Patient);

(E) D0191 Assessment of a Patient may be reimbursed under this subsection up to a maximum of once every 12 months;

(F) D0191 Assessment of a Patient from a medical practitioner does not count toward the maximum number of CDT code D0191-Assessment of a Patient services performed by a dental practitioner described in subsection three (3) of this rule;

(c) For tobacco cessation services provided during a medical visit, follow criteria outlined in OAR 410-130-0190;

(3) DIAGNOSTIC SERVICES:

(a) Exams:

(A) For children under 19 years of age:

(i) The Division shall reimburse exams (billed as CDT codes D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations:

(I) D0150: once every 12 months when performed by the same practitioner;

(II) D0150: twice every 12 months only when performed by different practitioners;

(III) D0180: once every 12 months;

(ii) The Division shall reimburse D0160 only once every 12 months when performed by the same practitioner;

(B) For adults 19 years of age and older, the Division shall reimburse exams (billed as CDT codes D0120, D0150, D0160, or D0180) once every 12 months;

(C) For problem focused exams (urgent or emergent problems), the Division shall reimburse D0140 for the initial exam. The Division shall reimburse D0170 for related problem-focused follow-up exams. Providers must not bill D0140 and D0170 for routine dental visits;

(D) The Division only covers oral exams performed by medical practitioners when the medical practitioner is an oral surgeon;

(E) As the American Dental Association's Current Dental Terminology (CDT) codebook specifies, the evaluation, diagnosis, and treatment planning components of the exam are the responsibility of the dentist. The Division may not reimburse dental exams when performed by a dental hygienist (with or without an expanded practice permit);

(b) Assessment of a patient (D0191):

(A) When performed by a dental practitioner, the Division shall reimburse:

(i) If performed by a dentist outside of a dental office;

(ii) If performed by a dental hygienist with an expanded practice dental hygiene permit;

(iii) Only if an exam (D0120-D0180) is not performed on the same date of service. Assessment of a patient (D0191) is included as part of an exam (D0120-D0180);

(iv) For children under 19 years of age, a maximum of twice every 12 months; and

(v) For adults age 19 and older, a maximum of once every 12 months;

(B) An assessment does not take the place of the need for oral evaluations/exams;

(c) Radiographs:

(A) The Division shall reimburse for routine radiographs once every 12 months;

(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;

(C) The Division shall reimburse a maximum of six radiographs for any one emergency;

(D) For clients under age six, radiographs may be billed separately every 12 months as follows:

(i) D0220 — once;

(ii) D0230 — a maximum of five times;

(iii) D0270 — a maximum of twice, or D0272 once;

(E) The Division shall reimburse for panoramic (D0330) or intra-oral complete series (D0210) once every five years, but both cannot be done within the five-year period;

(F) Clients shall be a minimum of six years old for billing intra-oral complete series (D0210). The minimum standards for reimbursement of intra-oral complete series are:

(i) For clients age six through 11- a minimum of ten periapicals and two bitewings for a total of 12 films;

(ii) For clients ages 12 and older - a minimum of ten periapicals and four bitewings for a total of 14 films;

(G) If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), the Division shall reimburse for the complete series;

(H) Additional films may be covered if dentally or medically appropriate, e.g., fractures (Refer to OAR 410-123-1060 and 410-120-0000);

(I) If the Division determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;

(J) The exception to these limitations is if the client is new to the office or clinic and the office or clinic is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records shall be included in the client's records;

(K) Digital radiographs, if printed, shall be on photo paper to assure sufficient quality of images.

(4) PREVENTIVE SERVICES:

(a) Prophylaxis:

(A) For children under 19 years of age — Limited to twice per 12 months;

(B) For adults 19 years of age and older — Limited to once per 12 months;

(C) Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily oral health care;

(D) Are coded using the appropriate Current Dental Terminology (CDT) coding:

(i) D1110 (Prophylaxis — Adult) — Use for clients 14 years of age and older; and

(ii) D1120 (Prophylaxis — Child) — Use for clients under 14 years of age;

(b) Topical fluoride treatment:

(A) For adults 19 years of age and older — Limited to once every 12 months;

(B) For children under 19 years of age — Limited to twice every 12 months;

(C) Additional topical fluoride treatments may be available, up to a total of four treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for clients who:

(i) Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;

(ii) Are pregnant;

(iii) Have physical disabilities and cannot perform adequate, daily oral health care;

(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or

(v) Are under seven years old with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.;

(D) Fluoride limits include any combination of fluoride varnish (D1206) or other topical fluoride (D1208);

(c) Sealants (D1351) and Sealant Repair (D1353):

(A) Are covered only for children under 16 years of age;

(B) The Division limits coverage to:

(i) Permanent molars; and

(ii) Only one sealant treatment per molar every five years, except for visible evidence of clinical failure;

(iii) Only one sealant repair treatment per molar every five years, and only when repair is clinically indicated and appropriate;

(d) Tobacco cessation:

(A) For services provided during a dental visit, bill as a dental service using CDT code D1320 when the following brief counseling is provided:

(i) Ask patients about their tobacco-use status at each visit and record information in the chart;

(ii) Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help; and

(iii) Refer patients who are ready to quit, utilizing internal and external resources, to complete the remaining three A's (assess, assist, arrange) of the standard intervention protocol for tobacco;

(B) The Division allows a maximum of ten services within a three-month period;

(e) Space management:

(A) The Division shall cover fixed and removable space maintainers (D1510, D1515, D1520, and D1525) only for clients under 19 years of age;

(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.

(5) RESTORATIVE SERVICES:

(a) Amalgam and resin-based composite restorations, direct:

(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;

(B) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;

(C) The Division limits payment for replacement of posterior composite restorations to once every five years;

(D) The Division limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures;

(E) Providers shall combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);

(F) The Division may not reimburse for an amalgam or composite restoration and a crown on the same tooth;

(G) Interim therapeutic restoration on primary dentition (D2941) is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration.

(H) Reattachment of tooth fragment (D2921) is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment.

(I) The Division reimburses for a surface not more than once in each treatment episode regardless of the number or combination of restorations;

(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration;

(b) Indirect crowns and related services:

(A) General payment policies:

(i) The fee for the crown includes payment for preparation of the gingival tissue;

(ii) The Division shall cover crowns only when:

(I) There is significant loss of clinical crown and no other restoration will restore function; and

(II) The crown-to-root ratio is 50:50 or better, and the tooth is restorable without other surgical procedures;

(iii) The Division shall cover core buildup (D2950) only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50 percent of the tooth structure must be remaining for coverage of the core buildup.

(iv) Reimbursement of retention pins (D2951) is per tooth, not per pin;

(B) The Division shall not cover the following services:

(i) Endodontic therapy alone (with or without a post);

(ii) Aesthetics (cosmetics);

(iii) Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason;

(C) The Division shall cover acrylic heat or light cured crowns (D2970 temporary crown, fractured tooth) — allowed only for anterior permanent teeth;

(D) The Division shall cover the following only for clients under 21 years of age or who are pregnant:

(i) Prefabricated plastic crowns (D2932) are allowed only for anterior teeth, permanent or primary;

(ii) Stainless steel crowns (D2930/D2931) are allowed only for anterior primary teeth and posterior permanent or primary teeth;

(iii) Prefabricated stainless steel crowns with resin window (D2933) are allowed only for anterior teeth, permanent or primary;

(iv) Prefabricated post and core in addition to crowns (D2954/D2957);

(v) Permanent crowns (resin-based composite — D2710 and D2712, and porcelain fused to metal (PFM) — D2751 and D2752) as follows:

(I) Limited to teeth numbers 6–11, 22 and 27 only, if dentally appropriate;

(II) Limited to four in a seven-year period. This limitation includes any replacement crowns allowed according to (E)(i) of this rule;

(III) Only for clients at least 16 years of age; and

(IV) Rampant caries are arrested, and the client demonstrates a period of oral hygiene before prosthetics are proposed;

(vi) PFM crowns (D2751 and D2752) shall also meet the following additional criteria:

(I) The dental practitioner has attempted all other dentally appropriate restoration options and documented failure of those options;

(II) Written documentation in the client's chart indicates that PFM is the only restoration option that will restore function;

(III) The dental practitioner submits radiographs to the Division for review; history, diagnosis, and treatment plan may be requested. (See OAR 410-123-1100 Services Reviewed by the Division);

(IV) The client has documented stable periodontal status with pocket depths within 1–3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, documentation shall be maintained in the client's chart of the dentist's findings supporting stability and why the increased pocket depths will not adversely affect expected long-term prognosis;

(V) The crown has a favorable long-term prognosis; and

(VI) If the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture shall have favorable expected long-term prognosis;

(E) Crown replacement:

(i) Permanent crown replacement limited to once every seven years;

(ii) All other crown replacement limited to once every five years; and

(iii) The Division may make exceptions to crown replacement limitations due to acute trauma, based on the following factors:

(I) Extent of crown damage;

(II) Extent of damage to other teeth or crowns;

(III) Extent of impaired mastication;

(IV) Tooth is restorable without other surgical procedures; and

(V) If loss of tooth would result in coverage of removable prosthetic;

(F) Crown repair (D2980) is limited to only anterior teeth.

(6) ENDODONTIC SERVICES:

(a) Endodontic therapy:

(A) Pulpal therapy on primary teeth (D3230 and D3240) is covered only for clients under 21 years of age;

(B) For permanent teeth:

(i) Anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all OHP Plus clients; and

(ii) Molar endodontic therapy (D3330):

(I) For clients through age 20, is covered only for first and second molars; and

(II) For clients age 21 and older who are pregnant, is covered only for first molars;

(C) The Division covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;

(b) Endodontic retreatment and apicoectomy:

(A) The Division does not cover retreatment of a previous root canal or apicoectomy for bicuspid or molars;

(B) The Division limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:

(i) Crown-to-root ratio is 50:50 or better;

(ii) The tooth is restorable without other surgical procedures; or

(iii) If loss of tooth would result in the need for removable prosthodontics;

(C) Retrograde filling (D3430) is covered only when done in conjunction with a covered apicoectomy of an anterior tooth;

(c) The Division does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service or if the same practitioner or dental practitioner in the same group practice completed the procedure;

(d) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;

(e) Apexification/recalcification procedures:

(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;

(B) Apexification/recalcification procedures are covered only for clients under 21 years of age or who are pregnant.

(7) PERIODONTIC SERVICES:

(a) Surgical periodontal services:

(A) Gingivectomy/Gingivoplasty (D4210 and D4211) — limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia; and

(B) Includes six months routine postoperative care;

(C) The Division shall consider gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) as part of the restoration and will not provide a separate reimbursement for this procedure;

(b) Non-surgical periodontal services:

(A) Periodontal scaling and root planing (D4341 and D4342):

(i) For clients through age 20, allowed once every two years;

(ii) For clients age 21 and over, allowed once every three years;

(iii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;

(iv) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater:

(I) D4341 is allowed for quadrants with at least four or more teeth with pockets 5 mm or greater;

(II) D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater;

(v) Prior authorization for more frequent scaling and root planing may be requested when:

(I) Medically/dentally necessary due to periodontal disease as defined above is found during pregnancy; and

(II) Client's medical record is submitted that supports the need for increased scaling and root planing;

(B) Full mouth debridement (D4355):

(i) For clients through age 20, allowed only once every two years;

(ii) For clients age 21 and older, allowed once every three years;

(c) Periodontal maintenance (D4910):

(A) For clients through age 20, allowed once every six months;

(B) For clients age 21 and older:

(i) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;

(ii) Allowed once every twelve months;

(iii) Prior authorization for more frequent periodontal maintenance may be requested when:

(I) Medically/dentally necessary, such as due to presence of periodontal disease during pregnancy; and

(II) Client's medical record is submitted that supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs);

(d) Records shall clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;

(e) The Division may not reimburse for procedures identified by the following codes if performed on the same date of service:

(A) D1110 (Prophylaxis — adult);

(B) D1120 (Prophylaxis — child);

(C) D4210 (Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant);

(D) D4211 (Gingivectomy or gingivoplasty — one to three contiguous teeth or bounded teeth spaces per quadrant);

(E) D4341 (Periodontal scaling and root planning — four or more teeth per quadrant);

(F) D4342 (Periodontal scaling and root planning — one to three teeth per quadrant);

(G) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and

(H) D4910 (Periodontal maintenance).

(8) REMOVABLE PROSTHODONTIC SERVICES:

(a) Clients age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140);

(b) The Division limits full dentures for clients age 21 and older to only those clients who are recently edentulous:

(A) For the purposes of this rule:

(i) "Edentulous" means all teeth removed from the jaw for which the denture is being provided; and

(ii) "Recently edentulous" means the most recent extractions from that jaw occurred within six months of the delivery of the final denture (or, for fabricated prosthetics, the final impression) for that jaw;

(B) See OAR 410-123-1000 for detail regarding billing fabricated prosthetics;

(c) The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to clients;

(d) Resin partial dentures (D5211-D5212):

(A) The Division may not approve resin partial dentures if stainless steel crowns are used as abutments;

(B) For clients through age 20, the client shall have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;

(C) For clients age 21 and older, the client shall have one or more missing anterior teeth or six or more missing posterior teeth per arch with documentation by the provider of resulting space causing serious impairment to mastication. Third molars are not a consideration when counting missing teeth;

(D) The dental practitioner shall note the teeth to be replaced and teeth to be clasped when requesting prior authorization (PA);

(e) Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:

(A) For clients at least 16 years and under 21 years of age, the Division shall replace full or partial dentures once every ten years, only if dentally appropriate. This does not imply that replacement of dentures or partials shall be done once every ten years, but only when dentally appropriate;

(B) For clients 21 years of age and older, the Division may not cover replacement of full dentures but shall cover replacement of partial dentures once every ten (10) years only if dentally appropriate;

(C) The ten year limitations apply to the client regardless of the client's OHP or Dental Care Organization (DCO)/Coordinated Care Organization (CCO) enrollment status at the time the client's last denture or partial was received. For example: A client receives a partial on February 1, 2002, and becomes a FFS OHP client in 2005. The client is not eligible for a replacement partial until February 1, 2012. The client gets a replacement partial on February 3, 2012 while FFS and a year later enrolls in a DCO or CCO. The client would not be eligible for another partial until February 3, 2022, regardless of DCO, CCO, or FFS enrollment;

(D) Replacement of partial dentures with full dentures is payable ten years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant replacement;

(f) The Division limits reimbursement of adjustments and repairs of dentures that are needed beyond six months after delivery of the denture as follows for clients 21 years of age and older:

(A) A maximum of four times per year for:

(i) Adjusting complete and partial dentures, per arch (D5410-D5422);

(ii) Replacing missing or broken teeth on a complete denture, each tooth (D5520);

(iii) Replacing broken tooth on a partial denture, each tooth (D5640);

(iv) Adding tooth to existing partial denture (D5650);

(B) A maximum of two times per year for:

(i) Repairing broken complete denture base (D5510);

(ii) Repairing partial resin denture base (D5610);

(iii) Repairing partial cast framework (D5620);

(iv) Repairing or replacing broken clasp (D5630);

(v) Adding clasp to existing partial denture (D5660);

(g) Replacement of all teeth and acrylic on cast metal framework (D5670, D5671):

(A) Is covered for clients age 16 and older a maximum of once every ten (10) years, per arch;

(B) Ten years or more shall have passed since the original partial denture was delivered;

(C) Is considered replacement of the partial so a new partial denture may not be reimbursed for another ten years; and

(D) Requires prior authorization as it is considered a replacement partial denture;

(h) Denture rebase procedures:

(A) The Division shall cover rebases only if a reline may not adequately solve the problem;

(B) For clients through age 20, the Division limits payment for rebase to once every three years;

(C) For clients age 21 and older:

(i) There shall be documentation of a current reline that has been done and failed; and

(ii) The Division limits payment for rebase to once every five years;

(D) The Division may make exceptions to this limitation in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing;

(i) Denture reline procedures:

(A) For clients through age 20, the Division limits payment for reline of complete or partial dentures to once every three years;

(B) For clients age 21 and older, the Division limits payment for reline of complete or partial dentures to once every five years;

(C) The Division may make exceptions to this limitation under the same conditions warranting replacement;

(D) Laboratory relines:

(i) Are not payable prior to six months after placement of an immediate denture; and

(ii) For clients through age 20, are limited to once every three years;

(iii) For clients age 21 and older, are limited to once every five years;

(j) Interim partial dentures (D5820-D5821, also referred to as "flippers"):

(A) Are allowed if the client has one or more anterior teeth missing; and

(B) The Division shall reimburse for replacement of interim partial dentures once every five years but only when dentally appropriate;

(k) Tissue conditioning:

(A) Is allowed once per denture unit in conjunction with immediate dentures; and

(B) Is allowed once prior to new prosthetic placement;

(L) Cleaning and inspection of a removable appliance (D9931):

(A) Is allowed for professional cleaning of a patient's denture through the use of an ultrasonic cleaner;

(B) The Division shall reimburse for cleaning and inspection of a denture once per client per year and only when a dental cleaning (prophylaxis) is not performed on the same day.

(9) MAXILLOFACIAL PROSTHETIC SERVICES:

(a) Fluoride gel carrier (D5986) is limited to those patients whose severity of oral disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The dental practitioner shall document failure of those options prior to use of the fluoride gel carrier;

(b) All other maxillofacial prosthetics (D5900-D5999) are medical services. Refer to the "Covered and Non-Covered Dental Services" document and OAR 410-123-1220:

(A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505 or 837P) claim format:

(B) For clients receiving services through a CCO or PHP, bill medical maxillofacial prosthetics to the CCO or PHP;

(C) For clients receiving medical services through FFS, bill the Division.

(10) ORAL SURGERY SERVICES:

(a) Bill the following procedures in an accepted dental claim format using CDT codes:

(A) Procedures that are directly related to the teeth and supporting structures that are not due to a medical condition or diagnosis, including such procedures performed in an ambulatory surgical center (ASC) or an inpatient or outpatient hospital setting;

(B) Services performed in a dental office setting or an oral surgeon's office:

(i) Such services include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs, and follow-up visits;

(ii) Refer to OAR 410-123-1160 for any PA requirements for specific procedures;

(b) Bill the following procedures using the professional claim format and the appropriate American Medical Association (AMA) CPT procedure and ICD9 diagnosis codes:

(A) Procedures that are a result of a medical condition (i.e., fractures, cancer);

(B) Services requiring hospital dentistry that are the result of a medical condition/diagnosis (i.e., fracture, cancer);

(c) Refer to the "Covered and Non-Covered Dental Services" document to see a list of CDT procedure codes on the Prioritized List that may also have CPT medical codes. See OAR 410-123-1220. The procedures listed as "medical" on the table may be covered as medical procedures, and the table may not be all-inclusive of every dental code that has a corresponding medical code;

(d) For clients enrolled in a DCO or CCO responsible for dental services, the DCO or CCO shall pay for those services in the dental plan package;

(e) Oral surgical services performed in an ASC or an inpatient or outpatient hospital setting:

(A) Require PA;

(B) For clients enrolled in a CCO or FCHP, the CCO or FCHP shall pay for the facility charge and anesthesia services. For clients enrolled in a Physician Care Organization (PCO), the PCO shall pay for the outpatient facility charge (including ASCs) and anesthesia. Refer to the current Medical Surgical Services administrative rules in OAR chapter 410, division 130 for more information;

(C) If a client is enrolled in a CCO or PHP, the provider shall contact the CCO or PHP for any required authorization before the service is rendered;

(f) All codes listed as "by report" require an operative report;

(g) The Division covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success;

(h) Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are reimbursed as a medical service;

(i) The Division does not cover surgical excisions of soft tissue lesions (D7410-D7415);

(j) Extractions — Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service;

(k) Surgical extractions:

(A) Include local anesthesia and routine post-operative care;

(B) The Division limits payment for surgical removal of impacted teeth or removal of residual tooth roots to treatment for only those teeth that have acute infection or abscess, severe tooth pain, and unusual swelling of the face or gums;

(C) The Division does not cover alveoloplasty in conjunction with extractions (D7310 and D7311) separately from the extraction;

(D) The Division covers alveoplasty not in conjunction with extractions (D7320-D7321) only for clients under 21 years of age or who are pregnant;

(l) Frenulectomy/frenulotomy (D7960) and frenuloplasty (D7963):

(A) The Division covers either frenulectomy or frenuloplasty once per lifetime per arch only for clients under age 21;

(B) The Division covers maxillary labial frenulectomy only for clients age 12 through 20;

(C) The Division shall cover frenulectomy/frenuloplasty in the following situations:

(i) When the client has ankyloglossia;

(ii) When the condition is deemed to cause gingival recession; or

(iii) When the condition is deemed to cause movement of the gingival margin when the frenum is placed under tension;

(m) The Division covers excision of pericoronal gingival (D7971) only for clients under age 21 or who are pregnant.

(11) ORTHODONTIA SERVICES:

(a) The Division limits orthodontia services and extractions to eligible clients:

(A) With the ICD-9-CM diagnosis of:

(i) Cleft palate; or

(ii) Cleft palate with cleft lip; and

(B) Whose orthodontia treatment began prior to 21 years of age; or

(C) Whose surgical corrections of cleft palate or cleft lip were not completed prior to age 21;

(b) PA is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate or cleft lip shall be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record shall include diagnosis, length, and type of treatment;

(d) Payment for appliance therapy includes the appliance and all follow-up visits;

(e) Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip as two phases. Stage one is generally the use of an activator (palatal expander), and stage two is generally the placement of fixed appliances (banding). The Division shall reimburse each phase separately;

(f) The Division shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist shall refund to the Division any unused amount of payment after applying the following formula: Total payment minus $300.00 (for banding) multiplied by the percentage of treatment remaining;

(g) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;

(h) As long as the orthodontist continues treatment, the Division may not require a refund even though the client may become ineligible for medical assistance sometime during the treatment period;

(i) Code:

(A) D8660 — PA required (reimbursement for required orthodontia records is included);

(B) Codes D8010-D8690 — PA required.

(12) ADJUNCTIVE GENERAL AND OTHER SERVICES:

(a) Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;

(b) Anesthesia:

(A) Only use general anesthesia or IV sedation for those clients with concurrent needs: age; physical, medical or mental status; or degree of difficulty of the procedure (D9220, D9221, D9241 and D9242);

(B) The Division reimburses providers for general anesthesia or IV sedation as follows:

(i) D9220 or D9241: For the first 30 minutes;

(ii) D9221 or D9242: For each additional 15-minute period, up to three hours on the same day of service. Each 15-minute period represents a quantity of one. Enter this number in the quantity column;

(iii) D9219: For thorough patient safety and appropriateness, evaluation in advance of in-office deep sedation or general anesthesia. Reimbursement is limited to once per in-office deep sedation or general anesthesia procedure;

(C) The Division reimburses administration of Nitrous Oxide (D9230) per date of service, not by time;

(D) Oral pre-medication anesthesia for conscious sedation (D9248):

(i) Limited to clients under 13 years of age;

(ii) Limited to four times per year;

(iii) Includes payment for monitoring and Nitrous Oxide; and

(iv) Requires use of multiple agents to receive payment;

(E) Upon request, providers shall submit a copy of their permit to administer anesthesia, analgesia, and sedation to the Division;

(F) For the purpose of Title XIX and Title XXI, the Division limits payment for code D9630 to those oral medications used during a procedure and is not intended for "take home" medication;

(c) The Division limits reimbursement of house/extended care facility call (D9410) only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience;

(d) Oral devices/appliances (E0485, E0486):

(A) These may be placed or fabricated by a dentist or oral surgeon but are considered a medical service;

(B) Bill the Division, CCO, or the PHP for these codes using the professional claim format

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 18-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 31-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 17-2011, f. & cert. ef. 7-12-11; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13; DMAP 68-2013, f. 12-5-13, cert. ef. 12-23-13; DMAP 75-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 10-2014(Temp), f. & cert. ef. 2-28-14 thru 8-27-14; DMAP 19-2014(Temp), f. 3-28-14, cert. ef. 4-1-14 thru 6-30-14; DMAP 36-2014, f. & cert. ef. 6-27-14; DMAP 56-2014, f. 9-26-14, cert. ef. 10-1-14; DMAP 7-2015(Temp), f. & cert. ef. 2-17-15 thru 8-15-15

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Rule Caption: Rewrite OHP Enrollment Rules to Reflect Current Enrollment Practices Including Full Pregnancy Enrollment Exemption Process

Adm. Order No.: DMAP 8-2015

Filed with Sec. of State: 2-26-2015

Certified to be Effective: 3-1-15

Notice Publication Date: 1-1-2015

Rules Amended: 410-141-0060, 410-141-3060

Rules Repealed: 410-141-0060(T), 410-141-3060(T)

Subject: These rules provide the framework for Coordinated Care Organization (CCO) and Managed Care Organization (MCO) enrollment requirements, including any existing exemptions from CCO and MCO enrollment. The Authority requested stakeholder and public comment on the following: The Licensed Direct Entry Midwives (LDEM) Staff Advisory Workgroup came out with recommendations related to perinatal service options for Medicaid enrollees. The Authority Director, Suzanne Hoffman responded with a letter dated May 21, 2014, stating the Division would implement changes, necessitating the removal of the sunset date, allowing for time to make further program implementations and additional rule revisions. It has been decided to implement the CCO enrollment exemption criteria on which to build additional program specific criteria later in 2015 outlining the detail level of the program requirements.

Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-141-0060

Oregon Health Plan Managed Care Enrollment Requirements

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

(a) Client means an individual found eligible to receive health services. "Client" is inclusive of members enrolled in PHPs and CCOs as stated in OAR 410-120-0000;

(b) Eligibility Determination means an approval or denial of eligibility and a renewal or termination of eligibility as stated in OAR 410-200-0015;

(c) Member means a client enrolled with a pre-paid health plan or coordinated care organization as stated in OAR 410-120-0000;

(d) Newly Eligible means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;

(e) Redetermination means a review of eligibility outside of regularly scheduled renewals. Redeterminations that result in the assignment of a new renewal date or a change in program are considered renewals as stated in OAR 410-200-0015;

(f) Renewal means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) The following populations may not be enrolled into an MCO or any type of health care coverage including:

(a) Persons who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without other Medicaid;

(c) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(3) The following populations may not be enrolled into an MCO under the following circumstances:

(a) Newly eligible clients are exempt from enrollment with an MCO but not exempt from enrollment in a DCO, if they became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client. The individual will receive dental services through the DCO.

(b) The client is covered under a major medical insurance policy or other third party resource (TPR) that covers the cost of services to be provided by a PHP as specified in and ORS 414.631 and, except as provided for children in Child Welfare though the BRS and PRTS programs, outlined OAR 410-141-3050. A client shall be enrolled with a DCO even if they have a dental TPR.

(4) Persons who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt from auto assignment mandatory enrollment for their managed care plans, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(5) Populations specified below are exempt from mandatory enrollment into a physical health MCO but are subject to mandatory enrollment into both dental and mental health plans as available in the member's service area. The member may be manually enrolled into a physical health plan as deemed appropriate by the Authority. These individuals are as follows:

(a) Children in the legal custody of the Department or Oregon Health Authority where the child is expected to be in a substitute care placement for less than 30 calendar days unless:

(A) Access to health care on a FFS basis is not available; or

(B) Enrollment would preserve continuity of care.

(b) Clients who are dually eligible for Medicare and Medicaid but not enrolled in a program of all-inclusive care for the elderly. The following apply to these clients:

(A) A client who is also a Medicare beneficiary and is in a hospice program may not enroll in an FCHP or PCO that is also a Medicare Advantage plan. The client may enroll in either an FCHP or PCO that does not have a Medicare Advantage plan unless exempt for some other reason listed in this rule;

(B) The client is enrolled in Medicare and the only FCHP or PCO in the service area is a Medicare Advantage plan. The client may choose not to enroll in an FCHP or PCO;

(C) Enrollment in a FCHP or PCO of a client who is receiving Medicare and who resides in a service area served by PHPs shall be as follows:

(i) If the client who is Medicare Advantage eligible selects a FCHP or PCO that has a corresponding Medicare Advantage plan, the client shall complete the 7208M or other CMS approved Medicare plan election form;

(ii) If the Medicare Advantage Plan Election form (OHP 7208M) described in this rule is signed by someone other than the client, the client's representative must complete and sign the Signature by Mark or State Approved Signature sections of the OHP 7208M;

(iii) If the client is a Medicare beneficiary who is capable of making enrollment decisions, the client's representative may not have authority to select FCHPs or PCOs that have corresponding Medicare Advantage components:

(I) If the FCHP or PCO has not received the form within ten calendar days after the date of enrollment, the FCHP or PCO shall send a letter to the member with a copy sent to the APD branch manager. The letter shall explain the need for the completion of the form; inform the member that if the form is not received within 30 days, the FCHP or PCO may request dis-

enrollment; and instruct the 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 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 shall notify the PHP coordinator of the PHP's annual decision to disenroll or maintain enrollment for the clients in writing. This notification shall be submitted by January 31 of each year or another date specified by the Authority. If the FCHP or PCO has decided to:

(III) Disenroll the clients and has not received a client's form at the end of 30 days, the FCHP or PCO shall request disenrollment. HMU will disenroll the member effective the end of the month following the notification;

(D) Maintain enrollment. The FCHP or PCO may not request disenrollment at the end of 30 days.

(E) If the client is enrolled as a private member of a Medicare Advantage plan, the client may choose to remain enrolled as a private member or to enroll in the FCHP or PCO that corresponds to the Medicare Advantage plan:

(F) If the client chooses to remain as a private member in the Medicare Advantage plan, the client shall remain in the Medicaid FFS delivery system for physical health care services but shall select a DCO and MHO where available;

(G) If the client chooses to discontinue the Medicare Advantage enrollment and then, within 60 calendar days of disenrollment from the Medicare Advantage plan, chooses the FCHP or PCO that corresponds to the Medicare Advantage plan that was discontinued, the client shall be allowed to enroll in the FCHP or PCO even if the FCHP or PCO is not open for Enrollment to other clients;

(H) A Fully Dual Eligible (FDE) client who has been exempted from enrollment in an MHO may not be enrolled in a FCHP or PCO that has a corresponding Medicare Advantage plan unless the exemption was done for a provider who is on the FCHP's or PCO's panel.

(6) The Authority may temporarily exempt clients from mandatory enrollment for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in MCOs on a case-by-case basis; children not enrolled in a MCO shall continue to receive services on a FFS basis;

(b) Until December 31, 2017, women who are pregnant and meet the qualifications in sub-sections A through E below may receive OHP benefits on a FFS basis for physical health only until 60 days after the birth of her child. Women meeting the criteria for the pregnancy enrollment exemption for their physical health plan coverage will continue to be enrolled in the appropriate MCO or CCO plan in their service area for dental and mental health coverage. After the 60 day period, the member shall enroll in a plan as appropriate. Those women under consideration for a pregnancy enrollment exemption for their physical health enrollment shall receive a response from the Authority within 30 working days of request. Upon approval of the FFS pregnancy exemption for physical health enrollment only, the client shall remain FFS for as long as she continues to meet the requirements in A through E below. In order to qualify for the FFS pregnancy exemption for physical health only, there shall be no home birth option available to the client through her plan and the client shall:

(A) Be pregnant;

(B) State that her intention is to have a home birth;

(C) Have an established relationship for the purpose of home birth with a licensed qualified practitioner who is not a participating provider with the client's MCO;

(D) Make a request to change to FFS. This request can be made at any point in the pregnancy prior to delivery; and

(E) Meet any OAR and statutory requirements that define when a home birth is eligible for reimbursement by the Authority:

(i) Should a woman become unable to meet any of the requirements specified in OAR 333-076-0650(1), Table 1, either upon initial evaluation or once the exemption is granted, the exemption shall be withdrawn, and the client will be subject to MCO enrollment requirements as stated in OAR 410-141-3060;

(ii) Conditions arising during the pregnancy as listed in subsections (I) through (V) below shall be reviewed by the Authority on a case-by-case basis for continuation of the FFS enrollment exemption:

(I) Fetal presentation other than vertex when known;

(II) Abnormal bleeding;

(III) Low–lying placenta within 2 cm. or less of cervical os;

(IV) Genital herpes, primary; secondary uncoverable at onset of labor; and

(V) Current substance abuse that has the potential to adversely affect labor and the infant.

(c) The following apply to clients and exemptions relating to organ transplants:

(A) Newly eligible clients are exempt from enrollment with an MCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;

(B) Newly eligible clients with existing transplants shall enroll into the appropriate MCO for their service area;

(d) Other just causes to preserve continuity of care include the following considerations:

(A) Enrollment would pose a serious health risk; and

(B) The Authority finds no reasonable alternatives.

(7) Unless exempted above, enrollment is mandatory in all areas served by an MCO.

(8) When a service area changes from mandatory to voluntary, the member will remain with their PHP for the remainder of their eligibility period unless the member meets the criteria stated in this rule or as provided by OAR 410-141-0080.

(9) If the client resides in a mandatory service area and fails to select a DCO, MHO, PCO, or FCHP at the time of application for the OHP, the Authority shall enroll the client with a DCO, MHO, PCO, or FCHP as follows:

(a) The client shall be assigned to and enrolled with a DCO, MHO, PCO, or FCHP that meets the following requirements where MCO enrollment is not available or services are not available through the MCO:

(A) Is open for enrollment;

(B) Serves the county in which the client resides;

(C) Has practitioners located within the community-standard distance for average travel time for the client.

(b) Assignment shall be made first to an MCO;

(c) The Authority shall send a notice to the client informing the 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, PCO, or FCHP open for enrollment in the county in which the client resides;

(10) Clients shall be enrolled with PHPs according to the following criteria:

(a) Areas with sufficient physical health service capacity through a combination of Coordinated Care Organizations (CCOs), Fully Capitated Health Plans (FCHP), and Physician Care Organizations (PCO) shall be called mandatory service areas. In mandatory service areas, a client shall select:

(A) A CCO; or

(B) An FCHP or PCO:

(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and

(ii) If approved by the Authority.

(b) Service areas without sufficient physical health service capacity shall be called voluntary service areas. In voluntary service areas, a client has the option to:

(A) Select a CCO; or

(B) Select an FCHP or PCO;

(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and

(ii) If approved by the Authority; or

(C) Remain in the Medicaid fee-for-service (FFS) physical health care delivery system.

(c) Service areas with sufficient mental health and dental care service capacity through MHOs and DCOs shall be called mandatory MHO and DCO service areas. A client shall select an MHO and DCO in a mandatory MHO and DCO service area if mental health and dental services are not available through a CCO or the client is otherwise exempt from CCO enrollment;

(d) Service areas without sufficient dental care service capacity through MHOs and DCOs shall be called voluntary MHO and DCO service areas. In voluntary MHO and DCO service areas, a client may choose to:

(A) Select a CCO open to enrollment that offers dental services; or

(B) Select any MHO and DCO open for enrollment if CCO enrollment is not available; or

(C) Remain in the Medicaid FFS mental health and dental care delivery system;

(11) Enrollments resulting from assignments shall be effective the first of the month or week after the Department enrolls the client and notifies the client of enrollment and the name of the PHP: If enrollment is initiated by an Authority worker on or before Wednesday, the date of enrollment shall be the following Monday. If enrollment is initiated by an Authority 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 plan or DCO, shall be initiated by an auto-enrollment program of the Authority, 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.

(12) The provision of capitated services to a member enrolled with a PHP shall begin as of the effective date of enrollment with the MCO 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 shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;

(c) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above.

Stat. Auth.: ORS 413.042, 414,615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 & 414.685

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; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 72-2014(Temp), f. 12-9-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 8-2015, f. 2-26-15, cert. ef. 3-1-15

410-141-3060
Enrollment Requirements in a CCO

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

(a) Client means an individual found eligible to receive OHP health services. "Client" is inclusive of members enrolled in PHPs and CCOs as stated in OAR 410-120-0000;

(b) Eligibility Determination means an approval or denial of eligibility and a renewal or termination of eligibility as stated in OAR 410-200-0015;

(c) Member means a client enrolled with a pre-paid health plan or coordinated care organization as stated in OAR 410-120-0000;

(d) Newly Eligible means recently determined, through the eligibility determination process, as having the right to obtain state health benefits, satisfying the appropriate conditions;

(e) Redetermination means a review of eligibility outside of regularly scheduled renewals. Redeterminations that result in the assignment of a new renewal date or a change in program are considered renewals as stated in OAR 410-200-0015;

(f) Renewal means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) The following populations may not be enrolled into a CCO for any type of health care coverage including:

(a) Persons who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without other Medicaid;

(c) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(3) The following populations may not be enrolled into a CCO under the following circumstances:

(a) Newly eligible clients are exempt from enrollment with a CCO but not exempt from enrollment in a DCO if they became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client. The individual will receive dental services through the DCO;

(b) The client is covered under a major medical insurance policy or other third party resource (TPR) that covers the cost of services to be provided by a PHP as specified in ORS 414.631 and except as provided for children in Child Welfare through the BRS and PRTS programs outlined in OAR 410-141-3050. A client shall be enrolled with a DCO even if they have a dental TPR.

(4) Persons who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt mandatory enrollment into a managed care plan, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(5) Populations specified below are exempt from mandatory enrollment into a physical health CCO but are subject to mandatory enrollment into both dental and mental health plans as available in the member's service area. The member may be manually enrolled into a physical health plan as deemed appropriate by the Authority. These populations are as follows:

(a) Children in the legal custody of the Department or where the child is expected to be in a substitute care placement for less than 30 calendar days unless:

(A) Access to health care on a FFS basis is not available; or

(B) Enrollment would preserve continuity of care;

(b) Clients who are dually eligible for Medicare and Medicaid but not enrolled in a program of all-inclusive care for the elderly. The following apply to these:

(A) A client has the option to enroll in a CCO regardless of whether they are enrolled in Medicare Advantage;

(B) A client enrolled in Medicare Advantage, whether or not they pay their own premium, has the option to enroll in a CCO even if the CCO does not have a corresponding Medicare Advantage plan;

(C) A client has the option to enroll with a CCO, even if the client withdrew from that CCO's Medicare Advantage plan. The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;

(D) A client has the option to enroll with a CCO even if the client is enrolled in Medicare Advantage with another entity.

(6) The Authority may temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in CCOs on a case-by-case basis. Children not enrolled in a CCO shall continue to receive services on a FFS basis;

(b) Until December 31, 2017, women who are pregnant and meet the qualifications in sub-sections A through E below may receive OHP benefits on a FFS basis for physical health only until 60 days after the birth of her child. Women meeting the criteria for the pregnancy enrollment exemption for their physical health plan coverage will continue to be enrolled in the appropriate MCO or CCO plan in their service area for dental and mental health coverage. After the 60-day period the member shall enroll in a plan as appropriate. Those women under consideration for a pregnancy enrollment exemption for their physical health enrollment shall receive a response from the Authority within 30 working days of request. Upon approval of the FFS pregnancy exemption for physical health enrollment only, the client shall remain FFS for as long as she continues to meet the requirements in A through E below. In order to qualify for the FFS pregnancy exemption for physical health only, there must be no home birth option available to the client through her plan and the client must:

(A) Be pregnant;

(B) State that her intention is to have a home birth;

(C) Have an established relationship for the purpose of home birth with a licensed, qualified practitioner who is not a participating provider with the client's CCO; and

(D) Make a request to change to FFS. This request can be made at any point in the pregnancy prior to delivery; and

(E) Meet any OAR and statutory requirements that define when a home birth is eligible for reimbursement by the Authority:

(i) Should a woman become unable to meet any of the requirements specified in OAR 333-076-0650(1) Table 1 either upon initial evaluation or once the exemption is granted, the exemption shall be withdrawn and the client will be subject to CCO enrollment requirements as stated in OAR 410-141-3060.

(ii) Conditions arising during the pregnancy as listed in subsections (I) through (V) below shall be reviewed by the Authority on a case-by-case basis for continuation of the FFS enrollment exemption:

(I) Fetal presentation other than vertex, when known;

(II) Abnormal Bleeding;

(III) Low–lying placenta within 2 cm. or less of cervical os;

(IV) Genital herpes, primary; secondary uncoverable at onset of labor; and

(V) Current substance abuse that has the potential to adversely affect labor and the infant;

(c) The following apply to clients and exemptions relating to organ transplants:

(A) Newly eligible clients are exempt from enrollment with a CCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;

(B) Newly eligible clients with existing transplants shall enroll into the appropriate CCO for their service area;

(d) Other just causes to preserve continuity of care include the following considerations:

(A) Enrollment would pose a serious health risk; and

(B) The Authority finds no reasonable alternatives.

(7) Unless stated above, CCO enrollment is mandatory in all areas served by a CCO. A client who is eligible for or receiving health services must enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and this rule.

(8) Enrollment is voluntary in service areas without adequate access and capacity to provide health care services through a CCO or PHP.

(9) Enrollment is mandatory in service areas with adequate health care access and capacity to provide health care services through a CCO or PHP. If upon application or redetermination, a client does not select a CCO, the Authority shall auto-assign the client and the client's household to a CCO that has adequate health care access and capacity. The following outlines the priority of enrollment in service areas where enrollment is mandatory and a PHP remains available for enrollment:

(a) Priority 1: The client shall enroll in a CCO that serves that area and has adequate health care access and capacity;

(b) Priority 2: The client has the option to enroll in a PHP through a manual process if:

(A) The client has an established relationship with a provider who is only contracted with the PHP; or

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care services capacity to accept new members. Clients will be FFS unless already established with a PHP's provider;

(c) Priority 3: The client shall receive services on a FFS basis.

(10) If a service area changes from mandatory enrollment to voluntary enrollment, the member shall remain with the PHP for the remainder of their eligibility period or until the Authority or Department redetermines eligibility, whichever comes sooner, unless otherwise eligible to disenroll pursuant to OAR 410-141-3080.

(11) Clients who are exempt from physical health services or who are enrolled with a PHP for physical health services will receive managed or coordinated mental health and oral health services as follows:

(a) The client shall be enrolled with a CCO if the CCO offers mental health and oral health services; or

(b) The client shall be enrolled with an MHO for mental health services and with a DCO for oral health services if the CCO does not offer those services; or

(c) The client shall be enrolled with a DCO for oral health services and remain FFS for mental health services if an MHO is not available; or

(d) The client shall remain FFS for both mental health and oral health services if an MHO or DCO is unavailable.

(12) The following pertains to the effective date of the enrollment. If the enrollment occurs:

(a) On or before Wednesday, the date of enrollment shall be the following Monday; or

(b) After Wednesday, the date of enrollment shall be one week from the following Monday.

(13) Coordinated care services shall begin as of the effective date of enrollment with the CCO except for:

(a) A newborn's date of birth when the mother was a member of a CCO at the time of birth;

(b) For persons other than newborns who are hospitalized on the date enrolled, the date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;

(c) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above.

(d) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 - 414.685

Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 62-2012(Temp), f. 12-27-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 4-2013(Temp), f. & cert. ef. 2-7-13 thru 6-29-13; DMAP 33-2013, f. & cert. ef. 6-27-13; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14; DMAP 65-2013, f. & cert. ef. 11-29-13; DMAP 35-2014(Temp), f. 6-25-14, cert. ef. 7-1-14 thru 12-27-14; DMAP 69-2014(Temp), f. 12-8-14, cert. ef. 12-27-14 thru 12-31-14; DMAP 70-2014, f. 12-8-14, cert. ef. 1-1-15; DMAP 72-2014(Temp), f. 12-9-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 8-2015, f. 2-26-15, cert. ef. 3-1-15

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Rule Caption: Tracheostomy Rule Amendment Requiring Additional Documentation

Adm. Order No.: DMAP 9-2015

Filed with Sec. of State: 2-26-2015

Certified to be Effective: 3-1-15

Notice Publication Date: 2-1-2015

Rules Amended: 410-122-0209

Subject: Tracheostomy rule amended with additional documentation requirements.

Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-122-0209

Tracheostomy Care Supplies

(1) Indications and Coverage: For a client following an open surgical tracheostomy that has been open or is expected to remain open for at least three months:

(a) Standard tracheostomy supplies, including tracheostomy tubes (A7520, A7521), do not require prior authorization;

(b) Custom/Specialized tracheostomy tubes must be a device that requires the manufacturer to complete substantive customization or modification for a specific individual's medical need;

(c) Custom/Specialized tracheostomy tubes require prior authorization and shall be approved with clinical documentation supporting the medical appropriateness and a statement from the prescribing practitioner explaining why a standard or off-the-shelf tracheostomy tube will not meet the client's medical needs.

(2) Documentation:

(a) A prescription for tracheal equipment that is signed by the prescribing practitioner shall be kept on file by the DMEPOS provider. The prescribing practitioner's records shall contain information that supports the medical appropriateness of the item ordered;

(b) Custom/Specialized tracheostomy tubes require an assessment every six months indicating a standard tracheostomy tube does not currently meet the medical needs of the client. Documentation shall be submitted to the Division at the time of request.

(3) Billing:

(a) Custom/Specialized tracheostomy tubes shall be billed using the correct HCPCS code and modifier 22;

(b) Custom/Specialized tracheostomy tubes shall be reimbursed following the payment methodology outlined in OAR 410-122-0186 for manually priced items.

(4) Procedure Codes – Table 122-0209.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: 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 4-2001, f. 3-30-01, cert. ef. 4-1-01; 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 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 9-2015, f. 2-26-15, cert. ef. 3-1-15

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Rule Caption: Amending PDL November 20, 2014 DUR/P&T Action

Adm. Order No.: DMAP 10-2015(Temp)

Filed with Sec. of State: 3-3-2015

Certified to be Effective: 3-3-15 thru 8-29-15

Notice Publication Date:

Rules Amended: 410-121-0030

Subject: The Pharmaceutical Services Program administrative rules (Division 121) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows:

410-121-0030:
Preferred:
Imitrex® — Brand only;
Tobramycin (Bethkis);
Calcium Acetate;
Anafranil — Brand only;
Escitalopram Oxalate;
Imipramine HCL;
Acamprosate Calcium;
Amiloride HCL;
Naltrexone HCL;
Pulmonary Drug Reorganization removed COPD, Asthma Controllers, Asthma Rescue;
(New Drug class names)
Combination Inhalers.
- Inhaled Anticholinergics
- Inhaled Corticosteroids
- Inhaled Long Acting Bronchodilators
- Miscellaneous Pulmonary Drugs
- Short Acting Bronchodilators
Tazarotene (Tazorac®);
Fenofibrate;
Epinephrine Injection;
Estradiol;
Legend Prenatal Vitamins;
Risperidone Microspheres.
Non-Preferred:
Clomipramine HCL;
Niacin;
Tricor™ — Brand only;
Trilipix™ — Brand only;
Golimumab (Simponi®);
Bendroflumethiazide;
Boceprevir (Victrelis®);
Memantine HCL (Namenda XR®);
NPH, Human Insulin Isophane;
Telaprevir (Incivek®).

Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-121-0030
Practitioner-Managed Prescription Drug Plan

(1) The Practitioner-Managed Prescription Drug Plan (PMPDP) is a plan that ensures fee-for-service clients of the Oregon Health Plan shall 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 Preferred Drug List (PDL):

(a) The PDL is the primary tool the Division 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 (as defined in 410-121-0000 (cc) consists of prescription drugs that the Division, in consultation with the Drug Use Review (DUR)/Pharmacy & Therapeutics Committee (P&T), has determined represent the most effective drugs available at the best possible price;

(c) The PDL shall include drugs that are Medicaid reimbursable and the Food and Drug Administration (FDA) has determined to be safe and effective.

(3) PMPDP PDL Selection Process:

(a) The Division shall utilize the recommendations made by the P&T that result from an evidence-based evaluation process as the basis for selecting the most effective drugs;

(b) The Division shall determine the drugs selected in section (3)(a) that are available for the best possible price and shall consider any input from the P&T about other FDA-approved drugs in the same class that are available for a lesser relative price. The Division shall determine relative price using the methodology described in section (4);

(c) The Division shall evaluate selected drugs for the drug classes periodically:

(A) Evaluation shall occur more frequently at the discretion of the Division if new safety information or the release of new drugs in a class or other information that makes an evaluation advisable;

(B) New drugs in classes already evaluated for the PDL shall be non-preferred until the new drug has been reviewed by the P&T;

(C) The Division shall make all changes or revisions to the PDL using the rulemaking process and shall publish the changes on the Division's Pharmaceutical Services provider rules website.

(4) Relative cost and best possible price determination:

(a) The Division shall 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) The Division may also consider dosing issues, patterns of use, and compliance issues. The Division shall weigh these factors with any advice provided by the P&T in reaching a final decision;

(5) Pharmacy providers shall dispense prescriptions in the generic form unless:

(a) The practitioner requests otherwise subject to the regulations outlined in OAR 410-121-0155;

(b) The brand name medication is listed as preferred on the PDL.

(6) The exception process for obtaining non-preferred physical health drugs that are not on the PDL drugs shall be as follows:

(a) If the prescribing practitioner in their professional judgment wishes to prescribe a physical health drug not on the PDL, they may request an exception subject to the requirements of OAR 410-121-0040;

(b) The prescribing practitioner must request an exception for physical health drugs not listed in the PDL subject to the requirements of OAR 410-121-0060;

(c) Exceptions shall be granted in instances:

(A) Where the prescriber in their professional judgment determines the non-preferred drug is medically appropriate after consulting with the Division or the Oregon Pharmacy Help Desk; or

(B) Where the prescriber requests an exception subject to the requirement of section (6)(b) and fails to receive a report of PA status within 24 hours, subject to OAR 410-121-0060.

(7) Table 121-0030-1, PMPDP PDL datedMarch 1, 2015 is incorporated in rule by reference and is found on the Division's website at: www.orpdl.org.

Stat. Auth.: ORS 413.032, 413.042, 414.065, 414.325, 414.330 to 414.414, 414.312 & 414.316

Stats. Implemented: ORS 414.065; 414.325, 414.334, 414.361, 414.369, 414.371, 414.353 & 414.354

Hist.: OMAP 25-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 31-2002, f. & cert. ef. 8-1-02; OMAP 36-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 35-2003, f. & cert. ef. 5-1-03; OMAP 47-2003, f. & cert. ef. 7-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 70-2003(Temp), f. 9-15-03, cert. ef. 10-1-03 thru 3-15-04; OMAP 82-2003, f. 10-31-03, cert. ef. 11-1-03; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 29-2004, f. 4-23-04 cert. ef. 5-1-04; OMAP 34-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 45-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 81-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 32-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 58-2005, f. 10-27-05, cert. ef. 11-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 48-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 39-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 17-2010, f. 6-15-10, cert. ef. 7-1-10; DMAP 40-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 2-2011(Temp), f. & cert. ef. 3-1-11 thru 8-20-11; DMAP 19-2011, f. 7-15-11, cert. ef. 7-17-11; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 12-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 18-2012, f. 3-30-12, cert. ef. 4-9-12; DMAP 26-2012, f. & cert. ef. 5-14-12; DMAP 29-2012, f. & cert. ef. 6-21-12; DMAP 33-2012(Temp), f. 7-18-12, cert. ef. 7-23-12 thru 1-18-13; DMAP 40-2012(Temp), f. & cert. ef. 8-20-12 thru 1-18-13; DMAP 44-2012(Temp), f. & cert. ef. 9-26-12 thru 1-18-13; DMAP 61-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 6-2013(Temp), f. & cert. ef. 2-21-13 thru 8-19-13; DMAP 23-2013(Temp), f. 4-30-13, cert. ef. 5-1-13 thru 8-19-13; Administrative correction, 7-18-13; DMAP 43-2013, f. & cert. ef. 8-16-13; DMAP 76-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; DMAP 1-2014(Temp), f. & cert. ef. 1-10-14 thru 7-9-14; DMAP 15-2014, f. & cert. ef. 3-21-14 thru 9-17-14; DMAP 28-2014(Temp), f. & cert. ef. 5-2-14 thru 6-30-14; DMAP 37-2014, f. & cert. ef. 6-30-14; DMAP 47-2014(Temp), f. & cert. ef. 7-15-14 thru 1-11-15; DMAP 52-2014(Temp), f. & cert. ef. 9-16-14 thru 1-11-15; DMAP 64-2014(Temp), f. 10-24-14, cert. ef. 10-29-14 thru 12-30-14; DMAP 77-2014, f. & cert. ef. 12-12-14; DMAP 78-2014(Temp), f. & cert. ef. 12-12-14 thru 6-9-15; DMAP 88-2014(Temp), f. 12-31-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 10-2015(Temp), f. & cert. ef. 3-3-15 thru 8-29-15

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Rule Caption: Annual Updates for Relative Value Units, Clinical Lab and Ambulatory Surgical Centers
Adm. Order No.: DMAP 11-2015
Filed with Sec. of State: 3-4-2015

Certified to be Effective: 3-4-15
Notice Publication Date: 2-1-2015
Rules Amended: 410-120-1340
Rules Repealed: 410-120-1340(T)
Subject: The Division of Medical Assistance Programs (Division) will amend this rule to implement annual updates to the Centers for Medicare and Medicaid (CMS) Relative Value Unit (RVU) weights for physician services and Clinical Laboratory and Ambulatory surgical services.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-120-1340
Payment

(1) The Division of Medical Assistance Programs (Division) shall make payment only to the enrolled provider (see OAR 410-120-1260) who actually performs the service or to the provider's enrolled billing provider for covered services rendered to eligible clients.

(2) Division reimbursement for services may be subject to review prior to reimbursement.

(3) The Division that is administering the program under which the billed services or items are provided sets fee-for-service (FFS) payment rates.

(4) The Division uses FFS payment rates in effect on the date of service that are the lesser of:

(a) The amount billed;

(b) The Division maximum allowable amount or;

(c) Reimbursement specified in the individual program provider rules.

(5) Amount billed may not exceed the provider's "usual charge" (see definitions).

(6) The Division's maximum allowable rate setting process uses the following methodology for:

(a) Relative Value Unit (RVU) weight-based rates: For all CPT/HCPCS codes assigned an RVU weight, the 2015 Total RVU weights published in the Federal Register, Vol. 79, November 13, 2014 to be effective for dates of services on or after January 1, 2015:

(A) For professional services not typically performed in a facility, the Non-Facility Total RVU weight;

(B) For professional services typically performed in a facility, the Facility Total RVU weight;

(C) The Division applies the following conversion factors:

(i) $40.79 for labor and delivery codes (59400-59622);

(ii) $36.0666 for Federally Qualified primary care codes billed by providers meeting the criteria in OAR 410-130-0005 for dates of service between January 1, 2013 and December 31, 2014;

(iii) $27.82 for Oregon primary care providers and services not specified in sub-paragraph (ii). A current list of primary care CPT, HCPCs, and provider specialty codes is available at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

(iv) $25.48 for all remaining RVU weight based CPT/HCPCS codes.

(D) Rate calculation: Effective January 1, 2015, the Division shall calculate rates for each RVU weight-based code using statewide Geographic Practice Cost Indices (GPCIs) as follows:

(i) Work RVU) X (Work GPCI of 1) + (Practice Expense RVU) X (Practice GPCI of 0.974) + (Malpractice RVU) X (Malpractice GPCI of 0.708);

(ii) Sum in paragraph (D)(i) multiplied by the applicable conversion factor in paragraph (C) .

(b) Non RVU based rates:

(A) $20.78 is the base rate for anesthesia service codes 00100-01996. The rate is based on per unit of service;

(B) Clinical lab codes are priced at 70 percent of the 2015 Medicare clinical lab fee schedule;

(C) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80 percent of the 2014 Medicare fee schedule;

(D) 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 shall be based upon the Wholesale Acquisition Price (WAC) plus 6.25 percent. If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. Pricing information for WAC is provided by First Data Bank. These rates may change periodically based on drug costs;

(E) All procedures used for vision materials and supplies are based on contracted rates that include acquisition cost plus shipping and handling;

(F) Individual provider rules may specify reimbursement rates for particular services or items.

(7) The rates in section (6) are updated periodically and posted on the Authority web site at http://www.oregon.gov/OHA/healthplan/data_pubs/feeschedule/main.shtml.

(8) The Division reimburses inpatient hospital service under the DRG methodology, unless specified otherwise in the Hospital Services program administrative rules (chapter 410, division 125). Reimbursement for services, including claims paid at DRG rates, may not exceed any upper limits established by federal regulation.

(9) The Division reimburses all out-of-state hospital services at Oregon DRG or FFS rates as published in the Hospital Services Program rules (OAR chapter 410, division 125) unless the hospital has a contract or service agreement with the Division to provide highly specialized services.

(10) Payment rates for in-home services provided through Department of Human Services (Department) Aging and People with Disabilities (APD) may not exceed the costs of nursing facility services unless the criteria in OAR 411-027-0020 have been met.

(11) The Division sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities and psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) The rate established by APD for out-of-state nursing facilities.

(12) The Division may not make payment on claims that have been assigned, sold, or otherwise transferred or when the billing provider, billing agent, or billing service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a provider for accounts receivable.

(13) The Division may 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 Program administrative rules (chapter 410, division 121) and Home Enteral/Parenteral Nutrition and IV Services Program administrative rules (chapter 410, division 148);

(b) Physical therapy, speech therapy, and occupational therapy provided by a non-employee of the nursing facility within the appropriate program administrative rules (chapter 410, division 129 and 131);

(c) Continuous oxygen that exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services program administrative rules (chapter 410, division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services program administrative rules (chapter 410, division 130);

(f) Medical services provided by a physician or other provider of medical services, such as radiology and laboratory, as outlined in the Medical-Surgical Services program rules (chapter 410, division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies program administrative rules (chapter 410, division 122).

(14) The Division reimburses hospice services based on CMS Core-Based Statistical Areas (CBSA's). A separate payment may not be made for services included in the core package of services as outlined in OAR chapter 410, division 142.

(15) Payment for Division clients with Medicare and full Medicaid:

(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not exceed the co-insurance and deductible amounts due;

(b) The Division pays the allowable rate for covered services that are not covered by Medicare.

(16) For clients with third-party resources (TPR), the Division pays the allowed rate less the TPR payment but not to exceed the billed amount.

(17) The Division payments, including contracted PHP or CCO payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For the Division, payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding Division 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.

(18) Payment by the Division does not restrict or limit the Authority or any state or federal oversight entity's right to review or audit a claim before or after the payment. Claim payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care or medical appropriateness of the care or payment.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.033, 414.065, 414.095, 414.727, 414.728, 414.742 & 414.743

Hist.: PWC 683, f. 7-19-74, ef. 8-11-784; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; Renumbered from 461-013-0061; PWC 833, f. 3-18-77, ef. 4-1-77; Renumbered from 461-013-0061; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0060, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 50-1985, f. 8-16-85, ef. 9-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0081, 461-013-0085, 461-013-0175 & 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040, 410-120-0220, 410-120-0200, 410-120-0240 & 410-120-0320; HR 2-1994, f. & cert. ef. 2-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 35-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 39-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 28-2012, f. 6-21-12, cert. ef. 7-1-12; DMAP 41-2012(Temp), f. 8-22-12, cert. ef. 9-1-12 thru 2-28-13; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 14-2013(Temp), f. & cert. ef. 3-29-13 thru 9-25-13; DMAP 49-2013, f. & cert. ef. 9-25-13; DMAP 71-2013, f. & cert. ef. 12-27-13; DMAP 24-2014, f. & cert. ef. 4-4-14; DMAP 83-2014(Temp), f. 12-23-14, cert. ef. 1-1-15 thru 6-29-15; DMAP 11-2015, f. & cert. ef. 3-4-15

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Rule Caption: Adopt and Incorporate by Reference Rules Established in OAR Chapter 461
Adm. Order No.: DMAP 12-2015(Temp)
Filed with Sec. of State: 3-5-2015
Certified to be Effective: 3-19-15 thru 9-14-15
Notice Publication Date:
Rules Amended: 410-120-0006
Subject: The Division incorporates rules established in OAR Chapter 461 for all overpayment, personal injury liens, and estates administration for Authority programs covered under OAR 410-200. References in OAR Chapter 461 in contracts of the Authority are deemed to be references to the requirements of this rule and shall be construed to apply to all eligibility policies, procedures, and determinations by or through the Authority.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-120-0006
Medical Eligibility Standards

As the state Medicaid and CHIP agency, the Oregon Health Authority (Authority) is responsible for establishing and implementing eligibility policies and procedures consistent with applicable law. As outlined in OAR 943-001-0020, the Authority and the Department of Human Services (Department) work together to adopt rules to assure that medical assistance eligibility procedures and determinations are consistent across both agencies.

(1) The Authority adopts and incorporates by reference the rules established in OAR Chapter 461 for all overpayment, personal injury liens and estates administration for Authority programs covered under OAR chapter 410, division 200.

(2) Any reference to OAR chapter 461 in contracts of the Authority are deemed to be references to the requirements of this rule and shall be construed to apply to all eligibility policies, procedures and determinations by or through the Authority.

(3) For purposes of this rule, references in OAR chapter 461 to the Department or to the Authority shall be construed to be references to both agencies.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042 & 414.065

Hist.: DMAP 10-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 18-2011(Temp), f. & cert. ef. 7-15-11 thru 1-11-12; DMAP 21-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-11-12; DMAP 25-2011(Temp), f. 9-28-11, cert. ef. 10-1-11 thru 1-11-12; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 1-2012(Temp), f. & cert. e.f 1-13-12 thru 7-10-12; DMAP 2-2012(Temp), f. & cert. ef. 1-26-12 thru 7-10-12; DMAP 3-2012(Temp), f. & cert. ef. 1-31-12 thru 2-1-12; DMAP 4-2012(Temp), f. 1-31-12, cert. ef. 2-1-12 thru 7-10-12; DMAP 9-2012(Temp), f. & cert. ef. 3-1-12 thru 7-10-12; DMAP 21-2012(Temp), f. 3-30-12, cert. ef. 4-1-12 thru 7-10-12; DMAP 25-2012(Temp), f. & cert. ef. 5-1-12 thru 7-10-12; Administrative correction 8-1-12; DMAP 35-2012(Temp), f. & cert. ef. 7-20-12 thru 1-15-13; DMAP 45-2012(Temp), f. & cert. ef. 10-5-12 thru 1-19-13; DMAP 50-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 53-2012(Temp), f. & cert. ef. 11-1-12 thru 4-29-13; DMAP 56-2012(Temp), f. 11-30-12, cert. ef. 12-1-12 thru 4-1-13; DMAP 60-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 65-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 2-2013(Temp), f. & cert. ef. 1-8-13 thru 6-29-13; DMAP 3-2013(Temp), f. & cert. ef. 1-30-13 thru 6-29-13; DMAP 5-2013(Temp), f. & cert. ef. 2-20-13 thru 6-29-13; DMAP 7-2013(Temp), f. & cert. ef. 3-1-13 thru 6-29-13; DMAP 12-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 17-2013, f. & cert. ef. 4-10-13; DMAP 24-2013, f. & cert. ef. 5-29-13; DMAP 32-2013, f. & cert. ef. 6-27-13; DMAP 39-2013(Temp), f. 7-26-13, cert. ef. 8-1-13 thru 1-28-14; DMAP 44-2013(Temp), f. 8-21-13, cert. ef. 8-23-13 thru 1-28-14; DMAP 51-2013, f. & cert. ef. 10-1-13; DMAP 52-2013(Temp), f. & cert. ef. 10-1-13 thru 3-30-14; DMAP 55-2013(Temp), f. & cert. ef. 10-2-13 thru 3-31-14; DMAP 59-2013(Temp), f. 10-31-13, cert. ef. 11-1-13 thru 3-31-14; DMAP 9-2014(Temp), f. 1-31-14, cert. ef. 2-1-14 thru 3-31-14; DMAP 18-2014, f. 3-28-14, cert. ef. 3-31-14; DMAP 41-2014, f. & cert. ef. 7-1-14; DMAP 54-2014, f. & cert. ef. 9-23-14; DMAP 12-2015(Temp), f. 3-5-15, cert. ef. 3-19-15 thru 9-14-15

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Rule Caption: Remove Not Covered Status from Billing Codes and Add Prior Authorization Requirement
Adm. Order No.: DMAP 13-2015
Filed with Sec. of State: 3-10-2015
Certified to be Effective: 3-10-15
Notice Publication Date: 2-1-2015
Rules Amended: 410-130-0200, 410-130-0220
Rules Repealed: 410-130-0200(T), 410-130-0220(T)
Subject: These rules list medical billing services not covered or services that the Division of Medical Assistance Programs (Division) considers to be bundled in other services for payment purposes. No payment is issued for services listed in this rule. This rule change will remove artificial disc procedures and intersex surgeries from this rule so that the Division may pay for these services. Payment consideration will be subject to prior authorization.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

410-130-0200
Prior Authorization

(1) For fee-for-service (FFS) clients, prior authorization (PA) is required for all procedure codes listed in Table 130-0200-1 regardless of the setting in which they are performed. For details on where to obtain PA, download a copy of the Medical-Surgical Services Supplemental Information booklet at: http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/med-surgsupp0912.pdf.

(2) For clients enrolled in a prepaid health plan (PHP), providers must obtain PA from the client's PHP.

(3) The Division shall authorize for the level of care or type of service that meets the client's medical need consistent with the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) and guideline notes, as referenced in OAR 410-141-0520.

(4) Codes for which medical need has not been specified by the HERC shall be authorized based on medical appropriateness as the term is defined in OAR 410-120-0000.

(5) For bariatric surgery, PA is required in two steps from:

(a) The OHP primary care provider prior to referral to a bariatric surgery center, and

(b) The bariatric surgery center prior to surgery.

(6) PA is not required:

(a) For clients with both Medicare and Medical Assistance Program coverage, and the service is covered by Medicare. However, PA is still required for bariatric surgeries and evaluations and most transplants, even if they are covered by Medicare;

(b) For kidney and cornea transplants unless they are performed out-of-state;

(c) For emergent or urgent procedures or services;

(d) For hospital admissions unless the procedure requires PA.

(7) A second opinion may be requested by the Division or the contractor before PA is given for a surgery.

(8) Treating and performing practitioners are responsible for obtaining PA.

(9) Refer to Table 130-0200-1 for all services and procedures requiring PA.

(10) **Table 130-0200-1**.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 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; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 27-2007(Temp), f. & cert. ef. 12-20-07 thru 5-15-08; DMAP 12-2008, f. 4-29-08, cert. ef. 5-1-08; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 34-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 43-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 43-2014, f. & cert. ef. 7-8-14; DMAP 55-2014(Temp), f. 9-26-14, cert. ef. 10-1-14 thru 3-30-15; DMAP 13-2015, f. & cert. ef. 3-10-15

410-130-0220
Not Covered/BundledServices

(1) Refer to the Oregon Health Plan administrative rules (chapter 410, division 141) and General Rules (chapter 410, division 120) for coverage of services. Refer to Table 130-0220-1 in this rule for additional information regarding not covered services or for services that the Division of Medical Assistance Programs (Division) considers to be bundled in other services.

(2) The following are examples of not covered services. This is not an all-inclusive list:

(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 that are normally provided in the practitioner's office but at the client's request are provided in a location other than the practitioner's office;

(d) Telephone calls for purposes other than tobacco cessation, maternity case management, and telemedicine.

(3) For specific information, see General Rules OAR 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations.

(4) **Table 130-0220-1**.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 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; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 15-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 43-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 55-2014(Temp), f. 9-26-14, cert. ef. 10-1-14 thru 3-30-15; DMAP 84-2014(Temp), .f & cert. ef. 12-24-14 thru 3-30-15; DMAP 13-2015, f. & cert. ef. 3-10-15

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Rule Caption: Repeal Outdated HIV/AIDS Prevention Program Rules Now Administered by Public Health in Chapter 333
Adm. Order No.: DMAP 14-2015
Filed with Sec. of State: 3-10-2015
Certified to be Effective: 3-10-15
Notice Publication Date: 2-1-2015
Rules Repealed: 410-143-0020, 410-143-0040, 410-143-0060
Subject: The Oregon Health Authority's Division of Medical Assistance Programs is repealing outdated HIV/AIDS prevention services program rules from Chapter 410. These rules were originally adopted in 1995 and have not been amended since that time. The HIV prevention program is currently administered by the Authority's Public Health Division, and the rules can be found in Chapter 333 division 22.
Rules Coordinator: Sandy Cafourek—(503) 945-6430

Oregon Health Authority, Oregon Educators Benefit Board
Chapter 111

Rule Caption: Clarifying participation requirements for the OEBB benefits program
Adm. Order No.: OEBB 1-2015(Temp)
Filed with Sec. of State: 3-13-2015
Certified to be Effective: 3-13-15 thru 9-8-15
Notice Publication Date:
Rules Amended: 111-020-0010
Subject: OAR 111-020-0010 is amended to clarify participation requirements for the OEBB benefits program and limits Local Governments electing to participate in the OEBB benefits program on or after April 1, 2015 to using the tiered rate structure.
Rules Coordinator: April Kelly—(503) 378-6588

111-020-0010
Entities Electing to Join OEBB

(1) Effective January 1, 2014 an Entity can elect to participate in benefit plans provided by the Board subject to the following conditions:

(a) The Entity completes and submits a Notice of Intent to join OEBB at least 90 days prior to the date OEBB coverage is to go into effect;

(b) OEBB will not transfer any deductibles or annual out-of-pocket maximums met with the prior carrier;

(c) For those members with an existing life insurance policy through the Entity, OEBB will transfer the life insurance amount in force on the last day the prior group coverage was in effect, rounded to the next highest $10,000 increment, if requested and documented by the Entity.

(d) Early retiree participation in the OEBB plans will be limited to those individuals and eligible dependents currently enrolled in the Entity's medical, dental and/or vision plans and those Early Retirees who retire on or after the effective date of OEBB coverage and their eligible dependents.

(2) Entities electing to participate in benefit plans provided by the Board are limited to offering the coverages and plans provided by OEBB for medical, dental, vision, life, AD&D, and disability plans. Entities cannot choose to offer some coverages or plans through OEBB and other coverages or plans outside of the OEBB benefits program.

(3) A Local Government must provide OEBB with medical plan premium rates and loss ratios for the two most-recent years, if available, with its Notice of Intent to join OEBB to allow OEBB's Consultant to perform an actuarial plan comparison. For self-funded groups, two years of claims experience data should be submitted in lieu of premium rates or loss ratios. The results of the actuarial analysis shall be used as follows:

(a) If the actuarial plan comparison for a Local Government demonstrates that costs are less than 10 percent over OEBB's costs during the same two-year period, the Local Government may participate in the OEBB plan(s) at current OEBB rates.

(b) If an actuarial plan comparison for a Local Government demonstrates that costs are equal to or greater than 10 percent higher than OEBB's costs during the same two year period, the Local Government may participate in the OEBB plan(s) subject to a special rate category, or surcharge, for up to three years.

(4) The Local Government must submit a final Letter of Participation to OEBB at least 30 days prior to the effective date of participation.

(5) Local Governments providing a cash incentive to a member for opting-out of medical coverage that exceeds 75 percent of the cost of employee only coverage of the lowest cost OEBB medical plan may be assessed a surcharge of up to $100 per month per opt-out election.

(6) Local Governments who elect to participate in benefit plans provided by the Board and then subsequently elect to leave OEBB and offer a plan or plans available through the health insurance exchange may re-elect to participate in benefit plans provided by the Board under the rate category the Local Government was in just prior to leaving OEBB on a one-time basis provided the Local Government completes and submits a Letter of Participation to OEBB at least 60 days prior to the date OEBB coverage is to go into effect.

(7) Once a Local Government re-elects to participate in benefit plans provided by the Board after leaving, they are not eligible to offer alternative plans through any other source or sponsor.

(8) Local Governments electing to join OEBB on or after April 1, 2015, are limited to using the tiered rate structure for medical, dental and vision plans.

Stat. Auth.: ORS 243.860 – 243.886
Stats. Implemented: ORS 243.864(1)(a)

Hist.: OEBB 11-2013(Temp), f. & cert. ef. 10-11-13 thru 4-8-13; OEBB 22-2013, f. & cert. ef. 12-27-13; OEBB 3-2014, f. & cert. ef. 7-22-14; OEBB 1-2015(Temp), f. & cert. ef. 3-13-15 thru 9-8-15

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Oregon Health Authority, Oregon Prescription Drug Program Chapter 431

Rule Caption: Transferring and Renumbering Prescription Drug Program Rules from OAR chapter 410 to OPDP chapter 431
Adm. Order No.: OPDP 1-2015
Filed with Sec. of State: 2-18-2015
Certified to be Effective: 2-18-15
Notice Publication Date:
Rules Renumbered: 410-121-2000 to 431-121-2000, 410-121-2005 to 431-121-2005, 410-121-2010 to 431-121-2010, 410-121-2020 to 431-121-2020, 410-121-2030 to 431-121-2030, 410-121-2050 to 431-121-2050, 410-121-2065 to 431-121-2065
Subject: The Oregon Prescription Drug Program (OPDP) rules are being removed from the Division of Medical Assistance Program's rules in chapter 410. These rules are being moved and renumbered to the newly created chapter 431 for OPDP.
Rules Coordinator: Betty Wilton—(503) 378-6583

431-121-2000
Definitions

(1) "340B" means Section 340B of the Public Health Service Act, "Limitation on Prices of Drugs Purchased by Covered Entities," and any and all related rules, guidance, interpretations, and operational directives adopted by the federal Health Resources and Services Administration (HRSA) or any other governmental agency with jurisdiction over the enforcement of Section 340B.

(2) "Administrator" means the Administrator of the Oregon Prescription Drug Program (OPDP).

(3) "Authority" means the Oregon Health Authority.

(4) "Critical Access Pharmacy (CAP)" means a pharmacy in Oregon that is further than a ten-mile radius from any other pharmacy. If one CAP's ten-mile radius intersects with that of another CAP, both shall be considered a CAP if either CAP's closure could result in impaired access for rural areas.

(5) "Designated Entity" means an entity contracted by the Authority to perform administrative duties of the OPDP including but not limited to determining program prices, processing and paying claims, issuing identification cards, maintaining eligibility files, network development maintenance, and performing replenishment administration. Designated entities may include but are not limited to pharmacy benefits managers, third party administrators, insurance carriers, health maintenance organizations (HMOs), mail order and specialty drug suppliers, replenishment administrators, group purchasing organizations, and wholesalers.

(6) "Discount Card Program" or "DCP" means a state pharmacy benefit program for eligible uninsured individuals pursuant to ORS 414.312(4)(e) administered by the OPDP.

(7) "Group Purchasing Organization (GPO)" means any organization purchasing on a group basis established to meet the criteria of the Nonprofit Institutions Act, 15 USC 13c, or that is exempt under the Robinson Patman Antidiscrimination Act, 15 USC 13, or is a governmental entity performing traditional government functions.

(8) "Mail Order Pharmacy" means a pharmacy that fulfills prescriptions by mail or other delivery service.

(9) "Member" means individuals enrolled in a participating program to receive services under the OPDP.

(10) "Participating Program" means:

(a) A group, facility, or entity that is eligible to participate in the OPDP pursuant to ORS 414.312(4) and has a participation agreement with the OPDP; or

(b) A DCP for individual Oregon residents who lack or are underinsured for prescription drug coverage pursuant to ORS 414.312(4)(e).

(11) "Pharmacy Benefit Manager (PBM)" means an entity that negotiates and executes contracts with pharmacies, manages Preferred Drug Lists (PDL), negotiates rebates with prescription drug manufacturers, and serves as an intermediary between the Administrator, prescription drug manufacturers, and pharmacies.

(12) "Pharmacy Provider" means retail, mail order, and specialty drug outlets that participate in the OPDP and that contract with the Authority or a designated entity as a pharmacy provider.

(13) "Preferred Drug List (PDL)" means a list of preferred prescription drugs in selected classes that the Authority, in consultation with the Office for Oregon Health Policy and Research (OHPR), has determined represent the most effective drugs available at the best possible price.

(14) "Prescription Drug" means:

(a) A drug prescribed by a prescribing practitioner;

(b) Supplies necessary to administer a prescription drug in a safe and effective manner, including but not limited to inhaler, spacers, diabetic test strips, syringes, and meters.

(15) "Prescribing Practitioner" means a physician or other practitioner authorized by law to prescribe prescription drugs.

(16) "Prescription Drug Claims Processor" (PDCP) means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the OPDP, and processes payments to pharmacies.

(17) "Program Price" means the reimbursement rates and prescription drug prices established by the OPDP Administrator directly or indirectly through a contract with a designated entity, including program cost, dispensing or administration fees, and all applicable manufacturers discounts and rebates.

(18) "Rebate" means all payments or discounts whether retrospective or not, including promotional or volume-related refunds, incentives or other credits however characterized, pre-arranged with pharmaceutical companies on certain prescription drugs, which are paid to or on behalf of OPDP or a designated entity, and are directly attributable to the utilization of certain drugs by members including administrative fees and software or data fees paid by pharmaceutical companies to OPDP or a designated entity. Rebate includes all rebates, discounts, payments or benefits (however characterized) generated by participating program's claims, or derived from any other payment or benefit for the dispensing of prescription drugs or classes or brands of drugs within participating program or arising out of any relationships OPDP or designated entity has with pharmaceutical companies, including but not limited to rebate sharing, market share allowances, educational allowances, gifts, promotions, or other form of revenue.

(19) "Replenishment Administration" means tracking GPO or 340B program usage by pharmacy providers and ordering replacement inventory including associated reporting; GPO and 340B retail and mail order pharmacy contracting; GPO and 340B contracting; or as otherwise defined by contract.

(20) "Retail Pharmacy" means a pharmacy in a retail store and excludes any mail order pharmacy or specialty pharmacy.

(21) "Specialty Pharmacy" means a pharmacy provider where specialty drugs are dispensed and delivered to members or to prescribing practitioners for members.

(22) "Third Party Administrator (TPA)" means an entity that, in addition to being a PDCP, facilitates program management including processing and paying prescription drug claims; transmitting prescription drug prices and claims and enrollment data between pharmacies and the OPDP and its participating programs; maintaining enrollment and issuing identification cards; and processing payments to pharmacies. The TPA may be contracted through the Authority or PBMs, or other designated entities.

Stat. Auth.: ORS 414.320
Stats. Implemented: ORS 414.312 - 414.320
Hist.: OHP 1-2004, f. & cert. ef. 9-24-04; OHP 2-2006(Temp), f. & cert. ef. 11-28-06 thru 5-23-07; OHP 2-2007(Temp), f. & cert. ef. 5-16-07 thru 11-6-07; OHP 3-2007, f. & cert. ef. 8-3-07; OHP 3-2009, f. & cert. ef. 10-1-09; Renumbered from 409-030-0000 by DMAP 1-2011, f. 2-10-11, cert. ef. 3-1-11; DMAP 10-2012, f. 3-6-12, cert. ef. 3-13-12; Renumbered from 410-121-2000, OPDP 1-2015, f. & cert. ef. 2-18-15

431-121-2005
General Administration

(1) The Administrator, or designee, may:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers and GPOs;

(b) Purchase prescription drugs on behalf of participating programs;

(c) Contract with a PDCP or PBM to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse or replenish pharmacies for prescription drugs dispensed or transferred;

(e) Adopt and implement a PDL for the OPDP;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participating programs; and

(g) Cooperate with any state or regional consortia in bulk purchasing of prescription drugs.

(2) The Administrator or designated entity shall oversee the implementation of the OPDP, including review of member eligibility informa-

tion, participating program information, and pharmacy provider compliance with program requirements. The Administrator, or designated entity, shall review records or other information, including health information, necessary to perform oversight responsibilities.

(3) The Administrator shall establish processes, terms, and conditions describing how the entities identified in ORS 414.312(4) may participate in the OPDP as a participating program, including entities otherwise subject to ORS 731.036(6).

(4) The Administrator or designated entity may contract with a PBM and directly or indirectly with pharmacy providers as the Administrator or designated entity considers necessary to maintain statewide access for OPDP members including consideration for CAP providers.

(5) The Administrator or designated entity may contract with replenishment administrators, GPO's, 340B providers, and pharmacy providers as necessary to utilize discount purchasing programs.

(6) Annually, no later than November 1, the Office of Rural Health shall determine any Oregon pharmacies that meet CAP status and report them to the OPDP for CAP designation. OPDP shall send the current list of all Oregon retail pharmacies to the Office of Rural Health no later than October l each year.

(7) Pursuant to ORS 414.312(5), the state agency that receives federal Medicaid funds and is responsible for implementing the state's medical assistance program may not participate in the program. The phrase "state agency" for this purpose means the Authority, which is the state Medicaid agency that administers funds from Title XIX of the Social Security Act, and is responsible for implementing the state's Medicaid program. State agency does not include other programs or functions within the Authority that do not receive federal Medicaid funds, such as the Public Employees' Benefit Board and the Oregon Educators Benefit Board.

Stat. Auth.: ORS 414.320
Stats. Implemented: ORS 414.312 - 414.320
Hist.: OHP 1-2004, f. & cert. ef. 9-24-04; OHP 2-2006(Temp), f. & cert. ef. 11-28-06 thru 5-23-07; Administrative Correction, 6-16-07; OHP 3-2007, f. & cert. ef. 8-3-07; OHP 3-2009, f. & cert. ef. 10-1-09; Renumbered from 409-030-0005 by DMAP 1-2011, f. 2-10-11, cert. ef. 3-1-11; DMAP 10-2012, f. 3-6-12, cert. ef. 3-13-12; Renumbered from 410-121-2005, OPDP 1-2015, f. & cert. ef. 2-18-15

431-121-2010
Pharmacy Providers

(1) The pharmacy shall contract with the Authority, or its designated entity, and must be licensed with their state Board of Pharmacy to be a pharmacy provider for the OPDP.

(2) The pharmacy provider must sign a pharmacy provider contract and comply with all applicable state and federal laws, regulations, rules, and the terms and conditions of the contract. The contract authorizes the pharmacy provider to serve members in the OPDP and outlines program compliance requirements.

(3) A contract may be issued to a qualified pharmacy provider upon:

(a) Completion and signature of the contract by the pharmacy provider or a person authorized by the pharmacy provider to bind the organization;

(b) Verification of Pharmacy licensing with their State Board of Pharmacy; and

(c) Approval of the contract by the Authority or its designated entity.

(4) To contract for the OPDP, the pharmacy provider must:

(a) Accept the program price in effect on the date of the transaction as established by the Administrator or designated entity including but not limited to dispensing fees which may be charged to the member;

(b) Maintain sufficient documentation of transactions to resolve disagreements with the member or participating program about the amount charged for the prescription drugs;

(c) Reimburse the member or participating program directly for overcharges as determined by program price in effect on the date of the transaction;

(d) Provide access to records and data required by the designated entity to administer claims, reimbursement, and other tasks as necessary for OPDP claims processing; and

(e) Not charge members for costs incurred by the pharmacy provider for the electronic transmittal of the program price from the Authority to the pharmacy.

(5) Pharmacy providers may advertise participation in the OPDP, provided that:

(a) Advertising or marketing materials must be accurate and not misleading or confusing to members or the public about participation in the OPDP or the savings offered by the pharmacy provider.

(b) The pharmacy provider must cease all advertisements pertaining to participation in the program if the Authority suspends or terminates the contract.

(6) The Administrator or designated entity shall, at its discretion, suspend or remove a pharmacy provider from the OPDP if the pharmacy provider loses licensure or fails to comply with applicable state and federal laws, rules, and regulations, and the terms and conditions of the contract.

Stat. Auth.: ORS 414.320
Stats. Implemented: ORS 414.312 - 414.320
Hist.: OHP 1-2004, f. & cert. ef. 9-24-04; OHP 2-2007(Temp), f. & cert. ef. 5-16-07 thru 11-6-07; OHP 3-2007, f. & cert. ef. 8-3-07; OHP 3-2009, f. & cert. ef. 10-1-09; Renumbered from 409-030-0010 by DMAP 1-2011, f. 2-10-11, cert. ef. 3-1-11; DMAP 10-2012, f. 3-6-12, cert. ef. 3-13-12; Renumbered from 410-121-2010, OPDP 1-2015, f. & cert. ef. 2-18-15

431-121-2020
Program Price

(1) The price for a prescription drug a pharmacy provider may charge a member under the OPDP is the lesser of the following on the date of the transaction:

(a) The program price, or

(b) The pharmacy provider's usual and customary price, including program cost and dispensing fee.

(2) The designated entity shall transmit the price of the prescription drugs to the pharmacy providers electronically.

(3) The OPDP is limited to prescription drugs prescribed in the name of and for the use by the member, except as otherwise provided in section (7) of this rule.

(4) Prescription drug benefit access shall be available on member identification cards.

(5) The OPDP does not include prescriptions for over-the-counter drugs.

(6) The Administrator, or designated entity, may establish different program prices for CAP providers in rural areas to maintain statewide access to the OPDP.

(7) Unique pricing arrangements may be agreed upon between pharmacy providers and designated entity to accommodate group purchasing or 340B pricing for qualified entities.

Stat. Auth.: ORS 414.320
Stats. Implemented: ORS 414.312 - 414.320
Hist.: OHP 1-2004, f. & cert. ef. 9-24-04; OHP 2-2006(Temp), f. & cert. ef. 11-28-06 thru 5-23-07; OHP 2-2007(Temp), f. & cert. ef. 5-16-07 thru 11-6-07; OHP 3-2007, f. & cert. ef. 8-3-07; OHP 3-2009, f. & cert. ef. 10-1-09; Renumbered from 409-030-0020 by DMAP 1-2011, f. 2-10-11, cert. ef. 3-1-11; DMAP 10-2012, f. 3-6-12, cert. ef. 3-13-12; Renumbered from 410-121-2020, OPDP 1-2015, f. & cert. ef. 2-18-15

431-121-2030
Preferred Drug List

(1) The Administrator shall consider any PDL developed and recommended by OHPR that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the OPDP by participating programs.

(2) The OPDP shall develop a PDL that participating programs may choose to adopt for beneficiaries of their prescription drug benefit program. The PDL shall include the most effective prescription drugs at the lowest possible prices, taking into account negotiated price discounts and rebates available to the OPDP, while allocating and distributing the operational costs of the OPDP.

(3) If a participating program uses the PDL developed by the OPDP, it must be used in conjunction with that participating program's benefit plan including all pharmacy management programs the participating program has or adopts.

(4) OPDP shall make the PDL available to individuals enrolled in the OPDP.

Stat. Auth.: ORS 414.320
Stats. Implemented: ORS 414.312 - 414.320
Hist.: OHP 1-2004, f. & cert. ef. 9-24-04; OHP 3-2009, f. & cert. ef. 10-1-09; Renumbered from 409-030-0030 by DMAP 1-2011, f. 2-10-11, cert. ef. 3-1-11; DMAP 10-2012, f. 3-6-12, cert. ef. 3-13-12; Renumbered from 410-121-2030, OPDP 1-2015, f. & cert. ef. 2-18-15

431-121-2050
Enrollment

(1) Participating programs, other than the DCP, shall enroll for participation through the designated entity chosen by the OPDP to administer the participating program's enrollment and claims processing.

(a) Eligibility for members of a participating program shall be maintained electronically between the participating program and designated entity.

(b) Participating programs or designated entities shall issue identification cards to members at initial enrollment and renewal, and between those times as needed.

(2) Residents of Oregon who do not have prescription drug coverage or who are underinsured for prescription drug coverage may be individually enrolled by the designated entity.

(a) The designated entity shall issue identification cards to members.

(b) Individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

(3) The OPDP may charge a nominal fee to participate in the program.

