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To: OMAP Home Health Services Providers

From: Joan M. Kapowich, Mana
OMAP Program and Poli

Re: Home Health Services Administrative Rules, Revision 3

Effective: August 1, 2004

The Home Health Services Program Rulebook is updated as follows:

OMAP revised 410-127-0055 to implement modifications to the Oregon Health Plan (OHP) Standard Benefit Package as directed by the 2003 Legislative Assembly in HB 2511. Some benefits are restored while other benefits are removed. Implementation of these amendments is approved by the Centers for Medicare and Medicaid Services (CMS).

If you are reading this letter on OMAP's website:
http://www.dhs.state.or.us/policy/healthplan/rules/,
this administrative rulebook contains a complete set of rules for this program, including the above revisions.

If you do not have web access and receive hardcopy of revisions, this letter is attached to the revised rule to be used for replacement in your rulebook. Each rule is numbered individually for easy replacement.

If you have billing questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697. TR 550-8/1/04

DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 127

HOME HEALTH CARE SERVICES

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410-127-0000 Foreword

(1) The Home Health Care Services Guide is a user's manual designed to help providers prepare claims for services they provide to medical assistance clients.

(2) The guide is published by the Office of Medical Assistance Programs (OMAP) in an attempt to furnish medical providers with up-to-date information on program changes and governmental requirements.

(3) Use the guide along with the OMAP General Rules and the Oregon Health Plan Administrative Rules. The guide includes administrative rules, procedures codes, instructions for completing claim forms, and examples of those forms.

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

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 414.065
Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03

410-127-0020 Definitions

(1) Acquisition Cost -- The purchase price plus shipping.

(2) Custodial Care -- Care that is not related to a plan of care. Supervision is not required.

(3) Department -- The Department of Human Services (DHS) which includes Children, Adults and Families (CAF), Seniors and People with Disabilities (SPD) and Health Services (HS). Included in HS is Health Planning and Community Relations, Public Health Systems, Family Health Services, Disease Prevention and Epidemiology, Office of Medical Assistance Programs (OMAP), Oregon State Public Health Laboratories, and the Office of Mental Health and Addiction Services.

(4) Home -- A place of temporary or permanent residence used as a person's home. This does not include a hospital, nursing facility, or intermediate care facility, but does include assisted living facilities, residential care facilities and adult foster care homes.

(5) Home Health Agency -- Any public or private agency which establishes, conducts or represents itself to the public as a home health agency or organization providing coordinated skilled home health services for compensation on a home visiting basis, and licensed by Health Services, Health Care Licensure and Certification as a Home Health Agency, and certified by Medicare Title XVIII. Home health agency does not include:

(a) Any visiting nurse service or home health service conducted by and for those who rely upon spiritual means through prayer alone for healing in accordance with tenets and practices of a recognized church or religious denomination;

(b) Health services offered by county health departments that are not formally designated and funded as home health agencies within the individual departments;

(c) Personal care services that do not pertain to the curative, rehabilitative or preventive aspect of nursing.

(6) Home Health Aide -- A person who meets the criteria for Home Health Aide defined in the Medicare Conditions of Participation 42 CFR 484.36 and certified by the Board of Nursing.

(7) Home Health Aide Services -- Services of a Home Health Aide must be provided under the direction and supervision of a registered nurse or licensed therapist. The focus of care shall be to provide personal care and/or other services under the plan of care which supports curative, rehabilitative or preventive aspects of nursing. These services are provided only in support of skilled nursing, physical therapy, occupational therapy, or speech therapy services. These services do not include custodial care.

(8) Home Health Services -- Only the services described in the Office of Medical Assistance Programs (OMAP) Home Health Services provider guide.

(9) Medicaid Home Health Provider -- A Home Health Agency licensed by Health Services, Health Care Licensure and Certification certified for Medicare and enrolled with OMAP as a Medicaid provider.

(10) Medical Supplies -- Supplies prescribed by a physician as a necessary part of the plan of care being provided by the Home Health Agency.

(11) Occupational Therapy Services -- Services provided by a registered occupational therapist or certified occupational therapy assistant supervised by a registered occupational therapist, due to the complexity of the service and client's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatments for a client's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver task oriented therapeutic activities designed to restore function and/or independence in the activities of daily living is included in this skilled service. Occupational Therapy Licensing Board ORS 675.210 -- ORS 675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association, Inc. govern the practice of occupational therapy.

