Section I
Notices of Development of Proposed Rules and Negotiated Rulemaking

DEPARTMENT OF EDUCATION

State Board of Education

RULE NO.:	RULE TITLE:
6A-1.0391	Grading System for State-Approved Supplemental Educational Services Providers

PURPOSE AND EFFECT: The purpose of this rule development is to implement a grading system for state-approved supplemental educational services providers as required by the 2008 amendments to Section 1008.331, Florida Statutes. The effect is a rule that is consistent with Florida Statutes.

SUBJECT AREA TO BE ADDRESSED: Supplemental educational services in Title I schools.

SPECIFIC AUTHORITY: 1008.331 FS.

LAW IMPLEMENTED: 1008.331 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME: January 8, 2009, 9:00 a.m. – 12:00 noon

PLACE: Florida Department of Education, Turlington Building, 325 West Gaines Street, Suite 1721/25, Tallahassee, FL 32399

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Samantha Love, Policy Consultant, Bureau of Student Assistance, 325 West Gaines Street, Tallahassee, FL 32399

TO REQUEST A RULE DEVELOPMENT WORKSHOP, please contact: Lynn Abbott, Agency Clerk, Department of Education, (850)245-9661 or e-mail lynn.abbott@fldoe.org or go to https://app1.fldoe.org/rules/default.aspx.

DEPARTMENT OF REVENUE

Sales and Use Tax

RULE NOS.:	RULE TITLES:
12A-1.004	Sales Tax Brackets
12A-1.038	Consumer's Certificate of Exemption; Exemption Certificates
12A-1.039	Sales for Resale
12A-1.060	Registration
12A-1.061	Rentals, Leases, and Licenses to Use Transient Accommodations
12A-1.0911	Self-Accrual Authorization; Direct Remittance on Behalf of Independent Distributors
12A-1.097	Public Use Forms

PURPOSE AND EFFECT: The purpose of the proposed amendments to Rule 12A-1.004, F.A.C. (Sales Tax Brackets), is to update the information on how to obtain copies of tax rate tables from the Department.

The purpose of the proposed amendments to Rule 12A-1.038, F.A.C. (Consumer's Certificate of Exemption; Exemption Certificates), and Rule 12A-1.039, F.A.C. (Sales for Resale), is to clarify that a transaction authorization number used by dealers to document tax-exempt sales or sales made for the purposes of resale may be obtained prior to or at the time of sale.

The purpose of the proposed amendments to subsection (3), Registration of Transient Accommodations, of Rule 12A-1.060, F.A.C. (Registration), and subsection (7), Registration, of Rule 12A-1.061, F.A.C. (Rentals, Leases, and Licenses to Use Transient Accommodations), is to add the requirement for the taxpayer to provide a federal identification number, social security number, or taxpayer identification number; and to provide that the Department uses the social security numbers as unique identifiers for the administration of Florida's taxes, and that they are held confidential by the Department.

The purpose of the proposed amendments to Rule 12A-1.0911, F.A.C. (Self-Accrual Authorization; Direct Remittance on Behalf of Independent Distributors), is to remove unnecessary provisions regarding the revocation of a sales and use direct pay permit. Administrative rules regarding the revocation of a license, which includes a direct pay permit, have been established by the Administration Commission in Rule Chapter 28-106, F.A.C. All agencies must comply with these rules.

The purpose of the proposed amendments to Rule 12A-1.097, F.A.C. (Public Use Forms), is to: (1) adopt, by reference, changes to forms used by the Department in the administration of sales and use tax for the enterprise zone jobs credit, the special estimation of taxes for boat, motor vehicle, or aircraft dealers, and the verification of customers authorized to purchase for resale; and (2) remove forms previously used for the reporting of sales tax collected by tax collectors and for the reporting regarding interest earned on the investment of funds by county officers that are now reported and remitted by electronic means to the Department.

Specifically, Form DR-15ZC (Application for Florida Enterprise Zone Jobs Credit for Sales Tax) and the instructions on Form DR-15ZCN are being revised to simplify the application and the instructions and provide necessary technical changes.

Form DR-300400 (Boat, Motor Vehicle, or Aircraft Dealer Application for Special Estimation of Taxes), used by the Department in the administration of the estimated sales tax provisions of Section 212.11(1)(d), F.S., is revised to reorganize and simplify the instructions for boat, motor vehicle, and aircraft dealers to submit an application to report estimated tax under that statutory provision. No procedural changes are being implemented with these revisions.

Form DR-600013 (Request for Verification that Customers are Authorized to Purchase for Resale) is revised to provide that a diskette or compact disk (CD) containing specified records must be submitted to verify which customers of a business are authorized to purchase for resale. The Department is no longer able to receive information for verification purposes on cartridge tapes. Revisions are also made to clarify the instructions regarding the verification process.

SUBJECT AREA TO BE ADDRESSED: The subject of this workshop is the revisions to these forms used by the Department in the administration of sales and use tax.

SPECIFIC AUTHORITY: 201.11, 202.17(3)(a), 202.22(6), 202.26(3), 212.0515(7), 212.07(1)(b), 212.08(5)(b)4., (7), 212.11(5)(b), 212.12(1)(b)2., (11), 212.17(6), 212.18(2), (3), 212.183, 213.06(1), 376.70(6)(b), 376.75(9)(b), 403.718(3)(b), 403.7185(3)(b), 443.171(2), (7) FS.