Stat. Auth.: ORS 414.320

Stats. Implemented: ORS 414.312 - 414.320

Hist.: OHP 1-2004, f. & cert. ef. 9-24-04; OHP 2-2006(Temp), f. & cert. ef. 11-28-06 thru 5-23-07; OHP 2-2007(Temp), f. & cert. ef. 5-16-07 thru 11-6-07; OHP 3-2007, f. & cert. ef. 8-3-07; OHP 3-2009, f. & cert. ef. 10-1-09; Renumbered from 409-030-0050 by DMAP 1-2011, f. 2-10-11, cert. ef. 3-1-11; DMAP 10-2012, f. 3-6-12, cert. ef. 3-13-12; Renumbered from 410-121-2050, OPDP 1-2015, f. & cert. ef. 2-18-15

431-121-2065
Contracted Services

(1) The Administrator may procure goods and services to perform any of the functions of OPDP.

(2) The Administrator shall delegate procurement authority to the Authority's designated Procurement Officer for OPDP goods and services, except as the Administrator determines to retain such authority in a particular case and as otherwise provided in section (4) of this rule.

(3) The Administrator shall act as the Authority's representative for each contract. The Administrator may delegate in writing the representative's responsibilities to a designee. The agency's representative may participate with the Authority's designated Procurement Officer in all aspects of procurement.

(4) OPDP's mechanism for and administration of the enrollment of participating groups shall not constitute procurements subject to this rule.

Stat. Auth.: ORS 414.312

Stats. Implemented: ORS 414.312, 414.314, 414.316 & 414.318

Hist.: OHP 3-2007, f. & cert. ef. 8-3-07; OHP 3-2009, f. & cert. ef. 10-1-09; OHP 2-2010(Temp) f. 4-20-10, cert. ef. 4-21-10 thru 10-17-10; OHP 6-2010, f. 9-23-10, cert. ef. 10-1-10; Renumbered from 409-030-0065 by DMAP 1-2011, f. 2-10-11, cert. ef. 3-1-11; DMAP 10-2012, f. 3-6-12, cert. ef. 3-13-12; Renumbered from 410-121-2065, OPDP 1-2015, f. & cert. ef. 2-18-15

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Oregon Health Authority, Public Health Division Chapter 333

Rule Caption: Hospital Satellite Providing Emergency Psychiatric Services
Adm. Order No.: PH 6-2015(Temp)
Filed with Sec. of State: 2-20-2015
Certified to be Effective: 2-20-15 thru 8-18-15
Notice Publication Date:
Rules Amended: 333-500-0010, 333-500-0025
Subject: The Oregon Health Authority (Authority), Public Health Division, is temporarily amending administrative rules in chapter 333, division 500 relating to hospitals that provide emergency psychiatric services and inpatient psychiatric services in a satellite location. The Authority has determined that rules recently adopted created an unintended gap and that the intent might be misunderstood by hospitals. These temporary rules address that gap and provide further clarification on intent.
Rules Coordinator: Brittany Sande—(971) 673-1291

333-500-0010
Definitions

As used in OAR chapter 333, divisions 500 through 535, unless the context requires otherwise, the following definitions apply:

(1) "Assessment" means a complete nursing assessment, including:

(a) The systematic and ongoing collection of information to determine an individual's health status and need for intervention;

(b) A comparison with past information; and

(c) Judgment, evaluation, or a conclusion that occurs as a result of subsections (a) and (b) of this definition.

(2) "Authentication" means verification that an entry in the patient medical record is genuine.

(3) "Authority" means the Oregon Health Authority.

(4) "Certified Nursing Assistant" (CNA) means a person who is certified by the Oregon State Board of Nursing (OSBN) to assist licensed nursing personnel in the provision of nursing care.

(5) "Chiropractor" means a person licensed under ORS chapter 684 to practice chiropractic.

(6) "Conditions of Participation" mean the applicable federal regulations that hospitals are required to comply with in order to participate in the federal Medicare and Medicaid programs.

(7) "Deemed" means a health care facility that has been inspected by an approved accrediting organization and has been approved by the Centers for Medicare and Medicaid Services (CMS) as meeting CMS Conditions of Participation.

(8) "Discharge" means the release of a person who was an inpatient of a hospital and includes:

(a) The release and transfer of a newborn to another facility, but not a transfer between acute care departments of the same facility;

(b) The release of a person from an acute care section of a hospital for admission to a long-term care section of a facility;

(c) Release from a long-term care section of a facility for admission to an acute care section of a facility;

(d) A patient who has died; and

(e) An inpatient who leaves a hospital for purposes of utilizing non-hospital owned or operated diagnostic or treatment equipment, if the person does not return as an inpatient of the same health care facility within a 24-hour period.

(9) "Direct ownership" has the meaning given the term 'ownership interest' in 42 CFR 420.201.

(10) "Division" means the Public Health Division within the Authority.

(11) "Emergency Medical Services" means medical services that are usually and customarily available at the respective hospital in an emergency department and that must be provided immediately to sustain a person's life, to prevent serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or to provide care to a woman in labor where delivery is imminent if the hospital is so equipped and, if the hospital is not equipped, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm.

(12) "Emergency Psychiatric Services" means mental health services that are usually and customarily available at the respective hospital and that must be provided immediately to prevent harm to the patient or others including but not limited to triage and assessment; observation and supervision; crisis stabilization; crisis intervention; and crisis counseling.

(13) "Financial interest" means a five percent or greater direct or indirect ownership interest.

(14) "Full compliance survey" means a survey conducted by the Division following a complaint investigation to determine a hospital's compliance with the CMS Conditions of Participation.

(15) "Governing body" means the body or person legally responsible for the direction and control of the operation of the hospital.

(16) "Governmental unit" has the meaning given that term in ORS 442.015.

(17) "Health care facility" (HCF) has the meaning given the term in ORS 442.015.

(18) "Health Care Facility Licensing Laws" means ORS 441.005 through 441.990 and its implementing rules.

(19) "Hospital" has the meaning given that term in ORS 442.015.

(20) "Indirect ownership" has the meaning given the term 'indirect ownership interest' in 42 CFR 420.201.

(21) "Licensed" means that the person to whom the term is applied is currently licensed, certified or registered by the proper authority to follow his or her profession or vocation within the State of Oregon, and when applied to a hospital means that the facility is currently licensed by the Authority.

(22) "Licensed nurse" means a nurse licensed under ORS chapter 678 to practice registered or practical nursing.

(23) "Licensed Practical Nurse" means a nurse licensed under ORS chapter 678 to practice practical nursing.

(24) "Major alteration" means any structural change to the foundation, roof, floor, or exterior or load bearing walls of a building, or the extension of an existing building to increase its floor area. Major alteration also means the extensive alteration of an existing building such as to change its function and purpose, even if the alteration does not include any structural change to the building.

(25) "Manager" means a person who:

(a) Has authority to direct and control the work performance of nursing staff;

(b) Has authority to take corrective action regarding a violation of law or a rule or a violation of professional standards of practice, about which a nursing staff has complained; or

(c) Has been designated by a hospital to receive the notice described in ORS 441.174(2).

(26) "Minor alteration" means cosmetic upgrades to the interior or exterior of an existing building, such as but not limited to wall finishes, floor coverings and casework.

(27) "Mobile Satellite" means a MRI, CAT Scan, Lithotripsy Unit, Cath Lab, or other such modular outpatient treatment or diagnostic unit that is capable of being moved, is housed in a vehicle with a vehicle identification number (VIN), and does not remain on a hospital campus for more than 180 days in any calendar year.

(28) "NFPA" means National Fire Protection Association.

(29) "Nurse Midwife/Nurse Practitioner" means a registered nurse certified by the OSBN as a nurse midwife/nurse practitioner.

(30) "Nurse Practitioner" has the meaning given that term in ORS 678.010.

(31) "Nursing staff" means a registered nurse, a licensed practical nurse, or other assistive nursing personnel.

(32) "OB Unit" means a dedicated obstetrical unit that meets the requirements of OAR 333-535-0120.

(33) "On-call" means a scheduled state of availability to return to duty, work-ready, within a specified period of time.

(34) "Oregon Sanitary Code" means the Food Sanitation Rules in OAR 333-150-0000.

(35) "Patient audit" means review of the medical record or physical inspection or interview of a patient.

(36) "Person" has the meaning given that term in ORS 442.015.

(37) "Physician" means a person licensed as a doctor of medicine or osteopathy under ORS chapter 677.

(38) "Physician Assistant" has the meaning given that term in ORS 677.495.

(39) "Plan of correction" means a document executed by a hospital in response to a statement of deficiency issued by the Division that describes with specificity how and when deficiencies of health care licensing laws or conditions of participation shall be corrected.

(40) "Podiatrist" has the same meaning as "podiatric physician and surgeon" in ORS 677.010.

(41) "Podiatry" means the diagnosis or the medical, physical or surgical treatment of ailments of the human foot, except treatment involving the use of a general or spinal anesthetic unless the treatment is performed in a licensed hospital or in a licensed ambulatory surgical center and is under the supervision of or in collaboration with a physician. "Podiatry" does not include the administration of general or spinal anesthetics or the amputation of the foot.

(42) "Public body" has the meaning given that term in ORS 30.260.

(43) "Registered Nurse" means a person licensed under ORS chapter 678 to practice registered nursing.

(44) "Respite care" means care provided in a temporary, supervised living arrangement for individuals who need a protected environment, but who do not require acute nursing care or acute medical supervision.

(45) "Retaliatory action" means the discharge, suspension, demotion, harassment, denial of employment or promotion, or layoff of a nursing staff person directly employed by the hospital, or other adverse action taken against a nursing staff person directly employed by the hospital in the terms or conditions of employment of the nursing staff person, as a result of filing a complaint.

(46) "Satellite" means a building or part of a building owned or leased by a hospital, and operated by a hospital in a geographically separate location from the hospital, with a separate physical address from the hospital but that is within 35 miles from the hospital, through which the hospital provides:

(a) Outpatient diagnostic, therapeutic, or rehabilitative services; or

(b) Psychiatric services in accordance with OAR 333-525-0000 including:

(A) Inpatient psychiatric services; and

(B) Emergency psychiatric services through an emergency department in accordance with OAR 333-520-0070.

(47) "Special Inpatient Care Facility" means a facility with inpatient beds and any other facility designed and utilized for special health care purposes that may include but is not limited to a rehabilitation center, a facility for the treatment of alcoholism or drug abuse, a freestanding hospice facility, or an inpatient facility meeting the requirements of ORS 441.065, and any other establishment falling within a classification established by the Division, after determination of the need for such classification and the level and kind of health care appropriate for such classification.

(48) "Stable newborn" means a newborn who is four or more hours post-delivery and who is free from abnormal vital signs, color, activity, muscle tone, neurological status, weight, and maternal-child interaction.

(49) "Stable postpartum patient" means a postpartum mother who is four hours or more postpartum and who is free from any abnormal fluctuations in vital signs, has vaginal flow within normal limits, and who can ambulate, be independent in self-care, and provide care to her newborn infant, if one is present.

(50) "Statement of deficiencies" means a document issued by the Division that describes a hospital's deficiencies in complying with health care facility licensing laws or conditions of participation.

(51) "Survey" means an inspection of a hospital to determine the extent to which a hospital is in compliance with health facility licensing laws and conditions of participation.

Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.025
Hist.: HB 183, f. & ef. 5-26-66; HB 209, f. 12-18-68; HD 11, f. 3-16-72, ef. 4-1-72; HD 11-1980, f. & ef. 9-10-80, HD 8-1985, f. & ef. 5-17-85; Renumbered from 333-023-0114; HD 13-1987, f. 9-1-87, ef. 9-15-87; HD 23-1987(Temp), f. 11-27-87, ef. 10-15-87 through 4-15-88; HD 10-1988, f. & cert. ef. 5-27-88; HD 29-1988, f. 12-29-88, cert. ef. 1-1-89, Renumbered from 333-070-0000; HD 21-1993, f. & cert. ef. 10-28-93; HD 30-1994, f. & cert. ef. 12-13-94; OHD 2-2000, f. & cert. ef. 2-15-00; OHD 20-2002, f. & cert. ef. 12-10-02; PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 17-2012, f. 12-20-12, cert. ef. 1-1-13; PH 5-2015, f. & cert. ef. 2-6-15; PH 6-2015(Temp), f. & cert. ef. 2-20-15 thru 8-18-15

333-500-0025
Indorsement of Satellite Operations

(1) The Division may indorse, under a hospital's license, a satellite or mobile satellite of a hospital.

(2) In order for a satellite to be indorsed under a hospital's license, the applicant or licensee shall pay the appropriate fee and provide evidence to the Division that:

(a) The satellite meets the requirements in OAR chapter 333, divisions 500 through 535;

(b) The services at the satellite are integrated with the hospital;

(c) The financial operations of the satellite are integrated with the hospital;

(d) The hospital and the satellite have the same governing body;

(e) The satellite is under the ownership and control of the hospital;

(f) Staff at the satellite have privileges at the hospital;

(g) Medical records of the satellite are integrated with the hospital into a unified system; and

(h) The facility is not subject to certificate of need requirements in ORS 442.315 to 442.361.

(3) A satellite shall be subject to a plans review and must pass life safety code requirements.

(4) In order for a mobile satellite to be indorsed under a hospital's license, the applicant or licensee shall pay the appropriate fee and provide evidence to the Division that:

(a) The mobile satellite is operated in whole or in part by the hospital through lease, ownership or other arrangement;

(b) The services at the mobile satellite are integrated with the hospital;

(c) The financial operations of the mobile satellite are integrated with the hospital;

(d) The mobile satellite is physically separate from the hospital and other buildings on the hospital campus by at least 20 feet; and

(e) It meets the 2000 NFPA 101 Life Safety Code for mobile units.

(5) A mobile satellite shall keep and provide to the Division and the Fire Marshal upon request, a log that shows where the mobile satellite is located every day of the year, and its use. A copy of the log shall be kept in the mobile satellite at all times.

(6) A hospital that has a satellite that provides inpatient services that is indorsed under its license as of October 1, 2009, may continue to have that satellite indorsed under its license. On or after October 1, 2009, a satellite must meet the definition of satellite in OAR 333-500-0010(46) and comply with all other rules related to satellites in order to have a satellite indorsed under a hospital license.

(7) Nothing in these rules is meant to:

(a) Prevent a satellite as defined in OAR 333-500-0010(46) from providing outpatient medical services; or

(b) Permit the indorsement of satellite under a hospital license as a means to circumvent the certificate of need laws in ORS chapter 442 and OAR chapter 333, divisions 545 through 670.

Stat. Auth.: ORS 441.025
Stats. Implemented: ORS 441.020
Hist.: PH 11-2009, f. & cert. ef. 10-1-09; PH 26-2010, f. 12-14-10, cert. ef. 12-15-10; PH 5-2015, f. & cert. ef. 2-6-15; PH 6-2015(Temp), f. & cert. ef. 2-20-15 thru 8-18-15

Oregon Health Insurance Exchange
Chapter 945

Rule Caption: Transition of authority over Oregon Health Insurance Exchange, Senate Bill 1 (2015) implementation.
Adm. Order No.: OHIE 1-2015(Temp)
Filed with Sec. of State: 3-11-2015
Certified to be Effective: 3-11-15 thru 9-4-15
Notice Publication Date:
Rules Adopted: 945-040-0005, 945-050-0005
Rules Amended: 945-001-0011, 945-020-0010, 945-020-0020, 945-030-0020, 945-030-0030, 945-030-0040, 945-030-0045
Rules Suspended: 945-010-0001, 945-010-0006, 945-010-0011, 945-010-0021, 945-010-0031, 945-010-0041, 945-010-0051, 945-010-0061, 945-010-0071, 945-010-0081, 945-010-0091, 945-010-0101
Subject: Conforms the administrative rules of the Oregon Health Insurance Exchange to SB 1 Enrolled (2015), which abolishes the exchange Board of Directors and Executive Director and transitions authority for the Oregon Health Insurance Exchange to the Director of the Department of Consumer and Business Services.
Rules Coordinator: Gregory Jolivette—(503) 373-9406

945-001-0011
Delegation of Rulemaking Authority

Any officer or employee of the Oregon Health Insurance Exchange who is identified on a completed Delegation of Authority form signed by the Director or Deputy Director of the Department of Consumer and Business Services and filed with the Secretary of State, Administrative Rules Unit, is vested with the authority to adopt, amend, repeal, or suspend administrative rules as provided on that form until the delegation is revoked by the Director or Deputy Director, or the person leaves employment with the Exchange.

Stat. Auth: ORS 183.341 & 2011 OL Ch. 415, Sec. 3(5) (2015 SB 1)
Stats. Implemented: ORS 183.330, 183.335 & 183.341
Hist.: OHIE 1-2012, f. & cert. ef. 3-6-12; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0001
Employee Criminal Records Check and Fitness Determination Rule

Statement of Purpose: These rules provide for the reasonable screening of subject individuals to determine if they have a history of criminal behavior such that they are not fit to be employed or volunteer in positions covered by OAR 945-010-0011. A determination by the Corporation that a subject individual is fit does not guarantee the individual a position with the corporation in any capacity.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0006
Definitions

As used in OAR chapter 945, division 010, unless the context of the rule requires otherwise, the following definitions apply:

(1) Conviction: A final judgment on a verdict or finding of guilty, a plea of guilty, a plea of nolo contendere (no contest); or any determination of guilt entered by a court of law against a subject individual in a criminal case unless that judgment has been reversed or set aside by a subsequent court decision.

(2) Corporation: The Oregon Health Insurance Exchange Corporation.

(3) Criminal Offender Information: Records and related data as to physical description and vital statistics; fingerprints received and compiled by the Oregon Department of State Police, Bureau of Criminal Identification, for purposes of identifying criminal offenders and alleged offenders; and records of arrests and the nature and disposition of criminal charges, including sentencing, confinement, parole, and release.

(4) Criminal Records Check: One or more of the following three processes used by the Corporation to check the criminal history of a subject individual:

(a) A name-based check of criminal offender information conducted through use of the Law Enforcement Data System (LEDS) maintained by the Oregon Department of State Police, in accordance with the rules adopted and procedures established by the Oregon Department of State Police (LEDS Criminal Records Check);

(b) A check of Oregon criminal offender information through fingerprint identification, conducted by the Oregon Department of State Police at the Corporation's request (Oregon Criminal Records Check); or

(c) A nationwide check of federal criminal offender information through fingerprint identification, conducted by the Oregon Department of State Police through the Federal Bureau of Investigation at the Corporation's request (Nationwide Criminal Records Check).

(5) Criminal records request form: A Corporation-approved form, completed by a subject individual, requesting the Corporation to conduct a criminal records check.

(6) False Statement: In association with an activity governed by these rules, a subject individual either:

(a) Provided the corporation with materially false information about his or her criminal history, such as, but not limited to, materially false information about his or her identity or conviction record; or

(b) Failed to provide to the corporation information material to determining his or her criminal history.

(7) Fitness Determination: A determination made by the corporation pursuant to the process established in OAR 945-010-0031 that a subject individual is or is not fit to be a corporation employee or to provide services in a position covered by 945-010-0011.

(8) Subject Individual: An individual identified in OAR 945-010-0021 as someone from whom the corporation may require a criminal records check.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0011
Subject Individual

The Health Insurance Exchange Corporation may require an individual to complete a criminal records check pursuant to these rules because the person:

(1) Works or has applied to work for the corporation; or

(2) Is or will be providing services to the corporation in the areas of:

(a) Information technology services;

(b) Payroll functions or financial transactions;

(c) Mailroom duties;

(d) Auditing responsibilities;

(e) Personnel or human resources functions;

(f) Tax or financial information; or

(g) Working with information that is confidential, including access to Social Security numbers, dates of birth or criminal background information.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0021
Criminal Records Check Required

The corporation may conduct, or request the Oregon Department of State Police to conduct, a criminal records check when:

(1) An individual meets the definition of a subject individual; or

(2) Required by federal law or regulation, by state or federal administrative rule or by contract or written agreement with the corporation.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0031
Criminal Records Check Process

(1) Disclosure of information by Subject Individual

(a) Preliminary to a criminal records check, a subject individual must complete and sign the corporation's criminal records request form and, if requested by the corporation, a fingerprint card. The corporation's criminal records request form will require the following information: name, birth date, social security number, physical characteristics, driver's license or identification card number and current address, prior residency in other states and any other identifying information deemed necessary by the corporation.

(b) A subject individual must complete and submit to the corporation the Criminal Records Request form and, if requested, a fingerprint card within three business days of receiving the forms. The corporation may extend the deadline for good cause.

(c) The corporation may require additional information from the subject individual as necessary to complete the criminal records check and fitness determination, such as, but not limited to, proof of identity; or additional criminal, judicial, or other background information.

(d) The corporation shall not request a fingerprint card from a subject individual under the age of 18 years unless the subject individual is emancipated pursuant to ORS 419B.550 et seq, or unless the corporation also requests the written consent of a parent or guardian. In such case, such parent or guardian and youth must be informed that they are not required to consent. Notwithstanding, failure to consent may be construed as a refusal to consent under OAR 863-003-0050(3).

(2) When the corporation determines under OAR 945-010-0021 that a criminal records check is required, the corporation may request or conduct a LEDS Criminal Records Check, an Oregon Criminal Records Check a Nationwide Criminal Records Check or any combination thereof.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0041
Potentially Disqualifying Crimes

(1) Crimes relevant to a fitness determination:

(a) All felonies;

(b) All misdemeanors; or

(c) Any United States Military crime or international crime.

(2) The corporation shall evaluate a crime on the basis of Oregon laws and, if applicable, federal laws or the laws of any other jurisdiction that are valid and in effect at the time of the fitness determination.

(3) At no time will a subject individual be determined to be not fit under these rules because of a juvenile record that has been sealed or deleted in agreement with ORS 419A.260 and 419A.262.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0051
Final Fitness Determination

(1) If a criminal records check is conducted, the corporation shall make a fitness determination about a subject individual based on:

(a) Information given to the corporation by the subject individual;

(b) Information received as a result of the criminal records check; and

(c) Any false statements made by the subject individual and found during the fitness determination process.

(2) When considering these factors, the corporation may request additional information from the subject individual or any source inside or outside Oregon, including;

(a) Law enforcement;

(b) Criminal justice agencies; or

(c) Courts.

(3) To obtain other criminal offender information from the subject individual, the corporation may request:

(a) To meet with the person;

(b) Written materials from the person; or

(c) Authorization from the person to acquire relevant information from other sources.

(4) If requested, the subject individual must meet with or provide the requested information to the corporation within a reasonable period of time determined by the corporation.

(5) In making the final fitness determination, the corporation will consider:

(a) The nature of the crime;

(b) Facts that support the conviction or pending charge or that indicate the making of a false statement; and

(c) The relevancy, if any, of the crime or the false statement to the specific requirements of the subject individual's present or proposed position, services, or employment.

(d) 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.

(6) If a subject individual refuses to submit information or consent to a criminal records check, including fingerprint identification, the corporation shall deny the employment of the subject individual or deny any applicable position or authority to provide services. A person may not appeal any determination made based on a refusal to consent.

(7) If a subject individual is determined to be not fit, the subject individual may not be employed by the corporation or provide services as a volunteer, contractor or vendor to the corporation in a position covered by OAR 945-010-0011.

(8) A completed final fitness determination is a final order of the corporation unless the affected subject individual appeals by requesting either a contested case hearing as provided by OAR 945-010-0081 or an alternative appeals process as provided by 945-010-0081.

(9) The corporation shall inform the subject individual who has been determined not to be fit on the basis of a criminal records check via personal service or registered or certified mail to the most current address provided by the subject individual.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0061
Hiring On a Preliminary Basis

(1) If the corporation conducts a criminal records check pursuant to these rules, the corporation, in its sole discretion, may hire, appoint or accept services from a subject individual on a preliminary basis pending completion of criminal records check when:

(a) The subject individual has provided all information (including a fingerprint card, if requested) as required by the corporation pursuant to OAR 945-010-0031; and

(b) The corporation, in its sole discretion, determines that it is in the corporation's best interests to hire, appoint, or accept services from the subject individual on a preliminary basis.

(2) A subject individual hired, appointed, or otherwise engaged to perform services on a preliminary basis under this rule may provide services, or participate in training, orientation, or work activities as deemed appropriate by the corporation.

(3) Nothing in this rule shall be construed as requiring the corporation to hire, appoint, or accept services from a subject individual on a preliminary basis.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0071
Incomplete Fitness Determination

(1) The corporation will close a preliminary or final fitness determination as incomplete when:

(a) Circumstances change so that a person no longer meets the definition of a "subject individual" under OAR 945-010-0011;

(b) The subject individual does not provide materials or information under OAR 945-010-0031 within the time frames established under that rule;

(c) The corporation cannot locate or contact the subject individual;

(d) The subject individual fails or refuses to cooperate with the corporation's attempts to acquire other relevant information under OAR 945-010-0031;

(e) The corporation determines that the subject individual is not eligible or not qualified for the position for a reason unrelated to the fitness determination process; or

(f) The position is no longer open.

(2) A subject individual does not have a right to a contested case hearing under OAR 945-010-0081 or a right to an alternate appeals process under 945-010-0081 to challenge the closing of a fitness determination as incomplete.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0081
Contesting a Fitness Determination

(1) Purpose. Sections (2)–(5) of this rule set forth the contested case hearing process a subject individual must use to appeal a completed final fitness determination made under OAR 945-010-0051 that the individual is not fit to hold a position with, or provide services to the corporation as an employee, volunteer, contractor, or vendor. Section (6) of this rule identifies an alternative appeal process available only to current corporation employees, if applicable.

(2) Appeal Process

(a) To request a contested case hearing, the subject individual or the subject individual's legal representative must submit a written request for a contested case hearing to the address specified in the notice provided under OAR 945-010-0031. To be timely, the request must be received by the corporation at the specified address within 14 calendar days of the date stated on the notice. The corporation shall address a request received after expiration of the deadline as provided under 137-003-0528.

(b) When a timely request is received by the corporation under subsection (a), a contested case hearing shall be conducted by an administrative law judge assigned by the Office of Administrative Hearings, pursuant to the Attorney General's Uniform and Model Rules, "Procedural Rules, Office of Administrative Hearings" OAR 137-003-0501 to 137-003-0700, as supplemented by the provision of this rule.

(3) Discovery. The administrative law judge may protect information made confidential by ORS 181.534(15) or other applicable law as provided under OAR 137-003-0570(7) or (8).

(4) No Public Attendance. Contested case hearings on fitness determinations are closed to non-participants.

(5) Proposed and Final Order:

(a) Proposed Order. After a hearing, the administrative law judge will issue a proposed order.

(b) Exceptions. Exceptions, if any, shall be filed within fourteen (14) calendar days after service of the proposed order. The proposed order shall provide an address to which exceptions must be sent.

(c) Default. A completed final fitness determination made under OAR 945-010-0051 becomes final:

(A) unless the subject individual makes a timely request for a hearing; or

(B) when a party withdraws a hearing request, notifies the corporation or the administrative law judge that the party will not appear, or fails to appear at a hearing.

(6) Alternative Process. A subject individual currently employed by the corporation may choose to appeal a fitness determination either under the process made available by this rule or through a process made available by applicable personnel rules and policies, if any. A subject individuals decision to appeal a fitness determination through applicable personnel rules and policies is an election of remedies as to the rights of the individual with respect to the fitness determination and is a waiver of the contested case process made available by this rule.

(7) Remedy. The only remedy that may be awarded is a determination that the subject individual is fit or not fit. Under no circumstances shall the corporation be required to place a subject individual in any position, nor shall the corporation be required to accept services or enter into a contractual agreement with a subject individual.

(8) Challenging Criminal Offender Information. A subject individual may not use the appeals process established by this rule to challenge the accuracy or completeness of information provided by the Oregon Department of State Police, the Federal Bureau of Investigation, or agencies reporting information to the Oregon Department of State Police or the Federal Bureau of Investigation.

(a) To challenge information identified in this section of the rule, a subject individual may use any process made available by the agency that provided the information.

(b) If the subject individual successfully challenges the accuracy or completeness of information provided by the Oregon Department of State Police, the Federal Bureau of Investigation, or an agency reporting information to the Oregon Department of State Police or the Federal Bureau of Investigation, the subject individual may request that the corporation conduct a new criminal records check and re-evaluate the original fitness determination made under OAR 863-003-0050 by submitting a new corporation criminal records request. This provision only applies if the position for which the original criminal history check is vacant and available.

(9)Appealing a fitness determination under section (2) or section (6) of this rule, challenging criminal offender information with the agency that provided the information, or requesting a new criminal records check and re-evaluation of the original fitness determination under section (8)(b) of this rule, will not delay or postpone the corporation's hiring process or employment decisions.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0091
Record Keeping, Confidentiality

Any information obtained in the criminal records check is confidential. The corporation must restrict the dissemination of information obtained in the criminal records check. Only those persons, as identified by the corporation, with a demonstrated and legitimate need to know the information, may have access to criminal records check records.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-010-0101
Fees

(1) The corporation may charge a fee for acquiring criminal offender information for use in making a fitness determination. In any particular instance, the fee shall not exceed the fee(s) charged the corporation by the Oregon Department of State Police and the Federal Bureau of Investigation to obtain criminal offender information on the subject individual.

(2) The corporation may charge a fee to the subject individual on whom criminal offender information is sought, or, if the subject individual is an employee of a corporation contractor and is undergoing a fitness determination in that capacity, the corporation may charge a fee to the subject individual's employer.

Stat. Auth.: SB 99 (2011)
Stats. Implemented:
Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-020-0010
Statutory Authority; Purpose; Applicability

(1) OAR chapter 945, division 20 is adopted pursuant to the general rulemaking authority of the Exchange in ORS 741.002.

(2) The purpose of OAR chapter 945, division 20 is to establish the process for certification of health plans as qualified health plans.

(3) OAR chapter 945, division 20 applies to all qualified health plans offered through the Exchange, except the following:

(a) Multistate plans, as defined in 45 CFR §800.20; and.

(b) Consumer Operated and Oriented Plans (CO-OPs), as defined in 45 CFR §156.505.

Stat. Auth.: ORS 741.002 (2015 SB 1)
Stats. Implemented: ORS 741.310
Hist.: OHIE 3-2012(Temp), f. 9-13-12, cert. ef. 10-1-12 thru 3-13-13; OHIE 4-2012, f. & cert. ef. 12-13-12; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-020-0020
Certification of Qualified Health Plans

Each health benefit plan offered through the Oregon Health Insurance Exchange (Exchange) must have in effect a certification issued by the Exchange. This certification demonstrates that the health benefit plan is a qualified health plan (QHP).

(1) The Exchange will issue a request for applications (RFA). To be considered for participation and plan certification, a health insurance issuer must submit a completed application to the Exchange in the form and manner, and within the timeframes specified by the Exchange.

(2) Conditional approval to participate in the Exchange will be granted to applicants who

(a) Are licensed and in good standing to offer health insurance in Oregon;

(b) Agree to offer at least one standardized QHP at the bronze, silver, and gold levels of coverage;

(c) Meet any other performance standards that may be adopted by the Exchange; and

(d) Agree to contract with the Exchange to offer QHPs. Contracts will require issuers to comply with Exchange standards and requirements, including but not limited to the following:

(A) Transparency in coverage standards;

(B) Accreditation requirements;

(C) Network adequacy standards;

(D) Exchange administrative fees and assessments;

(E) Quality improvement strategies, quality reporting, and enrollee satisfaction surveys;

(F) Exchange agent management program requirements;

(G) Tribal requirements;

(H) Premium tax credit and cost sharing reductions; and

(I) Exchange processes and procedures, including those related to enrollment, enrollment periods, premium payment, terminations of coverage, customer service, and QHP recertification and decertification.

(3) Issuer approval is conditioned upon certification of their health benefit plans. Issuers will be approved for a two-year period. No new issuers will be considered for participation during those two years unless there is a significant loss of statewide coverage.

(4) A loss of statewide coverage may include, but is not limited to, plan discontinuance, withdrawal, decertification, or enrollment closures that result in a lack of coverage choices in a geographic area(s) of the state.

(5) Any health benefit plan an approved issuer wants to offer through the Exchange must be filed with the Oregon Insurance Division and determined to meet applicable benefit design standards and all other insurance regulations as required under state and federal law.

(6) Benefit design standards means coverage that includes, but is not limited to, the following:

(a) The essential health benefits package as defined in 45 CFR §156.20;

(b) Cost sharing limits as defined in 45 CFR §156.130; and

(c) A bronze, silver, gold, or platinum level of coverage as defined in 45 CFR §156.140, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

(7) Subject to any limitation on the number of plans that may be offered through the Exchange, the Exchange will certify health benefit plans that are submitted by approved issuers and determined by the Oregon Insurance Division to meet all applicable standards.

Stat. Auth.: ORS 741.002
Stats. Implemented: ORS 741.310
Hist.: OHIE 3-2012(Temp), f. 9-13-12, cert. ef. 10-1-12 thru 3-13-13; OHIE 4-2012, f. & cert. ef. 12-13-12; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-030-0020
Establishment of Administrative Charge Paid by Insurers

(1) Exchange staff will annually provide a Report on Administrative Charges to the Director of the Department of Consumer and Business Services (Director).

(2) The report will be posted on the Exchange's website for public review and comment.

(3) At a minimum, the report will include

(a) A projection of Exchange operating expenses for the next calendar year,

(b) A projection of Exchange enrollment for the next calendar year, and

(c) A proposed administrative charge for the next calendar year.

(4) The Department will hold a public hearing on a proposed administrative charge.

(5) No later than the end of the first quarter of a calendar year the Director shall amend or approve, an administrative charge for the next calendar year.

(6) Any administrative charge adopted by the Director shall be established in rule.

(7) The administrative charge shall be expressed as a per member per month figure.

(8) The annual administrative charge assessed by the Exchange shall not exceed the limits set forth in ORS 741.105.

Stat. Auth.: ORS 741.002 (2015 SB 1)
Stats. Implemented: ORS 741.105
Hist.: OHIE 1-2013, f. & cert. ef. 3-18-13; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-030-0030
Annual Administrative Charge on Insurers

(1) Effective January 1, 2015, each health insurer offering qualified health plans through the Exchange shall pay a monthly administrative charge equal to $9.66 times the number of members enrolled through the Exchange in that month.

(2) Effective January 1, 2015, each health insurer offering standalone dental plans through the Exchange shall pay a monthly administrative charge equal to $0.97 times the number of members enrolled through the Exchange in that month.

(3) If the total charges collected exceed the maximum amount permissible under ORS 741.105, the Department of Consumer and Business Services will return excess funds to carriers on a pro-rata basis no later than the end of the 2nd quarter of the next calendar year.

Stat. Auth.: ORS 741.002 (2015 SB 1)
Stats. Implemented: ORS 741.105
Hist.: OHIE 1-2013, f. & cert. ef. 3-18-13; OHIE 3-2013(Temp), f. & cert. ef. 5-28-13 thru 11-22-13; OHIE 5-2013, f. & cert. ef. 8-19-13; OHIE 2-2014, f. & cert. ef. 4-15-14; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-030-0040
Assessment and Collection of Administrative Charge on Insurers

(1) The Exchange shall assess the administrative charge on or before the 10th business day of each month.

(2) Each insurer's monthly administrative charge will be based on the number of members enrolled through the Exchange in that month. The administrative charge will be adjusted for any changes to prior months enrollment.

(3) The administrative charge is due in full to the Exchange on the last business day of the month assessed.

(4) For any month in which the insurer does not make full payment within 10 days following the last business day of that month, the Exchange shall impose a late payment charge of 1 percent of the amount due.

(5) If an insurer fails to pay the administrative charge, the Director may:

(a) Close that insurer's Exchange plans to new enrollment until all outstanding charges are paid; and/or

(b) De-certify that insurer's qualified health plans and/or standalone dental plans.

Stat. Auth.: ORS 741.002 (2015 SB 1)
Stats. Implemented: ORS 741.105
Hist.: OHIE 1-2013, f. & cert. ef. 3-18-13; OHIE 3-2013(Temp), f. & cert. ef. 5-28-13 thru 11-22-13; OHIE 5-2013, f. & cert. ef. 8-19-13; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-030-0045
Administrative Assessment on State Programs

(1) The administrative assessment on state programs shall be established in an Intergovernmental Agreement between the Exchange and the Oregon Health Authority.

(2) The administrative assessment, expressed as a per member per month figure, shall be based on the number of individuals enrolled in state programs offered through the Exchange.

(3) The Intergovernmental Agreement shall specify the intervals and manner in which the administrative assessment is to be paid.

(4) Exchange staff will annually report to the Director on the assessment on state programs.

Stat. Auth.: ORS 741.002 (2015 SB 1)
Stats. Implemented: ORS 741.105
Hist.: OHIE 1-2014, f. & cert. ef. 1-16-14; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-040-0005
Scope

OAR 945-040-0060 to 945-040-0180 apply only to Exchange processes for coverage beginning on or before December 31, 2014. For coverage beginning on or after January 1, 2015, the application process and appeals of eligibility determinations are handled by the Center for Consumer Information and Insurance Oversight (CCIIO) through healthcare.gov.

Stat. Auth.: ORS 741.002
Stats. Implemented: ORS 741.500
Hist.: OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-050-0005
Scope

The rules in division 50 apply only to producer certifications on or before December 31, 2014. For coverage beginning on or after January 1, 2015, producer certifications are handled by the Center for Consumer Information and Insurance Oversight (CCIIO).

Stat. Auth.: ORS 741.002
Stats. Implemented: ORS 741.310
Hist.: OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

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Oregon Housing and Community Services Department
Chapter 813

Rule Caption: Requires permanent certificate of occupancy after an application has been submitted to the department.
Adm. Order No.: OHCS 1-2015(Temp)
Filed with Sec. of State: 2-26-2015
Certified to be Effective: 2-26-15 thru 8-24-15

Notice Publication Date:
Rules Amended: 813-013-0035
Subject: The Vertical Housing Program encourages the construction or rehabilitation of properties in targeted areas of communities in order to augment the availability of appropriate housing and to revitalize such communities. These rules set forth relevant aspects of the program, including processes and criteria for the designation of Vertical Housing Development Zones (VHDZs), for the application and approval of certified projects, for the calculation of any applicable partial property tax exemptions, and for the monitoring and maintenance of properties as qualifying certified projects. The amendment would require a permanent certificate of occupancy once an application has been delivered to the department for new construction projects.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-013-0035
Project Certification Applications

(1) A Project Applicant may file an application for certification of a Project by completing the Vertical Housing Project application form, as prescribed by and available from the Department, and by delivering it during normal business hours or by mail to: Oregon Housing and Community Services Vertical Housing, Housing Division 725 Summer Street NE, Suite B PO Box 14508 Salem, Oregon 97309-0409.

(2) Projects must be described in terms of entire tax lots. Projects may not include partial tax lots.

(3) The Project Applicant must provide both a legible and scaled site plan and a legal description of the land for the proposed Project.

(4) To be for 'Residential Use' or for 'Non-Residential use' does not mean that a building floor is actually being occupied accordingly, but rather that it is at least intended and ready for such use and is not converted or occupied for a contrary use.

(5) Low-Income Residential Housing floors or units must be set-aside as such for the entire tax year and occupied only by people who are income eligible in order for the Project to qualify for the low income vertical housing exemptions on land.

(6) The Non-Residential use of a particular floor or floors may be satisfied even if the entire floor is not devoted to that use.

(7) The Department will review applications upon their appropriate delivery subject to, but not limited to:

(a) Applications being complete and consistent with Department requirements; and

(b) Delivery to the Department of an application processing charge, monitoring charge and any other related charges. In determining charges for each Project Applicant, the Department may consider factors including, but not limited to, known and expected costs in processing the application, effecting appropriate monitoring of the Project and otherwise administering the Program with respect to the Project. Payment of charges may be made by check or money order payable to the Department and must be submitted along with the Project Application or as otherwise required by the Department.

(8) For new Construction Projects to qualify for certification, the application must be delivered to the Department before:

(a) The relevant permitting authority has issued a permanent certificate of occupancy; or

(b) If no certificate of occupancy is required, then occupancy otherwise is effectively prevented because the proposed Certified Project has not yet been completed.

(9) For Rehabilitation Projects to qualify for certification, the application must be delivered to the Department at any stage of the Rehabilitation, but not after Rehabilitation work on the Project is complete. The Department may provide a preliminary certification of the Project pending completion of the Rehabilitation of the Project. Notification of the Project's completion, together with appropriate documentation of the actual costs of the Rehabilitation and the real market value of the pre-rehabilitated Project must be forwarded by the Project Applicant to the Department within 90 days of Project completion. The Department may certify all or part of a rehabilitated Project or of a Project where the Rehabilitation is still in progress as a Certified Project.

(10) Project Applicants must provide the following information in a manner satisfactory to the Department:

(a) The address and boundaries of the proposed Project including the tax lot numbers, a legible and scaled site plan of the proposed Project, and a legal description of the land involved in the Project for which a partial tax exemption is sought by the Project Applicant;

(b) A description of the existing condition of the proposed Project property;

(c) A description of the proposed Project including, but not limited to current architectural plans that include verifiable square footage measurements, verified statements of Rehabilitation costs; and designation of the number of Project floors;

(d) A description of all Non-Residential Areas with related and total square footages, and identification of all non-residential uses;

(e) A description of all Residential Uses and residential areas with related and total residential square footages;

(f) A description of the number and nature of Low-Income Residential Housing units with related and total Low-Income Residential Housing square footages;

(g) Confirmation that the Project is entirely located in an established VHDZ;

(h) A commitment from the Project Applicant, acceptable to the Department, that the Project will be maintained and operated in a manner consistent with the Project application and the Program for a time period acceptable to the Department and not less than the term of any related property tax exemption;

(i) A calculation quantifying the various uses of the Project in total and by each Equalized Floor including allocations to Residential Uses, the allocations to Low-Income Residential Housing uses, and the allocations to Non-Residential Areas; and;

(j) Such other information as the Department, in its discretion, may require.

(11) The Project application must be submitted and received by the Department on or before the new Construction residential units are ready for occupancy or the Project Rehabilitation is complete;

(12) The Department may request such other information from a Project Applicant and undertake any investigation that it deems appropriate in processing any Project application or in the monitoring of a Certified Project. By filing an application, a Project Applicant irrevocably agrees to allow the Department reasonable access to the Project and to Project-related documents, including the right to enter onto and inspect the Project property and to copy any Project-related documents.

(13) To qualify to be a Certified Project, the Rehabilitation of any existing improvement must substantially alter and enhance the utility, condition, design or nature of the structure. In its application, the Project Applicant must verify such substantial alteration and enhancement. The following actions, by themselves, are not sufficient to satisfy this substantial alteration and enhancement requirement irrespective of cost or implementation throughout a Project:

(a) Ordinary maintenance and repairs;

(b) Refurbishment or redecoration that merely replaces, updates or restores certain fixtures, surfaces or components; or

(c) Similar such work of a superficial, obligatory or routine nature

(14) Unless an exception is granted by the Department, Projects "in progress" at the time of application may include only costs incurred within six (6) months of the application date. Factors that the Department may consider in determining whether or not to grant an exception to the six (6)-month limitation on costs include, but are not limited to the following:

(a) Delay due to terrorism or acts of God;

(b) Delay occasioned by requirements of the Department;

(c) Resultant undue hardship to the Project Applicant;

(d) The complexity of the Project; and

(e) The benefit of the Project to the Community.

(15) For applications filed before Project completion, the Department may provide a conditional letter of prospective certification of the Project pending its completion. To obtain a final certification of the Project, the Project Applicant must provide timely notification to the Department of the Project's completion, together with a copy of the certificate of occupancy and other information as the Department may require. A Project Applicant must provide the notice and required documentation to the Department within 90 days of Project completion which is typically the date of the certificate of occupancy unless the Department determines that another date is more appropriate.

(16) If an application is rejected for failure to meet Department review requirements, then:

(a) The Department will notify the Project Applicant that the application has been rejected; and

(b) The Department, at its own discretion, may allow the resubmission of a rejected application for Project certification ("as is" or with appro-

priate corrections or supplementations) or may reconsider a determination by it to reject an application. Factors that the Department may consider in allowing a resubmission of a rejected application or the reconsideration of a determination by it to reject an application include, but are not limited to the following:

(A) Whether or not rejection results in undue hardship to the Project Applicant;

(B) The best interests of the Community;

(C) The level of cooperation from the Project Applicant;

(D) The level and materiality of initial non-compliance by the Project Applicant, and;

(E) Mitigation of any initial non-compliance by the Project Applicant.