(12) Physical Therapy Services -- Services provided by a licensed physical therapist or licensed physical therapy assistant under the supervision of a licensed physical therapist, due to the inherent complexity of the service and the client's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatments for a patient's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver the necessary techniques, exercises or precautions for treatment and/or prevention of illness or injury is included in this skilled service. Physical Therapy Licensing Board ORS 688.010 to 688.235 and Standards for Physical Therapy as well as the Standards of Ethical Conduct for the Physical Therapy Assistant established by the American Physical Therapy Association govern the practice of physical therapy.

(13) Plan of Care -- Written instructions explaining how the client is to be cared for. The plan is initiated by the treating practitioner with assistance from Home Health Agency nurses and therapists. The plan must include but is not limited to:

(a) All pertinent diagnoses;

(b) Mental status;

(c) Types of services;

(d) Specific therapy services;

(e) Frequency of service delivery;

(f) Supplies and equipment needed;

(g) Prognosis;

(h) Rehabilitation potential;

(i) Functional limitations;

(j) Activities permitted;

(k) Nutritional requirements;

(l) Medications and treatments;

(m) Safety measures;

(n) Discharge plans;

(o) Teaching requirements;

(p) Goals;

(q) Other items as indicated.

(14) Responsible Unit -- The agency responsible for approving or denying payment authorization.

(15) Skilled Nursing Services -- The client care services pertaining to the curative, restorative or preventive aspects of nursing performed by a registered nurse or under the supervision of a registered nurse, pursuant to the plan of care established by the prescribing practitioner in consultation with the Home Health Agency staff. Skilled nursing emphasizes a high level of nursing direction, observation and skill. The focus of these services shall be the use of the nursing process to diagnose and treat human responses to actual or potential health care problems, health teaching, and health counseling. Skilled nursing services include the provision of direct client care and the teaching, delegation and supervision of others who provide tasks of nursing care to clients, as well as phlebotomy services. Such services will comply with the Nurse Practice Act and administrative rules of the Oregon State Board of Nursing and Health Division -- Division 27 -- Home Health Agencies, which rules are by this reference made a part hereof.

(16) Speech and Language Pathology Services -- Services provided by a licensed speech-language pathologist due to the inherent complexity of the service and the patient's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatment for a patient's condition under accepted standards of medical practice. Teaching the

client, family and/or caregiver task oriented therapeutic activities designed to restore function, and/or compensatory techniques to improve the level of functional communication ability is included in this skilled service. Speech-Language Pathology and Audiologist Licensing Board ORS 681.205 to 681.991 and the Standards of Ethics established by the American Speech and Hearing Association, govern the practice of speech and language pathology.

(17) Title XVIII (Medicare) -- Title XVIII of the Social Security Act.

(18) Title XIX (Medicaid) -- Title XIX of the Social Security Act.

(19) OASIS (Outcome and Assessment Information Set) - a client specific comprehensive assessment that identifies the client's need for home care and that meets the client's medical, nursing, rehabilitative, social and discharge planning needs.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 411-075-0001; HR 12-1991, f. & cert. ef. 3-1-91; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 4-1998(Temp), f. & cert. ef. 2-5-98 thru 7-15-98; OMAP 24-1998, f. & cert. ef. 7-15-98; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 36-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03

410-127-0040 Coverage

(1) Home health services are made available on a visiting basis to eligible clients in their homes as part of a written Plan of Care.

(2) Home health services must be prescribed by a physician and the signed order must be on file at the Home Health Agency. The prescription must include the ICD-9-CM diagnosis code indicating the reason the Home Health services are requested. The orders on the plan of care must specify the type of services to be provided to the client, with respect to the professional who will provide them, the nature of the individual services, specific frequency and specific duration. The orders must clearly indicate how many times per day, each week and/or each month the services are to be provided.

(3) The plan of care must be reviewed and signed by the physician every two months to continue services.