LAW IMPLEMENTED: 92.525(1)(b), (3), 95.091, 125.0104, 125.0108, 201.01, 201.08(1)(a), 201.133, 201.17(1)-(5), 202.11(2), (3), (6), (16), (24), 202.17, 202.22(3)-(6), 202.28(1), 203.01, 212.02, 212.03, 212.0305, 212.031, 212.04, 212.05, 212.0501, 212.0515, 212.053(10), 212.054, 212.055, 212.0596(1), (2), 212.0598, 212.06, 212.0601, 212.0606, 212.07(1), (8), (9), 212.08, 212.084(3), 212.085, 212.09, 212.096, 212.11(1), (2), (4), (5), 212.12(1), (2), (5), (6), (7), (9), (11), (12), (13), 212.13, 212.14(4), (5), 212.16(1), (2), 212.17, 212.18(2), (3), 212.183, 212.21(2), 213.053(10), 213.235, 213.29, 213.37, 213.756, 219.07, 288.1258, 376.70, 376.75, 403.717, 403.718, 403.7185, 443.036, 443.121(1), (3), 443.131, 443.1315, 443.1316, 443.171(2), (7) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME : January 15, 2009, 11:00 a.m.

PLACE: Room 118, Carlton Building, 501 S. Calhoun Street, Tallahassee, Florida

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 48 hours before the workshop/meeting by contacting: Larry Green at (850)922-4830. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Janet L. Young, Tax Law Specialist, Technical Assistance and Dispute Resolution, Department of Revenue, P. O. Box 7443, Tallahassee, Florida 32314-7443, telephone (850)922-9407

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS PUBLISHED ON THE DEPARTMENT'S INTERNET SITE AT: myflorida.com/dor/rules.

DEPARTMENT OF TRANSPORTATION

RULE NO.:	RULE TITLE:
14-78.005	Participation by Disadvantaged Business Enterprises

PURPOSE AND EFFECT: The language in the "Special Provisions for DBE Contracts" is amended and the reference to the Code of Federal Regulations is updated in order to incorporate the 2008 edition of 49 C.F.R. Part 26. Finally, a reference to 72 Federal Register No. 62 is added for informational purposes.

SUBJECT AREA TO BE ADDRESSED: The language in the "Special Provisions for DBE Contracts" is amended and the reference to the Code of Federal regulations is updated.

SPECIFIC AUTHORITY: 337.125, 337.137, 339.0805 FS.

LAW IMPLEMENTED: 337.125, 337.137, 339.0805 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: James C. Myers, Clerk of Agency Proceedings, Florida Department of Transportation, Office of the General Counsel, 605 Suwannee Street, Mail Station #58, Tallahassee, Florida 32399-0458

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

14-78.005 Participation by Disadvantaged Business Enterprises.

(1) The major purpose of the Disadvantaged Business Enterprise (DBE) Program is to assure nondiscrimination and DBE utilization in road and bridge construction and maintenance projects. Contractors are required to comply with the following special provision contained in all road and bridge contracts:

Special Provision for DBE Contracts

General. Prior to award of the contract, have an approved DBE Affirmative Action Program Plan filed with the Equal Opportunity Office. Update and resubmit the plan every three years. No contract will be awarded until the Department approves the Plan. The DBE Affirmative Action Program Plan and commitment to carry out the Plan must be incorporated into and become part of the awarded contract. Per 49 C.F.R. 26.13(b) each Contract FDOT signs with a Contractor (and each subcontract the prime contractor signs with a subcontractor) must include the following assurance: "The Contractor, sub-recipient or subcontractor shall not discrimiate on the basis of race, color, national origin, or sex in the performance of this contract. The Contractor shall carry out applicable requirements of 49 C.F.R. Part 26 in the award and administration of DOT-assisted Contracts. Failure by the Contractor to carry out these requirements is a material breach of this Contract, which may result in the termination of this Contract or such other remedy as the recipient deems appropriate." ~~Failure to keep these commitments will be deemed noncompliance with these specifications and a breach of the contract. Take all necessary and reasonable steps to ensure that Disadvantaged Business Enterprises, as defined in 49 C.F.R. Part 26, have the opportunity to participate in, compete for, and perform subcontracts. Do not discriminate on the basis of age, race, color, religion, national origin, sex, or disability in the award and performance of this contract.~~

Plan Requirements. Include the following in the DBE Affirmative Action Program Plan:

A policy statement, expressing a commitment to use DBEs in all aspects of contracting to the maximum extent feasible. The policy making body must issue a policy statement signed by the chairpersion, which expresses its commitment to utilize DBEs, outlines the various levels of responsibility, and states the objectives of the program. Circulate the policy statement throughout the Contractor's organization.

The designation of a Liaison Officer with the contractor's organization, as well as support staff, necessary and proper to administer the program, and a description of the authority, responsibility, and duties of the Liaison Officer and support staff. The Liaison Officer and staff are responsible for developing, managing, and implementing the program on a day-to-day basis for carrying out technical assistance activities for DBEs and for disseminating information on available business opportunities so that the DBEs are provided an equitable opportunity to participate in contracts let by the Department. Use techniques to facilitate DBE participation in contracting activities which include ~~such as~~:

1. Soliciting price quotations and arranging a time for the review of plans, quantities, specifications, and delivery schedules, and for the preparation and presentation of quotations.

2. Providing assistance to DBEs in overcoming barriers such as the inability to obtain bonding, financing, or technical assistance.

3. Carrying out information and communication programs or workshops on contracting procedures and specific contracting opportunities in a timely manner, with such programs being bilingual, where appropriate.