(c) If the Department accepts for review a previously rejected application, it may do so, at its sole discretion, on a prospective basis or based upon the original date of filing. Factors that the Department may consider in determining the date to apply to a previously rejected application include, but are not limited to the following:

(A) Whether or not occupancy or readiness to occupy residential units in the Project has occurred since the original application;

(B) Whether or not undue hardship would result to the Project Applicant;

(C) The best interests of the Community; and

(D) The level and materiality of non-compliance in the initial application.

(17) The Department will evaluate each accepted application to determine whether or not to certify the proposed Project.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 307.844, 307.857
Hist.: OHCS 1-2006(Temp), f. & cert. ef. 1-5-06 thru 7-4-06; OHCS 8-2006, f. & cert. ef. 6-28-06; OHCS 1-2015(Temp), f. & cert. ef 2-26-15 thru 8-24-15

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Rule Caption: Establishes purpose for Homeownership Assistance program funding and includes down-payment and other assistance to veterans.
Adm. Order No.: OHCS 2-2015(Temp)
Filed with Sec. of State: 3-11-2015
Certified to be Effective: 3-11-15 thru 9-5-15
Notice Publication Date:
Rules Adopted: 813-044-0045
Rules Amended: 813-044-0040
Subject: The rules are amended to incorporate language to provide veterans, as defined in ORS 408.225, with down-payment and other funding assistance. 813-044-0045 has been adopted to establish how funds may be used within the Home Ownership Assistance Program.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-044-0040
Application Procedure and Requirements

(1) An organization may apply for a grant from the Home Ownership Assistance Account under ORS 458.655 if the organization:

(a) Is a nonprofit corporation established under ORS Chapter 65, a housing authority established under 456.055 to 456.235 or a local government as defined in 197.015 and sponsors and manages low income homeownership programs as required in 458.655; or

(b) Is an organization affiliated with the Oregon Department of Veterans' Affairs (ODVA) and authorized by ODVA to provide down-payment assistance funding or other funding to veterans consistent with the following section 0045. For the purposes of this section, the term "veterans" has the meaning provided in ORS 408.225.

(2) An organization applies for a grant under this rule by submitting to the Department all of the following:

(a) An application, on a form established by the Department;

(b) A nonrefundable application charge established by the Department; and

(c) All project information required by the Department, including, but not limited to:

(A) A written description of the purposes for which the grant will be used, including but not limited to the proposed services to prospective homeowners, criteria for selecting prospective homeowners and any other pertinent information ;

(B) A description of the housing type and target home owners to be housed, the manner in which the project may expand the percentage of home ownership for Oregonians and how the project will provide home ownership opportunities for low or very low income households, persons with disabilities, minorities and farm workers;

(C) A proforma of project expenses, financing and, if applicable, income;

(D) The grant amount requested and total project development costs, including a description of all additional project funding and funding sources;

(E) A description of the experience of the sponsor or manager in developing, managing and operating home ownership programs;

(F) A description of the organization's program management responsibilities; and

(G) Any other documentation required by the Department

(3) An organization that requests additional resources on a project funded by the Home Ownership Assistance Account shall pay all supplemental application charges imposed by the Department for the resources.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.620 & 458.655
Hist.: HSG 2-1996, f. & cert. ef. 4-15-96; OHCS 4-2009, f. & cert. ef. 12-22-09; OHCS 9-2011(Temp), f. & cert. ef. 9-30-11 thru 3-27-12; OHCS 2-2012, f. & cert. ef. 3-27-12; OHCS 2-2015(Temp), f. & cert. ef. 3-11-15 thru 9-5-15

813-044-0045
Purposes for Funding

Funds within the Home Ownership Assistance Program may be used for the following purposes: down-payment assistance, regional housing centers, metro housing centers, innovation funding and training and other uses suitable to the department to mitigate the lack of home ownership.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.620 & 458.655
Hist.: OHCS 2-2015(Temp), f. & cert. ef. 3-11-15 thru 9-5-15

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Oregon Tourism Commission
Chapter 976

Rule Caption: Oregon Wine Country License Plates Matching Grant Program and Tourism Promotion Distribution
Adm. Order No.: ORTC 1-2015
Filed with Sec. of State: 2-17-2015
Certified to be Effective: 3-1-15
Notice Publication Date: 1-1-2015
Rules Adopted: 976-002-0010, 976-002-0020, 976-002-0030, 976-002-0040
Subject: Establishes rules for Wine Country License Plate matching grant guidelines, Tourism Promotion Distribution guidelines and clarifies eligibility and regional designations. These rules are believed to be fully compatible with legislative direction on the use of money generated from the net sales of Oregon Wine Country license plates. Businesses benefited by these rules are believed to be Oregon Wine and Tourism Industry small businesses.
Rules Coordinator: Sarah Watson—(503) 967-1568

976-002-0010
Matching Grant Guidelines

(1) The Oregon Tourism Commission shall prepare guidelines each biennium applicable to grants to be awarded under ORS 805.274(1)(a). The guidelines shall be available from the Oregon Tourism Commission and shall be published on the Oregon Tourism Commission's website.

(2) The guidelines shall include the maximum grant amount available for each matching grant award.

Stat. Auth.: ORS 284.111(6), ORS 805.274(3)
Stats. Implemented: ORS 805.274
Hist.: ORTC 1-2015, f. 2-17-15, cert. ef. 3-1-15

976-002-0020

Tourism Promotion Guidelines

(1) The Oregon Tourism Commission shall prepare guidelines each biennium applicable to Tourism Promotion Distribution to be awarded under ORS 805.274(1)(b). The guidelines shall be available from the Oregon Tourism Commission and shall be published on the Oregon Tourism Commission's website.

(2) The Oregon Tourism Commission will designate a tourism promotion agency for each region to receive the moneys described in ORS 805.274(1)(b).

Stat. Auth.: ORS 284.111(6), ORS 805.274(3)
Stats. Implemented: ORS 805.274
Hist.: ORTC 1-2015, f. 2-17-15, cert. ef. 3-1-15

976-002-0030
Tourism Promotion Distribution Eligibility

(1) A recipient of an Oregon Wine Country Plates Tourism Promotion Distribution must adhere to guidelines established by Oregon Tourism per OAR 976-002-0020 and must demonstrate experience engaging in tourism promotion on behalf of the wine industry in two or more of the counties in the region for which it is designated to receive money described in ORS 805.274(1)(b).

(2) To be eligible for consideration of an Oregon Wine Country Plates Tourism Promotion Distribution, a tourism promotion agency must establish an advisory committee that includes at least one representative of the wine industry and one representative of the culinary industry.

Stat. Auth.: ORS 284.111(6), ORS 805.274(3)
Stats. Implemented: ORS 805.274
Hist.: ORTC 1-2015, f. 2-17-15, cert. ef. 3-1-15

976-002-0040
Designation of Regions

The major wine producing regions of the state are:

(1) Region 1, also known as The Mid-Willamette Valley region, consisting of Marion, Polk and Yamhill Counties;

(2) Region 2, consisting of Lane, Linn, Benton, Lincoln, Tillamook, Clatsop, Columbia, Washington, Multnomah and Clackamas Counties;

(3) Region 3, consisting of Coos, Curry, Douglas, Josephine, Jackson, Klamath and Lake Counties; and

(4) Region 4, consisting of Hood River, Wasco, Sherman, Gilliam, Morrow, Umatilla, Union, Wallowa, Jefferson, Deschutes, Crook, Wheeler, Grant, Harney, Baker and Malheur Counties.

Stat. Auth.: ORS 284.111(6), ORS 805.274(3)
Stats. Implemented: ORS 805.274
Hist.: ORTC 1-2015, f. 2-17-15, cert. ef. 3-1-15

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Oregon Youth Authority
Chapter 416

Rule Caption: Amendments proposed to address certification standards of licensed and unlicensed employees, and correct working titles.
Adm. Order No.: OYA 1-2015
Filed with Sec. of State: 2-19-2015
Certified to be Effective: 2-19-15
Notice Publication Date: 1-1-2015
Rules Amended: 416-070-0010, 416-070-0020, 416-070-0030, 416-070-0040, 416-070-0050, 416-070-0060
Subject: Proposed rule amendments are to update an agency assistant director's title, and include certification standards for licensed and unlicensed practitioners.
Rules Coordinator: Winifred Skinner—(503) 373-7570

416-070-0010
Definitions

(1) Treatment Services Director: A person who leads and directs OYA clinical direction and treatment services statewide and reports to the OYA Director.

(2) Clinical Supervision: Oversight by a qualified person of mental health services and supports provided according to this rule, including ongoing evaluation and improvement of the effectiveness of those services and supports.

(3) Diagnosis: A diagnosis consistent with the most current Diagnostic and Statistical Manual of Mental Disorders (DSM).

(4) Mental Health Assessment: The written assessment by a QMHP of an offender's mental status and emotional, cognitive, family, developmental, behavioral, social, recreational, physical, nutritional, school or vocational, substance abuse, cultural and legal functioning, concluding with a completed DSM five-axes diagnosis, clinical formulation, prognosis for treatment, treatment recommendations and plan.

(5) Mental Status Examination: An overall standardized assessment of an offender's mental functioning and cognitive abilities.

(6) OYA: Oregon Youth Authority.

(7) Qualified Mental Health Professional (QMHP): A person who provides mental health treatment services to offenders in OYA facilities.

(8) Treatment Services Supervisor: A person who provides clinical supervision of the mental health treatment services and supports provided by a QMHP at an OYA facility.

Stat. Auth.: ORS 420A.010, 420A.025 & ORS 420A.022
Stat. Implemented: ORS 420A.022
Hist.: OYA 1-2011(Temp), f. & cert. ef. 6-14-11 thru 12-1-11; OYA 4-2011, f. 9-7-11, cert. ef. 9-9-11; OYA 1-2015, f. & cert. ef. 2-19-15

416-070-0020
Credentialing and Certification Process

(1) The Treatment Services Director is responsible for credentialing employees hired as OYA Treatment Services Supervisors and QMHPs.

(2) Treatment Services Supervisors and QMHPs must meet the requirements established in OAR 416-070-0030 as a Treatment Services Supervisor or QMHP.

(3) The Treatment Services Director is responsible for reviewing education, experience and competencies to determine if the individual can be certified as meeting the professional standards of a Treatment Services Supervisor or QMHP as set forth in these rules.

(4) A copy of transcripts, academic degrees, licenses, certifications, and verification forms used to record the credentialing and certification information must be retained in the Treatment Services Supervisor's or QMHP's personnel file.

(5) OYA must provide to each person certified as a QMHP or a Treatment Services Supervisor, a position description describing the duties that the person is certified to provide.

Stat. Auth.: ORS 420A.010, 420A.025 & 420A.022
Stat. Implemented: ORS 420A.022
Hist.: OYA 1-2011(Temp), f. & cert. ef. 6-14-11 thru 12-1-11; OYA 4-2011, f. 9-7-11, cert. ef. 9-9-11; OYA 1-2015, f. & cert. ef. 2-19-15

416-070-0030
Qualified Mental Health Professional (QMHP) and Treatment Services Supervisor Standards

(1) A person must meet the following minimum qualifications to be certified to work as a QMHP in an OYA facility:

(a) The person is a licensed medical practitioner;

(b) The person has a current Oregon clinical mental health license in good standing; or

(c) The person meets the following minimum qualifications:

(A) Holds any of the following educational degrees:

(i) Graduate degree in psychology; or

(ii) Bachelor's degree in nursing and licensed by the State of Oregon; or

(iii) Graduate degree in social work; or

(iv) Graduate degree in a behavioral science field; or

(v) Graduate degree in recreational, music, or art therapy; or

(vi) Bachelor's degree in occupational therapy and licensed by the State of Oregon; and

(B) Whose education and experience demonstrate the competency to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a Mental Status Examination; document a DSM Diagnosis; write and supervise a treatment plan; draft a Mental Health Assessment and provide individual, family and group therapy within the scope of their training.

(2) A person must meet the following minimum qualifications to be certified to work as a Treatment Services Supervisor in an OYA facility:

(a) A current Oregon clinical mental health license in good standing; and

(b) Provides documentation to OYA demonstrating that the person meets the requirements of the licensing board associated with subsection (a) for provision of independent licensure supervision.

Stat. Auth.: ORS 420A.010, 420A.025 & 420A.022
Stat. Implemented: ORS 420A.022
Hist.: OYA 1-2011(Temp), f. & cert. ef. 6-14-11 thru 12-1-11; OYA 4-2011, f. 9-7-11, cert. ef. 9-9-11; OYA 1-2015, f. & cert. ef. 2-19-15

416-070-0040
Clinical Supervision of QMHP Employees

(1) A QMHP must deliver services under the direct supervision of:

(a) A Treatment Services Supervisor; or

(b) A person designated by the Treatment Services Director to provide clinical supervision.

(2) The Treatment Services Supervisor or person designated by the Treatment Services Director to provide clinical supervision must operate within the scope of his or her practice or licensure, and demonstrate the competency to oversee and evaluate the mental health treatment services and supports provided by a QMHP.

(3) Clinical supervision must be provided at least monthly for each QMHP.

(4) The effectiveness of a QMHP's mental health services will be evaluated by overseeing the QMHP's service documentation, case planning, ethical practice, and assessment skills.

Stat. Auth.: ORS 420A.010, 420A.025 & 420A.022
Stat. Implemented: ORS 420A.022
Hist.: OYA 1-2011(Temp), f. & cert. ef. 6-14-11 thru 12-1-11; OYA 4-2011, f. 9-7-11, cert. ef. 9-9-11; OYA 1-2015, f. & cert. ef. 2-19-15

416-070-0050
QMHP Recertification

(1) A QMHP certification issued under these rules is subject to renewal every two years for unlicensed practitioners, and no longer than every two years for licensed practitioners.

(a) A QMHP certification of an unlicensed practitioner will expire on September 30. The issuance date of the certified person's first certification will determine if the certification expires on an odd or even year. Certifications issued in odd-numbered years expire in the next odd-numbered year, and certifications issued in even-numbered years expire in the next even-numbered year.

(b) A QMHP certification of a licensed practitioner will expire when the practitioner's license expires.

(c) A person seeking renewal of a certification must submit the following to the Treatment Services Director:

(A) A copy of the person's current annual performance appraisal reflecting performance in mental health services; and

(B) A copy of the person's current license, if the person is a licensed practitioner; or

(C) If the person is not a licensed practitioner, documentation of the following:

(i) At least 24 hours of clinical supervision per year, prorated based on the person's date of hire and budgeted position status; and

(ii) At least five hours of training pertinent to the mental health services in an OYA facility which may include OYA training, supervisor-approved completed readings, verified workshop attendance, or class participation in a graduate program focusing on mental health treatment of mental health disorders.

(2) If the person's previous certification has expired, the person must apply for recertification by submitting the documents listed in subsection (c) of this rule to the Treatment Services Director. The person may not provide mental health services until the person is recertified.

Stat. Auth.: ORS 420A.010, 420A.025 & 420A.022
Stat. Implemented: ORS 420A.022
Hist.: OYA 1-2011(Temp), f. & cert. ef. 6-14-11 thru 12-1-11; OYA 4-2011, f. 9-7-11, cert. ef. 9-9-11; OYA 1-2015, f. & cert. ef. 2-19-15

416-070-0060
Variances

(1) The Treatment Services Director may grant a variance to the criteria used to determine the certification status of a QMHP or Treatment Services Supervisor if the Treatment Services Director documents the reason for the variance and the proposed timeline for the variance.

(2) Signed documentation from the Treatment Services Director indicating support of the variance must be retained in the subject QMHP or Treatment Services Supervisor employee's personnel file.

Stat. Auth.: ORS 420A.010, 420A.025 & 420A.022
Stat. Implemented: ORS 420A.022
Hist.: OYA 1-2011(Temp), f. & cert. ef. 6-14-11 thru 12-1-11; OYA 4-2011, f. 9-7-11, cert. ef. 9-9-11; OYA 1-2015, f. & cert. ef. 2-19-15

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Rule Caption: Amendments incorporate "others in youth authority custody" in accordance with ORS 420A.035.
Adm. Order No.: OYA 2-2015
Filed with Sec. of State: 2-19-2015
Certified to be Effective: 2-19-15
Notice Publication Date: 1-1-2015
Rules Amended: 416-260-0010, 416-260-0015, 416-260-0020, 416-260-0030, 416-260-0040, 416-260-0050, 416-260-0060, 416-260-0070
Subject: Proposed amendments add offenders in the legal custody of the Department of Corrections (DOC) and physical custody of Oregon Youth Authority (OYA) to these rules. Senate Bill 188, section 11, amended ORS 420A.035 by changing the law to, "The Oregon Youth Authority may deposit money belonging to youth offenders or others in youth authority custody in a trust account in the State Treasury separate and distinct from the General Fund. Interest earned by the account, if any, shall accrue to the benefit of the account." Amendments also contain grammatical edits.
Rules Coordinator: Winifred Skinner—(503) 373-7570

416-260-0010
Purpose

(1) These rules describe how OYA establishes and maintains Offender Welfare Accounts and trust accounts for offenders in its custody.

(2) Definitions:

(a) "Offender Welfare Account" means a general account established by OYA dedicated to provide monies to benefit the close custody offender population and enhance offender activities and programs.

(b) "Care" means services provided to meet the needs of an offender (i.e., food, shelter, clothing, medical care, schooling, protection, supervision).

(c) "Financial accounting" means a detailed accounting of money spent by OYA for care of an offender and the amount of trust money, by funding source, reimbursed to OYA for these items.

(d) "Maintenance account" means a sub-section of an offender's trust account used to account for funds that may be used to pay for the offender's cost of care.

(e) "Offender" means a person in the legal and physical custody of OYA either in an OYA close-custody facility or placed in the community under supervision, or a person in the legal custody of the Department of Corrections and the physical custody of OYA in an OYA close-custody facility.

(f) "Special account" means a sub-section of an offender's trust account used to account for funds received for an offender for purposes other than paying for the offender's cost of care.

(g) "Termination of custody" means relinquishment of OYA custody as a result of a court order, the offender's age, or transfer to a supervising authority other than OYA.

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420A.030 & 420A.032, & 420A.035
Hist.: OYA 5-2001, f. & cert. ef. 4-20-01; OYA 5-2011, f. 9-14-11, cert. ef. 9-15-11; OYA 2-2015, f. & cert. ef. 2-19-15

416-260-0015
Offender Welfare Accounts

(1) OYA has established Offender Welfare Accounts for each OYA close-custody facility to provide funds to benefit the close-custody offender population and enhance offender activities and programs.

(2) Revenue from offender work programs, donations made to OYA for the benefit of all close custody facility offenders, and fundraisers benefiting close custody offender programs will be deposited into an Offender Welfare Account.

(3) OYA may use monies in Offender Welfare Accounts to fund a variety of programs, services and activities benefiting the close custody offender population and enhancing offender close custody facility activities and programs. Specific uses of the funds may include, but are not limited to, operations, support or enhancement of the following programs, services and activities:

(a) Recreational activities;

(b) Incentive awards;

(c) Holiday events, decorations, and gifts;

(d) Entertainment equipment and supplies;

(e) Repair of equipment purchased from an Offender Welfare Account; and

(f) Offender work or vocational program startup costs, equipment, attire, and safety supplies.

Stat. Auth.: ORS 420A.030, 420A.014 & 420A.100
Stats. Implemented: ORS 420A.030, 420A.014 & 420A.100
Hist.: OYA 5-2011, f. 9-14-11, cert. ef. 9-15-11; OYA 2-2015, f. & cert. ef. 2-19-15

416-260-0020
Establishing Offender Trust Accounts

OYA must establish a trust account for an offender when placed in OYA's legal or physical custody. This account must include both a maintenance and a special account in which all revenue received on an offender's behalf must be recorded.

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420A.030 & 420A.032
Hist.: OYA 5-2001, f. & cert. ef. 4-20-01; OYA 2-2015, f. & cert. ef. 2-19-15

416-260-0030
Sources and Uses of Maintenance Account Money

(1) OYA must deposit all money received for the purpose of caring for an offender in OYA's legal or physical custody, and interest earned thereon,

into the offender's maintenance account. The maintenance account must include subaccounts to separately track money and interest earned by source as follows:

(a) Social Security;

(b) Supplemental Security Income (SSI);

(c) Supplemental Security Income Dedicated (SSI Dedicated);

(d) Court-ordered support; and

(e) Other sources.

(2) OYA must apply money available in an offender's maintenance account against costs OYA expended for care of that offender.

(3) Offenders in OYA custody and placed in an unpaid placement may have monthly needs met from certain money available in their maintenance accounts. OYA must determine prior to forwarding money that a financial need exists. The maximum amount to be forwarded varies by source. For example:

(a) Benefits such as Social Security, Veteran's, and Railroad Retirement must not exceed the month's benefit;

(b) SSI benefits must be returned to the Social Security Administration (SSA);

(c) Voluntary support is limited only by financial need;

(d) Court-ordered support must not be used for this purpose.

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420A.030 & 420A.032
Hist.: OYA 5-2001, f. & cert. ef. 4-20-01; OYA 2-2015, f. & cert. ef. 2-19-15

416-260-0040
Sources and Uses of Special Account Money

(1)(a) OYA must deposit money received for an offender for purposes other than paying for that offender's cost of care into the offender's special account. Sources of money include the offender's earnings, restricted money gifts, restricted inheritances, money brought with the offender when entering OYA's physical or legal custody, interest earned on special account money, etc.

(b) OYA must consider all money not specifically designated for a purpose other than the offender's cost of care available for care of that offender and must deposit it in the offender's maintenance account.

(2) OYA must use special accounts to pay obligations incurred by offenders.

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420A.030, 420A.032, 420A.035
Hist.: OYA 5-2001, f. & cert. ef. 4-20-01; OYA 2-2015, f. & cert. ef. 2-19-15

416-260-0050
Financial Accounting

OYA must complete financial accountings as required for legal proceedings, audits, and when a maintenance account balance exists and the offender's OYA custody has been terminated.

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420A.030 & 420A.032
Hist.: OYA 5-2001, f. & cert. ef. 4-20-01; OYA 2-2015, f. & cert. ef. 2-19-15

416-260-0060
Clearing a Trust Account Upon Termination of Custody

(1)(a) When OYA's custody of an offender is terminated, funds available in the offender's trust accounts must be disbursed and accounts closed.

(b) Maintenance account money must be used to reimburse OYA expenditures in the following priority:

(A) Court-ordered support;

(B) Social Security;

(C) Voluntary support;

(D) Veteran's benefits;

(E) Workers' compensation insurance (SAIF);

(F) Civil service annuities;

(G) Military allotments;

(H) Railroad retirement;

(I) Other; and

(J) Supplemental Security Income (SSI).

(2)(a)OYA must release special account money to the offender or legal guardian no earlier than six weeks after the offender leaves close-custody, and at the juvenile parole/probation officer's discretion if the offender remains in OYA legal custody.

(b) OYA may not disburse accounts with balances less than $5.

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420A.030, 420A.032, 420A.035
Hist.: OYA 5-2001, f. & cert. ef. 4-20-01; OYA 2-2015, f. & cert. ef. 2-19-15

416-260-0070
Unclaimed Special Account Balances

(1) OYA must identify special account balances which are unclaimed and abandoned two years from the date OYA's custody terminated, in accordance with the Uniform Disposition of Unclaimed Property Act.

(2) OYA must diligently attempt to locate offenders who have special account balances of at least $100.

(a) OYA must, at a minimum, send a letter to the offender's last known address stating there is a trust account balance with OYA and the offender has 30 days from the date of the notice to claim the account.

(b) If the notice is returned because the offender moved without a forwarding address, or the 30 days elapses without a response, OYA must forward the special account balance to the Division of State Lands in accordance with that agency's administrative rules.

(3) OYA must forward special accounts with balances less than $100 to the Division of State Lands in accordance with that agency's administrative rules.

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420A.030, 420A.032, 420A.035
Hist.: OYA 5-2001, f. & cert. ef. 4-20-01; OYA 2-2015, f. & cert. ef. 2-19-15

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Public Utility Commission
Chapter 860

Rule Caption: Rulemaking to Streamline eFiling and Other Housekeeping Changes.
Adm. Order No.: PUC 1-2015
Filed with Sec. of State: 3-3-2015
Certified to be Effective: 3-3-15
Notice Publication Date: 10-1-2014
Rules Adopted: 860-001-0390
Rules Amended: 860-001-0020, 860-001-0070, 860-001-0140, 860-001-0150, 860-001-0160, 860-001-0170, 860-001-0180, 860-001-0300, 860-001-0310, 860-001-0340, 860-001-0350, 860-001-0400, 860-001-0420, 860-001-0480, 860-001-0540, 860-016-0000, 860-016-0020, 860-016-0021, 860-016-0025, 860-016-0030, 860-016-0050, 860-021-0015, 860-022-0005, 860-022-0047, 860-023-0151, 860-025-0060, 860-027-0300, 860-028-0070, 860-029-0100, 860-032-0002, 860-032-0005, 860-033-0006, 860-034-0060, 860-034-0300, 860-036-0025, 860-036-0605, 860-037-0025, 860-037-0410, 860-038-0400, 860-038-0420, 860-082-0085
Subject: These rule changes implement streamlined procedures for filing and serving documents in contested cases and other formal proceedings by eliminating the need for paper copies in most instances and generally eliminating the need for stakeholders to provide service of filings on other parties. There are also some housekeeping changes made to the rules.
Rules Coordinator: Diane Davis—(503) 378-4372

860-001-0020
Hours of Operation, Location, and Contact Information

(1) Office Hours: Commission offices are open to the public between 8:00 a.m. and 5:00 p.m., Monday through Friday, except on legal holidays as defined in ORS 187.010 or when the Commission's office is closed by a Department of Administrative Services directive.

(2) Location and general contact information: The information included in this section is current at the time of rule adoption, but may change. Current information and additional contact information is available on the Commission's website: http://www.puc.state.or.us

(a) Physical Location: 3930 Fairview Industrial Drive SE, Salem, OR 97302

(b) Mailing Address: PO Box 1088, Salem, OR 97308-1088.

(c) Telephone:

(A) Local to Salem: (503) 373-7394, TTY (Oregon Relay Service): (800)-735-2900;

(B) Consumer Services: (800) 522-2404;

(C) Telephone Assistance Programs: (800) 848-4442, TTY (800) 648-3458.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0070
Confidential Information

(1) This rule applies to information submitted under a claim of confidentiality under the Public Records Law, but does not apply to information designated as confidential under a protective order in a contested case proceeding.

(2) At the time of submission, a person may designate a document or portion of a document as containing confidential information. A designation must be made in good faith and be limited to information that qualifies for protection. The person asserting confidentiality must state the legal basis for the claim of confidentiality.

(3) Unless otherwise provided by Commission order, confidential information submitted under this rule must be clearly labeled on each electronic page as confidential and identified as confidential in the document name, or printed on yellow paper, separately bound, and placed in a sealed container or provided on a portable data storage device clearly labeled with the word CONFIDENTIAL and placed in a sealed container. Spreadsheets containing confidential information must be labeled with "confidential" in the header or footer. To the extent practicable, the provider must place only the portions of the document that contain confidential information in the container. The confidential information on each page must be clearly marked by inserting [Confidential] before and after the portion of information that is confidential. The container must be marked "CONFIDENTIAL." Multiple sealed containers may be mailed in one package.

(4) Confidential information submitted to the Commission is exempt from public disclosure to the extent provided under the Public Records Law, ORS 192.410 through 192.505.

(5) Any failure to comply with the requirements in this rule may result in the submission not being treated as including confidential information or being returned to the provider for correction and resubmission.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 192.420-192.505, & 756.040
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0140
General

(1) The Commission requires the use of its Filing Center for the filing of documents in agency proceedings. Contact information for the Filing Center is as follows:

(a) Electronic mail: PUC.FilingCenter@state.or.us.

(b) Phone: (503)378-6678 Fax: (503) 378-6163.

(c) Mailing Address: Filing Center, Public Utility Commission of Oregon, PO Box 1088, Salem, OR 97308-1088.

(d) Delivery Address: Filing Center, Public Utility Commission of Oregon, 3930 Fairview Industrial Drive SE, Salem, OR 97302.

(2) Documents submitted to the Commission must include the name of the person submitting the document, the person's physical and electronic mail addresses, and the person's telephone number. If applicable, the name of the business or organization that person represents must also be included.

(3) If possible, documents should fit on an 8-1/2 by 11-inch page and have at least 1 inch margins when printed.

(4) When the filing or serving of physical copies is required, the Commission encourages the use of recycled paper and printing on both sides of the page. Tariff filings of 100 pages or more must be filed single-sided.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 756.040 & 756.500 - 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0150
Filing Dates

(1) Except as modified by statute or by the rules in this division, a document is filed on the date received by the Commission at Salem, Oregon, between the hours of 8 a.m. and 5 p.m., Pacific Time.

(2) The period of time for doing an act governed by these rules is determined by excluding the first day and including the last day. For example, if a motion is filed on September 18, then any response (due 15 days after filing of the motion) must be filed by October 3. If the due date falls on a Saturday, Sunday, legal holiday as defined in ORS 187.010, or when the Commission office is closed by a Department of Administrative Services directive, then the filing is due on the next business day.

(3) Filings that are incomplete or not in substantial compliance with these rules, Commission orders, ALJ rulings, or statutes may be declined or conditionally accepted. The Commission must provide the reason for declining or conditionally accepting a filing to the filer.

(4) Documents required to be filed within a specified time but that fail to substantially comply with these rules may be accepted as conditionally received to meet the filing deadline.

(5) Conditionally received filings are not considered officially filed until brought into substantial compliance with these rules, the Commission's orders, ALJ rulings, and statutes. Conditionally received filings may be rejected unless brought into compliance within one business day of notice of the deficiency. A filer must file an amended or corrected filing to bring a conditionally accepted filing into compliance.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0160
Filing Requirements in Rulemaking Proceedings

(1) Written comments on proposed rules and other documents submitted in rulemaking proceedings must be filed with the Filing Center at the address listed in OAR 860-001-0140. Filing by electronic mail is preferred, but physical documents will be accepted.

(a) To be considered by the Commission, a document must be received by the deadline for the submission of written comments specified in the notice of proposed rulemaking.

(b) Documents must include the docket number assigned by the Commission to the rulemaking proceedings.

(2) Written comments on a proposed rule must comply with OAR 860-001-0210(3).

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 756.040 & 756.500 - 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0170
Filing Requirements in Contested Case and Declaratory Ruling Proceedings

(1) Every pleading or other document submitted to the Commission in contested case or declaratory ruling proceedings must be filed electronically with the Filing Center on or before the date due. All filings must be labeled with the applicable docket number, a description of the filing, and the date filed. Electronic copies of non-confidential documents must not be password protected, or have any PDF security features enabled.

(a) Documents may be electronically filed by sending the filing as an attachment to an electronic mail message addressed to the Filing Center or by personally delivering or mailing a portable data storage device to the Filing Center. If a portable data storage device is delivered or mailed to the Filing Center, it must be received on or before the date due to be considered timely filed.

(b) Electric copies of documents must be in text-searchable format and provided in either Microsoft Word, Microsoft Excel, or .pdf (Adobe Acrobat) format, unless otherwise permitted by the ALJ.

(c) An electronic mail message to the Filing Center and its attachments must be less than 20 megabytes in size. Filings larger than 20 megabytes may be divided into multiple electronic mail messages. Each message must be numbered sequentially, and the subject line of the message must include "E-mail x of y," where x equals the message number and y equals the total number of messages. Filings larger than 20 megabytes may also be provided to the Filing Center on a portable data storage device.

(d) The subject line of each electronic mail message to the Filing Center must include the docket number (if one is assigned), the party name or identifier, and the title or type of filing. For example, for a brief filed by the Citizens' Utility Board of Oregon in UE XXX, the subject line is UE XXX CUB Brief; and for a new application from NW Natural for financing authorization, the subject line is NWN New UF Application.

(e) If a document relates to multiple dockets that are officially consolidated, then the filer should file the document in the lead docket only. If a document relates to multiple dockets that are not officially consolidated, then the filer must file the document in each docket, even if all dockets are following the same procedural schedule.

(f) When electronically filing a redacted version of a filing that contains confidential information, the filer must file the confidential version so that it is received by the Filing Center within 2 business days after the date the redacted version was electronically filed.

(g) When filing a document that is entirely confidential, the filer must electronically file a cover letter. The file must file the confidential version so that it is received by the Filing Center within 2 business days after the date that the cover letter was electronically filed.

(2) Parties must supplement an electronic filing with physical copies of certain filings. For general rate revisions filed under OAR 860-022-0019, integrated resource plans filed under OAR 860-038-0080, the utility

must provide 20 physical copies. For filings of more than 100 pages, parties must coordinate with the Filing Center to determine the number of physical copies to be filed.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 756.040 & 756.500 - 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0180
Service in Contested Case and Declaratory Ruling Proceedings

(1) The Commission maintains an official service list for each contested case and declaratory ruling proceeding. The service list is posted on the Commission's website or may be obtained by contacting the Filing Center.

(a) Each party must identify at least one party representative to receive service, and may identify no more than three party representatives to receive service.

(b) Parties may designate party representatives in an initiating pleading, petition to intervene, or separate document. Parties must notify the Filing Center in writing of any change in contact information.

(2) Except as otherwise provided by statute or rule, a party completes service of any document by filing it electronically with the Filing Center.

(3) A party need only serve physical copies of a document in person, by first-class mail, or by any other reasonable means of delivery if:

(a) The document contains information that has been designated as confidential under a general protective order, and the protective order requires service of physical copies;

(b) The filing is more than 100 pages, unless the party has requested not to receive physical service of voluminous filings;

(c) A party has requested and received permission from the ALJ to receive physical service of all documents; or

(d) Physical service is required by rule or statute.

(4) Service of physical copies of a document is considered timely if the copy is received within two business days of the date the document was filed with the Filing Center.

(5) If service of physical copies is required in a contested case or declaratory ruling proceeding, then the filer must include a certificate of service with its filing to the Filing Center. The certificate must include the means of physical service, date of physical service, a list of the party representatives and addresses served, and a certifying signature.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0300
Practice Before the Commission

Participation in Contested Case and Declaratory Ruling Proceedings; Intervention

(1) Under ORS 774.180, the Citizens' Utility Board has the right to intervene in any Commission proceedings by filing a notice of intervention that includes the names and addresses of the representatives to be included on the service list.

(2) Any other person may file a petition to intervene in contested case proceedings before the Commission. A sample petition to intervene forms may be obtained by contacting the Administrative Hearings Division at puc.hearings@state.or.us or (503) 378-6678. The petition to intervene must contain the following information:

(a) The petitioner's name and contact information, including telephone number, physical address, and electronic mail address;

(b) The name and contact information of the petitioner's attorney or authorized representative, including telephone number, physical address, and electronic mail address;

(c) If the petitioner is an organization, the number of members in and the purpose of the organization;

(d) The nature and extent of the petitioner's interest in the proceedings;

(e) The issues petitioner intends to raise at the proceedings; and

(f) Any special knowledge or expertise of the petitioner that would assist the Commission in resolving the issues in the proceedings.

(3) Staff and parties named in the pleading initiating Commission action are original parties and need not petition to intervene. All original parties must provide the Commission with the names and contact information, including telephone number, physical address, and electronic mail address, of the party representatives to be included on the service list.

(4) Any person may file a petition to intervene in declaratory ruling proceedings before the Commission. In addition to the requirements in section (2) of this rule, the petition to intervene must also state whether the intervenor accepts:

(a) The statement of facts as set forth in and for the purposes of the petition for declaratory ruling; and

(b) The statement of the questions presented in the petition for declaratory ruling.

(5) A party may object to a petition to intervene. Objections must be filed within 10 days of the filing of the petition to intervene unless otherwise directed by an ALJ. The petitioner may file a reply to an objection within 7 days of the filing of the objection.

(6) If the Commission or ALJ finds the petitioner has sufficient interest in the proceedings and the petitioner's appearance and participation will not unreasonably broaden the issues, burden the record, or delay the proceedings, then the Commission or ALJ must grant the petition. The Commission or ALJ may impose appropriate conditions upon any intervenor's participation in the proceedings, such as restricted access to confidential information. The ALJ may rule on a petition to intervene at a prehearing conference.

(7) A person may ask to be listed as an "interested person" in a particular proceeding. An interested person receives electronic mail notifications of filings made and documents issued by the Commission or ALJ in that particular proceeding. An interested person is not a party to the proceeding, and is not entitled to file pleadings, present evidence for the record, conduct cross-examination of witnesses, become a signatory to a protective order, or file briefs.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 183.417, 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0310
Representation and Ethical Conduct

(1) All persons appearing in proceedings in a representative capacity must conform to the standards of ethical conduct required of attorneys appearing before the courts of Oregon. If a person does not conform to these standards, then the Commission may decline to permit the person to appear in a representative capacity in any proceedings.

(2) Except for Staff, a party to contested case proceedings may be represented by an authorized representative who is not an attorney.

(a) A party's initial pleading in the proceedings must designate the party's authorized representative.

(b) The ALJ has authority to limit an authorized representative's presentation of evidence, examination, and cross-examination of witnesses, or presentation of factual arguments to ensure the orderly and timely development of the hearing record. The ALJ may not allow an authorized representative who is not an attorney to present legal argument except to the extent authorized in ORS 183.457.

(c) Changes to the designation of authorized representative must be made by written notice to the Filing Center.

(3) Staff may represent the Commission in a contested case hearing in the following proceedings:

(a) Actions initiated by the Commission to recover telecommunications assistive devices, the value of devices which the recipients fail to return, or the cost of repairing equipment that the recipient returned in a damaged condition; and

(b) Denial or termination of Oregon Telephone Assistance Program benefits.

(4) Staff acting under the provisions of section (3) may not give legal advice to the Commission and may not present legal argument in contested case hearings, except to the extent authorized by this section.

(a) "Legal Argument" includes arguments on:

(A) The jurisdiction of the Commission to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirement to the Commission

(C) The application of court precedent to the facts of the particular contested case proceeding.

(b) "Legal Argument" does not include presentation of motions, evidence, examination and cross-examination of witnesses or presentation of factual arguments or arguments on:

(A) The application of the statutes or rules to the facts in the contested case;

(B) Comparison of prior actions to the Commission in handling similar situations;

(C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case;

(D) The admissibility of evidence; and

(E) The correctness of procedures being followed in the hearing.

(5) If the ALJ determines that statements or objections made by Staff appearing under section (3) involve legal argument as defined in this rule,

the ALJ will provide reasonable opportunity for Staff to consult with the Attorney General and permit the Attorney General to present argument at the hearing or to file written legal argument within a reasonable time after conclusion of the hearing.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 183.452-183.458, 756.040 & 756.500 - 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2014, f. & cert. ef. 1-9-14; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0340
Ex Parte Communications

(1) Ex parte communications are discouraged and, if made, must be disclosed to ensure an open and impartial decision-making process.

(2) Except as provided in this rule, an ex parte communication is any oral or written communication that:

(a) Is made by a person directly to a Commissioner or presiding ALJ outside the presence of any or all parties of record in pending contested case or declaratory ruling proceedings;

(b) Is made without notice to or an opportunity for rebuttal by all parties; and

(c) Relates to the merits of an issue in the proceedings.

(3) For purposes of this rule, a contested case or declaratory ruling proceeding is pending when the Commission or ALJ issues the first scheduling notice.

(4) A person who has an ex parte communication must promptly notify the presiding ALJ that the communication occurred.

(5) Upon notice of or receipt of an ex parte communication, the presiding ALJ must promptly notify the parties of record of the communication and place the following in the record:

(a) The name of each person who made the communication and the person's relationship, if any, to a party in the case;

(b) The date and time of the communication;

(c) The circumstances under which the communication was made;

(d) A summary of the matters discussed;

(e) A copy of any written communication; and

(f) Other relevant information concerning the communication.

(6) The presiding ALJ may require the person responsible for the ex parte communication to provide the disclosure and notice of the communication required by this rule.

(7) Within 10 days of the filing date of the notice, a party may file a written rebuttal of the facts or contentions contained in the ex parte communication.

(8) The provisions of this rule do not apply to communications that:

(a) Address procedural issues, such as scheduling or status inquiries, or requests for information having no bearing on the merits of the case;

(b) Are made to a Commissioner or presiding ALJ by a member of Staff who is not a witness in the proceedings;

(c) Are made to a Commissioner or presiding ALJ by an Assistant Attorney General who is not representing Staff in the proceedings;

(d) Are made in rulemaking proceedings conducted under ORS 183.325 through 183.410; or

(e) The presiding ALJ determines are not subject to this rule, including communications from members of the public that are made part of the administrative file or communications that are the subject of in camera proceedings.

(9) To avoid inadvertent ex parte communications, a person planning to meet individually with a Commissioner or ALJ must indicate whether the discussion will relate to pending proceedings and, if so, which proceedings.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 183.417, 183.462, 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0350
Settlements

(1) In all Commission contested case proceedings, some or all of the parties may enter into a settlement of any or all issues at any time during the proceedings.

(2) A settlement discussion is any communication between two or more parties for the purpose of resolving issues pending in contested case proceedings. Examples of communications not constituting settlement discussions for purposes of this rule include communications primarily for the purpose of discovery and communications occurring before initiation of docketed proceedings.

(3) Without the written consent of all parties, any statement, admission, or offer of settlement made during settlement discussions is not admissible in any Commission proceedings, unless independently discoverable or offered for other purposes allowed under ORS 40.190.

(4) Parties may agree in writing that the information exchanged exclusively within the context of any settlement discussion is confidential.

(5) Subject to the signing of an applicable confidentiality agreement, all parties may attend a meeting in which Staff participates to discuss settlement. Staff must provide to all parties to the proceedings reasonable prior notice of any settlement meeting in which Staff intends to participate. The notice must include the time and place of the settlement meeting, the party or parties involved, and the issues to be discussed. Once Staff has given notice of a settlement meeting involving a particular issue, additional notice of continuing settlement meetings involving the same issue need only be provided to parties attending the initial meeting or parties who request continuing notice. Persons who are not associated with a party may not attend a settlement meeting without the consent of all participating parties.

(6) For purposes of ORS 192.502(4), the Commission obligates itself to protect from disclosure any document submitted in confidence during settlement discussions.

(7) Settlements must be memorialized in a written stipulation signed by the settling parties and filed for review by the Commission. With the stipulation, the parties must file:

(a) An explanatory brief or written testimony in support of the stipulation, unless waived by the Commission or ALJ; and

(b) A motion to offer the stipulation and any testimony as evidence in the proceeding, together with witness affidavits in support of the testimony.

(8) Within 15 days of the filing of a stipulation, a party may file written objections to the stipulation or request a hearing. Upon request or its own motion, the Commission or ALJ may set another time period for objections and request for hearing. Objections may be on the merits or based upon failure of Staff or a party to comply with this rule. The Commission or ALJ may hold a hearing to receive testimony and evidence regarding the stipulation. The Commission or ALJ may require evidence of any facts stipulated. The parties must be afforded notice and an opportunity to submit proof if such evidence is requested.

(9) A stipulation is not binding on the Commission. The Commission may adopt or reject a stipulation, or propose that a stipulation be modified prior to approval. If the Commission proposes to modify a stipulation, the Commission must explain its decision and, if necessary, provide the parties sufficient opportunity on the record to present evidence and argument to support the stipulation. No further hearing need be held when a review hearing has already been held under section (8) of this rule and the Commission or ALJ determines that the issues were fully addressed in the prior hearing.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 183.417, 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0390
General

The Commission treats pleadings and motions differently.

(1) Pleadings are used to address formal requests to initiate a proceeding or for Commission authorization. There are two types of pleadings.

(a) Initiating pleadings include applications, petitions, and complaints.

(b) Responsive pleadings include answers, protests, responses, and replies.