(4) The following services or items are covered, if diagnoses are on the portion of the prioritized list above the line funded by the Legislature:

(a) Skilled nursing services;

(b) Skilled nursing evaluation (includes OASIS Assessment);

(c) Home Health aide services;

(d) Occupational therapy services;

(e) Occupational therapy evaluation;

(f) Physical therapy services;

(g) Physical therapy evaluation (includes OASIS Assessment);

(h) Speech and language pathology services;

(i) Speech and language pathology evaluation (includes OASIS Assessment);

(j) Medical/surgical supplies.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 682, f. 7-19-74, ef. 8-11-74; PWC 798, f. & ef. 6-1-76; AFS 8-1979, f. 3-30-79, ef. 4-1-79; Renumbered from 461-019-0400 by Chapter 784, Oregon Laws 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 411-075-0000; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00

410-127-0050 Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 79-2002, f. 12-24-02, cert. ef. 1-1-03

410-127-0055 Copayment for Standard Benefit Package

(1) Home Health Services are not covered for clients receiving the Standard Benefit Package. See General Rules 410-120-1210 for additional information.

(2) The OHP Standard Benefit Package includes limited home enteral/parenteral services and intravenous services (see 410-148-0090.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

8-1-04

410-127-0060 Reimbursement and Limitations

(1) Reimbursement. The Office of Medical Assistance Programs (OMAP) reimburses home health services on a fee schedule (see table 127-0060) basis by type of visit. Effective October 1, 2003, reimbursement rates were recalculated using a methodology that includes actual cost as reported on Medicare Cost Reports and the application of the DRI - WEFA home health trend rates (as recommended by OMAP's independent actuary). This budget-neutral fee schedule is based on OMAP home health reimbursement rates set as a percentage of cost.

(2) Future reimbursement rate changes, if applicable, will be calculated by applying an administratively determined percentage to each service rate to determine the new rate.

(3) OMAP reimburses only for service, which is medically appropriate.

(4) Limitations:

(a) Limits of Covered Services:

(A) Skilled nursing visits are limited to two visits per day with payment authorization;

(B) All therapy services are limited to one visit or evaluation per day for physical therapy, occupational therapy or speech and language pathology services. Therapy visits require payment authorization;

(C) OMAP will authorize home health visits for clients with uterine monitoring only for medical problems, which could adversely affect the pregnancy and are not related to the uterine monitoring;

(D) Medical supplies must be billed at acquisition cost and the total of all medical supplies revenue codes may not exceed $75 per day. Only supplies that are used during the visit are billable. Clients visit notes must include documentation of supplies used;

(E) Durable medical equipment must be obtained by the client by prescription through a durable medical equipment provider.

(b) Not Covered Service:

(A) Service not medically appropriate;

(B) A service whose diagnosis does not appear on a line of the Prioritized List of Health Services which has been funded by the Oregon Legislature (OAR 410-141-0520);

(C) Medical Social Worker Service;

(D) Registered dietician counseling or Instruction;

(E) Drug and or Biological;

(F) Fetal Non-Stress Testing;

(G) Respiratory therapist service;

(H) Flu shot;

(I) Psychiatric Nursing Service.

Table 127-0060

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-03

Table 127-0060

Home Health Rates Effective October 1, 2003			
Revenue Code	Fee - Allowable	Plus Copay (effective 1/1/2003)	Standard Copay (effective 2/1/2003)
421 - Physical Therapy visit	$ 58.64	$ 3.00	$ 5.00
424 – Physical Therapy evaluation or re-evaluation	$ 58.64	$ 3.00	$ 5.00
431 – Occupational Therapy visit	$ 63.92	$ 3.00	$ 5.00
434 – Occupational Therapy evaluation or re-evaluation	$ 63.92	$ 3.00	$ 5.00
441 - Speech-language pathology visit	$ 64.01	$ 3.00	$ 5.00
444 - Speech - language pathology evaluation or re-evaluation	$ 64.01	$ 3.00	$ 5.00
551 - Skilled Nursing visit	$ 62.85	$ 3.00	$ 5.00
559 - Skilled Nursing evaluation	$ 62.85	$ 3.00	$ 5.00
571 - Home Health Aid visit	$ 29.49	$ 3.00	$ 5.00
270 - Medical / Surgical supplies, general classification	Acquisition cost	None	None
271 - Medical / Surgical supplies, non-sterile supplies	Acquisition cost	None	None
272 - Medical / Surgical supplies, sterile supplies	Acquisition cost	None	None

10-1-03

410-127-0080 Payment Authorization

Payment authorization (PA) is approval by the responsible unit for services:

(1) Payment authorization is required for home health services as indicated in the Revenue Code section of the Home Health Care Services provider guide. For services requiring authorization, providers must contact the responsible unit for authorization within five working days following initiation or continuation of services. The FAX or postmark date on the request will be honored as the request date. It is the provider's responsibility to obtain payment authorization.