4. Encouraging eligible DBEs to apply for certification with the Department.

5. Contacting Minority Contractor Associations and city and county agencies with programs for disadvantaged individuals for assistance in recruiting and encouraging eligible DBE contractors to apply for certification with the Department.

DBE Records and Reports. Submit the Anticipated DBE Participation Statement at or before the Pre-construction Conference. Report monthly, through the Equal Opportunity Reporting System, ~~manually or~~ on the Department's website, actual payments, retainage of all DBE and Minority Business Enterprise (MBE) subcontractors and DBE and MBE construction material ~~, minority status, and work type of all subcontractors~~ and major suppliers. The Equal Opportunity Office will provide instructions on accessing this system. Develop a record keeping system to monitor DBE affirmative action efforts which include the following:

1. The procedures adopted to comply with these specifications;

2. The number of subordinated contracts on Department projects awarded to DBEs;

3. The dollar value of the contracts awarded to DBEs;

4. The percentage of the dollar value of all subordinated contracts awarded to DBEs as a percentage of the total contract amount.

5. A description of the general categories of contracts awarded to DBEs; and

6. The specific efforts employed to identify and award contracts to DBEs.

Upon request, provide the records to the Department for review.

All such records are required to be maintained for a period of five years following acceptance of final payment and available for inspection by the Department and the Federal Highway Administration.

(2) 49 C.F.R. Part 26 (10-1-08 ~~10-1-03~~ Edition) is incorporated herein by reference and adopted by the Department for participation by disadvantaged business enterprises in the Department's federally funded projects. The provisions of 64 Federal Register No. 21, February 2, 1999, and 68 Federal Register No. 115, June 16, 2003, and 72 Fed. Register No. 62, April 2, 2007, are available from the Department for informational purposes only. They also can be obtained on the Internet at http://www.gpoaccess.gov/fr/index.html.

Specific Authority 337.125, 337.137, 339.0805 FS. Law Implemented 337.125, 337.137, 339.0805 FS. History–New 12-9-81, Amended 5-23-84, Formerly 14-78.05, Amended 9-21-87, 5-4-88, 6-24-91, 12-2-93, 4-30-96, 8-31-04, _____.

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND

Notices for the Board of Trustees of the Internal Improvement Trust Fund between December 28, 2001 and June 30, 2006, go to http://www.dep.state.fl.us/ under the link or button titled "Official Notices."

STATE BOARD OF ADMINISTRATION

RULE NOS.:	RULE TITLES:
19-8.010	Reimbursement Contract
19-8.012	Procedures to Determine Ineligibility for Participation in the Florida Hurricane Catastrophe Fund and to Determine Exemption from Participation in the Florida Hurricane Catastrophe Fund
19-8.013	Revenue Bonds Issued Pursuant to Section 215.555(6), F.S.
19-8.028	Reimbursement Premium Formula
19-8.029	Insurer Reporting Requirements
19-8.030	Insurer Responsibilities

PURPOSE AND EFFECT: To discuss proposed amendments to the following rules: Rule 19-8.010, F.A.C., the annual Reimbursement Contract, Rule 19-8.012, F.A.C., the procedures to determine ineligibility or exemption from participation in the Florida Hurricane Catastrophe Fund, Rule 19-8.013, F.A.C., Revenue Bonds Issued Pursuant to Section 215.555(6), F.S., Rule 19-8.028, F.A.C., the annual Reimbursement Premium Formula, Rule 19-8.029, F.A.C., the Insurer Reporting Requirements, and Rule 19-8.030, F.A.C., Insurer Responsibilities.

SUBJECT AREA TO BE ADDRESSED: Contract requirements, exemption and ineligibility, bonding, premium formula requirements, insurer reporting requirements for the 2009-2010 contract year, and insurer responsibilities.

SPECIFIC AUTHORITY: 215.555 FS.

LAW IMPLEMENTED: 215.555 FS.

A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME: January 9, 2009, 9:00 a.m. – 12:00 Noon (ET)

PLACE: Room 116 (Hermitage Conference Room), 1801 Hermitage Blvd., Tallahassee, Florida 32308

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Tracy Allen, Senior FHCF Attorney, State Board of Administration, P. O. Box 13300, Tallahassee, Florida 32317-3300; telephone (850)413-1341; email: tracy.allen@sbafla.com

WATER MANAGEMENT DISTRICTS

Suwannee River Water Management District

RULE NO.:	RULE TITLE:
40B-3.411	Completion Report

PURPOSE AND EFFECT: The purpose of the rule development is to update this section of Chapter 40B-3, Florida Administrative Code, to require a latitude and longitude for each well on water well completion reports. The effect of the proposed rule amendments will provide for better identification of wells in the data base, and in turn, staff will be able to better assist with public inquiries.

SUBJECT AREA TO BE ADDRESSED: This proposed rule development will require a latitude and longitude for each well on water well completion reports, thereby enabling staff to better assist the public when inquiries are made.

SPECIFIC AUTHORITY: 373.044, 373.113, 373.171 FS.