(2) Motions are requests seeking a ruling in a Commission proceeding. There are two types of motions.

(a) Substantive motions address the rights or duties of a party or seek summary determination of any or all issues in the proceeding, such as a motion to dismiss.

(b) Procedural motions address the means by which the Commission regulates its proceedings; for example, a motion to modify a schedule.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 183.417, 756.040 & 756.500 – 756.575
Hist.: PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0400
Pleadings Requirements

(1) All pleadings must be signed by the person filing the pleading or an authorized representative. By signing a pleading, the signatory makes the certification in ORCP 17C. For electronic filings, a person may use any identifier that is adopted by the person with the intent to authenticate a document (for example, "/s/John Doe").

(2) Applications, petitions, complaints, and other initiating pleadings must include:

(a) The filer's name and contact information, including telephone number, physical address, and electronic mail address;

(b) The name and contact information, including telephone number, physical address, and electronic mail address of any other party named in the filing;

(c) A clear and concise statement of the authorization, action, or relief sought;

(d) Appropriate references to the statutory provision or other authority under which the filing is made; and

(e) Other information as required by the Commission's rules.

(3) Answers, protests, and other responsive pleadings must be in writing and must include:

(a) The filer's name and address;

(b) The identification of the initiating pleading to which the response is made, including the docket number if one had been assigned; and

(c) A specific response to the pleading including, if necessary, an answer to material allegations and affirmative defenses.

(4) Unless otherwise directed by the Commission or ALJ, responses must be filed within the following timeframes:

(a) An answer to a complaint, application, or petition must be filed within 20 days after the pleading is filed.

(b) An answer to a consumer complaint under OAR 860-021-0015 must be filed within 15 days after the Commission serves the complaint.

(c) An answer to a petition to intervene must be filed within 10 days after filing of the petition.

(d) An answer to a complaint under OAR 860-029-0100 must be filed within 10 days after the Commission serves the complaint.

(e) An answer to any other type of pleading must be filed within 15 days after the pleading is filed.

(5) A reply to a responsive pleading is not permitted unless otherwise allowed by the Commission or ALJ.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0420
Motions, Responses, and Replies

(1) A motion must be made in writing unless otherwise allowed by the Commission or ALJ.

(2) Before filing a procedural motion, the moving party must make a good faith effort to confer with other parties to seek agreement about the subject of the motion. A procedural motion must describe the effort to confer and the result of the effort.

(3) A motion against an initiating or responsive pleading under OAR 860-001-0400 must be filed within 10 days after the pleading is filed.

(4) A party may file a response to a motion. A response to a substantive motion must be filed within 15 days of filing of the motion. A response to a procedural motion must be filed within 7 days of filing of the motion.

(5) The moving party may file a reply to a response to a substantive motion within 7 days of filing of the response. The moving party is not permitted to file a reply to a response to a procedural motion unless permitted by the ALJ.

(6) If expedited consideration of a motion is requested, the moving party must:

(a) Certify that the moving party has attempted to contact the other parties to the proceedings to discuss the motion and state whether the parties support the motion;

(b) Identify the request for expedited consideration in the document caption; and

(c) Include a request to shorten the time for responses and, if applicable, replies.

(7) Unless granted by the ALJ, a request for an extension or other related motion does not stay a pending due date.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0480
Testimony and Exhibits

(1) Unless otherwise directed by the ALJ, all written testimony and exhibits must be paginated in the top right corner as follows:

Party Name/Exhibit Number

Witness Last Name/Page Number

(2) Each party must consecutively number its written testimony and exhibits, beginning with 100. Within each round of testimony, each witness or witnesses testifying jointly must be designated with a separate numbering series. For example, Mr. Smith, Staff's first witness in the first round of testimony, would be assigned Staff/100. Ms. Jones, Staff's second witness in first round, would be assigned Staff/200. Mr. Smith's second round of testimony would be assigned Staff/300. Each attachment must be marked as a separate exhibit. For example, the first attachment to Staff/100 would be marked as Staff/101. A separate numbering series must also be used to identify all exhibits marked at hearing.

(3) Each page of a multipage exhibit must be marked with a page number. Pages within each exhibit must be marked consecutively, beginning with page 1.

(4) The ALJ may waive the requirement of marking each page of voluminous photocopied documents.

(5) When filing testimony and exhibits, the filing party must simultaneously provide a copy of all work papers to Staff, the utility named in the initiating pleading, and all other parties that have asked to receive a copy. If a shared workspace is being used for data requests and responses, this provision is satisfied by uploading the work papers to that workspace and electing to share the upload with other authorized users. As used in this rule, work papers consist of documents that show the source, calculations, and details supporting the testimony and other exhibits submitted.

(6) Within the time specified by the ALJ, each party must file a list, in numerical order, of the written testimony and exhibits the party offered during the proceedings. The list must specify the document, witness, number of pages, and whether the exhibit was received into evidence.

(7) When testimony or exhibits are offered in evidence at a hearing and were not previously filed, the offering party must give copies to each party, the Commission, and the ALJ. When practicable, the parties must distribute copies of exhibits before or at the beginning of the hearing.

(8) When relevant evidence offered by a party is included in a book, paper, or document containing irrelevant material, the party offering the exhibit must plainly designate the relevant material offered:

(a) If irrelevant material is included in the exhibit and would encumber the record, then the exhibit may be excluded. The exhibit may be marked for identification and the relevant material may be read into the record if properly authenticated.

(b) If the Commission or ALJ directs, a copy of the relevant portions of the exhibit may be received as evidence. The offering party must offer copies of the document to all other parties appearing at the hearing. The parties must be afforded an opportunity to examine the exhibit and to offer in evidence other relevant portions of the exhibit.

(9) Papers and documents on file with the Commission may be introduced by reference to number, date, or by any other method of identification satisfactory to the Commission or ALJ.

(10) The Commission or ALJ may direct that the testimony of a witness, including supporting exhibits, be submitted in writing prior to hearing. Unless otherwise directed by the Commission or ALJ, written testimony, when sworn to orally or in writing by the witness under oath to be true, will be received in the same manner as an exhibit. The written testimony must be double-spaced, prepared in question and answer or narrative form, and contain a statement of the qualifications of the witness. The written testimony is subject to rules of admissibility and cross-examination.

(11) The Commission or ALJ may direct that demonstrative evidence be reduced to a diagram, map, photograph, or similar representation.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 183.450, 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-001-0540
Data Requests

(1) A party may submit data requests to any other party, subject to the discovery rules in the ORCP. Data requests are written interrogatories or requests for production of documents. Data requests must be answered within 14 days from the date of service. Each data request must be answered fully and separately in writing or by production of documents, or objected to in writing.

(2) A party submitting a data request must serve the request on all parties to the proceedings. For nonconfidential requests, service may be made by electronic mail or by electronic mail notification of upload to a designated shared workspace for data requests and responses. If the request contains confidential information, then the submitting party must serve a complete copy on all parties eligible to receive confidential information under the terms of a protective order and a redacted copy to all other parties. The complete confidential copy must be served using means identified in the protective order. Nonconfidential data requests and responses submitted to the Staff of the Commission must be sent to PUC.Datarequest@state.or.us. If a designated shared workspace is being used for data requests and responses, the notification of uploaded data requests and responses must be sent to PUC.Datarequest@state.or.us.

(3) The party answering the data request must provide a response or an electronic mail notification of upload to a designated shared workspace to the submitting party and all other parties that filed a written request for a copy of the response. A party must agree to be bound by the applicable protective order to be eligible to receive a response containing confidential information.

(4) A party may offer into evidence data requests and the answers to the data requests. Any objection to substance or form of a data request or answer must be attached to the submitted data request or answer with specific reference and grounds. Every remedy available to a party using deposition procedures is available to a party using data requests.

(5) Except when requested by the Commission or ALJ, or when seeking resolution of a discovery dispute under these rules, data requests are not filed with the Filing Center or provided to the ALJ.

Stat. Auth.: ORS 756.040 & 756.060
Stats. Implemented: ORS 756.040 & 756.500 – 756.575
Hist.: PUC 5-2010, f. & cert. ef. 10-22-10; PUC 1-2015, f. & cert. ef. 3-3-15

860-016-0000
Definitions and Filing Dates

As used in Division 016 of the rules:

(1) "The Act" means the federal Communications Act of 1934, as amended by the Telecommunications Act of 1996.

(2) "Arbitration" means the submission of a dispute for resolution by a neutral third party appointed by the Commission pursuant to Section 252(b) of the Act.

(3) "Commission" means the Public Utility Commission of Oregon.

(4) "Mediation" means a process in which a neutral third party assists negotiating parties to reach their own solution pursuant to Section 252(a)(2) of the Act.

(5) "Petitioner" means a person who has filed a petition for arbitration under the Act.

(6) "Respondent" means the party to a negotiation, which did not make the request for arbitration.

(7) Filing dates are calculated and enforced per OAR 860-001-0150.

Stat. Auth.: ORS 183 & 756
Stats. Implemented: 47 USC 252
Hist.: PUC 8-1998, f. & cert. ef. 4-8-98; PUC 25-2001, f. & cert. ef 11-5-01; PUC 6-2002, f. & cert. ef. 2-13-02; PUC 1-2015, f. & cert. ef. 3-3-15

860-016-0020
Agreements Arrived at Through Negotiation

(1) Upon receiving a request for interconnection, services, or network elements pursuant to Section 251 of the Act, the affected telecommunications carrier may negotiate and enter into a binding agreement with the requesting telecommunications carrier.

(2) The negotiating parties may ask a mediator outside the Commission to help them reach agreement. If they request the Commission to mediate, the Commission will use an Administrative Law Judge (ALJ) or a member of the utility Staff to mediate. Only the negotiating parties and the mediator will participate in mediation sessions.

(3) After the parties reach agreement under Section 252(a) of the Act, they must file an application with the Commission seeking approval of the agreement, or for approval of an amendment to an approved agreement on file with the Commission. The application must include the negotiated agreement and a completed Carrier-to-Carrier Agreement Checklist. A copy of the checklist is available on the Commission's website. The parties may also include any other supporting information with their application. The application and checklist must be filed electronically as required in OAR 860-001-0170.

(4) The Commission will approve or reject the agreement within 90 days of filing, with written findings as to any deficiencies. Prior to rejecting the agreement, the Commission will notify the negotiating parties of its intended action and provide an opportunity for the carriers to respond. The grounds for rejection are that the agreement:

(a) Discriminates against a carrier not a party to the agreement; or

(b) Is not consistent with the public interest, convenience, and necessity. Applicable Commission policies will be a factor in public interest, convenience, and necessity determinations.

Stat. Auth.: ORS 183 & 756
Stats. Implemented: 47 USC 252
Hist.: PUC 8-1998, f. & cert. ef. 4-8-98; PUC 25-2001, f. & cert. ef 11-5-01; PUC 6-2002, f. & cert. ef. 2-13-02; PUC 12-2004(Temp), f. & cert. ef. 8-31-04 thru 2-26-05; PUC 2-2005, f. & cert. ef. 2-11-05; PUC 11-2006, f. & cert .ef. 12-15-06; PUC 1-2015, f. & cert. ef. 3-3-15

860-016-0021
Wholesale Promotions

(1) A carrier intending to offer a wholesale promotion that would modify the terms of a Carrier-to-Carrier Agreement must provide the Commission and other telecommunications carriers notice of the promotion at least 30 days prior to the effective date of the promotion. The notice to the Commission must include:

(a) A copy of a form contract, containing the terms and conditions of the promotional offering that would be submitted as an amendment to an existing Carrier-to-Carrier Agreement; and

(b) A description of the means used to notify other telecommunications carriers of the promotion.

(2) The offering carrier must file the notice with the Commission and must include a completed Carrier-to-Carrier Agreement Checklist, a copy of which is available on the Commission's website. The notice and checklist must be filed electronically as required in OAR 860-001-0170.

(3) The Commission will approve the form contract unless it finds that the contract, if filed as an amendment to an interconnection agreement, would be subject to rejection under OAR 860-016-0020(4).

(4) If another carrier accepts the promotional offering, the offering and accepting carriers must file, within 10 days of execution by the parties, an amendment to an existing Carrier-to-Carrier Agreement incorporating the exact terms and conditions of the approved amendment in the form contract. Any such filed amendment will be deemed effective upon the later of the Commission approval of the form contract or execution of the amendment by the parties.

Stat. Auth.: ORS 183 & 756
Stats. Implemented: 47 USC 252
Hist.: PUC 12-2004(Temp), f. & cert. ef. 8-31-04 thru 2-26-05; PUC 2-2005, f. & cert. ef. 2-11-05; PUC 11-2006, f. & cert .ef. 12-15-06; PUC 1-2015, f. & cert. ef. 3-3-15

860-016-0025
Adoption of Previously Approved Agreement or Statement of Generally Available Terms

(1) If a requesting telecommunications carrier decides to adopt an identical agreement or an identical individual arrangement contained in an agreement, pursuant to Section 252(i) of the Act and 47 CFR Section 51.809, with the exception of the adopting party's name and new effective date, previously approved by and on file with the Commission, or a Statement of Generally Available Terms approved by the Commission under OAR 860-016-0040, it must file notice of the adoption with the Commission. The notice must include a completed Carrier-to-Carrier Agreement Checklist.

(2) The notice documents must be filed electronically as required in OAR 860-001-0170.

(3) If the notice is filed jointly with the affected telecommunications carrier, the adoption becomes effective on the date filed.

(4) If the notice is filed unilaterally by the requesting telecommunications carrier, the requesting telecommunications carrier must simultaneously provide notice of the adoption to the affected carrier. The affected carrier may then file objections to the adoption within 21 calendar days of such notice. If no objections are filed, the adoption becomes effective on the 22nd day after filing.

(5) An affected carrier may object to an adoption on the following grounds:

(a) The costs of providing a particular interconnection, service, or element to the requesting telecommunications carrier are greater than the costs of providing it to the telecommunications carrier that originally negotiated the agreement;

(b) The provision of a particular interconnection, service, or element to the requesting carrier is not technically feasible;

(c) There is new federal or state law that requires modification of the agreement proposed to be adopted;

(d) The agreement proposed to be adopted has expired or been cancelled; or

(e) The proposed adoption is unlawful.

(6) If the affected carrier files objections, the requesting carrier may file a reply within 14 calendar days after the objections are filed. An assigned Administrative Law Judge (ALJ) will schedule a conference within 5 business days after the reply is filed, to be held as soon thereafter as practicable. At the conference, the ALJ will determine whether the issues raised by the affected carrier's objection can resolved based on the pleadings and all supporting documentation, or whether further proceedings are necessary. If further proceedings are necessary, the ALJ will establish a schedule for resolving the dispute on an expedited basis. Pending resolution

of the dispute, other provisions of the proposed adoption not contested by the affected carrier will become effective.

Stat. Auth.: ORS 183 & 756
Stats. Implemented 47 USC 252
Hist.: PUC 25-2001, f. & cert. ef 11-5-01; PUC 6-2002, f. & cert. ef. 2-13-02; PUC 11-2006, f. & cert .ef. 12-15-06; PUC 1-2015, f. & cert. ef. 3-3-15

860-016-0030
Arbitration of Disputes

(1) Negotiating parties may engage the services of an outside arbitrator rather than file a petition with the Commission. If the negotiating parties petition the Commission to arbitrate their dispute, the Commission will use an ALJ as arbitrator unless workload constraints necessitate the use of an outside arbitrator.

(2) A petition for arbitration must contain:

(a) Identification of the parties' representatives, including contact information with electronic mail addresses;

(b) A statement of all unresolved issues;

(c) A description of each party's position on the unresolved issues;

(d) A proposed agreement addressing all issues, including those on which the parties have reached agreement and those that are in dispute. Wherever possible, the petitioner should rely on the fundamental organization of clauses and subjects contained in an agreement previously approved by the Commission; and

(e) Documentation showing that the request complies with the time requirements of the Act.

(3) Respondent may file a response within 25 days of the request for arbitration. In the response, the respondent must address each issue listed in the request, describe the respondent's position on those issues, and identify and present any additional issues for which the respondent seeks resolution.

(4) The arbitration will be conducted in a manner similar to a contested case proceeding, and the arbitrator will have the same authority to conduct the arbitration process as an ALJ has in conducting hearings under the Commission's rules. However, the arbitration process will be streamlined to meet the Act's timelines. An early conference will be held to discuss processing of the case, and to receive the proposal put forth by each party. The arbitrator will establish the schedule, and decide whether an oral hearing would be helpful. After the oral hearing or other procedures (for example, rounds of comments), each party will submit its "final offer" proposed agreement. The arbitrator will choose between the two final offers. However, if neither offer is consistent with the Act and Commission policies, the arbitrator will make an award that meets those requirements.

(5) Formal discovery procedures will be allowed only to the extent deemed necessary by the arbitrator. Parties will be required to cooperate in good faith in voluntary, prompt, and informal exchanges of information relevant to the matter. Unresolved discovery disputes will be resolved by the arbitrator upon request of a party. The arbitrator will order a party to provide information if the arbitrator determines the requesting party has a reasonable need for the requested information and that the request is not overly burdensome.

(6) Only the two negotiating parties will have full party status. The arbitrator may confer with Staff for assistance throughout the arbitration process. If Staff assistance is desired, the arbitrator will notify (by telephone or other means) the parties at least 24 hours before the consultation with Staff. The parties may attend or listen to the consultation and may respond in a manner allowed by the arbitrator.

(7) To keep the process moving forward, appeals to the Commission will not be allowed during the arbitration process. An arbitrator may certify a question to the Commission if deemed necessary.

(8) To accommodate the need for flexibility, the arbitrator may use procedures that vary from those set out here if the arbitrator deems it helpful in a particular arbitration, as long as the procedures are fair, treat the parties equitably, and substantially comply with the procedures listed here.

(9) Each arbitration award must:

(a) Ensure that the requirements of sections 251 and 252 of the Act and any valid applicable Federal Communications Commission regulations under that section are met;

(b) Establish interconnection and network element prices consistent with the Act;

(c) Establish a schedule for implementation of the agreement; and

(d) Be consistent with Commission policies.

(10) After an arbitration award is submitted to the Commission, notice will be served on those who have indicated a desire to receive notice of mediated and arbitrated agreements. Any person may then file comments within 10 days of service of the award.

(11) The Commission will accept or reject an arbitration award within 30 days.

(12) Within 14 days after the Commission issues its arbitration decision, petitioner must prepare an interconnection agreement complying with the terms of the arbitration decision and serve it on respondent. Within 10 days of service of this interconnection agreement, respondent must either sign and file the agreement or file objections to it. If objections are filed, respondent must state how the agreement fails to comply with the arbitration decision, and offer substitute language complying with the decision. The Commission will approve or reject a filed interconnection agreement within 30 days of its filing, or the agreement will be deemed approved. If petitioner, without respondent's consent, fails to timely prepare and serve an interconnection agreement on respondent, respondent may file a motion requesting the Commission dismiss the petition for arbitration with prejudice. The Commission may grant such motion if the petitioner's failure to timely prepare and serve the interconnection agreement was the result of inexcusable neglect on the part of petitioner.

Stat. Auth.: ORS 756
Stats. Implemented: 47 USC 252
Hist.: PUC 8-1998, f. & cert. ef. 4-8-98; PUC 11-2006, f. & cert .ef. 12-15-06; PUC 1-2015, f. & cert. ef. 3-3-15

860-016-0050
Petitions for Enforcement of Interconnection Agreements

(1) This rule specifies the procedure for a telecommunications provider, as defined in OAR 860-032-0001, to file a complaint for the enforcement of an interconnection agreement executed pursuant to the Telecommunications Act of 1996 (the Act). This includes interconnection agreements, resale agreements, agreements for the purchase or lease of unbundled network elements (UNEs), or statements of generally available terms and conditions (SGATs), whether those agreements were entered into through negotiation, mediation, arbitration, or adoption of a prior agreement or portions of prior agreements. Section (13) of this rule specifies procedures for complaints alleging that telecommunications utilities have engaged in prohibited acts under ORS 759.455.

(2) At least 10 days prior to filing a complaint for enforcement, complainant must give written notice to defendant and the Commission that complainant intends to file a complaint for enforcement. The notice must identify the provisions in the agreement that complainant alleges were or are being violated and the specific acts or failure to act that caused or are causing the violation, and whether complainant anticipates requesting temporary or injunctive relief. On the same day the notice is filed with the Commission, complainant must serve a copy of the notice on defendant's authorized representative, attorney of record, or designated agent for service of process. Complainant must also serve the notice on all persons designated in the interconnection agreement to receive notices;

(3) A complaint for enforcement of an interconnection agreement must:

(a) Contain a statement of specific facts demonstrating that the complainant conferred with defendant in good faith to resolve the dispute, and that despite those efforts the parties failed to resolve the dispute;

(b) Include a copy of the written notice, required by section (2), indicating that the complainant intends to file a complaint for enforcement;

(c) Include a copy of the interconnection agreement or the portion of the interconnection agreement that the complainant contends was or is being violated. If a copy of the entire interconnection agreement is provided, complainant must specify provisions at issue. If the interconnection agreement adopted a prior agreement or portions of prior agreements, the complaint must also indicate the provisions adopted in those agreements;

(d) Contain a statement of the facts or law demonstrating defendant's failure to comply with the agreement and complainant's entitlement to relief. The statement must indicate that the remedy sought is consistent with the dispute resolution provisions in the agreement, if any. Statements of facts must be supported by written testimony with affidavits, made by persons competent to testify and having personal knowledge of the relevant facts. Statements of law must be supported by appropriate citations. If exhibits are attached to the affidavits, the affidavits must contain the foundation for the exhibits;

(e) Designate up to three persons to receive copies of other pleadings and documents;

(f) Include any motions for affirmative relief, filed as a separate document and clearly marked. Nothing in this subsection precludes complainant from filing a motion subsequent to the filing of the complaint if the motion is based upon facts or circumstances unknown or unavailable to complainant at the time the complaint was filed; and

(g) Include an executive summary, filed as a separate document not to exceed 8 pages, outlining the issues and relief requested.

(4) On the same day the complaint is filed with the Commission, complainant must serve a copy of the complaint on defendant's authorized representative, attorney of record, or designated agent for service of process. Service may be by electronic mail, fax, or overnight mail, but the complaint must arrive at defendant's location on the same day the complaint is filed with the Commission. Service by electronic mail or fax must be followed by a physical copy the next day by overnight delivery.

(5) Within 10 business days after service of the complaint, defendant may file an answer with the Commission. Any allegations raised in the complaint and not addressed in the answer are deemed admitted. The answer must:

(a) Contain a statement of specific facts demonstrating that the defendant conferred with complainant in good faith to resolve the dispute, and that despite those efforts the parties failed to resolve the dispute;

(b) Respond to each allegation set forth in the complaint and set forth all affirmative defenses;

(c) Contain a statement of the facts or law supporting defendant's position. Statements of facts must be supported by written testimony or one or more affidavits, made by persons competent to testify and having personal knowledge of the relevant facts. Statements of law must be supported by appropriate citations. If exhibits are attached to the affidavits, the affidavits must contain the foundation for the exhibits; and

(d) Designate up to three persons to receive copies of other pleadings and documents;

(6) On the same day as the answer is filed, the defendant must also file its response to any motion filed by complainant and its motions for affirmative relief. Each response and each motion must be filed as a separate filing. Nothing in this section precludes defendant from filing a motion subsequent to the filing of the answer if the motion is based upon facts or circumstances unknown or unavailable to defendant at the time the answer was filed.

(7) On the same day the answer is filed with the Commission, defendant must serve a copy of the answer to the complainant's authorized representative, attorney of record, or designated agent for service of process.

(8) Complainant must file a reply to an answer that contains affirmative defenses within 5 business days after the answer is filed. On the same day the reply is filed with the Commission, complainant must serve a copy of the reply to defendant's authorized representative, attorney of record, or designated agent for service of process.

(9) A cross-complaint or counterclaim must be answered within the 10-business day time frame allowed for answers to complaints.

(10) The Commission will conduct a conference regarding each complaint for enforcement of an interconnection agreement.

(a) The Administrative Law Judge (ALJ) will schedule a conference within 5 business days after the answer is filed, to be held as soon as practicable. At the discretion of the ALJ, the conference may be conducted by telephone;

(b) Based on the complaint and the answer, all supporting documents filed by the parties, and the parties' oral statements at the conference, the ALJ will determine whether the issues raised in the complaint can be determined on the pleadings and submissions without further proceedings or whether further proceedings are necessary. If further proceedings are necessary, the ALJ will establish a procedural schedule. The procedural schedule may include a mandatory mediation session. Either party may request that a person other than the ALJ preside over the mediation. Nothing in this subsection is intended to prohibit the bifurcation of issues where appropriate;

(c) In determining whether further proceedings are necessary, the ALJ will consider, but is not limited to, the positions of the parties; the need to clarify evidence through the examination of witnesses; the complexity of the issues; the need for prompt resolution; and the completeness of the information presented;

(d) The ALJ may make oral rulings on the record during the conference on all matters relevant to the conduct of the proceeding.

(11) A party may file with the complaint or answer a request for discovery, stating the matters to be inquired into and their relationship to matters directly at issue.

(12) When warranted by the facts, the complainant or defendant may file a motion requesting that an expedited procedure be used. The moving party must file a proposed expedited procedural schedule along with its motion. The ALJ will schedule a conference to be held as soon as practicable, to determine whether an expedited schedule is warranted.

(a) The ALJ will consider whether the issues raised in the complaint or answer involve a risk of imminent, irrevocable harm to a telecommunications provider and to the public interest;

(b) If a determination is made that an expedited procedure is warranted, the ALJ will establish a procedure that ensures a prompt resolution of the merits of the dispute, consistent with due process and other relevant considerations. The ALJ will consider, but is not bound by, the moving party's proposed expedited procedural schedule;

(c) An expedited procedure may be appropriate if the complainant shows that its ability to provide telecommunications services will be substantially harmed unless the Commission acts promptly. In general, the Commission will not entertain a motion for expedited procedure where the dispute solely involves the payment of money.

(13) Procedures for complaints alleging violation of ORS 759.455.

(a) An answer under section (5) of this rule must be filed with the Commission and served on the complainant within 10 calendar days after service of the complaint;

(b) A reply under section (8) of this rule must be filed with the Commission and served on the defendant within 5 calendar days after the answer is filed;

(c) The ALJ will schedule a conference to be held not later than 15 calendar days after the complaint is filed;

(d) A hearing will begin no later than 30 days after the complaint is filed;

(e) The ALJ may consult with the Commission Staff in the manner set forth in OAR 860-016-0030(6).

Stat. Auth.: ORS 183 & 756
Stats. Implemented: ORS 756.040, 756.518, 759.030(1), 759.455, Ch. 1093, OL 1999 & 47 USC § 252
Hist.: PUC 7-1999, f. & cert. ef. 10-18-99; PUC 7-2000, f. & cert. ef. 5-3-00; PUC 21-2002, f. & cert. ef. 12-9-02; PUC 1-2005, f. & cert. ef. 2-2-05; PUC 1-2015, f. & cert. ef. 3-3-15

860-021-0015
Dispute Resolution

(1) When a dispute occurs between a customer or applicant and a utility about any charge or service, the utility must:

(a) Thoroughly investigate the matter;

(b) Promptly report the results of its investigation to the complainant;

(c) Inform the complainant of the right to have a utility supervisor review any dispute;

(d) Prepare a written record of the dispute including the name and address of the complainant involved, the date the complaint was received, the issues in dispute, and the disposition of the matter; and

(e) Retain records of the dispute for at least 36 months after the investigation is closed.

(2) If the utility and complainant cannot resolve the dispute, the utility must inform the complainant of the right to contact the Consumer Services Section and request assistance in resolving the dispute. The utility must provide the following contact information for the Consumer Services Section:

(a) Telephone: 503-378-6600; 1-800-522-2404; TTY 711;

(b) Mailing address: Public Utility Commission of Oregon, Consumer Services Section, PO Box 1088, Salem, Oregon 97308;

(c) Physical address: Public Utility Commission of Oregon, 3930 Fairview Industrial Drive SE, Salem, Oregon 97302;

(d) Electronic mail address: puc.consumer@state.or.us; and

(e) Website: http://www.puc.state.or.us/consumer/customer%20complaint%20process.pdf.

(3) The Consumer Services Section will investigate any dispute upon request to determine whether it can be resolved as an informal complaint.

(4) If the Consumer Services Section cannot resolve the dispute the complainant may file a formal written complaint with the Commission under ORS 756.500. The formal complaint must be submitted on an approved form available from the Consumer Services Section.

(a) The complaint must be filed electronically with the Filing Center at PUC.FilingCenter@state.or.us.

(b) If complainant does not have access to electronic mail,

(A) The complaint may be mailed, faxed, or delivered to the Filing Center at the address set out in OAR 860-001-0140; and

(B) The complaint must include a request for waiver of electronic service and filing requirements. This request is included on the form available from the Commission's Consumer Services Division.

(c) The Commission will serve the complaint on the utility. The Commission may electronically serve the utility with the complaint if the electronic mail address is verified prior to service of the complaint and the delivery receipt is maintained in the official file.

(d) The utility must answer the complaint within 15 days of service of the complaint by the Commission.

(e) The Commission will determine a procedural schedule after the utility's answer is filed. The utility must serve a copy of its answer on the complainant.

(A) If the utility files a motion to dismiss, the complainant may file a response within 15 days of the motion. If the complainant responds, the complainant must file the response with the Filing Center and send a copy to the utility. The Commission may make a decision on the formal complaint based on the information in the complaint, the utility's response and motion to dismiss, and the complainant's response to the utility's motion; or

(B) The Commission may set a procedural schedule for the complaint proceedings, including but not limited to, scheduling dates for receiving additional information from the parties, telephone conferences, or a hearing. A hearing may be held on less than 10 days' notice when good cause is shown.

(5) Upon filing a formal complaint, the complainant may request a hearing to determine whether the complainant is entitled to continued or restored service pending the resolution of the complaint. Unless extraordinary circumstances exist, the Commission will conduct the hearing by telephone within 3 business days. Notice of the hearing will be provided to the complainant and the utility at least 12 hours before the date and time of the hearing. Pending resolution of the dispute, the complainant's obligation to pay undisputed amounts continues.

(6) A complainant who has a registered dispute or formal complaint pending with the Commission is entitled to continued or restored service provided:

(a) Service was not terminated for tampering with utility property, stealing, diverting, or using unauthorized service, or failure to establish credit;

(b) A bona fide dispute exists in which the facts asserted entitle the complainant to service;

(c) When termination is based on nonpayment, the customer agrees to pay undisputed charges; and

(d) The complainant diligently pursues conflict resolution under the Commission's rules.

(7) If the conditions in section (6) of this rule are not satisfied, the utility has no obligation to provide continued service. A utility discontinuing service because of a failure to meet the conditions of subsections (6)(c) or (6)(d) of this rule must give the customer five-day notice served in the same manner as provided by OAR 860-021-0405 or 860-021-0505, whichever applies, except the notice need only describe the defect in performance, the date and time when utility service will terminate, and the toll-free number of the Commission's Consumer Services Division.

Stat. Auth.: ORS 183, 756, 757 & 759
Stats. Implemented: ORS 756.040, 756.500 & 756.512
Hist.: PUC 164, f. 4-18-74. ef. 5-11-74 (Order No. 74-307); PUC 5-1983, f. 5-31-83, ef. 6-1-83 (Order No. 83-284); PUC 12-1983, f. & ef. 10-7-83 (Order No. 83-623); PUC 1-1985, f. & ef. 2-1-85 (Order No. 85-075); PUC 4-1985, f. & ef, 4-22-85 (Order No. 85-350); PUC 5-1987, f. & ef. 7-2-87 (Order No. 87-723); PUC 16-1990, f. 9-28-90, cert. ef. 10-1-90 (Order No. 90-1105); PUC 11-1998, f. & ef. 5-7-98 (Order No. 98-188); PUC 8-1999, f. & cert. ef. 10-18-99; PUC 19-2001, f. & cert. ef. 6-21-01; PUC 11-2003, f. & cert. ef. 7-3-03; PUC 6-2013, f. & cert. ef. 8-7-13; PUC 1-2015, f. & cert. ef. 3-3-15

860-022-0005
Tariff Specifications for Energy Utilities and Large Telecommunications Utilities

(1) Form and style of tariffs:

(a) Each energy or large telecommunications utility must designate the initial tariff as PUC Oregon No. 1, and designate successive tariffs with the next number in consecutive numerical order. Supplemental information not otherwise provided by the tariff must be inserted in the most appropriate location and denoted by the previous sheet numbers plus a letter, for example, 3A, 3B, etc. Revisions to tariffs must be denoted by 1st Revised Sheet No. 3, 2nd Revised Sheet No. 3, etc.;

(b) The title page should be uniform. Rates, rules, and regulations must be written only on one side of a sheet. If a single sheet is insufficient, two or more pages should be used; and

(c) Separate tariffs must be filed for electric, telecommunications, telegraph, gas, heat, or for any other service entered.

(2) Size of tariffs and copies required: an

(a) Tariffs and supplements thereto must be prepared using a readable font that, when printed, will fit on an 8-1/2 x 11 inch page; and

(b) Energy and large telecommunication utilities must file with the Commission an original of each tariff, rate schedule, revision, or supplement in electronic form as required in OAR 860-001-0170. The advice letter accompanying the tariffs must bear the signature of the issuing officer or utility representative. The tariffs do not require a signature.

Stat. Auth.: ORS 183, 756 & 757
Stats. Implemented: ORS 757.205
Hist.: PUC 164, f. 4-18-74, ef. 5-11-74 (Order No. 74-307); PUC 176, f. 11-17-76, ef. 12-1-76 (Order No. 76-806); PUC 15-1987, f. & ef. 12-3-87 (Order No. 87-1185); PUC 8-1995, f. & cert. ef. 8-30-95 (Order No. 95-858); PUC 9-1998, f. & cert. ef. 4-28-98; PUC 16-2001, f. & cert. ef. 6-21-01; PUC 18-2004, f. & cert. ef. 12-30-04; PUC 1-2015, f. & cert. ef. 3-3-15

860-022-0047
Recovery of Certain Facility Relocation Costs

(1) This rule provides a means for a utility to recover from its customers the unreimbursed costs of facility relocation activities required by a public body, as provided in ORS 758.025.

(2) As used in this rule:

(a) "Facility" or "facilities" refers to a utility's tangible plant which ordinarily has a service life of more than one year that provides utility service, and is included in the utility's books of account as Telecommunications Plant in Service (account 2001. 47 C.F.R. 32).

(b) "Facility costs" represent the cost of materials installed because of a facility relocation required by a public body.

(c) "Nonfacility costs" are those non-material costs (e.g. labor) incurred to place or move utility facilities and which are authorized for recovery by the utility under this rule.

(d) "Public body" has the meaning given that term in ORS 174.109.

(e) "Recoverable relocation costs" has the meaning given in ORS 758.025(5)(a).

(f) "Undepreciated value of facilities replaced" represents the net book value (original cost minus accumulated depreciation) of the facilities removed or retired.

(g) "Utility" means a telecommunications utility or competitive telecommunications provider, as those terms are defined in ORS 759.005.

(3) A telecommunications utility that is not subject to rate-of-return regulation, including a utility regulated under ORS 759.255 may, after participating in the process described in 758.025(3), petition the Commission for approval to recover from its customers prudent costs incurred for the relocation of facilities required by a public body that are not otherwise paid or reimbursed from another source.

(4) The utility's petition must follow the requirements of filing for contested cases found in OAR Chapter 860, Division 001 and include:

(a) The name of the utility as it appears on its certificate of authority.

(b) The name, telephone number, electronic mail address, and mailing address of the person to be contacted for additional information about the petition.

(c) The name, telephone number, electronic mail address, and mailing address of the person to be contacted for regulatory information, if different from the person specified in subsection (b) of this section.

(d) A general description of the relocation project or projects including a statement as to why the relocation was necessary and unavoidable, and a description of the locations and public bodies involved.

(e) A statement that, for each project identified in subsection (d) above, the utility participated in the planning and design process described in ORS 758.025(3).

(f) Evidence from each public body that the public body required the utility to relocate its facilities within the public body's jurisdiction.

(g) A general statement of the overall impact on the utility of the relocation project or projects.

(h) One or more schedules of costs for which the utility seeks recovery. The utility must:

(A) Include in its petition only those costs directly related to a relocation required by a public body.

(B) Exclude any costs subject to reimbursement from other sources, such as state or federal highway funds.

(C) Identify capital and expense costs separately.

(D) Identify facility and nonfacility costs separately.

(E) Exclude all costs related to improvements and upgrades, except that costs related to mandatory conversions ordered by a public body may be included.

(F) Ensure that all schedules, plant records, and job costs meet FCC accounting requirements (47 C.F.R. 32).

(G) Limit recoverable facility costs to the undepreciated value of the facilities replaced.

(i) The utility's proposed allocation of costs between services, customers, jurisdictions, or other groups as appropriate.

(j) The utility's proposed method of cost recovery.

(A) Approved relocation costs may be recovered by one or more line items on customer bills.

(B) The utility may propose alternative forms of cost recovery subject to Commission review and approval.

(C) Line items must not be described on the customer's bill as a tax or other mandatory government fee.

(k) The utility's proposed time period for cost recovery. A utility may recover its cost over no less than twelve months, subject to an annual true up.

(l) A copy of the customer notice required by section (8) of this rule.

(m) An affidavit of notice required by section (10) of this rule.

(5) The petition may include any other relevant information the utility wishes the Commission to consider.

(6) If the utility designates any portion of the petition to be confidential, it must provide an affidavit stating the legal basis for the claim of confidentiality and comply with the requirements of OAR 860-001-0070 or 860-001-0080.

(7) The petition must be filed at least 90 days before the proposed effective date of the cost recovery.

(8) The customer notice (notice) must include:

(a) The name of the utility as it normally appears on a customer bill.

(b) A statement that the utility has petitioned the Commission for recovery of certain mandatory facility relocation costs.

(c) The proposed impact on the customer's bill and the proposed duration of any cost recovery billing.

(d) The proposed effective date of cost recovery billing.

(e) A statement that customers may submit objections or comments regarding the petition to the Commission within 45 days of receipt of the notice.

(f) The name, telephone number, electronic mail address, and mailing address of the utility's contact person for more information.

(9) The utility must provide the notice:

(a) To all customers whose bills will be affected if the requested cost recovery is approved by the Commission.

(b) To affected customers on or before the date the utility submits its petition for cost recovery to the Commission.

(c) To persons who are not customers of the utility if the utility seeks cost recovery from those persons. The utility must explain in its petition why those persons should contribute to the utility's cost recovery. The utility must provide notice to those persons at the same time as the utility provides notice to its customers.

(10) The affidavit of notice must include:

(a) A certificate of service stating when and by what means (for example, direct mail, bill message, bill insert, or electronic mail) the notice was provided to the persons identified in section (9) above.

(b) A statement of efforts taken by the utility to provide notice in those instances when service was not completed.

(11) The utility must identify in its petition its recoverable costs that are substantial and beyond the normal course of business, subject to Commission review and approval.

(12) In its review of the petition under ORS 758.025(5), the Commission will:

(a) Verify the utility's participation in the design and planning process described in ORS 758.025(3).

(b) Verify the relocation costs for which the utility requests recovery.

(c) Determine the allocation of costs between interstate and intrastate services, geographic areas, customers and services.

(d) Prescribe the method of cost recovery.

(13) The Commission may audit any relocation costs or other information submitted by the utility.

(14) The Commission may administratively approve an unopposed petition without a hearing. For good cause, the Commission may suspend the effective date of a petition (whether opposed or unopposed) without a hearing for a period not to exceed six months.

(15) If opposition to the petition is filed with the Commission within 45 days of service of the notice, the Commission will schedule a conference to determine the schedule and proceedings necessary to complete its review of the petition. Contested cases will follow the procedures in OAR Chapter 860, Division 001.

(16) The utility must file the approved surcharge (or other approved cost recovery mechanism) in its tariff and price list before it can bill the surcharge to its customers.

(17) With respect to relocation of utility facilities required by a public body, this rule does not supersede any franchise agreement, ordinance, or applicable state law.

(18) This rule applies to relocations for which construction began on or after January 1, 2010.

Stat. Auth.: ORS Ch. 183, 756, 758 & 759
Stats. Implemented: ORS 758.025
Hist.: PUC 5-2012, f. & cert. ef. 8-23-12; PUC 1-2015, f. & cert. ef. 3-3-15

860-023-0151
Annual Report on Electric Reliability

(1) On or before May 1 of each year, an electric company must file with the Commission a report that includes the information set forth in section (2) of this rule for the reporting period. The electric company must file the report in electronic form. The electric company must make electronic copies of the report available to the public upon request. For paper copies requested by the public, the electric company may charge a reasonable cost for production of the copy.

(2) The annual Electric Service Reliability Report must contain:

(a) The results of the calculated SAIDI, SAIFI, and MAIFIE indices required by OAR 860-023-0111. The electric company must also report this information on a system-wide basis compared with the previous four years' performance, and on a reliability reporting area basis compared with the previous four years' performance.

(b) A summary of system-wide and reliability reporting area sustained interruption causes compared to the previous four-year performance. Cause categories to be evaluated include:

(A) Loss of Supply — Transmission;
(B) Loss of Supply — Substation;
(C) Distribution — Equipment;
(D) Distribution — Lightning;
(E) Distribution — Planned;
(F) Distribution — Public;
(G) Distribution — Vegetation;
(H) Distribution — Weather (other than lightning);
(I) Distribution — Wildlife;
(J) Distribution — Unknown; and
(K) Distribution — Other.

(c) A listing of the Major Events experienced during the reporting period, including reliability reporting area involved; operating areas involved; dates involved; TMED applied; interruption causes; and SAIDI, SAIFI, and CAIDI impacts to customers for the Event on both a reliability reporting area basis and a system-wide basis.

(d) A listing of the TMED values that will be used for each reliability reporting area for the forthcoming annual reporting period compared with the previous four years of TMED values.

(e) A summary of the characteristics of the systems covered under OAR 860-023-0091(4) and estimation methodologies covered by OAR 860-023-0101(3) and 860-023-0111(3) for the collection of interruption data, calculation of reliability information, and facilitation of interruption restoration and mitigation.

(f) A summary addressing the changes that the electric company has made or will make in the collection of data and the calculation, estimation, and reporting of reliability information. The electric company must explain why the changes occurred and explain how the change affects the comparison of newer and older information.

(g) A map showing the reliability reporting areas and operating- areas.

(h) A listing of circuits by reliability reporting area and substation, indicating circuit voltage and number of customers connected.

(3) This rule is effective beginning January 1, 2012.

Stat. Auth.: ORS 183, 756 & 757
Stats. Implemented: ORS 757.020
Hist.: PUC 10-2011, f. 10-14-11, cert. ef. 1-1-12; PUC 1-2015, f. & cert. ef. 3-3-15

860-025-0060
Reinstatement of Carrier of Last Resort (COLR) Obligations

(1) Any resident or occupant of the property for which the Commission allowed an exemption of the COLR obligations under OAR 860-025-0055, or the exempted COLR utility, may petition the Commission to reinstate the COLR obligations.

(2) The petition for reinstatement of the COLR obligations must be filed as set forth in OAR 860-001-0140 and 860-001-0170 and include the information required in OAR 860-001-0400(2) and the proposed effective date of COLR obligations reinstatement.

(3) Within 14 days of the filing of a complete petition for reinstatement of the COLR obligations, the Commission will electronically serve notice of the petition on the COLR identified in the petition (unless the petitioner is the exempted COLR), the Commission's general notification list, and the service list of the docket under which the COLR exemption was granted.

(4) The Petitioner must serve notice of the petition upon:

(a) The property owner or developer;

(b) The residents within the property that the COLR is able to identify.