(2) A payment authorization number must be present on all claims for home health services which require payment authorization or the claim will be denied.

(3) An initial authorization is given for 60 days. Each continuation of an authorization is for a period of 60 days.

(4) Where to request payment authorization:

(a) Managed health care clients - Services for clients identified on their Office Medical Assistance Programs (OMAP) Medical Care Identification as having an "OMAP Contracted Plan" will be authorized by the plan. Contact the plan to determine their procedures;

(b) Children, Adults and Families (CAF) clients (formerly known as Adult and Family Services and State Office for Services to Children and Families): Services for clients identified on Medical Care Identification as AFS or CSD clients are authorized by OMAP;

(c) Seniors and People with Disabilities (SPD) clients (formerly Senior and Disabled Services Division) will be authorized by OMAP;

(d) Medically Fragile Children's Unit (MFCU) clients: Services for clients identified as Medically Fragile Children will be authorized by MFCU;

(e) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, authorization must be obtained from the MCM Contractor prior to the initiation of services. For FFS MCM clients, OMAP will not reimburse for a service that requires payment authorization if the service is provided prior to receiving authorization from the MCM Contractor.

(A) For enteral/parenteral IV services, call OMAP;

(B) Services for clients utilizing a Group 2 pressure-reducing support service will be authorized by OMAP.

(5) Each payment authorization must include:

(a) Client's name;

(b) Medicaid recipient ID number;

(c) Revenue codes;

(d) Date range;

(e) Frequency of service;

(f) Performing provider number;

(g) Medical justification;

(h) Diagnosis and Primary ICD-9-CM code; (as indicated as the reason for the request);

(i) Goals and Objectives;

(j) Assessment of availability of other resources to care for the client.

(6) OASIS documentation does not need to be submitted with PA request.

(7) To continue an authorization, submit the most current visit notes and justification for continuing services.

(8) Changing a payment authorization - Requests to change an existing payment authorization should be mailed or FAXed to the responsible unit which issued the original authorization. Include the following information:

(a) Client's name;

(b) Medicaid recipient ID number;

(c) Payment authorization number;

(d) Change requested;

(e) Visit notes to support the change.

(9) Payment authorization does not guarantee eligibility or payment. It is the provider's responsibility to verify eligibility on the date of service.

(10) Payment authorization does not relieve the provider of the responsibility to follow all applicable rules regarding the provision of services.

(11) For skilled nursing visits involving home enteral/parenteral nutrition and IV services, refer to the OMAP Home Enteral/Parenteral Nutrition and IV Services provider guide.

(12) For skilled nursing visits involving a Group 2 pressure-reducing support surface, refer to the OMAP Durable Medical Equipment and Medical Supplies provider guide.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1/1/04

410-127-0100 Billing Information

(1) If the client has the Basic Health Care Package, but is not enrolled in a prepaid health plan, bill with the appropriate Revenue Codes using the instructions on how to complete the UB-92.

(2) If the client is enrolled in the Medicare Part A, do not bill Office of Medical Assistance Programs (OMAP) for home health services, bill Medicare. OMAP considers Medicare payment as payment in full.

(3) Submit your claim on a UB-92, electronically or on paper. Send the paper claim of the UB-92 to OMAP.

(4) Do not put services that require payment authorization and services that do not require authorization on the same claim form.

(5) Bill only one PA number per claim form.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00

410-127-0120 How to Complete the UB-92

The following fields are required to be completed. Use the Medicare Home Health Billing Manual format if optional Form Locators are included:

(1) Form Locator 1 -- Provider Identification -- Enter the provider name, mailing address and zip code if billing on a paper claim.

(2) Form Locator 4 -- Type of Bill -- enter the appropriate three-digit numeric code to identify the type of claim; codes are:

(a) First digit -- Type of Facility -- 3 denotes home health;

(b) Second digit -- Classification -- 2 denotes "in home visits";

(c) Third digit -- Frequency/Definition -- 1 denotes "Admit through discharge claim": used for a claim encompassing an entire home health care span of service for which the agency expects reimbursement. 2 denotes "first claim": used for the first of an expected series of payment claims for the same home health care start of care. 3 denotes "Interim-continuing claim": used when one or more payment claims for the same home health start of care have already been submitted and further claims are expected to be submitted at a later date. 4 denotes "Interim-last claim": used for a claim which is the last of a series for a home health start of care. The "through" date of this claim (Form locator 6) is the discharge date or date of death for this service span.