LAW IMPLEMENTED: 373.308, 373.309, 373.313, 373.326, 373.342 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Linda Welch, Administrative Assistant, Suwannee River Water Management District, 9225 C.R. 49, Live Oak, Florida 32060, (386)362-1001 or (800)226-1066 (FL only)

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

WATER MANAGEMENT DISTRICTS

Suwannee River Water Management District

RULE NOS.:	RULE TITLES:
40B-400.091	Publications and Agreements Incorporated by Reference
40B-400.115	Limiting Conditions

PURPOSE AND EFFECT: The purpose of the rule development is to update these sections of Chapter 40B-400, Florida Administrative Code (F.A.C.), to amend and include additional items incorporated by reference in Rule 40B-400.091, F.A.C. The proposed rule development will also amend limiting conditions for environmental resource permits (ERP), in Rule 40B-400.115, F.A.C. The effect of the proposed rule development will be to amend the ERP Applicant's Handbook regarding the de-listing of the bald eagle as threatened species, include a new publication incorporated by reference, Florida Stormwater, Erosion and Sedimentation Control Inspectors Manual, and correct terminology to reflect the new publication incorporated by reference. In addition, the proposed rule development will amend procedures for notification if historical or archaeological artifacts are discovered on property permitted under an ERP.

SUBJECT AREA TO BE ADDRESSED: This proposed rule development will incorporate the most recent version of the Environmental Resource Permit (ERP) Applicant's Handbook, which will de-list the bald eagle, incorporate a new publication, Florida Stormwater, Erosion and Sedimentation Control Inspectors Manual, and correct terminology to reflect the new publication incorporated by reference. In addition, the proposed rule development will amend procedures for notification if historical or archaeological artifacts are discovered on property permitted under an ERP.

SPECIFIC AUTHORITY: 373.044, 373.046(4), 373.113, 373.118, 373.171, 373.415, 373.421(2), 373.461(3) FS.

LAW IMPLEMENTED: 373.046, 373.118, 373.413, 373.4135, 373.415, 373.416, 373.421(2)-(6), 373.426, 373.461(3) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Linda Welch, Administrative Assistant, Suwannee River Water Management District, 9225 C.R. 49, Live Oak, Florida 32060, (386)362-1001 or (800)226-1066 (FL only)

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

WATER MANAGEMENT DISTRICTS

St. Johns River Water Management District

RULE NOS.:	RULE TITLES:
40C-2.042	General Permit by Rul
40C-2.101	Publications Incorporated by Reference
40C-2.301	Conditions for Issuance of Permits

PURPOSE AND EFFECT: The purpose and effect of the proposed rule development is to amend the General Permit by Rule that regulates small irrigation uses below consumptive use permit thresholds in Rule 40C-2.041, F.A.C. Amendments include: repeal of the exceptions from irrigation day and time limitations for use of reclaimed water and the use of recycled water from wet detention treatment ponds for irrigation; providing that when a reclaimed water provider cannot feasibly operate its disposal system unless it provides reclaimed water to its customers on a more frequent basis than would occur under the limitations in the General Permit by Rule irrigation schedules, then such customers who receive written notification that this condition exists can irrigate with reclaimed water on the additional days specified in the notification; and revising Rule 40C-2.101, F.A.C., and the Applicant's Handbook: Consumptive Uses of Water, to reflect these changes. The District is also considering amending Rules 40C-2.101 and 40C-2.301, F.A.C., and the Applicant's Handbook: Consumptive Uses of Water, to address the use of reclaimed water and the use of recycled water from wet detention treatment ponds for irrigation by applicants who require a consumptive use permit from the District and do not qualify for the General Permit by Rule.

SUBJECT AREA TO BE ADDRESSED: Amendments related to the use of water for irrigation in both the General Permit by Rule for small water uses and the conditions for issuance of permits applicable to applicants who require a consumptive use permit from the District and do not qualify for the General Permit by Rule.

SPECIFIC AUTHORITY: 373.044, 373.113, 373.118, 373.171 FS.

LAW IMPLEMENTED: 373.118, 373.219, 373.223, 373.250, 373.609 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 5 days before the workshop/meeting by contacting: Sandy Bertram, Asst. District Clerk, (386)329-4127. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Norma Messer, Rules Coordinator, Office of General Counsel, St. Johns River Water Management District, 4049 Reid Street,

Palatka, Florida 32177-2529, (386)329-4459, email nmesser@sjrwmd.com. Rule Text for Rules 40C-2.101 and 40C-2.301 is not available at this time

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

40C-2.042 General Permit by Rule.

A general consumptive use permit by rule is hereby established for consumptive uses of water listed below that do not meet or exceed any permitting threshold under subsection 40C-2.041(1), F.A.C., except as provided in subsection (8). However, this section shall not apply to domestic uses of water by individuals, i.e., water used for the household purposes of drinking, bathing, cooking or sanitation. Persons using or proposing to use water in a manner not authorized under this section, must obtain a permit pursuant to Chapter 40C-2, 40C-20, or 40C-22, F.A.C.

(1) The Board hereby grants a general permit to each person located within the District to use, withdraw or divert water from any source to irrigate agricultural crops, nursery plants, golf courses, and recreational areas, provided the irrigation does not occur between the hours of 10:00 a.m. and 4:00 p.m. daily. Such water use shall be subject to the following exceptions:

(a) No change.

~~(b) The use of water for irrigation from a reclaimed water system is allowed anytime. For the purpose of this paragraph, a reclaimed water system includes systems in which the primary source is reclaimed water, which may or may not be supplemented by water from another source during peak demand periods.~~

~~(c) The use of recycled water from wet detention treatment ponds for irrigation is allowed anytime provided the ponds are not augmented from any ground or off-site surface water, or public supply sources.~~

(d) through (n) renumbered (b) through (l) No change.