(5) The Commission will conduct contested case proceedings, including a public hearing, to determine if the existing public convenience and necessity require reinstatement of the COLR obligations. The petitioner has the burden of proving that the COLR should be reinstated. Parties to the proceedings may present in support of or opposition to the petition for the Commission's consideration:

(a) Evidence of the willingness of at least 60 percent of the occupants or residents of the property (including the Petitioner) to subscribe to the utility's service and pay for the incremental cost of providing the service;

(b) Evidence of the estimated costs of the telecommunications utility, cooperative corporation, or municipality to serve the exempted area that are over and above the original cost to serve;

(c) The service record of the Alternative Service Provider, including but not limited to, statistics about complaints, delays, and service quality;

(d) Legal argument or evidence as to why reinstating COLR obligations to the telecommunications utility, cooperative corporation, or municipality is or is not in the public interest; and

(e) Other relevant evidence that the parties wish to be considered by the Commission.

(6) If the Commission determines that the existing public convenience and necessity requires reinstatement of the COLR obligations to the exempted COLR:

(a) The COLR may not be required to incur any costs until the incremental costs necessary to construct the facilities to provide service have been received from the parties identified in section 5(a) of this rule. The COLR may not unreasonably deny payment terms in lieu of one-time payments; and

(b) The COLR must receive from the existing provider (if any) the access necessary for the COLR to install and maintain its facilities, including necessary easements, before the Commission requires the COLR to re-establish service. The existing provider may not unreasonably deny such access.

Stat. Auth: ORS 756.060, 759.036, & 759.506
Stats. Implemented: ORS 759.506
Hist.: PUC 4-2011, f. & cert. ef. 8-26-11; PUC 1-2015, f. & cert. ef. 3-3-15

860-027-0300
Use of Deferred Accounting by Energy and Large Telecommunications Utilities

(1) As used in this rule:

(a) "Amortization" means the inclusion in rates of an amount which has been deferred under ORS 757.259 or 759.200 and which is designed to eliminate, over time, the balance in an authorized deferred account. Amortization does not include the normal positive and negative fluctuations in a balancing account;

(b) "Deferred Accounting" means recording the following in a balance sheet account, with Commission authorization for later reflection in rates:

(A) Electric companies, gas utilities, and steam heat utilities: a current expense or revenue associated with current service, as allowed by ORS 757.259; or

(B) Large telecommunications utilities: an amount allowed by ORS 759.200.

(2) Expiration: Any authorization to use a deferred account expires 12 months from the date the deferral is authorized to begin. If a deferral under ORS 757.259 or 759.200 is reauthorized, the reauthorization expires 12 months from the date the reauthorization becomes effective.

(3) Contents of Application: An application for deferred accounting, by an energy or large telecommunications utility or a customer, must include:

(a) A description of the utility expense or revenue for which deferred accounting is requested;

(b) The reason(s) deferred accounting is being requested and a reference to the section(s) of ORS 757.259 or 759.200 under which deferral may be authorized;

(c) The account proposed for recording of the amounts to be deferred and the account which would be used for recording the amounts in the absence of approval of deferred accounting;

(d) An estimate of the amounts to be recorded in the deferred account for the 12-month period subsequent to the application; and

(e) A copy of the notice of application for deferred accounting and list of persons served with the notice.

(4) Reauthorization: An application for reauthorization to use a deferred account must be made not more than 60 days prior to the expiration of the previous authorization for the deferral. An application for reauthorization must include the requirements set forth in subsections (3)(a) through (3)(e) of this rule and the following information:

(a) A description and explanation of the entries in the deferred account to the date of the application for reauthorization; and

(b) The reason(s) for continuation of deferred accounting.

(5) Exceptions: Authorization under ORS 757.259 or 759.200 to use a deferred account is necessary only to add amounts to an account, not to retain an existing account balance and not to amortize amounts which have been entered in an account under an authorization by the Commission. Interest, once authorized to accrue on unamortized balances in an account, may be added to the account without further authorization by the Commission, even though authorization to add other amounts to an account has expired.

(6) Notice of Application: The applicant must serve a notice of application upon all persons who were parties in the energy or large telecommunications utility's last general rate case. If the applicant is other than an energy or large telecommunications utility, the applicant must serve a copy of the application upon the affected utility. A notice of application must include:

(a) A statement that the applicant has applied to the Commission for authorization to use deferred accounting; or for an order requiring that deferred accounting be used by an energy or large telecommunications utility;

(b) A description of the utility expense or revenue for which deferred accounting is requested;

(c) The manner in which a person can obtain a copy of the application;

(d) A statement that any person may submit to the Commission written comment on the application by the date set forth in the notice, which date may be no sooner than 25 days from the date of the application; and

(e) A statement that the granting of the application will not authorize a change in rates, but will permit the Commission to consider allowing such deferred amounts in rates in a subsequent proceeding.

(7) Public Meetings: Unless otherwise ordered by the Commission, applications for use of deferred accounting will be considered at the Commission's public meetings.

(8) Reply Comments: Within ten days after the due date for comments, the applicant, and the energy or large telecommunications utility if the utility is not the applicant, may file reply comments with the Commission. Filing dates for reply comments are calculated and enforced per OAR 860-001-0150.

(9) Amortization: Amortization in rates of a deferred amount is allowed only as authorized by the Commission. The Commission may authorize amortization of such amounts only for utility expenses or revenues for which the Commission previously has authorized deferred accounting. Upon request for amortization of a deferred account, the energy or large telecommunications utility must provide the Commission with its financial results for a 12-month period or for multiple 12-month periods to allow the Commission to perform an earnings review. The period selected for the earnings review will encompass all or part of the period during which the deferral took place or must be reasonably representative of the deferral period. Unless authorized by the Commission to do otherwise:

(a) An energy utility may request that amortizations of deferred accounts commence no later than one year from the date that deferrals cease for that particular account; and

(b) In the case of ongoing balancing accounts, the energy utility may request amortization at least annually, unless amortization of the balancing account is then in effect; or

(c) A large telecommunications utility may request amortization of deferred accounts as soon as practical after the deferrals cease but no later than in its next rate proceeding.

(10) An electric company customer may prepay under ORS 757.259(11) all or a portion of its obligation of deferred power supply expense. The obligation must be calculated as the customer's pro rata share of the utility's total energy usage within the state of Oregon during 2001, multiplied by the unrecovered deferral balance at the time of prepayment. When such customer has prepaid its obligation in full, the customer may no longer be charged the power supply adjustment related to the deferral.

Stat. Auth.: ORS 183, 756, 757 & 759
Stats. Implemented: ORS 756.040, 756.105, 757.259 & 759.200
Hist.: PUC 11-1988, f. & cert. ef. 6-9-88 (Order No. 88-597); PUC 2-1990, f. & cert. ef. 3-2-90 (Order No. 90-235); PUC 12-1997, f. & cert. ef. 10-30-97; PUC 4-1998, f. & cert. ef. 2-24-98; PUC 16-2001, f. & cert. ef. 6-21-01; PUC 6-2004(Temp), f. & cert. ef. 3-24-04 thru 9-20-04; PUC 14-2004, f. & cert. ef. 9-7-04; PUC 7-2005, f. & cert. ef. 11-30-05; PUC 1-2015, f. & cert. ef. 3-3-15

860-028-0070
Resolution of Disputes for Proposed New or Amended Contractual Provisions

(1) This rule applies to a complaint alleging a violation of ORS 757.273, 757.276, 757.279, 757.282, 759.655, 759.660, or 759.665.

(2) In addition to the generally applicable filing and contested case procedures contained in OAR chapter 860, division 001, the procedures set forth in this rule apply to a complaint that an existing or proposed contract is unjust and unreasonable.

(3) The party filing a complaint under this rule is the "complainant." The other party to the contract, against whom the complaint is filed, is the "respondent."

(4) Before a complaint is filed with the Commission, one party must request, in writing, negotiations for a new or amended attachment agreement from the other party.

(5) Ninety (90) calendar days after one party receives a request for negotiation from another party, either party may file with the Commission for a proceeding under ORS 757.279 or 759.660.

(6) The complaint must contain each of the following:

(a) Proof that a request for negotiation was received at least 90 calendar days earlier. The complainant must specify the attempts at negotiation or other methods of dispute resolution undertaken since the date of receipt of the request and indicate that the parties have been unable to resolve the dispute.

(b) A statement of the specific attachment rates, terms and conditions that are claimed to be unjust or unreasonable.

(c) A description of the complainant's position on the unresolved provisions.

(d) A proposed agreement addressing all issues, including those on which the parties have reached agreement and those that are in dispute.

(e) All information available as of the date the complaint is filed with the Commission that the complainant relied upon to support its claims:

(A) In cases in which the Commission's review of a rate is required, the complaint must provide all data and information in support of its allegations, in accordance with the administrative rules set forth to evaluate the disputed rental rate.

(B) If the licensee is the party submitting the complaint, the licensee must request the data and information required by this rule from the owner. The owner must supply the licensee the information required in this rule, as applicable, within 30 calendar days of the receipt of the request. The licensee must submit this information with its complaint.

(C) If the owner does not provide the data and information required by this rule after a request by the licensee, the licensee must include a statement indicating the steps taken to obtain the information from the owner, including the dates of all requests.

(D) No complaint by a licensee will be dismissed because the owner has failed to provide the applicable data and information required under paragraph (6)(e)(B) of this rule.

(7) The Commission will serve a copy of the complaint upon the respondent. Service may be made by electronic mail if the Commission verifies the respondent's electronic mail address prior to service of the complaint and a delivery receipt is maintained in the official file. Within 30 calendar days of service of the complaint, the respondent must file its response with the Commission, addressing in detail each claim raised in the complaint and a description of the respondent's position on the unresolved provisions.

(8) If the Commission determines after a hearing that a rate, term or condition that is the subject of the complaint is not just, fair, and reasonable, it may reject the proposed rate, term or condition and may prescribe a just and reasonable rate, term or condition.

Stat. Auth.: ORS 183, 756, 757 & 759
Stats. Implemented: ORS 756.040, 757.035, 757.270 - 290, 759.045 & 759.650 - 675
Hist.: PUC 3-2007, f. & cert. ef. 4-16-07; PUC 1-2015, f. & cert. ef. 3-3-15

860-029-0100
Resolution of Disputes for Proposed Negotiated Power Purchase Agreements

(1) This rule applies to a complaint, filed pursuant to ORS 756.500, regarding the negotiation of a Qualifying Facility power purchase agreement for facilities with a capacity greater than 10 MWs. These provisions supplement the generally applicable filing and contested case procedures contained in OAR chapter 860, division 001.

(2) Before a complaint is filed with the Commission, the Qualifying Facility must have followed the procedures set forth in the applicable public utility's tariff regarding negotiated power purchase agreements.

(3) At any time after 60 calendar days from the date a Qualifying Facility has provided written comments to the public utility regarding the public utility's draft power purchase agreement, the Qualifying Facility may file a complaint with the Commission asking for adjudication of any unresolved terms and conditions of its proposed agreement with the public utility.

(4) A Qualifying Facility filing a complaint under this rule is the "complainant." The public utility against whom the complaint is filed is the "respondent."

(5) The complaint must contain each of the following, as described by the complainant:

(a) A statement that the Qualifying Facility provided written comments to the utility on the draft power purchase agreement at least 60 calendar days before the filing of the complaint.

(b) A statement of the attempts at negotiation or other methods of informal dispute resolution undertaken by the negotiating parties.

(c) A statement of the specific unresolved terms and conditions.

(d) A description of each party's position on the unresolved provisions.

(e) A proposed agreement encompassing all matters, including those on which the parties have reached agreement and those that are in dispute.

(6) Along with the complaint, the Qualifying Facility must submit written direct testimony that includes all information upon which the complainant bases its claims.

(7) The Commission will serve a copy of the complaint upon the respondent. Service may be made by electronic mail if the Commission verifies the respondent's electronic mail address to service of the complaint and a delivery receipt is maintained in the official file. Within 10 calendar days of service of the complaint, the respondent must file its response with the Commission, addressing in detail each claim raised in the complaint and a description of the respondent's position on the unresolved provisions. The respondent may also identify and present any additional issues for which the respondent seeks resolution.

(8) Along with its response the respondent must submit written direct testimony that includes all information upon which the respondent relies to support its position.

(9) An assigned Administrative Law Judge (ALJ) will conduct a conference with the parties to identify disputed issues, to establish a procedural schedule and to adopt procedures for the complaint proceeding. To accommodate the need for flexibility and to implement the intent of this streamlined complaint process, the ALJ retains the discretion to adopt appropriate procedures provided such procedures are fair, treat the parties equitably, and substantially comply with this rule. Such procedures may include, but are not limited to, hosting a technical workshop, holding a hearing, or submitting written comments.

(10) Only the counterparties to the agreement will have full party status. The ALJ may confer with members of the Commission Staff for technical assistance.

(11) After the hearing, or other procedures set forth in section (9), if the Commission determines that a term or provision of the proposed agreement is not just, fair, and reasonable, it may reject the proposed term or provision and may prescribe a just and reasonable term or provision. The Commission's review is limited to the open issues identified in the complaint and in the response.

(12) Within 15 business days after the Commission issues its final order, the public utility must prepare a final version of the power purchase agreement complying with the Commission decision and serve it upon the Qualifying Facility. Within 10 days of service of the final power purchase agreement, the Qualifying Facility and the public utility may sign and file the agreement with the Commission, may request clarification whether the agreement terms comply with the Commission order, or may apply for rehearing or reconsideration of the order. The terms and conditions in the power purchase agreement will not be final and binding until the agreement is executed by both parties.

(13) The provisions of any power purchase agreement approved pursuant to this rule apply only to the parties to the agreement and are not to be considered as precedent for any other power purchase agreement negotiation or adjudication.

Stat. Auth.: ORS 183 & 756
Stats. Implemented: ORS 756.040 & 756.500 - 756.575
PUC 3-2008, f. & cert. ef. 7-8-08; PUC 1-2015, f. & cert. ef. 3-3-15

860-032-0002
Notice and Procedures for a Proceeding Initiated Under Division 032

(1) All notices initiating a proceeding under this Division, including, but not limited to, applications, petitions, complaints, and other pleadings,

must be served on all telecommunications providers and all persons on the Commission's new application mailing list. Any person wishing to be included on the list must submit his or her name, electronic mail address, and mailing address to the Commission's Administrative Hearings Division.

(2) Except as otherwise provided, every proceeding under this Division will follow the procedures in ORS 756.500 et seq. and the Commission's rules of procedure.

(3) Any person submitting information under the Commission's rules may request that the information be held in confidence pursuant to the public records law, ORS 192.500.

Stat. Auth.: ORS 183, 756 & 759
Stats. Implemented: ORS 756.040, 759.020 & 759.025
Hist.: PUC 27-1985(Temp), f. & ef. 12-19-85 (Order No. 85-1203); PUC 16-1986, f. & ef. 11-17-86 (Order No. 86-1159); PUC 1-1990, f. & cert. ef. 2-6-90 (Order No. 90-96); PUC 10-1998, f. & cert. ef. 4-28-98; PUC 8-1999, f. & cert. ef. 10-18-99; PUC 4-2000, f. & cert. ef. 2-9-00; PUC 9-2001, f. & cert. ef. 3-21-01; PUC 4-2003, f. & cert. ef. 3-11-03; PUC 1-2015, f. & cert. ef. 3-3-15

860-032-0005
Application for New or Amended Certificate of Authority, or to Transfer Authority

(1) A person may not provide intrastate telecommunications service on a for-hire basis, or transfer a certificate of authority to provide such service, except as authorized by the Commission.

(2) Any person intending to provide intrastate telecommunications service in Oregon, or to transfer a certificate of authority to provide such service, must file an application, on a form prescribed by the Commission. A copy of the applicable application form is available on the Commission's website.

(3) The application and any subsequent amendments must be filed electronically as set forth in OAR 860-001-0140 and 860-001-0170.

(4) Applicant(s) must complete all applicable parts of the application. If an application, in any material respect, is incomplete, inaccurate, false, or misleading, the Commission may reject the application.

(5) An application for a new or amended certificate must contain:

(a) A request for classification as a telecommunications utility or competitive provider;

(b) The name, mailing address, telephone number, and electronic mail address of the applicant;

(c) A description of the service the applicant seeks to provide, including designation of such service as local exchange, shared, or interexchange service, and a designation of such service as switched or non-switched service, and a description of how applicant will provide such service;

(d) A description of the territory where the service is to be offered. An application to provide local exchange service must include a description and map of the local exchange service boundaries or a list of the local exchanges to be served;

(e) The names of affiliated interests of the applicant, as defined in OAR 860-032-0001, which are certified to provide or are actually providing telecommunications service in Oregon;

(f) A list of each certificate of authority to provide service in Oregon, which was granted to applicant or to an affiliated interest, whether such certificate is in effect or canceled; and

(g) In addition to the requirements of subsections (5)(a) through (f) of this rule, an application to provide shared service must:

(A) Describe the user group to whom service will be provided;

(B) List the street address of the building(s) where service will be provided; and

(C) If service will be provided to a user group located in two or more buildings, the application must include a clear, precise, legible map, of the area to be served.

(6) An application to transfer a certificate of authority must contain:

(a) The names, mailing addresses, telephone numbers, and electronic mail addresses of the transferor and transferee;

(b) A description of the telecommunications services and service area for which authority is to be transferred; and

(c) The names of affiliated interests of the transferee, as defined in OAR 860-032-0001, which are certified to provide or are actually providing telecommunications service in Oregon.

(7) For all applications:

(a) The Commission will serve notice of the application as provided in OAR 860-032-0002(1).

(b) Within 20 days of the date of service of the notice, any person may file a protest to an application. The protest must set forth the grounds for the protest and be filed in accordance with requirements of OAR 860-001-0140 and 860-001-0170.

(c) The Commission may require a person filing a protest to show that it is affected by the application or that its appearance and participation will not unreasonably broaden the issues or burden the record. Failure of the telecommunications utility or cooperative to protest an application to provide local exchange service, other than shared service, is not considered consent to the application.

(d) Any protestant will be made a party to the application proceeding. Other persons may be made a party upon formal request to the Commission.

(e) If an applicant intends to broaden the authority requested during the application process, it must file a new application pursuant to sections (2) through (6) of this rule. However, an applicant may narrow its request by filing its amendment with the Filing Center.

(f) The Commission may grant or deny an application without hearing, unless a hearing is required by ORS 759.020(4).

(g) If the Commission processes the application without a hearing, the Commission staff may issue to the parties a proposed order that grants or denies the application. Within 60 days of service of any proposed order, any party may file exceptions or request a hearing. Exceptions must be filed with the Filing Center. Within 10 days of filing of any exceptions, Commission staff and any party may file a reply. In its reply, Commission staff may modify its proposed order in response to the exceptions filed. Filing dates for exceptions and replies are calculated and enforced per OAR 860-001-0150.

(h) A party to the application proceeding may request rehearing or reconsideration of the order, which grants or denies the application, pursuant to ORS 756.561 and OAR 860-001-0720.

(8) For applicants who request classification as a telecommunications utility, all services proposed to be offered by the applicant must be deemed essential services. However, applicant may accompany the application with a petition to exempt some services pursuant to OAR 860-032-0025 or to price-list some or all services pursuant to OAR 860-032-0035.

(9) The Commission reviews applications for interexchange service or shared service pursuant to ORS 759.020. Applications for local exchange service, other than shared service, will be reviewed pursuant to ORS 759.020 and 759.050.

(10) For applications for local exchange service, other than shared service, the following apply in addition to provisions of sections (7) through (9) of this rule:

(a) The Commission may apply the public interest criteria from ORS 759.050(2), or the Commission may determine pursuant to ORS 759.020(3) that the affected telecommunications utility is unable to provide service; and

(b) Failure by the telecommunications utility to provide reasonable and adequate local exchange service constitutes inability to provide service.

(11) Applications to transfer authority to provide telecommunications service are subject to sections (1) through (4) and (6) through (10) of this rule. With Commission approval, a telecommunications provider may transfer a certificate of authority subject to the following requirements:

(a) The transferor may transfer some or all of its authority;

(b) Transferee is liable for all fees incurred and reports due by the transferor as of the date the transfer is approved; and

(c) All relevant conditions and restrictions which attend the authority held by the transferor will apply to the certificate held by the transferee.

(d) When the application is granted the transferor will no longer be authorized to provide the telecommunications services that are transferred.

Stat. Auth.: ORS 183, 756 & 759
Stats. Implemented: ORS 756.040, 759.020, 759.025, 759.030, 759.050, 759.225 & 759.690
Hist.: PUC 27-1985(Temp), f. & ef. 12-19-85 (Order No. 85-1203); PUC 16-1986, f. & ef. 11-17-86 (Order No. 86-1159); PUC 10-1989(Temp), f. & cert. ef. 7-10-89 (Order No. 89-847); PUC 1-1990, f. & cert. ef. 2-6-90 (Order No. 90-96); PUC 23-1990, f. & cert. ef. 12-31-90 (Order No. 90-1918); PUC 9-1991, f. & cert. ef. 7-16-91 (Order No. 91-854); PUC 2-1998, f. & cert. ef. 2-24-98; PUC 10-1998, f. & cert. ef. 4-28-98; PUC 3-1999, f. & cert. ef. 8-10-99; PUC 4-2000, f. & cert. ef. 2-9-00; PUC 26-2001, f. & cert. ef. 11-5-01; PUC 4-2003, f. & cert. ef. 3-11-03; PUC 1-2015, f. & cert. ef. 3-3-15

860-033-0006
Monthly RSPF Surcharge: General Provisions, Remittance Reports and Payment

(1) The surcharge rate and the balance in the RSPF are reviewed annually by the Commission each October. The Commission may adjust the amount of the surcharge to ensure the fund has adequate resources but does not exceed six months of projected expenses. A rate adjustment ordered by the Commission following the annual review becomes effective January 1 of the year following the review.

(2) The surcharge imposed by 1987 Oregon Laws Chapter 290, Section (7)(1) does not apply to entities upon which the state is prohibited from imposing the surcharge by the Constitution or laws of the United

States or the Constitution or laws of the State of Oregon including, but not limited to:

(a) Counties and political subdivisions.

(b) Federal, state and municipal government bodies or public corporations. For purposes of this rule, "public corporation" means a corporation formed by a state or local government authority for the public's benefit or for a public purpose. A regional housing authority qualifies as a public corporation.

(c) Federally chartered corporations specifically exempt from state excise taxes by federal law.

(d) Federally recognized Native-American Tribes, and tribal members who live within federally recognized Indian country and are enrolled members of the tribe with sovereignty over that Indian country.

(e) Foreign government offices and representatives that are exempt from state taxation by treaty provisions.

(f) Interconnection between telecommunications utilities, telecommunications cooperatives, competitive telecommunications services providers certified under ORS 759.020, radio common carriers and interexchange carriers.

(g) Any other agency, organization or person claiming an exemption is required to identify the authority for its claim to a provider. If a telecommunications provider is unable to determine the status of a subscriber the Commission will determine whether the subscriber is exempt.

(3) Collection of RSPF Surcharge.

(a) Each telecommunications provider must collect the RSPF surcharge by charging the specified amount to each retail subscriber with access to the telecommunications relay service, including OTAP eligible subscribers. The RSPF surcharge is applied on a telecommunications circuit designated for a particular subscriber.

(A) One subscriber line is counted for each circuit that is capable of generating usage on the line side of the switched network regardless of the quantity of customer premises equipment connected to each circuit.

(B) For providers of central office based services, the surcharge is applied to each line that has unrestricted connection to the telecommunications relay service. For central office based service lines that have restricted access to the OTRS, the surcharge is charged based on software design.

(b) Each cellular, wireless, or other radio common carrier must collect the RSPF surcharge by charging the specified amount to each retail subscriber with access to the telecommunications relay service, including OTAP eligible subscribers. The surcharge is applied on a per-instrument basis.

(c) Each telecommunications provider and each cellular, wireless, or other radio common carrier must identify the surcharge on each retail customer's bill as a separate line item named "RSPF Surcharge."

(4) A telecommunications provider or a cellular, wireless, or other radio common carrier may remit surcharges due to the Commission by electronic transfer, mail or in person.

(5) The Remittance Report and surcharges are due to the Commission on or before the 21st calendar day after the close of each month and must be received in the Commission's offices no later than 5 p.m. Pacific Standard Time on the due date. A surcharge remittance or Remittance Report postmarked on the due date does not meet the requirements of this section and will not be considered as timely submitted.

(6) Each telecommunications provider and each cellular, wireless, or other radio common carrier must submit the Remittance Report and surcharge with no exceptions. If no surcharge is collected, the telecommunications provider or the cellular, wireless, or other radio common carrier must still submit its monthly Remittance Report specified in section (5) of this rule.

(7) For each billing period that a telecommunications provider or a cellular, wireless, or other radio common carrier fails to submit the surcharge fees in full on or before the due date required by these rules, the telecommunications provider or the cellular, wireless, or other radio common carrier must pay a late payment fee in accordance with OAR 860-001-0050.

(8) If the telecommunications provider or the cellular, wireless, or other radio common carrier fails to remit the surcharge in full on or before the due date, the telecommunications provider or the cellular, wireless, or other radio common carrier must pay interest in accordance with OAR 860-001-0050.

(9) If a telecommunications provider or a cellular, wireless, or other radio common carrier fails to file a Remittance Report as required by these rules, the telecommunications provider or the cellular, wireless, or other radio common carrier must pay a late report fee in accordance with OAR 860-001-0050.

(10) If the amount shown due on a Remittance Report is not paid by the due date, the Commission may issue a proposed assessment to set the sum due. The Commission may waive the late report fee, the late payment fees and the interest on the unpaid surcharge fees, or any combination thereof, if the telecommunications provider or the cellular, wireless, or other radio common carrier files a written waiver request and provides evidence showing that the telecommunications provider or the cellular, wireless, or other radio common carrier submitted the Remittance Report and surcharge fees late due to circumstances beyond its control. The request must be filed in accordance with OAR 860-001-0140 and 860-001-0170.

(11) The telecommunications provider or the cellular, wireless, or other radio common carrier must pay a fee in accordance with OAR 860-001-0050 for each payment returned for non-sufficient funds.

(12) The telecommunications provider or the cellular, wireless, or other radio common carrier is responsible for and must pay all costs incurred by the Commission to collect a past-due RSPF surcharge from the telecommunications provider or the cellular, wireless, or other radio common carrier.

(13) Remittance Report Records: A telecommunications provider and a cellular, wireless, or other radio common carrier must keep all records supporting each Remittance Report for three years, or if a Commission review or audit is pending, until the review or audit is complete, whichever is later.

(14) In addition to any other penalty, obligation, or remedy provided by law, the Commission may suspend or cancel the telecommunications provider's certificate of authority to provide telecommunications service in Oregon for its failure to file its Remittance Report or its failure to remit the surcharge in full.

(15) Except as otherwise provided by law, if after an audit or review the Commission determines that the telecommunications provider or the cellular, wireless, or other radio common carrier has remitted an excessive amount, the Commission will provide the telecommunications provider or the cellular, wireless, or other radio common carrier a credit in that amount against sums subsequently due from that telecommunications provider or that cellular, wireless, or other radio common carrier.

(16) A telecommunications provider or a cellular, wireless, or other radio common carrier must submit any revisions to a Remittance Report no later than three years from the due date of the Remittance Report. If the Commission concludes that a telecommunications provider or cellular, wireless, or other common carrier remitted an excessive amount and that refunding the excess would have a material and adverse financial impact on the RSPF, the Commission may enter into an agreement with the telecommunications provider or the cellular, wireless, or other radio common carrier to spread payments of the refunds over a period not to exceed three years.

(17) The RSPF Surcharge Exception Form is due annually by March 15. A telecommunications provider or a cellular, wireless, or other radio common carrier that qualifies for the exception must electronically submit the completed form so that it is received in the Commission's offices no later than 5 p.m. Pacific Standard Time on March 15.

(18) In computing any period of time prescribed or allowed by these rules, the first day of the act or event is not included. The last day of the period is included, unless the last day is a Saturday or legal holiday; then the period runs until the end of the next day that is not a Saturday or a legal holiday. Legal holidays are those identified in ORS 187.010 and 187.020.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290

Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290

Hist.: PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 18-2004, f. & cert. ef. 12-30-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 1-2010, f. & cert. ef. 5-18-10; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13; PUC 7-2013, f. & cert. ef. 12-20-13; PUC 1-2015, f. & cert. ef. 3-3-15

860-034-0060
Dispute Resolution

(1) When a dispute occurs between a customer or applicant and a small telecommunications utility about any charge or service, the utility must:

(a) Thoroughly investigate the matter;

(b) Promptly report the results of its investigation to the complainant;

(c) Inform the complainant of the right to have a small telecommunications utility supervisor review any dispute;

(d) Prepare a written record of the dispute including the name and address of the complainant involved, the date the complaint was received, the issues in dispute, and the disposition of the matter; and

(e) Retain records of the dispute for at least 36 months after the investigation is closed.

(2) If the utility and complainant cannot resolve the dispute, the small telecommunications utility must inform the complainant of the right to contact the Consumer Services Section and request assistance in resolving the dispute. The small telecommunications utility must provide the following contact information for the Consumer Services Section:

(a) Telephone: 503-378-6600; 1-800-522-2404; TTY 711;

(b) Mailing address: Public Utility Commission of Oregon, Consumer Services Section, PO Box 1088, Salem, Oregon 97308;

(c) Physical address: Public Utility Commission of Oregon, 3930 Fairview Industrial Drive SE, Salem, Oregon 97202;

(d) Electronic mail address: puc.consumer@state.or.us; and

(e) Website: http://puc.state.or.us/consumer/customer%20complaint%20process.pdf.

(3) The Consumer Services Section will investigate any dispute upon request to determine whether it can be resolved as an informal complaint.

(4) If the Consumer Services Section cannot resolve the dispute, the complainant may file a formal written complaint with the Commission under ORS 756.500. The formal complaint must be submitted on an approved form available from the Consumer Services Section.

(a) The complaint must be filed electronically with the Filing Center at PUC.FilingCenter@state.or.us.

(b) If the complainant does not have access to electronic mail,

(A) The complaint may be mailed or delivered to the Filing Center at the address set out in OAR 860-001-0140; and

(B) The complaint must include a request for waiver of electronic service and filing requirements. This request is included on the form available from the Commission's Consumer Services Division.

(c) The Commission will serve the complaint on the small telecommunications utility. The Commission may electronically serve the small telecommunications utility with the complaint if the electronic mail address is verified prior to service of the complaint and the delivery receipt is maintained in the official file.

(d) The small telecommunications utility must answer the complaint within 15 days of service of the complaint by the Commission.

(e) The Commission will determine a procedural schedule after the small telecommunications utility's answer is filed. The small telecommunications utility must serve a copy of its answer on the complainant.

(A) If the small telecommunications utility files a motion to dismiss, the complainant may file a response within 15 days of the motion. If the complainant responds, the complainant must file the response with the Filing Center and send a copy to the utility. The Commission may make a decision on the formal complaint based on the information in the complaint, the small telecommunications utility's response and motion to dismiss, and the complainant's response to the utility's motion; or

(B) The Commission may set a procedural schedule for the complaint proceedings, including, but not limited to, scheduling dates for receiving additional information from the parties, telephone conferences, or a hearing. A hearing may be held on less than 10 days' notice when good cause is shown.

(5) Upon filing a formal complaint, the complainant may request a hearing to determine whether the complainant is entitled to continued or restored service pending resolution of the complaint. Unless extraordinary circumstances exist, the Commission will conduct the hearing by telephone within 3 business days. Notice of the hearing will be provided to the complainant and the small telecommunications utility at least 12 hours before the date and time of the hearing. Pending resolution of the dispute, the complainant's obligation to pay undisputed amounts continues.

(6) A complainant who has a registered dispute or formal complaint pending with the Commission is entitled to continued or restored service provided:

(a) Service was not terminated for tampering with utility property, stealing, diverting, or using unauthorized service or failure to establish credit;

(b) A bona fide dispute exists in which the facts asserted entitle the complainant to service;

(c) When termination is based on nonpayment, the complainant agrees to pay undisputed charges;

(d) The complainant diligently pursues conflict resolution under the Commission's rules.

(7) If the conditions in section (6) of this rule are not satisfied, the small telecommunications utility has no obligation to provide continued service. A small telecommunications utility discontinuing service because of a failure to meet the conditions of subsections (6)(c) or (6)(d) of this rule must give the customer five-day notice served in the same manner as provided by OAR 860-034-0260 except the notice need only describe the defect in performance, the date and time after which utility service will terminate, and the toll-free number of the Commission's Consumer Services Division.

Stat. Auth.: ORS 183, 756 & 759

Stats. Implemented: ORS 756.040, 759.045 & 759.500

Hist.: PUC 6-1993, f. & cert. ef. 2-19-93 (Order No. 93-185); PUC 12-1998, f. & cert. ef. 5-7-98; PUC 8-1999, f. & cert. ef. 10-18-99; PUC 15-2001, f. & cert. ef. 6-21-01; PUC 11-2003, f. & cert. ef. 7-3-03; PUC 1-2015, f. & cert. ef. 3-3-15

860-034-0300

Tariffs of Small Telecommunications Utilities

(1) Small telecommunications utilities not subject to ORS 759.175 must, upon the Commission's request, provide copies of any schedules showing rates, tolls, and charges, including all rules and regulations that in any manner affect the rates charged or to be charged for any service.

(2) Small telecommunications utilities subject to ORS 759.175 must file tariffs in accordance with the following provisions:

(a) Form and style of tariffs:

(A) Each small telecommunications utility must designate the initial tariff as PUC Oregon No. 1, and thereafter designate successive tariffs with the next number in consecutive numerical order. Supplemental information not otherwise provided by the tariff must be inserted in the most appropriate location and denoted by the previous sheet numbers plus a letter, for example, 3A, 3B, etc. Revisions to tariffs must be denoted by 1st Revised Sheet No. 3, 2nd Revised Sheet No. 3, etc.;

(B) The title page should be uniform. Rates, rules, and regulations must be written only on one side of a sheet. If a single sheet is insufficient, two or more pages should be used. Blank forms will be furnished upon request;

(b) Size of tariffs and required:

(A) Tariffs and supplements thereto must be prepared using a readable font that, when printed, will fit on an 8-1/2 x 11 inch page; and

(B) Small telecommunications utilities must file with the Commission an original of each tariff, rate schedule, revision, or supplement in electronic form as required in OAR 860-001-0170. The advice letter accompanying the tariffs must bear the signature of the issuing officer or utility representative. The tariffs do not require a signature.

(c) Tariffs must explicitly state the rates and charges for each class of service rendered, designating the area or district to which they apply;

(d) The small telecommunications utility's rules and regulations that in any manner affect the rates charged or to be charged or that define the extent or character of the service to be given must be included with each tariff;

(e) Changes in tariffs may be made by filing an entirely new tariff or by filing revised sheets which must refer to the tariffs on file. Additions to the tariff on file may be made by filing additional sheets;

(f) Each small telecommunications utility filing tariffs or schedules changing existing tariffs or schedules must submit in the advice letter or other document the following information:

(A) A statement plainly indicating the increase, decrease, or other change thereby made in existing rates, charges, tolls, or rules and regulations;

(B) A statement setting forth the number of customers affected by the proposed change and the resulting change in annual revenue; and

(C) A detailed statement setting forth the reasons or grounds relied upon in support of the proposed change;

(g) All tariff changes must be made applicable with service rendered on and after the effective date of the changes, unless the Commission by order provides otherwise. As used in this rule, "service rendered" means units of toll calls connected, basic service provided, or likewise as the context requires;

(h) Small telecommunications utilities entering into special contracts with certain customers prescribing and providing rates, services, and practices not covered by or permitted in the general tariffs, schedules, and rules filed by such utilities are in legal effect tariffs and are subject to supervision, regulation, and control to the extent not exempted under ORS 759.040; and

(i) All special agreements designating service to be furnished at rates other than those shown in tariffs now on file in the Commission's office are rate schedules. A true and certified copy must be filed pursuant to requirements of this Division.

Stat. Auth.: ORS 183, 756 & 759

Stats. Implemented: ORS 756.040, 759.045 & 759.175

Hist.: PUC 6-1993, f. & cert. ef. 2-19-93 (Order No. 93-185); PUC 12-1998, f. & cert. ef. 5-7-98; PUC 3-1999, f. & cert. ef. 8-10-99; PUC 15-2001, f. & cert. ef. 6-21-01; PUC 18-2004, f. & cert. ef. 12-30-04; PUC 1-2015, f. & cert. ef. 3-3-15

860-036-0025
Dispute Resolution

(1) When a dispute occurs between a customer or applicant and a water utility about any charge or service, the water utility must:

(a) Thoroughly investigate the matter;

(b) Promptly report the results of its investigation to the complainant;

(c) Inform the complainant of the right to have a water utility supervisor review any dispute;

(d) Prepare a written record of the dispute including the name and address of the complainant involved, the date the complaint was received, the issues in dispute, and the disposition of the matter; and

(e) Retain records of the dispute for at least 36 months after the investigation is closed.

(2) If the utility and complainant cannot resolve the dispute, the water utility must inform the complainant of the right to contact the Consumer Services Section and request assistance in resolving the dispute. The water utility must provide the following contact information for the Consumer Services Section:

(a) Telephone: 503-378-6600; 1-800-522-2404; TTY 711;

(b) Mailing address: Public Utility Commission of Oregon, Consumer Services Section, PO Box 1088, Salem, Oregon 97308;

(c) Physical address: Public Utility Commission of Oregon, 3930 Fairview Industrial Drive SE, Salem, Oregon 97202;

(d) Electronic mail address: puc.consumer@state.or.us; and

(e) Website: http://puc.state.or.us/consumer/customer%20complaint%20process.pdf.

(3) The Consumer Services Section will investigate any dispute upon request to determine whether it can be resolved as an informal complaint.

(4) If the Consumer Services Section cannot resolve the dispute, the complainant may file a formal written complaint with the Commission under ORS 756.500. The formal complaint must be submitted on an approved form available from the Consumer Services Section.

(a) The complaint must be filed electronically with the Filing Center at PUC.FilingCenter@state.or.us.

(b) If the complainant does not have access to electronic mail,

(A) The complaint may be mailed, faxed, or delivered to the Filing Center at the address set out in OAR 860-001-0140; and

(B) The complaint must include a request for waiver of electronic service and filing requirements. This request is included on the form available from the Commission's Consumer Services Section.

(c) The Commission will serve the complaint on the water utility. The Commission may electronically serve the water utility with the complaint if the electronic mail address is verified prior to service of the complaint and the delivery receipt is maintained in the official file.

(d) The water utility must answer the complaint within 15 days of service of the complaint by the Commission.

(e) The Commission will determine a procedural schedule after the water utility's answer is filed. The water utility must serve a copy of its answer on the complainant.

(A) If the water utility files a motion to dismiss, the complainant may file a response within 15 days of the motion. If the complainant responds, the complainant must file the response with the Filing Center and send a copy to the utility. The Commission may make a decision on the formal complaint based on the information in the complaint, the utility's response and motion to dismiss, and the complainant's response to the utility's motion; or

(B) The Commission may set a procedural schedule for the complaint proceedings, including, but not limited to, scheduling dates for receiving additional information from the parties, telephone conferences, or a hearing. A hearing may be held on less than 10 days' notice when good cause is shown.

(5) Upon filing a formal complaint, the complainant may request a hearing to determine whether the complainant is entitled to continued or restored service pending the resolution of the complaint. Unless extraordinary circumstances exist, the Commission will conduct the hearing by telephone within 3 business days. Notice of the hearing will be provided to the complainant and the water utility at least 12 hours before the date and time of the hearing. Pending resolution of the dispute, the complainant's obligation to pay undisputed amounts continues.

(6) A complainant who has a registered dispute or formal complaint pending with the Commission is entitled to continued or restored service provided:

(a) Service was not terminated for tampering with utility property, stealing, diverting, or using unauthorized service, or failure to establish credit;

(b) A bona fide dispute exists in which the facts asserted entitle the complainant to service;

(c) When termination is based on nonpayment, the customer agrees to pay undisputed charges; and

(d) The complainant diligently pursues conflict resolution under the Commission's rules.

(7) If the conditions in section (6) of this rule are not satisfied, the water utility has no obligation to provide continued service. A water utility discontinuing service because of a failure to meet the conditions of subsections (6)(c) or (6)(d) of this rule must give the customer a five-day disconnect notice. The notice must be served in the same manner as provided by OAR 860-036-0245, except that it need only describe the defect in performance, the date and time when water utility service will terminate and the toll-free number of the Commission's Consumer Services.

Stat. Auth.: ORS 183, 756 & 757
Stats. Implemented: ORS 756.040, 756.500 & 756.512
Hist.: PUC 13-1997, f. & cert. ef. 11-12-97; PUC 15-1998, f. & cert. ef 8-27-98; PUC 8-1999, f. & cert. ef. 10-18-99; PUC 18-2003, f. & cert. ef. 10-6-03; PUC 1-2015, f. & cert. ef. 3-3-15

860-036-0605
Tariff Specifications

(1) This rule applies to rate-regulated water utilities.

(2) Form, requirements, and style of tariffs:

(a) A separate tariff must be filed for each service provided;

(b) All tariffs, including rates and rules and regulations, must be prepared using a readable font that, when printed, will fit on 8-1/2 inch by 11 inch pages and so that changes can be made by reprinting and inserting a single page. If a tariff cannot fit on one page, use additional pages. Blank forms will be furnished by the Commission upon request;

(c) Each water utility must designate the initial tariff as PUC Oregon No. 1, and designate successive tariffs with the next number in consecutive numerical order;

(d) Supplemental information not otherwise provided by the tariff must be inserted in the most appropriate location and denoted by the previous sheet numbers plus a letter, for example, 3A, 3B, etc. Revisions to tariffs must be denoted by 1st Revised Sheet No. 3, 2nd Revised Sheet No. 3, etc.;

(e) The tariffs must include a uniform title page and table of contents;

(f) Tariffs and supplements must be prepared using a readable font that, when printed, will fit on an 8-1/2 x 11 inch page; and

(g) Water utilities must file with the Commission an original of each tariff, rate schedule, revision, or supplement in electronic form as required by OAR 860-001-0170. The advice letter accompanying the tariffs must bear the signature of the issuing officer or water utility representative. Tariffs do not require a signature.

Stat. Auth.: ORS 183, 756 & 757
Stats. Implemented: ORS 756.040 & 757.205
Hist.: PUC 13-1997, f. & cert. ef. 11-12-97; PUC 15-1998, f. & cert. ef. 8-27-98; PUC 8-2002, f. & cert. ef. 2-26-02; PUC 18-2004, f. & cert. ef. 12-30-04; PUC 13-2011, f. 12-29-11, cert. ef. 1-1-12; PUC 1-2015, f. & cert. ef. 3-3-15

860-037-0025
Dispute Resolution

(1) When a dispute occurs between a customer or applicant and a wastewater utility about any charge or service, the wastewater utility must:

(a) Thoroughly investigate the matter;

(b) Promptly report the results of its investigation to the complainant;

(c) Inform the complainant of the right to have a wastewater utility supervisor review any dispute;

(d) Prepare a written record of the dispute including the name and address of the complainant involved, the date the complaint was received, the issues in dispute, and the disposition of the matter; and

(e) Retain records of the dispute for at least 36 months after the investigation is closed.

(2) If the utility and complainant cannot resolve the dispute, the wastewater utility must inform the complainant of the right to contact the Consumer Services Section and request assistance in resolving the dispute. The wastewater utility must provide the following contact information for the Consumer Services Section:

(a) Telephone: 503-378-6600; 1-800-522-2404; TTY 711;

(b) Mailing address: Public Utility Commission of Oregon, Consumer Services Section, PO Box 1088, Salem, Oregon 97308;

(c) Physical address: Public Utility Commission of Oregon, 3930 Fairview Industrial Drive SE, Salem, Oregon 97202;

(d) Electronic mail address: puc.consumer@state.or.us; and

(e) Website: http://puc.state.or.us/consumer/customer%20complaint%20process.pdf.

(3) The Consumer Services Section will investigate any dispute upon request to determine whether it can be resolved as an informal complaint.