(3) For Locator 6 -- Statement Covers Period -- enter the beginning and ending dates of service covered by this claim, using MMDDYY format.

(4) Form Locator 12 -- Patient's Name -- enter the client's last name, first name and middle initial as it appears on the client's Office of Medical Assistance Programs (OMAP) Medical Care Identification.

(5) Form Locators 24-30 -- Condition codes -- Enter A1 if EPSDT (Medicheck).

(6) Form Locator 42 -- Revenue Codes -- Enter the Revenue code which most accurately describes the service provided.

(7) Form Locator 46 -- Service Units -- Enter total units of service for each type of service. One visit equals one unit of service. One supply item equals one unit of service. Combine all units of the same code for the same date of service on the same line.

(8) Form Locator 47 -- Total Charges -- Enter the total charges pertaining to the related code. At the bottom of Form Locator 42 enter Revenue Code 001. At the bottom of Form Locator 47, enter the total charge.

(9) Form Locator 50 -- Payer Identification -- Enter the names of up to three payer organizations in order. Do not include OMAP copayments in this field. Line A for primary payer; line B for secondary payer and line C for tertiary payer. If Medicaid is primary, enter "Medicaid" one line A. If Medicaid is secondary or tertiary payer, enter the primary payer on line A and Medicaid on line B or C as appropriate.

(10) Form Locator 51 -- Provider number -- Enter your six-digit OMAP provider number on the line (A, B or C) which corresponds to the line you used to identify OMAP in Locator Code 50. Your OMAP provider number is required. Do not use a Billing Provider Number. OMAP does not require that you report your provider number for other payers listed in Locator Code 50.

(11) Form Locator 54 -- Prior payments -- Enter the amount of any payments received from a third party resource on the same letter line as is in Form Locator 50.

(12) Form Locator 60 -- Cert-SSN-HIC-ID No. -- Enter the patient's Medicaid Identification number on the same letter line (A, B or C) that corresponds to the line on which Medicaid payer information is shown in Form Locator 50.

(13) Form Locator 63 -- Treatment Authorization codes -- Enter the nine digit payment authorization number for authorized services. The PA number will begin with the number 0.

(14) Form Locator 67 -- Principal Diagnosis Codes -- Enter the ICD-9-CM codes describing the principal diagnosis (i.e., the condition for which the plan of treatment was established and the patient taken into service). The ICD-9-CM must be carried out to its highest degree of specificity, (see OMAP General Rules for details). Do not enter decimal points or unnecessary characters.

(15) Form locator 82 -- Attending Physician I.D: Enter the attending physician's six-digit OMAP provider number or UPIN.

(16) Form Locator 84 -- Remarks -- Use this space for the appropriate Third Party Resource (TPR) Explanation Codes:

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; HR 12-1992, f. & cert. ef. 4-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 50-2002, f. & cert. ef. 10-1-02; OMAP 79-2002, f. 12-24-02, cert. ef. 1-1-03

410-127-0200 Home Health Revenue Center Codes

Payment authorization is required for those services indicated by the Code PA. Following are the procedure codes to be used for billing:

(1) Medical/surgical supplies and devices:

(a) 270 -- General classification;

(b) 271 -- Non sterile supply;

(c) 272 -- Sterile supply.

(2) Physical Therapy:

(a) 421 -- Visit charge -- PA;

(b) 424 -- Evaluation (includes OASIS assessment) or re-evaluation.

(3) Occupational Therapy:

(a) 431 -- Visit charge -- PA;

(b) 434 -- Evaluation or re-evaluation.

(4) Speech-language pathology:

(a) 441 -- Visit charge -- PA;

(b) 444 -- Evaluation (includes OASIS assessment) or re-evaluation.

(5) Skilled nursing:

(a) 551 -- Visit charge -- PA;

(b) 559 -- Other skilled nursing -- evaluation (includes OASIS assessment).

(6) Home health aid -- 571 -- Visit charge -- PA.

(7) Total charge -- 001 -- Total Charge.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; HR 12-1991, f. & cert. ef. 3-1-91; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00