(2)(a) The Board hereby grants a general permit to each person located within the District to use, withdraw or divert water from any source for landscape irrigation, provided the irrigation does not occur more than two days per week and does not occur between the hours of 10:00 a.m. and 4:00 p.m. daily. An irrigator may select the two irrigation days unless a local government adopts an ordinance identifying the specific two days irrigation is allowed pursuant to paragraph (b). A contiguous property may be divided into different zones and each zone may be irrigated on different days than other zones of the property unless a local government adopts an ordinance identifying the specific two days irrigation is allowed pursuant to paragraph (b). However, no single zone may be irrigated more than 2 days a week. Additionally, any person who irrigates landscape with an automatic lawn sprinkler system installed after May, 1991, shall install, maintain and operate a rain sensor device or switch that overrides the irrigation system when adequate rainfall has occurred**.** For the purpose of this rule, "landscape irrigation" means the outside watering of plants in a landscape such as shrubbery, trees, lawns, grass, ground covers, plants, vines, gardens and other such flora that are situated in such diverse locations as residential areas, cemeteries, public, commercial, and industrial establishments, and public medians and rights of way. For the purpose of this rule, "landscape irrigation" does not include golf course greens, tees, fairways, primary roughs, and vegetation associated with intensive recreational areas such as, but not limited to, playgrounds, football, baseball and soccer fields. Landscape irrigation shall be subject to the following exceptions:

1. through 6. No change.

~~7. The use of water from a reclaimed water system is allowed anytime. For the purpose of this paragraph, a reclaimed water system includes systems in which the primary source is reclaimed water, which may or may not be supplemented from another source during peak demand periods.~~

~~8. The use of recycled water from wet detention treatment ponds for irrigation is allowed anytime provided the ponds are not augmented from any ground or off-site surface water, or public supply sources.~~

(b) through (d) No change.

(e) Although the use of reclaimed water for landscape irrigation is subject to the irrigation schedule set forth in paragraph 40C-2.042(2)(a), F.A.C., in those limited conditions described in this paragraph, a person is authorized to irrigate landscape with reclaimed water on more than the 2 days specified. This additional authorization is provided under certain conditions because some reclaimed water providers cannot feasibly operate their wastewater disposal systems currently unless they provide reclaimed water to their customers for use on a more continuous basis than what would occur under the day limitations. Those persons who receive written notification from their reclaimed water provider that this condition exists are authorized to irrigate landscape with reclaimed water on those additional days specified in the notification. The additional authorization shall cease upon written notification that this condition no longer exists. During the period in which additional days of irrigation are authorized, the irrigation prohibition between 10:00 a.m. and 4:00 p.m. shall continue to apply.

(3) through (8) No change.

Specific Authority 373.044, 373.113, 373.118, 373.171 FS. Law Implemented 373.118, 373.219, 373.223, 373.250, 373.609 FS. History–New 7-23-91, Amended 1-7-99, 2-15-06, _____.

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

RULE NO.:	RULE TITLE:
40D-2.091	Publications Incorporated by Reference

PURPOSE AND EFFECT: The rulemaking is intended to develop District-wide water use permitting rules that include water conservation standards and criteria consistent with those adopted for the Southern Water Use Caution Area for public supply, recreation and aesthetic water uses and to enhance and add conservation measures District-wide for public supply, recreation and aesthetic water uses.

SUBJECT AREA TO BE ADDRESSED: The subject area of the proposed rulemaking is amendments to the District water use permitting rules in Chapter 40D-2, F.A.C., and Part B, Basis of Review For Water Use Permit Applications, of the Water Use Permit Information Manual regarding additional and enhanced conservation requirements for public supply, recreation and aesthetic water use permits. Some of the requirements for public supply permits within the Southern Water Use Caution Area (SWUCA) are proposed to apply also in areas not within the SWUCA. These include conservation rate structures, water billing requirements, water audits, wholesale permits and annual reports for public supply utilities. Some of the other District-wide proposed additions and enhancements include, limiting unaccounted water to a maximum of ten percent of production, requiring utilities to report conservation programs and initiatives within their service areas, information regarding reclaimed water generation, use and rate structure information, landscape codes, efficient irrigation of common areas and water conservation projects/programs. Also proposed are amendments to apply District-wide the SWUCA conservation requirements for recreation and aesthetic water use permits, including a phased elimination of irrigation of golf course roughs and adding identification and repair of system water losses. Other requirements may be developed during rulemaking.

SPECIFIC AUTHORITY: 373.044, 373.113, 373.118, 373.171 FS.

LAW IMPLEMENTED: 373.036, 373.0361, 373.042, 373.0421, 373.0831, 373.116, 373.117, 373.118, 373.149, 373.171, 373.1963, 373.216, 373.219, 373.223, 373.229, 373.239, 373.243 FS.

A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME: January 9, 2009, 1:00 p.m.

PLACE: Southwest Florida Water Management District, Tampa Service Office, Governing Board Room, 7601 U.S. Highway 301, Tampa, FL 33637-6759

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 5 days before the workshop/meeting by contacting: Dianne Lee at (352)796-7211 or 1(800)423-1476, extension 4658; TDD only number 1(800)231-6103; FAX number (352)754-6878/SUNCOM 663-6878. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Charlotte Edwards, Sr. Administrative Assistant, Office of General Counsel, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, extension 4651

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS AVAILABLE AT NO CHARGE FROM THE CONTACT PERSON LISTED ABOVE.