(4) If the Consumer Services Section cannot resolve the dispute, the complainant may file a formal written complaint with the Commission under ORS 756.500. The formal complaint must be submitted on an approved form available from the Consumer Services Section.

(a) The complaint must be filed electronically with the Filing Center @PUC.FilingCenter@state.or.us.

(b) If the complainant does not have access to electronic mail,

(A) The complaint may be mailed or delivered to the Filing Center at the address set out in OAR 860-001-0140; and.

(B) The complaint must include a request for waiver of electronic service and filing requirements. This request is included on the form available from the Consumer Services Division.

(c) The Commission will serve the complaint on the wastewater utility. The Commission may electronically serve the utility with the complaint if the electronic mail address is verified prior to service of the complaint and the delivery receipt is maintained in the official file.

(d) The wastewater utility must answer the complaint within 15 days of service of the complaint by the Commission.

(e) The Commission will determine a procedural schedule after the wastewater utility's answer is filed. The wastewater utility must serve a copy of its answer on the complainant.

(A) If the wastewater utility files a motion to dismiss, the complainant may file a response within 15 days of the motion. If the complainant responds, the complainant must file the response with the Filing Center and send a copy to the utility. The Commission may make a decision the formal complaint based on the information in the complaint, the utility's response and motion to dismiss, and the complainant's response to the utility's motion; or

(B) The Commission may set a procedural schedule for the complaint proceedings, including, but not limited to, scheduling dates for receiving additional information from the parties, telephone conferences, or a hearing. A hearing may be held on less than 10 days' notice when good cause is shown.

(5) Upon filing a formal complaint, the complainant may request a hearing to determine whether the complainant is entitled to continued or restored service pending the resolution of the complaint. Unless extraordinary circumstances exist, the Commission will conduct the hearing by telephone within 3 business days. Notice of the hearing will be provided to the complainant and the wastewater utility at least 12 hours before the date and time of the hearing. Pending resolution of the dispute, the complainant's obligation to pay undisputed amounts continues.

(6) A complainant who has a registered dispute or formal complaint pending with the Commission is entitled to continued or restored service provided:

(a) Service was not terminated for tampering with utility property, stealing, diverting, or using unauthorized service, or failure to establish credit;

(b) A bona fide dispute exists in which the facts asserted entitle the complainant to service;

(c) When termination of wastewater service is based on nonpayment, the customer agrees to pay undisputed charges; and

(d) The complainant diligently pursues conflict resolution under the Commission's rules.

(7) If the conditions in section (6) of this rule are not satisfied, the wastewater utility has no obligation to provide continued service. A wastewater utility discontinuing water service because of a customer's failure to meet the conditions of subsections (6)(c) or (6)(d) of this rule for wastewater utility service must give the customer a five-day disconnect notice. The notice must be served in the same manner as provided by OAR 860-037-0245, except that it need only describe the defect in performance, the date and time when water service will be disconnected in order to terminate wastewater service and the toll-free number of the Commission's Consumer Services Section.

Stat. Auth.: ORS 183, 756 & 757
Stats. Implemented: ORS 756.040, 756.500, 756.512, 757.005 & 757.061
Hist.: PUC 9-1999(Temp), f. 10-22-99, cert. ef. 10-23-99 thru 4-19-00; PUC 6-2000, f. 4-18-00, cert. ef. 4-20-00; PUC 5-2004, f. & cert. ef. 1-29-04; PUC 1-2015, f. & cert. ef. 3-3-15

860-037-0410
Tariff Specifications

(1) Form and style of tariffs:

(a) Each wastewater utility must designate the initial tariff as PUC Oregon No. 1, and designate successive tariffs with the next number in consecutive numerical order. Supplemental information not otherwise provided by the tariff must be inserted in the most appropriate location and denoted by the previous sheet numbers plus a letter, for example, 3A, 3B, etc. Revisions to tariffs must be denoted by 1st Revised Sheet No. 3, 2nd Revised Sheet No. 3, etc.;

(b) The title page should be uniform. Rates, rules, and regulations must be written only on one side of a sheet. If a single sheet is insufficient, two or more pages should be used. Blank forms will be furnished by the Commission upon request; and

(c) Separate tariffs must be filed for wastewater service or for any other service entered.

(2) Size of tariffs and required:

(a) Tariffs and supplements thereto must be prepared using a readable font that, when printed, will fit on an 8-1/2 x 11 inch page; and

(b) Wastewater utilities must file with the Commission an original of each tariff, rate schedule, revision, or supplement in electronic form as required by OAR 860-001-0170. The advice letter accompanying the tariffs must bear the signature of the issuing officer or utility representative. The tariffs do not require a signature.

Stat. Auth.: ORS 183, 756 & 757
Stats. Implemented: ORS 756.040, 757.005, 757.061 & 757.205
Hist.: PUC 9-1999(Temp), f. 10-22-99, cert. ef. 10-23-99 thru 4-19-00; PUC 6-2000, f. 4-18-00, cert. ef. 4-20-00; PUC 5-2004, f. & cert. ef. 1-29-04; PUC 18-2004, f. & cert. ef. 12-30-04; PUC 1-2015, f. & cert. ef. 3-3-15

860-038-0400
Electricity Service Supplier Certification Requirements

(1) An electricity service supplier (ESS) must be certified by the Commission to sell electricity services to consumers.

(2) An ESS must be certified as either scheduling or nonscheduling as prescribed in OAR 860-038-0410.

(3) The initial certification fee is $400.

(4) The annual renewal fee is $200.

(5) An ESS applicant must file an application that contains the following information:

(a) Name of applicant, including owners, directors, partners, and officers, with a description of the work experience of key personnel in the sale, procurement, and billing of energy services or similar products;

(b) Name, address, and phone number of the ESS applicant's regulatory contact;

(c) Proof of authorization to do business in the state of Oregon;

(d) Dun and Bradstreet number, if available;

(e) Confirmation that the applicant (including owners, directors, partners, and officers) has not violated consumer protection laws or rules in the past three years;

(f) Audited financial statements of the ESS applicant (and its guarantor, if applicable) and credit reports consisting of:

(A) A balance sheet, income statement, and statement of cash flow for each of the three years preceding the filing and for the interim quarters between the end of the last audited year and the filing date; or

(B) For an applicant that has been in operation for less than three years, the audited balance sheets, income statements, and statements of cash flow for each of the years the company was in operation and for the interim quarters between the end of the last audited year and the filing date; or

(C) For an applicant that has been in operation for less than 12 months on the date the application is filed, such financial statements as are kept in the regular course of the applicant's business operations and pro-forma financial statements for a period of not less than 36 months.

(D) If audited financial statements are unavailable, the applicant may submit unaudited financial statements for each of the three years preceding the filing and for the interim quarters between the end of the last unaudited year and the filing date. The applicant must also submit a statement explaining why audited statements are not available.

(g) A showing of creditworthiness through documentation of tangible assets in excess of liabilities (i.e., tangible net worth) of at least $1,000,000 on its most recent balance sheet and demonstration of either its own investment grade credit rating pursuant to (A) or fulfillment of bond/guaranty requirements pursuant to (B):

(A) Investment grade rating means a suitable rating on the long term, senior unsecured debt, or if this rating is unavailable, the corporate rating, of a major credit rating agency.

(B) An applicant may use any of the financial instruments listed below, in an amount commensurate with the services and products it intends to offer, to satisfy the credit requirements established by this rule.

(i) Cash or cash equivalent (i.e., cashier's check);

(ii) A letter of credit issued by a bank or other financial institution, irrevocable for a period of at least 18 months;

(iii) A bond in a form acceptable to the Commission, irrevocable for a period of at least 18 months; or

(iv) A guaranty in a form acceptable to the Commission issued by a principal of the applicant or a corporation holding controlling interest in the applicant, which is irrevocable for at least 18 months. To the extent the applicant relies on a guaranty, the applicant must provide financial evidence sufficient to demonstrate that the lender or guarantor possesses the cash or cash equivalent needed to fund the guaranty.

(h) A showing of technical competence in energy procurement and delivery, information systems, billing & collection, and if subject to the requirements of section 16 of this rule, safety & engineering;

(i) A showing that its financial and technical competence is consistent with the services and products it intends to offer, and the targeted customer class(es) and geographical areas; and

(j) A statement as to whether the ESS is applying for certification as a scheduling or nonscheduling ESS and information documenting an ability to comply to the requirements of OAR 860-038-0410; and

(k) The authorized representative of the applicant must state that all information provided is true and correct and sign the application.

(6) At a minimum, an applicant must attest that it will:

(a) Furnish to consumers a toll-free number or local number that is staffed during normal business hours to enable a consumer to resolve complaints or billing disputes and a statement of the ESS's terms and conditions that detail the customer's rights and responsibilities;

(b) Comply with all applicable laws, rules, Commission orders, and electric company tariffs;

(c) Maintain insurance coverage, security bond, or other financial assurance commensurate with the types and numbers of consumers and loads being served, meet any other credit requirements contained in the electric company's tariffs, and cover creditors for a minimum of 90 days from the date of cancellation; and

(d) Adequately respond to Commission information requests within 10 business days.

(7) As conditions for certification, an ESS must agree to:

(a) Enter into an agreement or agreements with each respective electric company to assign to the electric companies any federal system benefits available from the Bonneville Power Administration to the residential and small-farm customers who receive distribution from an electric company and are served by the ESS; and

(b) Not enter into a Residential Sale and Purchase Agreement with the Bonneville Power Administration pursuant to Section 5(c) of the Pacific Northwest Power Act concerning federal system benefits available to residential and small farm customers receiving distribution from an electric company.

(8) Staff will notify interested persons of the application, allow 14 days from the date of notification for the filing of protests to the application (through submission of an email or letter to the staff), review the application, and make a recommendation to the Commission whether the application should be approved or denied.

(9) An applicant or a protesting party may request a hearing within 60 calendar days of the date of the staff recommendation. Upon determining the appropriateness of the request, the Commission will conduct a hearing as provided for in division 001 of the Commission's rules.

(10) The Commission may issue an Order granting the applicant's request for certification upon a finding that:

(a) The applicant paid the initial certification PUC fee, as required by OAR 860-038-0400(3);

(b) The applicant filed an application containing accurate, complete and satisfactory information that demonstrates it meets the requirements to be certified as an ESS.

(11) If the Commission grants the application, the Commission may include any conditions it deems reasonable and necessary. Further, upon granting the application, the Commission will certify the ESS for a period of one year from the date of the order.

(12) An ESS must take all reasonable steps, including corrective actions, to ensure that persons or agents hired by the ESS adhere at all times to the terms of all laws, rules, Commission orders, and electric company tariffs applicable to the ESS.

(13) An ESS must notify the Commission that it will not be renewing its certification or it must renew its certification each year as follows:

(a) An ESS must file its application for renewal 30 days prior to the expiration date of its current certificate;

(b) In its application for renewal the ESS must include the renewal fee, update the information specified in subsections (5)(a), (b), (i), and (j) of this rule, and state whether it violated or is currently being investigated for violation of any attestation made under the current certificate. The ESS must state that it continues to attest that it will meet the requirements of sections (6) and (7) of this rule. The authorized representative of the ESS must state that all information provided is true and correct and sign the renewal application;

(c) If the Commission takes no action on the renewal application, the renewal is granted for a period of one year from the expiration date of the prior certificate;

(d) If a written complaint is filed, or if on the Commission's own motion, the Commission has reason to believe the renewal should not be granted, the Commission will conduct a revocation proceeding per section (14) of this rule. The renewal applicant will be considered temporarily certified during the pending revocation proceeding.

(14) Upon review of a written complaint or on its own motion the Commission may, after reasonable notice and opportunity for hearing, revoke the certification of an ESS for reasons including, but not limited to, the following:

(a) Material misrepresentations in its application for certification or in any report of material changes in the facts upon which the certification was based;

(b) Material misrepresentations in customer solicitations, agreements, or in the administration of customer contracts;

(c) Dishonesty, fraud, or deceit that benefits the ESS or disadvantages customers;

(d) Demonstrated lack of financial, or operational capability; or

(e) Violation of agreements stated in sections (6) and (7) of this rule.

(15) An ESS must promptly report to the Commission any circumstances or events that materially alter information provided to the Commission in the certification or renewal process or otherwise materially impacts their ability to reasonably serve electricity consumers in Oregon.

(16) Each ESS that owns, operates, or controls electrical supply lines and facilities subject to ORS 757.035 must have and maintain its entire plant and system in such condition that it will furnish safe, adequate, and reasonably continuous service. Each such ESS must inspect its lines and facilities in such a manner and with such frequency as may be needed to ensure a reasonably complete knowledge about their condition and adequacy at all times. Such record must be kept of the conditions found as the ESS considers necessary to properly maintain its system, unless in special cases the Commission specifies a more complete record. The ESS must have written plans describing its inspection, operation, and maintenance programs necessary to ensure the safety and reliability of the facilities. The written plans and records required herein must be made available to the Commission upon request. The ESS must report serious injuries to persons or property in accordance with OAR 860-024-0050.

Stat. Auth.: ORS 183, 756 & 757
Stats. Implemented: ORS 756.040 & 757.600 - 757.667
Hist.: PUC 17-2000, f. & cert. ef. 9-29-00; PUC 23-2001, f. & cert. ef. 10-11-01; PUC 7-2005, f. & cert. ef. 11-30-05; PUC 1-2015, f. & cert. ef. 3-3-15

860-038-0420
Electricity Service Supplier Consumer Protection

(1) All advertising and marketing activities by electricity service suppliers must be truthful, not misleading, and in compliance with Oregon's Unfair Trade Practices Act (ORS 646.605 through 646.656).

(2) No person or entity may offer to sell electricity services available pursuant to direct access unless it has been certified by the Commission as an ESS.

(3) Sections (3) through (6) of this rule do not apply when a consumer is changing suppliers. Sections (3) through (6) apply when an ESS is discontinuing service to a consumer. An ESS must give its customers at least 10 business days written notice, as prescribed in section (5) of this rule, before the ESS may discontinue service.

(4) The written notice of intent to discontinue service to the ESS customer must be printed in boldface type and must state in easy to understand language:

(a) The name and contact information of the ESS and the service location intended to be discontinued;

(b) The reasons for the proposed discontinuance;

(c) The earliest date for discontinuance; and

(d) The amount necessary to be paid to avoid discontinuance of services, if applicable.

(5) The ESS must serve the notice of discontinuance in person or send it by first class mail to the last known address of the ESS customer. Service is complete on the date of personal delivery or, if service is by U. S. mail, on the day after the U. S. Postal Service postmark or the day after the date of postage metering.

(6) Not less than 10 business days prior to discontinuance of service to an ESS customer, the ESS must notify the serving electric company, by mutually acceptable means, that the ESS will no longer be supplying energy to that ESS customer. If an ESS and a consumer waive the 10-day notice, pursuant to section (8) of this rule, the ESS must still notify the electric company of its intent to discontinue a consumer's service as soon as it notifies the consumer that service is to be discontinued. The written notice must contain the following:

(a) Name and contact information of the ESS that is discontinuing service, the consumer's name, account number, service location and, if applicable, the electric company's unique location identifier;

(b) Earliest date for discontinuance; and

(c) Necessary information applicable to the transfer of the consumer's service.

(7) This section of this rule applies to any alleged violation of the rules in Division 038 applicable to electricity service suppliers.

(a) When a dispute occurs between an ESS customer and an ESS about any charge or service, the ESS must acknowledge the dispute with a response to the customer within 5 calendar days. The ESS must thoroughly investigate the matter and report the results of its investigation to the ESS customer within 15 calendar days. If the ESS is unable to resolve the matter within 15 calendar days, the ESS must advise the customer of the option to request internal supervisory review of unregulated disputes and to request the Commission's assistance in resolving a dispute within the Commission's jurisdiction;

(b) An ESS customer may request the Commission's assistance in resolving a dispute within the Commission's jurisdiction by contacting the Commission's Consumer Services Division. The Commission must notify the electricity service supplier upon receipt of such a request;

(c) The Commission's Consumer Services Division will assist the complainant and the electricity service supplier in an effort to reach an informal resolution of the dispute. The ESS must provide the Commission with the necessary information to assist in resolving the dispute. The ESS must answer the registered ESS dispute within 15 calendar days of service of the complaint;

(d) If a registered ESS dispute cannot be resolved informally, the Commission's Consumer Services Division will advise the complainant of the right to file a formal written complaint.

(A) The formal written complaint must state the facts of the dispute and the relief requested and must be filed with the Filing Center in compliance with the rules regarding confidential information and filing set out in OAR 860-001-0070, 860-001-0140 through 860-001-0150,and 860-001-0170.

(B) The formal complaint must be filed with the Filing Center at PUC.FilingCenter@state.or.us. If complainant does not have access to electronic mail, the complaint may be mailed, faxed, or delivered to the Filing Center at the address set out in OAR 860-001-0140, and the formal complaint must include a request for waiver of the electronic filing and service requirements.

(C) The Commission will serve the complaint on the ESS. The Commission may electronically serve the ESS with the complaint if the electronic mail address is verified prior to service of the complaint and the delivery receipt is maintained in the official file.

(D) The ESS must answer the complaint within 15 calendar days of service of the complaint by the Commission.

(E) The Commission will set the matter for expedited hearing. A hearing may be held on less than 10 calendar days' notice when good cause is shown. Notice of the hearing will be provided to the complainant and the ESS at least 12 hours before the date and time of the hearing.

(F) Filing dates for formal complaint proceedings are calculated and enforced per OAR 860-001-0150.

(8) Within the terms of a written contract, a customer and an ESS may agree to arrangements other than those specified in sections (3), (4), (5), and (6) of this rule, if the following requirements are met:

(a) The contract must include an exact copy of the paragraphs in subsection (8)(b) of this rule. The paragraphs must be in bold type of at least 12-font size. Immediately following the paragraphs, there must be a line for the consumer's signature and the date.

(b) The agreement must contain the following notice: IF YOU SIGN THIS AGREEMENT, YOU MAY GIVE UP CERTAIN RIGHTS YOU HAVE UNDER OAR 860-038-0420(3) through (6). These rules state: The ESS must insert the complete text of OAR 860-038-0420(3) through (6). THIS MAY AFFECT YOUR ABILITY TO ARRANGE FOR OTHER ENERGY SERVICE.

Stat. Auth.: ORS 183, 756 & 757
Stats. Implemented: ORS 756.040 & 757.600 - 757.667
Hist.: PUC 17-2000, f. & cert. ef. 9-29-00; PUC 21-2001(Temp), f. & cert. ef. 9-11-01 thru 3-10-02; PUC 11-2002, f. & cert. ef. 3-8-02; PUC 11-2003, f. & cert. ef. 7-3-03; PUC 1-2015, f. & cert. ef. 3-3-15

860-082-0085
Complaints for Enforcement

(1) This rule specifies the procedure for a public utility, an interconnection customer, or an applicant to file a complaint for the enforcement of an interconnection agreement. Filing dates for enforcement complaint proceedings are calculated and enforced per OAR 860-001-0150.

(2) At least 10 days prior to filing a complaint for enforcement, complainant must give written notice to defendant and the Commission that complainant intends to file a complaint for enforcement. The notice must identify the provisions in the agreement that complainant alleges were or are being violated and the specific acts or failure to act that caused or are causing the violation, and whether complainant anticipates requesting temporary or injunctive relief. On the same day the notice is filed with the Commission, complainant must serve a copy of the notice on defendant's authorized representative, attorney of record, or designated agent for service of process. Complainant must also serve the notice on all persons designated in the interconnection agreement to receive notices;

(3) A complaint for enforcement must:

(a) Contain a statement of specific facts demonstrating that the complainant conferred with defendant in good faith to resolve the dispute, and that despite those efforts the parties failed to resolve the dispute;

(b) Include a copy of the written notice, required by section (2), indicating that the complainant intends to file a complaint for enforcement;

(c) Include a copy of the interconnection agreement or the portion of the agreement that the complainant contends that defendant violated or is violating. If a copy of the entire agreement is provided, complainant must specify the provisions at issue;

(d) Contain a statement of the facts or law demonstrating defendant's failure to comply with the interconnection agreement and complainant's entitlement to relief. The statement must indicate that the remedy sought is consistent with the dispute resolution provisions in the agreement, if any. Statements of facts must be supported by written testimony with affidavits made by persons competent to testify and having personal knowledge of the relevant facts. Statements of law must be supported by appropriate citations. If exhibits are attached to the affidavits, the affidavits must contain the foundation for the exhibits;

(e) Designate up to three persons to receive copies of pleadings and documents;

(f) Include an executive summary, filed as a separate document not to exceed 8 pages, outlining the issues and relief requested; and

(g) Include any motions for affirmative relief, filed as a separate document and clearly marked. Nothing in this subsection precludes complainant from filing a motion subsequent to the filing of the complaint if the motion is based upon facts or circumstances unknown or unavailable to complainant at the time the complaint was filed.

(4) On the same day the complaint is filed with the Commission, complainant must serve a copy of the complaint on defendant's authorized representative, attorney of record, or designated agent for service of process. Service may be by telephonic facsimile, electronic mail, or overnight mail, but the complaint must arrive at defendant's location on the same day the complaint is filed with the Commission. Service by facsimile or electronic mail must be followed by a physical copy of the complaint the next day by overnight delivery.

(5) Within 10 business days after service of the complaint, defendant may file an answer with the Commission. Any allegations raised in the complaint and not addressed in the answer are deemed admitted. The answer must:

(a) Contain a statement of specific facts demonstrating that the defendant conferred with complainant in good faith to resolve the dispute and that despite those efforts the parties failed to resolve the dispute;

(b) Respond to each allegation in the complaint and set forth all affirmative defenses;

(c) Contain a statement of the facts or law supporting defendant's position. Statements of facts must be supported by written testimony with affidavits made by persons competent to testify and having personal knowledge of the relevant facts. Statements of law must be supported by appropriate citations. If exhibits are attached to the affidavits, then the affidavits must contain the foundation for the exhibits; and

(d) Designate up to three persons to receive copies of other pleadings and documents.

(6) On the same day as the answer is filed, the defendant must also file its response to any motion filed by complainant and its motions for

affirmative relief. Each response and each motion must be filed as a separate filing. Nothing in this section precludes defendant from filing a motion subsequent to the filing of the answer if the motion is based upon facts or circumstances unknown or unavailable to defendant at the time the answer was filed.

(7) On the same day the answer is filed with the Commission, the defendant must serve a copy of the answer to the complainant's authorized representative, attorney of record, or designated agent for service of process.

(8) Complainant must file a reply to an answer that contains affirmative defenses within 5 business days after the answer is filed. On the same day the reply is filed with the Commission, complainant must serve a copy of the reply to defendant's authorized representative, attorney of record, or designated agent for service of process.

(9) A cross-complaint or counterclaim must be answered within the 10-business day time frame allowed for answers to complaints.

(10) The Commission will conduct a conference regarding each complaint for enforcement of an interconnection agreement.

(a) The administrative law judge (ALJ) schedules a conference within 5 business days after the answer is filed, to be held as soon as practicable. At the discretion of the ALJ, the conference may be conducted by telephone.

(b) Based on the complaint and the answer, all supporting documents filed by the parties, and the parties' oral statements at the conference, the ALJ determines whether the issues raised in the complaint can be determined on the pleadings and submissions without further proceedings or whether further proceedings are necessary. If further proceedings are necessary, the ALJ establishes a procedural schedule. Nothing in this subsection is intended to prohibit the bifurcation of issues where appropriate.

(c) In determining whether further proceedings are necessary, the ALJ must consider, at a minimum, the positions of the parties, the need to clarify evidence through the examination of witnesses, the complexity of the issues, the need for prompt resolution, and the completeness of the information presented.

(d) The ALJ may make oral rulings on the record during the conference on all matters relevant to the conduct of the proceeding.

(11) A party may file with the complaint or answer a request for discovery, stating the matters to be inquired into and their relationship to matters directly at issue.

(12) When warranted by the facts, the complainant or defendant may file a motion requesting that an expedited procedure be used. The moving party must file a proposed expedited procedural schedule along with its motion. The ALJ must schedule a conference to be held as soon as practicable to determine whether an expedited schedule is warranted.

(a) The ALJ will consider whether the issues raised in the complaint or answer involve a risk of imminent, irrevocable harm to a party or to the public interest.

(b) If a determination is made that an expedited procedure is warranted, the ALJ will establish a procedure that ensures a prompt resolution of the merits of the dispute, consistent with due process and other relevant considerations. The ALJ will consider, but is not bound by, the moving party's proposed expedited procedural schedule.

(c) In general, the ALJ will not entertain a motion for expedited procedure where the dispute solely involves the payment of money.

Stat. Auth.: ORS 756
Stats. Implemented: ORS 756.040, 756.500
Hist.: PUC 10-2009, f. & cert. ef. 8-26-09; PUC 1-2015, f. & cert. ef. 3-3-15

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Secretary of State, Elections Division
Chapter 165

Rule Caption: Adopts Filing Deadlines for Vacancies appearing on the May 19, 2015, Regular District Election
Adm. Order No.: ELECT 2-2015(Temp)
Filed with Sec. of State: 2-24-2015
Certified to be Effective: 2-24-15 thru 3-20-15
Notice Publication Date:
Rules Adopted: 165-020-2034
Subject: A vacancy in the position of Director of the Neskowin Regional Sanitary Authority (Tillamook County) and in Zone 5 of the Silver Falls School District 4J (Marion County) occurred after the deadline for publishing notice of district election but before the 62nd day before the May 19, 2015 Regular District Election. This rule provides the deadlines for the county to publish notice of district election and sets the deadline to accept candidate filings.
Rules Coordinator: Brenda Bayes—(503) 986-1518

165-020-2034
Filing Deadline for Vacancies Appearing on the May 19, 2015, Regular District Election

Due to a vacancy in the position of Director of the Neskowin Regional Sanitary Authority (Tillamook County) and in Zone 5 of the Silver Falls School District 4J (Marion County) the following deadlines apply:

(1) March 2, 2015, last date for clerk to publish notice of district election in newspaper of general circulation in the district.

(2) March 19, 2015, last date for candidates to file declaration of candidacy or completed nominating petition with the appropriate county clerk.

Sstat. Auth.: ORS 246.150
Stats. Implemented: ORS 255.245
Hist.: ELECT 2-2015(Temp), f. & cert. ef. 2-24-15 thru 3-20-15

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Rule Caption: Adopts Filing Deadlines for Vacancy in Neah-Kah-Nie School District #56 Board of Directors
Adm. Order No.: ELECT 3-2015(Temp)
Filed with Sec. of State: 3-3-2015
Certified to be Effective: 3-3-15 thru 3-20-15
Notice Publication Date:
Rules Adopted: 165-020-2035
Subject: A vacancy in the office of Director, Zone 3, of the Neah-Kah-Nie School District #56 occurred after the deadline for publishing notice of district election but before the 62nd day before the May 19, 2015 Regular District Election. This rule provides the deadlines for the county to publish notice of district election and sets the deadline to accept candidate filings.
Rules Coordinator: Brenda Bayes—(503) 986-1518

165-020-2035
Filing Deadline for Vacancy Appearing on the May 19, 2015, Regular District Election

Due to a vacancy in the position of Director, Zone 3, Neah-Kah-Nie School District #56 (Tillamook County) the following deadlines apply:

(1) March 6, 2015, last date for clerk to publish notice of district election in newspaper of general circulation in the district.

(2) March 19, 2015, last date for candidates to file declaration of candidacy or completed nominating petition with the Tillamook County Clerk.

Sstat. Auth.: ORS 246.150
Stats. Implemented: ORS 255.245
Hist.: ELECT 3-2015(Temp), f. & cert. ef. 3-3-15 thru 3-20-15

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Rule Caption: Adopts Filing Deadlines for Vacancy, Position #4, Mid-Columbia Fire and Rescue District Board of Directors
Adm. Order No.: ELECT 4-2015(Temp)
Filed with Sec. of State: 3-10-2015
Certified to be Effective: 3-10-15 thru 3-20-15
Notice Publication Date:
Rules Adopted: 165-020-2036
Subject: A vacancy in Position #4 of the Mid-Columbia Fire and Rescue District Board of Directors occurred after the deadline for publishing notice of district election but before the 62nd day before the May 19, 2015 Regular District Election. This rule provides the deadlines for the county to publish notice of district election and sets the deadline to accept candidate filings.
Rules Coordinator: Brenda Bayes—(503) 986-1518

165-020-2036
Filing Deadline for Vacancy Appearing on the May 19, 2015, Regular District Election

Due to a vacancy in Position #4 of the Mid-Columbia Fire and Rescue District Board of Directors (Wasco County) the following deadlines apply:

(1) March 13, 2015, last date for clerk to publish notice of district election in newspaper of general circulation in the district.

(2) March 19, 2015, last date for candidates to file declaration of candidacy or completed nominating petition with the Wasco County Clerk.

Sstat. Auth.: ORS 246.150
Stats. Implemented:
Hist.: ELECT 4-2015(Temp), f. & cert. ef. 3-10-15 thru 3-20-15

Rule Caption: Adopts Filing Deadlines for Vacancy in Position #1, Idanha-Detroit Rural Fire Protection Board of Directors
Adm. Order No.: ELECT 5-2015(Temp)
Filed with Sec. of State: 3-12-2015
Certified to be Effective: 3-12-15 thru 3-23-15
Notice Publication Date:
Rules Adopted: 165-020-2037
Subject: A vacancy in Position #1, of the Idanha-Detroit Rural Fire Protection District Board of Directors occurred after the deadline for publishing notice of district election but before the 62nd day before the May 19, 2015 Regular District Election. This rule provides the deadlines for the county to publish notice of district election and sets the deadline to accept candidate filings.
Rules Coordinator: Brenda Bayes—(503) 986-1518

165-020-2037
Filing Deadline for Vacancy Appearing on the May 19, 2015, Regular District Election

Due to a vacancy in Position #1 of the Idanha-Detroit Rural Fire Protection Board of Directors located in (Marion County) the following deadlines apply:

(1) March 16, 2015, last date for clerk to publish notice of district election in newspaper of general circulation in the district.

(2) March 20, 2015, last date for candidates to file declaration of candidacy or completed nominating petition with the Marion County Clerk.

Stat. Auth.: ORS 246.150
Stats. Implemented: ORS 255.245
Hist.: ELECT 5-2015(Temp), f. & cert. ef. 3-12-15 thru 3-23-15

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166-200-0370	1-27-2015	Amend	3-1-2015
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230-001-0010	2-9-2015	Amend	3-1-2015
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259-060-0010	1-5-2015	Amend	2-1-2015
259-060-0130	1-5-2015	Amend	2-1-2015
259-061-0005	1-5-2015	Amend	2-1-2015
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330-070-0027	1-1-2015	Amend	1-1-2015
330-070-0029	1-1-2015	Amend	1-1-2015
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333-106-0040	1-1-2015	Amend	2-1-2015
333-106-0045	1-1-2015	Amend	2-1-2015
333-106-0055	1-1-2015	Amend	2-1-2015
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333-106-0245	1-1-2015	Amend	2-1-2015
333-106-0301	1-1-2015	Amend	2-1-2015
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333-119-0050	1-1-2015	Amend	2-1-2015
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407-025-0060	2-11-2015	Amend(T)	3-1-2015
407-025-0070	2-11-2015	Amend(T)	3-1-2015
407-025-0080	2-11-2015	Amend(T)	3-1-2015
407-025-0090	2-11-2015	Amend(T)	3-1-2015
407-025-0100	2-11-2015	Amend(T)	3-1-2015
407-025-0110	2-11-2015	Amend(T)	3-1-2015
409-035-0020	2-1-2015	Amend	2-1-2015
409-035-0040	2-1-2015	Amend	2-1-2015
409-055-0010	2-1-2015	Amend	3-1-2015
409-055-0030	2-1-2015	Amend	3-1-2015
409-055-0040	2-1-2015	Amend	3-1-2015
409-055-0045	2-1-2015	Adopt	3-1-2015
410-050-0861	12-1-2014	Amend	1-1-2015
410-050-0861(T)	12-1-2014	Repeal	1-1-2015
410-120-0000	2-10-2015	Amend	3-1-2015
410-120-0006	3-19-2015	Amend(T)	4-1-2015
410-120-1340	1-1-2015	Amend(T)	2-1-2015
410-120-1340	3-4-2015	Amend	4-1-2015
410-120-1340(T)	3-4-2015	Repeal	4-1-2015
410-121-0030	12-12-2014	Amend	1-1-2015
410-121-0030	12-12-2014	Amend(T)	1-1-2015
410-121-0030	1-1-2015	Amend(T)	2-1-2015
410-121-0030	3-3-2015	Amend(T)	4-1-2015
410-121-0030(T)	12-12-2014	Repeal	1-1-2015
410-121-0040	12-12-2014	Amend	1-1-2015
410-121-0040	12-12-2014	Amend(T)	1-1-2015
410-121-0040	1-1-2015	Amend(T)	2-1-2015
410-121-0040	2-3-2015	Amend(T)	3-1-2015
410-121-0040(T)	12-12-2014	Repeal	1-1-2015
410-121-2000	2-18-2015	Renumber	4-1-2015
410-121-2005	2-18-2015	Renumber	4-1-2015
410-121-2010	2-18-2015	Renumber	4-1-2015
410-121-2020	2-18-2015	Renumber	4-1-2015
410-121-2030	2-18-2015	Renumber	4-1-2015
410-121-2050	2-18-2015	Renumber	4-1-2015
410-121-2065	2-18-2015	Renumber	4-1-2015
410-122-0080	1-1-2015	Amend	2-1-2015
410-122-0187	1-29-2015	Adopt(T)	3-1-2015
410-122-0202	1-1-2015	Amend	2-1-2015
410-122-0209	3-1-2015	Amend	4-1-2015
410-122-0520	1-1-2015	Amend	2-1-2015
410-123-1220	2-17-2015	Amend(T)	4-1-2015
410-123-1260	2-17-2015	Amend(T)	4-1-2015
410-130-0160	1-1-2015	Amend(T)	1-1-2015
410-130-0200	3-10-2015	Amend	4-1-2015
410-130-0200(T)	3-10-2015	Repeal	4-1-2015
410-130-0220	12-24-2014	Amend(T)	2-1-2015
410-130-0220	3-10-2015	Amend	4-1-2015
410-130-0220(T)	3-10-2015	Repeal	4-1-2015
410-130-0240	1-1-2015	Amend	1-1-2015
410-141-0060	1-1-2015	Amend(T)	1-1-2015
410-141-0060	3-1-2015	Amend	4-1-2015
410-141-0060(T)	3-1-2015	Repeal	4-1-2015
410-141-0420	1-1-2015	Amend	1-1-2015
410-141-0420(T)	1-1-2015	Repeal	1-1-2015
410-141-0520	12-31-2014	Amend	2-1-2015
410-141-0520	1-1-2015	Amend(T)	2-1-2015
410-141-0520(T)	12-31-2014	Repeal	2-1-2015
410-141-3060	12-27-2014	Amend(T)	1-1-2015
410-141-3060	1-1-2015	Amend	1-1-2015
410-141-3060	1-1-2015	Amend(T)	1-1-2015
410-141-3060	3-1-2015	Amend	4-1-2015
410-141-3060(T)	1-1-2015	Repeal	1-1-2015
410-141-3060(T)	3-1-2015	Repeal	4-1-2015
410-141-3269	1-1-2015	Adopt(T)	2-1-2015
410-141-3420	1-1-2015	Amend	1-1-2015
410-141-3420(T)	1-1-2015	Repeal	1-1-2015
410-143-0020	3-10-2015	Repeal	4-1-2015
410-143-0040	3-10-2015	Repeal	4-1-2015
410-143-0060	3-10-2015	Repeal	4-1-2015
410-165-0000	2-3-2015	Amend(T)	3-1-2015
410-165-0020	2-3-2015	Amend(T)	3-1-2015
410-165-0040	2-3-2015	Amend(T)	3-1-2015
410-165-0060	2-3-2015	Amend(T)	3-1-2015
410-165-0080	2-3-2015	Amend(T)	3-1-2015
410-165-0100	2-3-2015	Amend(T)	3-1-2015
410-172-0000	1-1-2015	Suspend	2-1-2015
410-172-0010	1-1-2015	Suspend	2-1-2015
410-172-0020	1-1-2015	Suspend	2-1-2015
410-172-0030	1-1-2015	Suspend	2-1-2015
410-172-0040	1-1-2015	Suspend	2-1-2015
410-172-0050	1-1-2015	Suspend	2-1-2015
410-172-0060	1-1-2015	Suspend	2-1-2015
410-172-0070	1-1-2015	Suspend	2-1-2015
410-172-0080	1-1-2015	Suspend	2-1-2015

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410-172-0090	1-1-2015	Suspend	2-1-2015
410-172-0100	1-1-2015	Suspend	2-1-2015
410-172-0110	1-1-2015	Suspend	2-1-2015
410-172-0120	1-1-2015	Suspend	2-1-2015
410-172-0130	1-1-2015	Suspend	2-1-2015
410-172-0140	1-1-2015	Suspend	2-1-2015
410-172-0150	1-1-2015	Suspend	2-1-2015
410-172-0160	1-1-2015	Suspend	2-1-2015
410-172-0170	1-1-2015	Suspend	2-1-2015
410-172-0180	1-1-2015	Suspend	2-1-2015
410-172-0190	1-1-2015	Suspend	2-1-2015
410-172-0200	1-1-2015	Suspend	2-1-2015
410-172-0210	1-1-2015	Suspend	2-1-2015
410-172-0220	1-1-2015	Suspend	2-1-2015
410-172-0230	1-1-2015	Suspend	2-1-2015
410-172-0240	1-1-2015	Suspend	2-1-2015
410-172-0250	1-1-2015	Suspend	2-1-2015
410-172-0260	1-1-2015	Suspend	2-1-2015
410-172-0270	1-1-2015	Suspend	2-1-2015
410-172-0280	1-1-2015	Suspend	2-1-2015
410-172-0290	1-1-2015	Suspend	2-1-2015
410-172-0300	1-1-2015	Suspend	2-1-2015
410-172-0310	1-1-2015	Suspend	2-1-2015
410-172-0320	1-1-2015	Suspend	2-1-2015
410-172-0330	1-1-2015	Suspend	2-1-2015
410-172-0340	1-1-2015	Suspend	2-1-2015
410-172-0350	1-1-2015	Suspend	2-1-2015
410-172-0360	1-1-2015	Suspend	2-1-2015
410-172-0370	1-1-2015	Suspend	2-1-2015
410-172-0380	1-1-2015	Suspend	2-1-2015
410-172-0390	1-1-2015	Suspend	2-1-2015
410-172-0400	1-1-2015	Suspend	2-1-2015
410-172-0410	1-1-2015	Suspend	2-1-2015
410-172-0420	1-1-2015	Suspend	2-1-2015
410-172-0430	1-1-2015	Suspend	2-1-2015
410-172-0440	1-1-2015	Suspend	2-1-2015
410-172-0450	1-1-2015	Suspend	2-1-2015
410-172-0460	1-1-2015	Suspend	2-1-2015
410-172-0470	1-1-2015	Suspend	2-1-2015
410-172-0480	1-1-2015	Suspend	2-1-2015
410-172-0490	1-1-2015	Suspend	2-1-2015
410-172-0500	1-1-2015	Suspend	2-1-2015
410-172-0510	1-1-2015	Suspend	2-1-2015
410-172-0600	1-1-2015	Adopt(T)	2-1-2015
410-172-0610	1-1-2015	Adopt(T)	2-1-2015
410-172-0620	1-1-2015	Adopt(T)	2-1-2015
410-172-0630	1-1-2015	Adopt(T)	2-1-2015
410-172-0640	1-1-2015	Adopt(T)	2-1-2015
410-172-0650	1-1-2015	Adopt(T)	2-1-2015
410-172-0660	1-1-2015	Adopt(T)	2-1-2015
410-172-0670	1-1-2015	Adopt(T)	2-1-2015
410-172-0680	1-1-2015	Adopt(T)	2-1-2015
410-172-0690	1-1-2015	Adopt(T)	2-1-2015
410-172-0700	1-1-2015	Adopt(T)	2-1-2015
410-172-0710	1-1-2015	Adopt(T)	2-1-2015
410-172-0720	1-1-2015	Adopt(T)	2-1-2015
410-172-0730	1-1-2015	Adopt(T)	2-1-2015
410-172-0740	1-1-2015	Adopt(T)	2-1-2015
410-172-0750	1-1-2015	Adopt(T)	2-1-2015
410-172-0760	1-1-2015	Adopt(T)	2-1-2015
410-172-0770	1-1-2015	Adopt(T)	2-1-2015
410-172-0780	1-1-2015	Adopt(T)	2-1-2015
410-172-0790	1-1-2015	Adopt(T)	2-1-2015
410-172-0800	1-1-2015	Adopt(T)	2-1-2015
410-172-0810	1-1-2015	Adopt(T)	2-1-2015
410-172-0820	1-1-2015	Adopt(T)	2-1-2015
410-172-0830	1-1-2015	Adopt(T)	2-1-2015
410-172-0840	1-1-2015	Adopt(T)	2-1-2015
410-172-0850	1-1-2015	Adopt(T)	2-1-2015
410-200-0010	1-30-2015	Amend	3-1-2015
410-200-0010(T)	1-30-2015	Repeal	3-1-2015
410-200-0015	1-30-2015	Amend	3-1-2015
410-200-0015(T)	1-30-2015	Repeal	3-1-2015
410-200-0100	1-30-2015	Amend	3-1-2015
410-200-0100(T)	1-30-2015	Repeal	3-1-2015
410-200-0105	1-30-2015	Amend	3-1-2015
410-200-0105(T)	1-30-2015	Repeal	3-1-2015
410-200-0110	1-30-2015	Amend	3-1-2015
410-200-0110(T)	1-30-2015	Repeal	3-1-2015
410-200-0111	1-30-2015	Amend	3-1-2015
410-200-0111(T)	1-30-2015	Repeal	3-1-2015
410-200-0115	1-30-2015	Amend	3-1-2015
410-200-0115(T)	1-30-2015	Repeal	3-1-2015
410-200-0120	1-30-2015	Amend	3-1-2015
410-200-0120(T)	1-30-2015	Repeal	3-1-2015
410-200-0125	1-30-2015	Amend	3-1-2015
410-200-0125(T)	1-30-2015	Repeal	3-1-2015
410-200-0130	1-30-2015	Amend	3-1-2015
410-200-0130(T)	1-30-2015	Repeal	3-1-2015
410-200-0135	1-30-2015	Amend	3-1-2015
410-200-0135(T)	1-30-2015	Repeal	3-1-2015
410-200-0140	1-30-2015	Amend	3-1-2015
410-200-0140(T)	1-30-2015	Repeal	3-1-2015
410-200-0145	1-30-2015	Amend	3-1-2015
410-200-0145(T)	1-30-2015	Repeal	3-1-2015
410-200-0146	1-30-2015	Amend	3-1-2015
410-200-0146(T)	1-30-2015	Repeal	3-1-2015
410-200-0200	1-30-2015	Amend	3-1-2015
410-200-0200(T)	1-30-2015	Repeal	3-1-2015
410-200-0205	1-30-2015	Amend	3-1-2015
410-200-0205(T)	1-30-2015	Repeal	3-1-2015
410-200-0210	1-30-2015	Amend	3-1-2015
410-200-0210(T)	1-30-2015	Repeal	3-1-2015
410-200-0215	1-30-2015	Amend	3-1-2015
410-200-0215(T)	1-30-2015	Repeal	3-1-2015
410-200-0220	1-30-2015	Amend	3-1-2015
410-200-0220(T)	1-30-2015	Repeal	3-1-2015
410-200-0225	1-30-2015	Amend	3-1-2015
410-200-0225(T)	1-30-2015	Repeal	3-1-2015
410-200-0230	1-30-2015	Amend	3-1-2015
410-200-0230(T)	1-30-2015	Repeal	3-1-2015
410-200-0235	1-30-2015	Amend	3-1-2015