AGENCY FOR HEALTH CARE ADMINISTRATION

Certificate of Need

RULE NO.:	RULE TITLE:
59C-1.0355	Hospice Programs

PURPOSE AND EFFECT: The administrative rule related to Certificate of Need for Hospice programs has been determined to require revision to incorporate the data reports from the Department of Health Office of Vital Statistics and the Office of the Governor Population Estimates. While this revision is a change that will recognize a process that has been in place for some time, it will require that a rule promulgation be initiated.

SUBJECT AREA TO BE ADDRESSED: Certificate of need rule on Hospice Fixed Need Pool and Needs Projection statistical utilization and implementation.

SPECIFIC AUTHORITY: 408.15(8), 408.034(3), (5) FS.

LAW IMPLEMENTED: 408.034(3), 408.035, 408.036(1)(d), 408.043(2), 400.606(4), (5) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Calvin J. Vice, Sr., PhD, 2727 Mahan Drive, MS #28, Tallahassee, Florida 32308, (850)488-8672

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59C-1.0355 Hospice Programs.

(1) Agency Intent. This rule implements the provisions of subsection 408.034(3), paragraphs 408.036(1) (d) ~~and (e)~~, and subsection 408.043(2), F.S. It is the intent of the agency to ensure the availability of hospice programs as defined in this rule to all persons requesting and eligible for hospice services,

regardless of ability to pay. This rule regulates the establishment of new hospice programs, the construction of freestanding inpatient hospice facilities as defined in this rule, and a change in licensed bed capacity of a freestanding inpatient hospice facility. A separate certificate of need application shall be submitted for each service area defined in this rule.

(2) Definitions.

(a) "Agency." The Agency for Health Care Administration.

(b) "Approved Hospice Program." A hospice program for which the agency has issued an intent to grant a certificate of need, or has issued a certificate of need, and that is not yet licensed as of 3 weeks prior to publication of the fixed need pool.

(c) "Contractual Arrangement." An arrangement for contractual services, as described in Section 400.6085, F.S.

(d) "Fixed Need Pool." The fixed need pool defined in subsection 59C-1.002(19)~~(20)~~, F.A.C. The agency shall publish a fixed need pool for hospice programs twice a year.

(e) "Freestanding Inpatient Hospice Facility." For purposes of this rule, a facility that houses inpatient beds licensed exclusively to the hospice program but does not house any inpatient beds licensed to a hospital or nursing home.

(f) "Hospice Program." A program described in subsections 400.601(3)~~(2)~~, 400.602(1)~~(5)~~, 400.609, and 400.6095(1), F.S., that provides a continuum of palliative and supportive care for the terminally ill patient and his family. Hospice services must be available 24 hours a day, 7 days a week, and must be available to all terminally ill persons and their families without regard to age, gender, national origin, sexual orientation, disability, diagnosis, cost of therapy, ability to pay, or life circumstances.

(g) "Inpatient Bed." Inpatient beds located in a freestanding inpatient hospice facility, a hospital, or a nursing home and available for hospice inpatient care.

(h) "Local Health Council." The council referenced in Section 408.033(1), F.S.

(i) "Planning Horizon." The date by which a proposed new hospice program is expected to be licensed. For purposes of this rule, the planning horizon for applications submitted between January 1 and June 30 is July 1 of the year 1 year subsequent to the year the application is submitted; the planning horizon for applications submitted between July 1 and December 31 is January 1 of the year 2 years subsequent to the year the application is submitted.

(j) "Residential Facility." For purposes of this rule, a facility operated by a licensed hospice program to provide a residence for hospice patients, as defined in Section 400.601(5)~~(4)~~, F.S. A residential facility is not subject to regulation under this rule. Provided, however, that a proposal to convert such a residence to a freestanding inpatient hospice facility is subject to regulation under this rule.

(k) "Service Area." The geographic area consisting of a specified county or counties, as follows:

1. Service Area 1 consists of Escambia, Okaloosa, Santa Rosa, and Walton Counties.

2. Service Area 2A consists of Bay, Calhoun, Gulf, Holmes, Jackson, and Washington Counties.

3. Service Area 2B consists of Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla Counties.

4. Service Area 3A consists of Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties.

5. Service Area 3B consists of Marion County.

6. Service Area 3C consists of Citrus County.

7. Service Area 3D consists of Hernando County.

8. Service Area 3E consists of Lake and Sumter Counties.

9. Service Area 4A consists of Baker, Clay, Duval, Nassau, and St. Johns Counties.

10. Service Area 4B consists of Flagler and Volusia Counties.

11. Service Area 5A consists of Pasco County.

12. Service Area 5B consists of Pinellas County.

13. Service Area 6A consists of Hillsborough County.

14. Service Area 6B consists of Hardee, Highlands, and Polk Counties.

15. Service Area 6C consists of Manatee County.

16. Service Area 7A consists of Brevard County.

17. Service Area 7B consists of Orange and Osceola Counties.

18. Service Area 7C consists of Seminole County.

19. Service Area 8A consists of Charlotte and DeSoto Counties.

20. Service Area 8B consists of Collier County.

21. Service Area 8C consists of Glades, Hendry and Lee Counties.

22. Service Area 8D consists of Sarasota County.

23. Service Area 9A consists of Indian River County.

24. Service Area 9B consists of Martin, Okeechobee, and St. Lucie Counties.

25. Service Area 9C consists of Palm Beach County.

26. Service Area 10 consists of Broward County.

27. Service Area 11 consists of Dade and Monroe Counties.

(l) "Terminally Ill." As defined in subsection 400.601(10)~~(9)~~, F.S., terminally ill refers to a medical prognosis that a patient's life expectancy is 1 year or less if the illness runs its normal course.

(3) General Provisions.

(a) Quality of Care. Hospice programs shall comply with the standards for program licensure described in Chapter 400, Part IV ~~VI~~, F.S., and Chapter 58A-2 ~~59A-2~~**,** F.A.C. Applicants proposing to establish a new hospice program shall demonstrate how they will meet the standards.

(b) Conformance with Statutory Review Criteria. A certificate of need for the establishment of a new hospice program, construction of a freestanding inpatient hospice facility, or change in licensed bed capacity of a freestanding inpatient hospice facility, shall not be approved unless the applicant meets the applicable review criteria in Sections 408.035 and 408.043(2), F.S., and the standards and need determination criteria set forth in this rule. Applications to establish a new hospice program shall not be approved in the absence of a numeric need indicated by the formula in paragraph (4)(a) of this rule, unless other criteria in this rule and in Sections 408.035 and 408.043(2), F.S., outweigh the lack of a numeric need.

(4) Criteria for Determination of Need for a New Hospice Program.

(a) Numeric Need for a New Hospice Program. Numeric need for an additional hospice program is demonstrated if the projected number of unserved patients who would elect a hospice program is 350 or greater. The net need for a new hospice program in a service area is calculated as follows:

(HPH) - (HP) ≥ 350

where:

(HPH) is the projected number of patients electing a hospice program in the service area during the 12 month period beginning at the planning horizon. (HPH) is the sum of (U65C x P1) + (65C x P2) + (U65NC x P3) + (65NC x P4)

where:

U65C is the projected number of service area resident cancer deaths under age 65, and P1 is the projected proportion of U65C electing a hospice program.

65C is the projected number of service area resident cancer deaths age 65 and over, and P2 is the projected proportion of 65C electing a hospice program.

U65NC is the projected number of service area resident deaths under age 65 from all causes except cancer, and P3 is the projected proportion of U65NC electing a hospice program.

65NC is the projected number of service area resident deaths age 65 and over from all causes except cancer, and P4 is the projected proportion of 65NC electing a hospice program.

The projections of U65C, 65C, U65NC, and 65NC for a service area are calculated as follows:

U65C = (u65c/CT) x PT

65C = (65c/CT) x PT

U65NC = (u65nc/CT) x PT

65NC = (65nc/CT) x PT

where:

u65c, 65c, u65nc, and 65nc are the service area's current number of resident cancer deaths under age 65, cancer deaths age 65 and over, deaths under age 65 from all causes except cancer, and deaths age 65 and over from all causes except cancer.

CT is the service area's current total of resident deaths, excluding deaths with age unknown, and is the sum of u65c, 65c, u65nc, and 65nc.

PT is the service area's projected total of resident deaths for the 12-month period beginning at the planning horizon.

"Current" deaths means the number of deaths during the most recent calendar year for which data are available from the Department of Health ~~and Rehabilitative Services'~~ Office of Vital Statistics at least 3 months prior to publication of the fixed need pool.

"Projected" deaths means the number derived by first calculating a 3-year average resident death rate, which is the sum of the service area resident deaths for the three most recent calendar years available from the Department of Health ~~and Rehabilitative Services'~~ Office of Vital Statistics at least 3 months prior to publication of the fixed need pool, divided by the sum of the July 1 estimates of the service area population for the same 3 years. The resulting average death rate is then multiplied by the projected total population for the service area at the mid-point of the 12-month period which begins with the applicable planning horizon. Population estimates for each year will be the most recent population estimates from ~~published by~~ the Office of the Governor at least 3 months prior to publication of the fixed need pool. The following materials are incorporated by reference within this rule; Department of Health Office of Vital Statistics death statistics received October 2007 and the Office of the Governor Population Estimates received September 2007.

The projected values of P1, P2, P3, and P4 are equal to current statewide proportions calculated as follows:

P1 = (Hu65c/Tu65c)

P2 = (H65c/T65c)

P3 = (Hu65nc/Tu65nc)

P4 = (H65nc/T65nc)

where:

Hu65c, H65c, Hu65nc, and H65nc are the current 12-month statewide total admissions of hospice cancer patients under age 65, hospice cancer patients age 65 and over, hospice patients under age 65 admitted with all other diagnoses, and hospice patients age 65 and over admitted with all other diagnoses. The current totals are derived from reports submitted under subsection (9) of this rule.

Tu65c, T65c, Tu65nc, and T65nc are the current 12-month statewide total resident deaths for the four categories used above.

(HP) is the number of patients admitted to hospice programs serving an area during the most recent 12-month period ending on June 30 or December 31. The number is derived from reports submitted under subsection (9) of this rule.

350 is the targeted minimum 12-month total of patients admitted to a hospice program.

(b) Licensed Hospice Programs. Regardless of numeric need shown under the formula in paragraph (4)(a), the agency shall not normally approve a new hospice program for a service area unless each hospice program serving that area has been licensed and operational for at least 2 years as of 3 weeks prior to publication of the fixed need pool.

(c) Approved Hospice Programs. Regardless of numeric need shown under the formula in paragraph (4)(a), the agency shall not normally approve another hospice program for any service area that has an approved hospice program that is not yet licensed.