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410-200-0235(T)	1-30-2015	Repeal	3-1-2015
410-200-0240	1-30-2015	Amend	3-1-2015
410-200-0240(T)	1-30-2015	Repeal	3-1-2015
410-200-0305	1-30-2015	Amend	3-1-2015
410-200-0305(T)	1-30-2015	Repeal	3-1-2015
410-200-0310	1-30-2015	Amend	3-1-2015
410-200-0310(T)	1-30-2015	Repeal	3-1-2015
410-200-0315	1-30-2015	Amend	3-1-2015
410-200-0315	3-1-2015	Amend(T)	3-1-2015
410-200-0315(T)	1-30-2015	Repeal	3-1-2015
410-200-0400	1-30-2015	Amend	3-1-2015
410-200-0400(T)	1-30-2015	Repeal	3-1-2015
410-200-0405	1-30-2015	Amend	3-1-2015
410-200-0405(T)	1-30-2015	Repeal	3-1-2015
410-200-0410	1-30-2015	Amend	3-1-2015
410-200-0410(T)	1-30-2015	Repeal	3-1-2015
410-200-0415	1-30-2015	Amend	3-1-2015
410-200-0415(T)	1-30-2015	Repeal	3-1-2015
410-200-0420	1-30-2015	Amend	3-1-2015
410-200-0420(T)	1-30-2015	Repeal	3-1-2015
410-200-0425	1-30-2015	Amend	3-1-2015
410-200-0425(T)	1-30-2015	Repeal	3-1-2015
410-200-0435	1-30-2015	Amend	3-1-2015
410-200-0435(T)	1-30-2015	Repeal	3-1-2015
410-200-0440	1-30-2015	Amend	3-1-2015
410-200-0440(T)	1-30-2015	Repeal	3-1-2015
410-200-0500	1-30-2015	Amend	3-1-2015
410-200-0500(T)	1-30-2015	Repeal	3-1-2015
410-200-0505	1-30-2015	Amend	3-1-2015
410-200-0505(T)	1-30-2015	Repeal	3-1-2015
410-200-0510	1-30-2015	Amend	3-1-2015
410-200-0510(T)	1-30-2015	Repeal	3-1-2015
411-015-0100	1-1-2015	Amend(T)	2-1-2015
411-020-0000	1-1-2015	Amend	1-1-2015
411-020-0002	1-1-2015	Amend	1-1-2015
411-020-0010	1-1-2015	Amend	1-1-2015
411-020-0015	1-1-2015	Amend	1-1-2015
411-020-0020	1-1-2015	Amend	1-1-2015
411-020-0025	1-1-2015	Amend	1-1-2015
411-020-0030	1-1-2015	Amend	1-1-2015
411-020-0040	1-1-2015	Amend	1-1-2015
411-020-0060	1-1-2015	Amend	1-1-2015
411-020-0080	1-1-2015	Amend	1-1-2015
411-020-0085	1-1-2015	Amend	1-1-2015
411-020-0090	1-1-2015	Amend	1-1-2015
411-020-0100	1-1-2015	Amend	1-1-2015
411-020-0110	1-1-2015	Amend	1-1-2015
411-020-0120	1-1-2015	Amend	1-1-2015
411-020-0123	1-1-2015	Amend	1-1-2015
411-020-0130	1-1-2015	Amend	1-1-2015
411-030-0040	1-1-2015	Amend(T)	2-1-2015
411-032-0050	12-28-2014	Adopt	2-1-2015
411-032-0050(T)	12-28-2014	Repeal	2-1-2015
411-035-0010	3-9-2015	Amend	4-1-2015
411-035-0010(T)	3-9-2015	Repeal	4-1-2015
411-035-0015	1-1-2015	Amend(T)	2-1-2015
411-035-0025	1-1-2015	Amend(T)	2-1-2015
411-035-0040	1-1-2015	Amend(T)	2-1-2015
411-035-0055	1-1-2015	Amend(T)	2-1-2015
411-035-0070	1-1-2015	Amend(T)	2-1-2015
411-035-0085	1-1-2015	Amend(T)	2-1-2015
411-050-0602	1-1-2015	Amend(T)	2-1-2015
411-050-0625	1-1-2015	Amend(T)	2-1-2015
411-050-0640	1-1-2015	Amend(T)	2-1-2015
411-050-0645	1-1-2015	Amend(T)	2-1-2015
411-050-0655	1-1-2015	Amend(T)	2-1-2015
411-050-0665	1-1-2015	Amend(T)	2-1-2015
411-054-0005	1-15-2015	Amend	2-1-2015
411-054-0012	1-15-2015	Amend	2-1-2015
411-054-0090	1-15-2015	Amend	2-1-2015
411-054-0093	1-15-2015	Amend	2-1-2015
411-054-0120	1-29-2015	Amend(T)	3-1-2015
411-054-0200	1-15-2015	Amend	2-1-2015
411-054-0300	1-15-2015	Amend	2-1-2015
411-070-0005	3-9-2015	Amend	4-1-2015
411-070-0027	3-9-2015	Amend	4-1-2015
411-070-0035	3-9-2015	Amend	4-1-2015
411-070-0043	3-9-2015	Amend	4-1-2015
411-070-0091	3-9-2015	Amend	4-1-2015
411-085-0005	1-1-2015	Amend(T)	2-1-2015
411-085-0010	1-1-2015	Amend(T)	2-1-2015
411-085-0013	1-1-2015	Amend(T)	2-1-2015
411-085-0015	1-1-2015	Amend(T)	2-1-2015
411-085-0030	1-1-2015	Amend(T)	2-1-2015
411-085-0040	1-1-2015	Amend(T)	2-1-2015
411-085-0060	1-1-2015	Amend(T)	2-1-2015
411-085-0310	1-1-2015	Amend(T)	2-1-2015
411-085-0350	1-1-2015	Amend(T)	2-1-2015
411-085-0360	1-1-2015	Amend(T)	2-1-2015
411-085-0370	1-1-2015	Amend(T)	2-1-2015
411-088-0050	3-2-2015	Amend(T)	4-1-2015
411-088-0060	3-2-2015	Amend(T)	4-1-2015
411-089-0010	1-1-2015	Amend(T)	2-1-2015
411-089-0020	1-1-2015	Amend(T)	2-1-2015
411-089-0030	1-1-2015	Amend(T)	2-1-2015
411-089-0040	1-1-2015	Amend(T)	2-1-2015
411-089-0050	1-1-2015	Amend(T)	2-1-2015
411-089-0070	1-1-2015	Amend(T)	2-1-2015
411-089-0075	1-1-2015	Amend(T)	2-1-2015
411-089-0100	1-1-2015	Amend(T)	2-1-2015
411-089-0110	1-1-2015	Amend(T)	2-1-2015
411-089-0120	1-1-2015	Amend(T)	2-1-2015
411-089-0130	1-1-2015	Amend(T)	2-1-2015
411-089-0140	1-1-2015	Amend(T)	2-1-2015
411-300-0100	2-16-2015	Amend	3-1-2015
411-300-0110	2-16-2015	Amend	3-1-2015
411-300-0110(T)	2-16-2015	Repeal	3-1-2015
411-300-0120	2-16-2015	Amend	3-1-2015
411-300-0120	3-12-2015	Amend	4-1-2015
411-300-0120(T)	2-16-2015	Repeal	3-1-2015
411-300-0130	2-16-2015	Amend	3-1-2015
411-300-0130(T)	2-16-2015	Repeal	3-1-2015

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411-300-0140	2-16-2015	Repeal	3-1-2015
411-300-0150	2-16-2015	Amend	3-1-2015
411-300-0150(T)	2-16-2015	Repeal	3-1-2015
411-300-0155	2-16-2015	Amend	3-1-2015
411-300-0165	2-16-2015	Adopt	3-1-2015
411-300-0165(T)	2-16-2015	Repeal	3-1-2015
411-300-0170	2-16-2015	Amend	3-1-2015
411-300-0170(T)	2-16-2015	Repeal	3-1-2015
411-300-0175	2-16-2015	Adopt	3-1-2015
411-300-0190	2-16-2015	Amend	3-1-2015
411-300-0190(T)	2-16-2015	Repeal	3-1-2015
411-300-0200	2-16-2015	Amend	3-1-2015
411-300-0200(T)	2-16-2015	Repeal	3-1-2015
411-300-0205	2-16-2015	Amend	3-1-2015
411-300-0205(T)	2-16-2015	Repeal	3-1-2015
411-300-0210	2-16-2015	Repeal	3-1-2015
411-300-0220	2-16-2015	Repeal	3-1-2015
411-308-0010	12-28-2014	Amend	2-1-2015
411-308-0010	1-29-2015	Amend	3-1-2015
411-308-0020	12-28-2014	Amend	2-1-2015
411-308-0020	1-29-2015	Amend	3-1-2015
411-308-0020(T)	12-28-2014	Repeal	2-1-2015
411-308-0030	12-28-2014	Amend	2-1-2015
411-308-0030	1-29-2015	Amend	3-1-2015
411-308-0030(T)	12-28-2014	Repeal	2-1-2015
411-308-0040	12-28-2014	Amend	2-1-2015
411-308-0040	1-29-2015	Amend	3-1-2015
411-308-0050	12-28-2014	Amend	2-1-2015
411-308-0050	1-29-2015	Amend	3-1-2015
411-308-0050(T)	12-28-2014	Repeal	2-1-2015
411-308-0060	12-28-2014	Amend	2-1-2015
411-308-0060	1-29-2015	Amend	3-1-2015
411-308-0060(T)	12-28-2014	Repeal	2-1-2015
411-308-0070	12-28-2014	Amend	2-1-2015
411-308-0070	1-29-2015	Amend	3-1-2015
411-308-0070(T)	12-28-2014	Repeal	2-1-2015
411-308-0080	12-28-2014	Amend	2-1-2015
411-308-0080	1-29-2015	Amend	3-1-2015
411-308-0080(T)	12-28-2014	Repeal	2-1-2015
411-308-0090	12-28-2014	Amend	2-1-2015
411-308-0090	1-29-2015	Amend	3-1-2015
411-308-0100	12-28-2014	Amend	2-1-2015
411-308-0100	1-29-2015	Amend	3-1-2015
411-308-0100(T)	12-28-2014	Repeal	2-1-2015
411-308-0110	12-28-2014	Amend	2-1-2015
411-308-0110	1-29-2015	Amend	3-1-2015
411-308-0120	12-28-2014	Amend	2-1-2015
411-308-0120	1-29-2015	Amend	3-1-2015
411-308-0120(T)	12-28-2014	Repeal	2-1-2015
411-308-0130	12-28-2014	Amend	2-1-2015
411-308-0130	1-29-2015	Amend	3-1-2015
411-308-0130(T)	12-28-2014	Repeal	2-1-2015
411-308-0135	12-28-2014	Adopt	2-1-2015
411-308-0135	1-29-2015	Amend	3-1-2015
411-308-0135(T)	12-28-2014	Repeal	2-1-2015
411-308-0140	12-28-2014	Amend	2-1-2015
411-308-0140	1-29-2015	Amend	3-1-2015
411-308-0150	12-28-2014	Amend	2-1-2015
411-308-0150	1-29-2015	Amend	3-1-2015
411-317-0000	12-28-2014	Adopt	2-1-2015
411-317-0000(T)	12-28-2014	Repeal	2-1-2015
411-318-0000	12-28-2014	Adopt	2-1-2015
411-318-0000(T)	12-28-2014	Repeal	2-1-2015
411-318-0005	12-28-2014	Adopt	2-1-2015
411-318-0005(T)	12-28-2014	Repeal	2-1-2015
411-318-0010	12-28-2014	Adopt	2-1-2015
411-318-0010(T)	12-28-2014	Repeal	2-1-2015
411-318-0015	12-28-2014	Adopt	2-1-2015
411-318-0015(T)	12-28-2014	Repeal	2-1-2015
411-318-0020(T)	12-28-2014	Repeal	2-1-2015
411-318-0025	12-28-2014	Adopt	2-1-2015
411-318-0025(T)	12-28-2014	Repeal	2-1-2015
411-318-0030	12-28-2014	Adopt	2-1-2015
411-318-0030(T)	12-28-2014	Repeal	2-1-2015
411-320-0020	12-28-2014	Amend	2-1-2015
411-320-0020(T)	12-28-2014	Repeal	2-1-2015
411-320-0040	12-28-2014	Amend	2-1-2015
411-320-0040(T)	12-28-2014	Repeal	2-1-2015
411-320-0060	12-28-2014	Amend	2-1-2015
411-320-0060(T)	12-28-2014	Repeal	2-1-2015
411-320-0070	12-28-2014	Amend	2-1-2015
411-320-0080	12-28-2014	Amend	2-1-2015
411-320-0080(T)	12-28-2014	Repeal	2-1-2015
411-320-0090	12-28-2014	Amend	2-1-2015
411-320-0090(T)	12-28-2014	Repeal	2-1-2015
411-320-0100	12-28-2014	Amend	2-1-2015
411-320-0100(T)	12-28-2014	Repeal	2-1-2015
411-320-0110	12-28-2014	Amend	2-1-2015
411-320-0110(T)	12-28-2014	Repeal	2-1-2015
411-320-0120	12-28-2014	Amend	2-1-2015
411-320-0120(T)	12-28-2014	Repeal	2-1-2015
411-320-0130	12-28-2014	Amend	2-1-2015
411-320-0130(T)	12-28-2014	Repeal	2-1-2015
411-320-0160	12-28-2014	Amend	2-1-2015
411-320-0170	12-28-2014	Amend	2-1-2015
411-320-0170(T)	12-28-2014	Repeal	2-1-2015
411-320-0175	12-28-2014	Amend	2-1-2015
411-320-0175(T)	12-28-2014	Repeal	2-1-2015
411-320-0190	12-28-2014	Amend	2-1-2015
411-320-0200	12-28-2014	Amend	2-1-2015
411-323-0010	12-28-2014	Amend	2-1-2015
411-323-0010(T)	12-28-2014	Repeal	2-1-2015
411-323-0020	12-28-2014	Amend	2-1-2015
411-323-0020(T)	12-28-2014	Repeal	2-1-2015
411-323-0030	12-28-2014	Amend	2-1-2015
411-323-0030(T)	12-28-2014	Repeal	2-1-2015
411-323-0035	12-28-2014	Amend	2-1-2015
411-323-0035(T)	12-28-2014	Repeal	2-1-2015
411-323-0040	12-28-2014	Amend	2-1-2015
411-323-0050	12-28-2014	Amend	2-1-2015
411-323-0050(T)	12-28-2014	Repeal	2-1-2015
411-323-0060	12-28-2014	Amend	2-1-2015

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411-323-0060(T)	12-28-2014	Repeal	2-1-2015
411-323-0070	12-28-2014	Amend	2-1-2015
411-323-0070(T)	12-28-2014	Repeal	2-1-2015
411-325-0020	12-28-2014	Amend	2-1-2015
411-325-0020(T)	12-28-2014	Repeal	2-1-2015
411-325-0060	12-28-2014	Amend	2-1-2015
411-325-0060(T)	12-28-2014	Repeal	2-1-2015
411-325-0110	12-28-2014	Amend	2-1-2015
411-325-0110(T)	12-28-2014	Repeal	2-1-2015
411-325-0120	12-28-2014	Amend	2-1-2015
411-325-0120(T)	12-28-2014	Repeal	2-1-2015
411-325-0180	12-28-2014	Amend	2-1-2015
411-325-0185	12-28-2014	Amend	2-1-2015
411-325-0230	12-28-2014	Amend	2-1-2015
411-325-0300	12-28-2014	Amend	2-1-2015
411-325-0300(T)	12-28-2014	Repeal	2-1-2015
411-325-0320	12-28-2014	Repeal	2-1-2015
411-325-0330	12-28-2014	Repeal	2-1-2015
411-325-0360	12-28-2014	Amend	2-1-2015
411-325-0390	12-28-2014	Amend	2-1-2015
411-325-0390(T)	12-28-2014	Repeal	2-1-2015
411-325-0400	12-28-2014	Repeal	2-1-2015
411-325-0430	12-28-2014	Amend	2-1-2015
411-325-0430(T)	12-28-2014	Repeal	2-1-2015
411-325-0460	12-28-2014	Amend	2-1-2015
411-325-0460(T)	12-28-2014	Repeal	2-1-2015
411-328-0550	12-28-2014	Amend	2-1-2015
411-328-0560	12-28-2014	Amend	2-1-2015
411-328-0560(T)	12-28-2014	Repeal	2-1-2015
411-328-0570	12-28-2014	Amend	2-1-2015
411-328-0620	12-28-2014	Amend	2-1-2015
411-328-0630	12-28-2014	Amend	2-1-2015
411-328-0640	12-28-2014	Amend	2-1-2015
411-328-0650	12-28-2014	Amend	2-1-2015
411-328-0660	12-28-2014	Amend	2-1-2015
411-328-0680	12-28-2014	Amend	2-1-2015
411-328-0690	12-28-2014	Amend	2-1-2015
411-328-0700	12-28-2014	Amend	2-1-2015
411-328-0700(T)	12-28-2014	Repeal	2-1-2015
411-328-0710	12-28-2014	Amend	2-1-2015
411-328-0715	12-28-2014	Amend	2-1-2015
411-328-0720	12-28-2014	Amend	2-1-2015
411-328-0720(T)	12-28-2014	Repeal	2-1-2015
411-328-0740	12-28-2014	Repeal	2-1-2015
411-328-0750	12-28-2014	Amend	2-1-2015
411-328-0750(T)	12-28-2014	Repeal	2-1-2015
411-328-0760	12-28-2014	Amend	2-1-2015
411-328-0760(T)	12-28-2014	Repeal	2-1-2015
411-328-0770	12-28-2014	Amend	2-1-2015
411-328-0770(T)	12-28-2014	Repeal	2-1-2015
411-328-0780	12-28-2014	Amend	2-1-2015
411-328-0790	12-28-2014	Amend	2-1-2015
411-328-0790(T)	12-28-2014	Repeal	2-1-2015
411-328-0800	12-28-2014	Repeal	2-1-2015
411-330-0020	12-28-2014	Amend	2-1-2015
411-330-0020(T)	12-28-2014	Repeal	2-1-2015
411-330-0030	12-28-2014	Amend	2-1-2015
411-330-0030(T)	12-28-2014	Repeal	2-1-2015
411-330-0040	12-28-2014	Amend	2-1-2015
411-330-0040(T)	12-28-2014	Repeal	2-1-2015
411-330-0050	12-28-2014	Amend	2-1-2015
411-330-0050(T)	12-28-2014	Repeal	2-1-2015
411-330-0060	12-28-2014	Amend	2-1-2015
411-330-0060(T)	12-28-2014	Repeal	2-1-2015
411-330-0065	12-28-2014	Amend	2-1-2015
411-330-0070	12-28-2014	Amend	2-1-2015
411-330-0070(T)	12-28-2014	Repeal	2-1-2015
411-330-0080	12-28-2014	Amend	2-1-2015
411-330-0080(T)	12-28-2014	Repeal	2-1-2015
411-330-0090	12-28-2014	Amend	2-1-2015
411-330-0090(T)	12-28-2014	Repeal	2-1-2015
411-330-0100	12-28-2014	Amend	2-1-2015
411-330-0100(T)	12-28-2014	Repeal	2-1-2015
411-330-0110	12-28-2014	Amend	2-1-2015
411-330-0110(T)	12-28-2014	Repeal	2-1-2015
411-330-0130	12-28-2014	Amend	2-1-2015
411-330-0130(T)	12-28-2014	Repeal	2-1-2015
411-330-0140	12-28-2014	Amend	2-1-2015
411-340-0020	12-28-2014	Amend	2-1-2015
411-340-0020(T)	12-28-2014	Repeal	2-1-2015
411-340-0050	12-28-2014	Amend	2-1-2015
411-340-0060	12-28-2014	Amend	2-1-2015
411-340-0060(T)	12-28-2014	Repeal	2-1-2015
411-340-0080	12-28-2014	Amend	2-1-2015
411-340-0090	12-28-2014	Amend	2-1-2015
411-340-0100	12-28-2014	Amend	2-1-2015
411-340-0100(T)	12-28-2014	Repeal	2-1-2015
411-340-0110	12-28-2014	Amend	2-1-2015
411-340-0110(T)	12-28-2014	Repeal	2-1-2015
411-340-0120	12-28-2014	Amend	2-1-2015
411-340-0120(T)	12-28-2014	Repeal	2-1-2015
411-340-0125	12-28-2014	Amend	2-1-2015
411-340-0130	12-28-2014	Amend	2-1-2015
411-340-0130(T)	12-28-2014	Repeal	2-1-2015
411-340-0135	12-28-2014	Adopt	2-1-2015
411-340-0135(T)	12-28-2014	Repeal	2-1-2015
411-340-0140	12-28-2014	Amend	2-1-2015
411-340-0150	12-28-2014	Amend	2-1-2015
411-340-0150(T)	12-28-2014	Repeal	2-1-2015
411-340-0160	12-28-2014	Amend	2-1-2015
411-340-0160(T)	12-28-2014	Repeal	2-1-2015
411-340-0170	12-28-2014	Amend	2-1-2015
411-340-0170(T)	12-28-2014	Repeal	2-1-2015
411-340-0180	12-28-2014	Amend	2-1-2015
411-345-0010	12-28-2014	Amend	2-1-2015
411-345-0010(T)	12-28-2014	Repeal	2-1-2015
411-345-0020	12-28-2014	Amend	2-1-2015
411-345-0020(T)	12-28-2014	Repeal	2-1-2015
411-345-0025	12-28-2014	Amend	2-1-2015
411-345-0025(T)	12-28-2014	Repeal	2-1-2015
411-345-0027	12-28-2014	Adopt	2-1-2015
411-345-0027(T)	12-28-2014	Repeal	2-1-2015

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411-345-0030	12-28-2014	Amend	2-1-2015
411-345-0030(T)	12-28-2014	Repeal	2-1-2015
411-345-0050	12-28-2014	Amend	2-1-2015
411-345-0050(T)	12-28-2014	Repeal	2-1-2015
411-345-0085	12-28-2014	Adopt	2-1-2015
411-345-0085(T)	12-28-2014	Repeal	2-1-2015
411-345-0090	12-28-2014	Amend	2-1-2015
411-345-0090(T)	12-28-2014	Repeal	2-1-2015
411-345-0095	12-28-2014	Amend	2-1-2015
411-345-0095(T)	12-28-2014	Repeal	2-1-2015
411-345-0100	12-28-2014	Repeal	2-1-2015
411-345-0110	12-28-2014	Amend	2-1-2015
411-345-0110(T)	12-28-2014	Repeal	2-1-2015
411-345-0130	12-28-2014	Amend	2-1-2015
411-345-0130(T)	12-28-2014	Repeal	2-1-2015
411-345-0140	12-28-2014	Amend	2-1-2015
411-345-0140(T)	12-28-2014	Repeal	2-1-2015
411-345-0160	12-28-2014	Amend	2-1-2015
411-345-0160(T)	12-28-2014	Repeal	2-1-2015
411-345-0170	12-28-2014	Amend	2-1-2015
411-345-0170(T)	12-28-2014	Repeal	2-1-2015
411-345-0180	12-28-2014	Amend	2-1-2015
411-345-0180(T)	12-28-2014	Repeal	2-1-2015
411-345-0190	12-28-2014	Amend	2-1-2015
411-345-0190(T)	12-28-2014	Repeal	2-1-2015
411-345-0200	12-28-2014	Amend	2-1-2015
411-345-0200(T)	12-28-2014	Repeal	2-1-2015
411-345-0230	12-28-2014	Amend	2-1-2015
411-345-0230(T)	12-28-2014	Repeal	2-1-2015
411-345-0240	12-28-2014	Amend	2-1-2015
411-345-0240(T)	12-28-2014	Repeal	2-1-2015
411-345-0250	12-28-2014	Amend	2-1-2015
411-345-0250(T)	12-28-2014	Repeal	2-1-2015
411-345-0260	12-28-2014	Amend	2-1-2015
411-345-0260(T)	12-28-2014	Repeal	2-1-2015
411-345-0270	12-28-2014	Amend	2-1-2015
411-345-0270(T)	12-28-2014	Repeal	2-1-2015
411-346-0110	12-28-2014	Amend	2-1-2015
411-346-0110(T)	12-28-2014	Repeal	2-1-2015
411-346-0150	12-28-2014	Amend	2-1-2015
411-346-0150(T)	12-28-2014	Repeal	2-1-2015
411-346-0180	12-28-2014	Amend	2-1-2015
411-346-0180(T)	12-28-2014	Repeal	2-1-2015
411-346-0190	12-28-2014	Amend	2-1-2015
411-346-0190(T)	12-28-2014	Repeal	2-1-2015
411-346-0210	12-28-2014	Amend	2-1-2015
411-350-0010	2-16-2015	Amend	3-1-2015
411-350-0020	2-16-2015	Amend	3-1-2015
411-350-0020(T)	2-16-2015	Repeal	3-1-2015
411-350-0030	2-16-2015	Amend	3-1-2015
411-350-0030	3-12-2015	Amend	4-1-2015
411-350-0030(T)	2-16-2015	Repeal	3-1-2015
411-350-0040	2-16-2015	Amend	3-1-2015
411-350-0040(T)	2-16-2015	Repeal	3-1-2015
411-350-0050	2-16-2015	Amend	3-1-2015
411-350-0050	3-12-2015	Amend	4-1-2015
411-350-0050(T)	2-16-2015	Repeal	3-1-2015
411-350-0075	2-16-2015	Adopt	3-1-2015
411-350-0075(T)	2-16-2015	Repeal	3-1-2015
411-350-0080	2-16-2015	Amend	3-1-2015
411-350-0080(T)	2-16-2015	Repeal	3-1-2015
411-350-0085	2-16-2015	Adopt	3-1-2015
411-350-0100	2-16-2015	Amend	3-1-2015
411-350-0100(T)	2-16-2015	Repeal	3-1-2015
411-350-0110	2-16-2015	Amend	3-1-2015
411-350-0110(T)	2-16-2015	Repeal	3-1-2015
411-350-0115	2-16-2015	Amend	3-1-2015
411-350-0115(T)	2-16-2015	Repeal	3-1-2015
411-350-0118	2-16-2015	Repeal	3-1-2015
411-350-0120	2-16-2015	Repeal	3-1-2015
411-360-0020	12-28-2014	Amend	2-1-2015
411-360-0020(T)	12-28-2014	Repeal	2-1-2015
411-360-0030	12-28-2014	Amend	2-1-2015
411-360-0130	12-28-2014	Amend	2-1-2015
411-360-0140	12-28-2014	Amend	2-1-2015
411-360-0140(T)	12-28-2014	Repeal	2-1-2015
411-360-0170	12-28-2014	Amend	2-1-2015
411-360-0170(T)	12-28-2014	Repeal	2-1-2015
411-360-0190	12-28-2014	Amend	2-1-2015
411-360-0190(T)	12-28-2014	Repeal	2-1-2015
411-360-0250	12-28-2014	Amend	2-1-2015
411-360-0250(T)	12-28-2014	Repeal	2-1-2015
411-360-0275	12-28-2014	Amend	2-1-2015
411-360-0275(T)	12-28-2014	Repeal	2-1-2015
411-375-0000	12-28-2014	Adopt	2-1-2015
411-375-0000(T)	12-28-2014	Repeal	2-1-2015
411-375-0010	12-28-2014	Adopt	2-1-2015
411-375-0010(T)	12-28-2014	Repeal	2-1-2015
411-375-0020	12-28-2014	Adopt	2-1-2015
411-375-0020(T)	12-28-2014	Repeal	2-1-2015
411-375-0030	12-28-2014	Adopt	2-1-2015
411-375-0030(T)	12-28-2014	Repeal	2-1-2015
411-375-0040	12-28-2014	Adopt	2-1-2015
411-375-0040(T)	12-28-2014	Repeal	2-1-2015
411-375-0050	12-28-2014	Adopt	2-1-2015
411-375-0050(T)	12-28-2014	Repeal	2-1-2015
411-375-0060	12-28-2014	Adopt	2-1-2015
411-375-0060(T)	12-28-2014	Repeal	2-1-2015
411-375-0070	12-28-2014	Adopt	2-1-2015
411-375-0070(T)	12-28-2014	Repeal	2-1-2015
411-375-0080	12-28-2014	Adopt	2-1-2015
411-375-0080(T)	12-28-2014	Repeal	2-1-2015
413-010-0180	1-1-2015	Amend	2-1-2015
413-010-0185	1-1-2015	Amend	2-1-2015
413-010-0310	2-1-2015	Amend	3-1-2015
413-015-0115	12-24-2014	Amend	2-1-2015
413-015-0115(T)	12-24-2014	Repeal	2-1-2015
413-015-0400	12-24-2014	Amend	2-1-2015
413-015-0409	12-24-2014	Amend	2-1-2015
413-015-0409(T)	12-24-2014	Repeal	2-1-2015
413-015-0415	12-24-2014	Amend	2-1-2015
413-015-0415(T)	12-24-2014	Repeal	2-1-2015

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413-015-0420	12-24-2014	Amend	2-1-2015
413-015-0420(T)	12-24-2014	Repeal	2-1-2015
413-015-0432	12-24-2014	Amend	2-1-2015
413-015-0432(T)	12-24-2014	Repeal	2-1-2015
413-015-0450	12-24-2014	Amend	2-1-2015
413-015-0540	12-24-2014	Amend	2-1-2015
413-015-0540(T)	12-24-2014	Repeal	2-1-2015
413-015-1105	12-24-2014	Amend	2-1-2015
413-015-1105(T)	12-24-2014	Repeal	2-1-2015
413-015-9030	12-24-2014	Amend	2-1-2015
413-015-9040	12-24-2014	Amend	2-1-2015
413-015-9040(T)	12-24-2014	Repeal	2-1-2015
413-070-0063	2-1-2015	Amend	3-1-2015
413-070-0069	1-21-2015	Amend(T)	3-1-2015
413-070-0072	1-21-2015	Amend(T)	3-1-2015
413-070-0410	1-1-2015	Amend	2-1-2015
413-070-0430	1-1-2015	Amend	2-1-2015
413-070-0450	1-1-2015	Amend	2-1-2015
413-070-0470	1-1-2015	Amend	2-1-2015
413-070-0480	1-1-2015	Amend	2-1-2015
413-070-0490	1-1-2015	Amend	2-1-2015
413-070-0505	2-1-2015	Amend	3-1-2015
413-070-0620	2-1-2015	Amend	3-1-2015
413-070-0655	2-1-2015	Amend	3-1-2015
413-070-0905	1-21-2015	Amend(T)	3-1-2015
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413-070-0905	2-1-2015	Amend(T)	3-1-2015
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413-090-0110	1-1-2015	Amend	2-1-2015
413-090-0120	1-1-2015	Amend	2-1-2015
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413-090-0133	2-5-2015	Amend(T)	3-1-2015
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413-090-0136	1-1-2015	Amend	2-1-2015
413-090-0140	1-1-2015	Amend	2-1-2015
413-090-0150	1-1-2015	Amend	2-1-2015
413-090-0150	2-5-2015	Amend(T)	3-1-2015
413-090-0210	1-1-2015	Amend	2-1-2015
413-120-0010	2-1-2015	Amend	3-1-2015
413-120-0195	2-1-2015	Amend	3-1-2015
413-120-0510	2-1-2015	Amend	3-1-2015
413-120-0710	2-1-2015	Amend	3-1-2015
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413-300-0260	3-6-2015	Repeal	4-1-2015
413-300-0270	3-6-2015	Repeal	4-1-2015
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414-700-0040	11-25-2014	Amend	1-1-2015
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603-048-0700	1-29-2015	Adopt	3-1-2015
603-048-0800	1-29-2015	Adopt	3-1-2015
603-048-0900	1-29-2015	Adopt	3-1-2015
603-048-1000	1-29-2015	Adopt	3-1-2015
603-052-0860	1-13-2015	Amend	2-1-2015
603-052-0861	1-13-2015	Amend	2-1-2015
603-052-0862	1-13-2015	Amend	2-1-2015
603-052-0870	1-13-2015	Amend	2-1-2015
603-052-0880	1-13-2015	Amend	2-1-2015
603-052-0882	1-13-2015	Amend	2-1-2015
603-052-0884	1-13-2015	Amend	2-1-2015
603-052-0886	1-13-2015	Amend	2-1-2015
603-052-0888	1-13-2015	Amend	2-1-2015
603-052-0921	1-13-2015	Amend	2-1-2015
603-057-0388	2-27-2015	Adopt	4-1-2015
603-095-0100	1-29-2015	Amend	3-1-2015
603-095-0120	1-29-2015	Amend	3-1-2015
603-095-0140	1-29-2015	Amend	3-1-2015
603-095-0160	1-29-2015	Repeal	3-1-2015
603-095-0180	1-29-2015	Amend	3-1-2015
632-030-0025	1-7-2015	Amend	2-1-2015
635-004-0215	1-15-2015	Amend	2-1-2015
635-004-0275	1-1-2015	Amend(T)	1-1-2015
635-004-0275	3-10-2015	Amend	4-1-2015
635-004-0275(T)	3-10-2015	Repeal	4-1-2015
635-004-0350	1-15-2015	Amend	2-1-2015
635-004-0355	1-1-2015	Amend(T)	1-1-2015
635-004-0355	1-15-2015	Amend	2-1-2015
635-004-0355(T)	1-15-2015	Repeal	2-1-2015
635-004-0505	1-16-2015	Amend(T)	3-1-2015
635-005-0355	2-6-2015	Amend(T)	3-1-2015
635-005-0465	11-25-2014	Amend(T)	1-1-2015
635-005-0485	11-25-2014	Amend(T)	1-1-2015
635-006-0209	1-1-2015	Amend(T)	1-1-2015
635-006-0209	1-15-2015	Amend	2-1-2015
635-006-0209(T)	1-15-2015	Repeal	2-1-2015
635-006-0215	1-15-2015	Amend	2-1-2015
635-006-0232	1-13-2015	Amend	2-1-2015
635-011-0100	1-1-2015	Amend	2-1-2015
635-011-0104	1-1-2015	Amend	2-1-2015
635-013-0004	1-1-2015	Amend	2-1-2015
635-014-0080	1-1-2015	Amend	2-1-2015
635-014-0090	1-1-2015	Amend	2-1-2015
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635-017-0090	1-1-2015	Amend	2-1-2015
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635-021-0090	1-1-2015	Amend	2-1-2015
635-023-0080	1-1-2015	Amend	2-1-2015
635-023-0090	1-1-2015	Amend	2-1-2015
635-023-0095	1-1-2015	Amend	2-1-2015
635-023-0095	1-1-2015	Amend(T)	2-1-2015
635-023-0125	1-1-2015	Amend	2-1-2015
635-023-0125	3-1-2015	Amend(T)	3-1-2015
635-023-0125	3-5-2015	Amend(T)	4-1-2015
635-023-0125(T)	3-5-2015	Suspend	4-1-2015
635-023-0128	1-1-2015	Amend	2-1-2015
635-023-0130	1-1-2015	Amend	2-1-2015
635-023-0134	1-1-2015	Amend	2-1-2015
635-023-0140	1-1-2015	Amend	2-1-2015
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635-039-0080	3-10-2015	Amend	4-1-2015
635-039-0090	1-1-2015	Amend	2-1-2015
635-039-0090	1-15-2015	Amend	2-1-2015
635-039-0090	1-15-2015	Amend(T)	2-1-2015
635-039-0090(T)	3-10-2015	Repeal	4-1-2015
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635-041-0063(T)	11-25-2014	Suspend	1-1-2015
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635-041-0065	2-20-2015	Amend(T)	4-1-2015

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635-041-0065(T)	3-12-2015	Suspend	4-1-2015
635-041-0525	1-1-2015	Adopt	1-1-2015
635-042-0130	2-2-2015	Amend(T)	3-1-2015
635-042-0145	2-9-2015	Amend(T)	3-1-2015
635-042-0145	3-9-2015	Amend(T)	4-1-2015
635-042-0145(T)	3-9-2015	Suspend	4-1-2015
635-042-0160	2-9-2015	Amend(T)	3-1-2015
635-042-0170	2-9-2015	Amend(T)	3-1-2015
635-042-0180	2-9-2015	Amend(T)	3-1-2015
635-043-0151	1-15-2015	Adopt(T)	2-1-2015
635-043-0151(T)	1-15-2015	Suspend	2-1-2015
635-048-0005	12-10-2014	Amend	1-1-2015
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635-053-0111	2-25-2015	Repeal	4-1-2015
635-053-0125	2-25-2015	Repeal	4-1-2015
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635-065-0011	1-6-2015	Amend	2-1-2015
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635-065-0090	1-6-2015	Amend	2-1-2015
635-065-0401	1-6-2015	Amend	2-1-2015
635-065-0625	1-6-2015	Amend	2-1-2015
635-065-0705	1-6-2015	Amend	2-1-2015
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635-065-0765	1-6-2015	Amend	2-1-2015
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635-073-0000	2-26-2015	Amend	4-1-2015
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635-075-0001	1-6-2015	Amend	2-1-2015
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690-215-0045	11-25-2014	Amend	1-1-2015
690-240-0005	11-25-2014	Amend	1-1-2015
690-240-0035	11-25-2014	Amend	1-1-2015
690-240-0046	11-25-2014	Amend	1-1-2015
690-310-0080	1-1-2015	Amend	1-1-2015
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690-340-0040	1-1-2015	Amend	1-1-2015
690-382-0400	1-1-2015	Amend	1-1-2015
710-010-0000	11-30-2014	Adopt	1-1-2015
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715-010-0015	12-18-2014	Amend	2-1-2015
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734-059-0040	12-19-2014	Adopt	2-1-2015
734-059-0220	12-19-2014	Amend	2-1-2015
734-060-0000	12-19-2014	Amend	2-1-2015
734-060-0007	12-19-2014	Amend	2-1-2015
734-060-0175	12-19-2014	Amend	2-1-2015
734-060-0190	12-19-2014	Adopt	2-1-2015
735-001-0040	12-19-2014	Amend	2-1-2015
735-022-0065	1-1-2015	Adopt	1-1-2015
735-062-0005	12-1-2014	Amend	1-1-2015
735-062-0007	12-1-2014	Amend	1-1-2015
735-062-0010	12-1-2014	Amend	1-1-2015
735-062-0015	12-1-2014	Amend	1-1-2015
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735-062-0200	12-1-2014	Amend	1-1-2015
735-170-0000	7-1-2015	Amend	1-1-2015
735-170-0010	7-1-2015	Amend	1-1-2015
735-170-0015	7-1-2015	Adopt	1-1-2015
735-170-0020	7-1-2015	Amend	1-1-2015
735-170-0035	7-1-2015	Adopt	1-1-2015
735-170-0040	7-1-2015	Amend	1-1-2015
735-170-0045	7-1-2015	Amend	1-1-2015
735-170-0105	7-1-2015	Amend	1-1-2015
735-174-0000	7-1-2015	Amend	1-1-2015
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735-174-0030	7-1-2015	Amend	1-1-2015
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735-174-0045	7-1-2015	Amend	1-1-2015
735-176-0000	7-1-2015	Repeal	1-1-2015
735-176-0010	7-1-2015	Repeal	1-1-2015
735-176-0017	7-1-2015	Repeal	1-1-2015
735-176-0019	7-1-2015	Repeal	1-1-2015
735-176-0020	7-1-2015	Repeal	1-1-2015
735-176-0021	7-1-2015	Repeal	1-1-2015
735-176-0022	7-1-2015	Repeal	1-1-2015
735-176-0023	7-1-2015	Repeal	1-1-2015
735-176-0030	7-1-2015	Repeal	1-1-2015
735-176-0040	7-1-2015	Repeal	1-1-2015
735-176-0045	7-1-2015	Repeal	1-1-2015
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800-030-0050	2-1-2015	Amend	3-1-2015
801-001-0000	1-8-2015	Amend	1-1-2015
801-001-0005	1-8-2015	Amend	1-1-2015
801-001-0015	1-8-2015	Repeal	1-1-2015
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801-010-0010	1-8-2015	Amend	1-1-2015
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801-010-0050	1-8-2015	Amend	1-1-2015
801-010-0060	1-8-2015	Amend	1-1-2015
801-010-0065	1-8-2015	Amend	1-1-2015
801-010-0073	1-8-2015	Amend	1-1-2015
801-010-0078	1-8-2015	Repeal	1-1-2015
801-010-0079	1-8-2015	Amend	1-1-2015
801-010-0080	1-8-2015	Amend	1-1-2015
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801-010-0110	1-8-2015	Amend	1-1-2015
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801-030-0005	1-8-2015	Amend	1-1-2015
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801-030-0015	1-8-2015	Amend	1-1-2015
801-030-0020	1-8-2015	Amend	1-1-2015
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813-090-0010(T)	12-2-2014	Repeal	1-1-2015
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813-090-0031(T)	12-2-2014	Repeal	1-1-2015
813-090-0036	12-2-2014	Amend	1-1-2015
813-090-0036(T)	12-2-2014	Repeal	1-1-2015
813-090-0037	12-2-2014	Amend	1-1-2015
813-090-0037(T)	12-2-2014	Repeal	1-1-2015
813-090-0039	12-2-2014	Amend	1-1-2015
813-090-0039(T)	12-2-2014	Repeal	1-1-2015
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813-090-0080(T)	12-2-2014	Repeal	1-1-2015
813-090-0095	12-2-2014	Repeal	1-1-2015
813-090-0110(T)	12-2-2014	Repeal	1-1-2015
813-110-0005	12-2-2014	Amend	1-1-2015
813-110-0005(T)	12-2-2014	Repeal	1-1-2015
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813-110-0020	12-2-2014	Amend	1-1-2015
813-110-0021	12-2-2014	Amend	1-1-2015
813-110-0026	12-2-2014	Amend	1-1-2015
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820-010-0505	2-3-2015	Amend	3-1-2015
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836-011-0000	3-10-2015	Amend	4-1-2015
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836-051-0220	1-1-2015	Amend	2-1-2015
836-051-0230	1-1-2015	Amend	2-1-2015
836-051-0235	1-1-2015	Adopt	2-1-2015
837-085-0260	1-1-2015	Amend	2-1-2015
837-085-0270	1-1-2015	Amend	2-1-2015
837-085-0280	1-1-2015	Amend	2-1-2015
837-085-0290	1-1-2015	Amend	2-1-2015
837-085-0300	1-1-2015	Amend	2-1-2015
837-085-0305	1-1-2015	Amend	2-1-2015
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839-010-0020	1-28-2015	Amend	3-1-2015
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839-010-0200	1-28-2015	Amend	3-1-2015
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839-010-0310	1-28-2015	Amend	3-1-2015
839-025-0700	1-1-2015	Amend	1-1-2015
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851-056-0000	1-1-2015	Amend	1-1-2015
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851-056-0006	1-1-2015	Amend	1-1-2015
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851-061-0080	1-1-2015	Amend	1-1-2015
851-061-0090	1-1-2015	Amend	1-1-2015
851-062-0010	1-1-2015	Amend	1-1-2015
851-062-0016	1-1-2015	Repeal	1-1-2015
851-062-0050	1-1-2015	Amend	1-1-2015
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851-063-0035	1-1-2015	Amend	1-1-2015
851-063-0070	1-1-2015	Amend	1-1-2015
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852-010-0023	1-1-2015	Amend	2-1-2015
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852-020-0029	1-1-2015	Amend	1-1-2015
852-020-0029	1-1-2015	Amend	2-1-2015
852-020-0031	1-1-2015	Amend	1-1-2015
852-020-0031	1-1-2015	Amend	2-1-2015
852-020-0035	1-1-2015	Amend	1-1-2015
852-020-0035	1-1-2015	Amend	2-1-2015
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852-060-0025	1-1-2015	Amend	1-1-2015
852-060-0025	1-1-2015	Amend	2-1-2015
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852-060-0027	1-1-2015	Amend	2-1-2015
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852-070-0016	1-1-2015	Amend	2-1-2015
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852-070-0020	1-1-2015	Amend	2-1-2015
852-070-0025	1-1-2015	Amend	1-1-2015
852-070-0025	1-1-2015	Amend	2-1-2015
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