(d) Approval Under Special Circumstances. In the absence of numeric need identified in paragraph (4)(a), the applicant must demonstrate that circumstances exist to justify the approval of a new hospice. Evidence submitted by the applicant must document one or more of the following:

1. That a specific terminally ill population is not being served.

2. That a county or counties within the service area of a licensed hospice program are not being served.

3. That there are persons referred to hospice programs who are not being admitted within 48 hours (excluding cases where a later admission date has been requested). The applicant shall indicate the number of such persons.

(e) Preferences for a New Hospice Program. The agency shall give preference to an applicant meeting one or more of the criteria specified in subparagraphs 1. through 5.:

1. Preference shall be given to an applicant who has a commitment to serve populations with unmet needs.

2. Preference shall be given to an applicant who proposes to provide the inpatient care component of the hospice program through contractual arrangements with existing health care facilities, unless the applicant demonstrates a more cost-efficient alternative.

3. Preference shall be given to an applicant who has a commitment to serve patients who do not have primary caregivers at home; the homeless; and patients with AIDS.

4. In the case of proposals for a hospice service area comprised of three or more counties, preference shall be given to an applicant who has a commitment to establish a physical presence in an underserved county or counties.

5. Preference shall be given to an applicant who proposes to provide services that are not specifically covered by private insurance, Medicaid, or Medicare.

(5) Consistency with Plans. An applicant for a new hospice program shall provide evidence in the application that the proposal is consistent with the needs of the community and other criteria contained in local health council plans and the State Health Plan. The application for a new hospice program shall include letters from health organizations, social services organizations, and other entities within the proposed service area that endorse the applicant's development of a hospice program.

(6) Required Program Description. An applicant for a new hospice program shall provide a detailed program description in its certificate of need application, including:

(a) Proposed staffing, including use of volunteers.

(b) Expected sources of patient referrals.

(c) Projected number of admissions, by payer type, including Medicare, Medicaid, private insurance, self-pay, and indigent care patients for the first 2 years of operation.

(d) Projected number of admissions, by type of terminal illness, for the first 2 years of operation.

(e) Projected number of admissions by two age groups, under 65 and 65 or older, for the first 2 years of operation.

(f) Identification of the services that will be provided directly by hospice staff and volunteers and those that will be provided through contractual arrangements.

(g) Proposed arrangements for providing inpatient care (e.g., construction of a freestanding inpatient hospice facility; contractual arrangements for dedicated or renovated space in hospitals or nursing homes).

(h) Proposed number of inpatient beds that will be located in a freestanding inpatient hospice facility, in hospitals, and in nursing homes.

(i) Circumstances under which a patient would be admitted to an inpatient bed.

(j) Provisions for serving persons without primary caregivers at home.

(k) Arrangements for the provision of bereavement services.

(l) Proposed community education activities concerning hospice programs.

(m) Fundraising activities.

(7) Construction of a Freestanding Inpatient Hospice Facility. The agency will not normally approve a proposal for construction of a freestanding inpatient hospice facility unless the applicant demonstrates that the freestanding facility will be more cost-efficient than contractual arrangements with existing hospitals or nursing homes in the service area. The application shall include the following:

(a) A description of any advantages that the hospice program will achieve by constructing and operating its own inpatient beds.

(b) Existing contractual arrangements for inpatient care at hospitals and nursing homes; or, in the case of a proposed new hospice program, contacts made with hospitals and nursing homes regarding contractual arrangements for inpatient care.

(c) Anticipated sources of funds for the construction.

(8) Change in Licensed Bed Capacity of a Freestanding Inpatient Hospice Facility. A hospice program proposing to change the licensed bed capacity of its freestanding inpatient hospice facility shall indicate in its application:

(a) The annual occupancy rate for the freestanding inpatient hospice facility beds for the most recent 12-month period preceding the application submission.

(b) The extent to which the number of contracted beds in hospitals and nursing homes will be modified as a result of the change in licensed capacity of the freestanding inpatient hospice facility.

(9) Semi-Annual Utilization Reports. Each hospice program shall report utilization information to the agency or its designee on or before July 20 of each year and January 20 of the following year. The July report shall indicate the number of new patients admitted during the 6-month period composed of the first and second quarters of the current year, the census on the first day of each month included in the report, and the number of patient days of care provided during the reporting period. The January report shall indicate the number of new patients admitted during the 6-month period composed of the third and fourth quarters of the prior year, the census on the first day of each month included in the report, and the number of patient days of care provided during the reporting period. The following detail shall also be provided.

(a) For the number of new patients admitted:

1. The 6-month total of admissions under age 65 and age 65 and over by type of diagnosis (e.g., cancer; AIDS).

2. The number of admissions during each of the 6 months covered by the report, by service area of residence.

(b) For the patient census on April 1 or October 1, as applicable, the number of patients receiving hospice care in:

1. A private home.

2. An adult congregate living facility.

3. A hospice residential unit.

4. A nursing home.

5. A hospital.

(10) Grandfathering Provisions. A hospice program licensed as of the effective date of this rule is authorized to continue to serve all counties in the service area where its principal place of business is located. A hospice program whose certificate of need or current license permits hospice services in a county or counties in an adjacent service area may continue to serve those adjacent counties. Any expansion to provide service to other counties in an adjacent service area is subject to regulation under this rule.

Specific Authority 408.15(8), 408.034(3), (5) FS. Law Implemented 408.034(3), 408.035, 408.036(1)(d)~~(c),(e), (f)~~, 408.043(2), 400.606(4), (5) FS. History–New 4-17-95, Amended 7-30-95, _____.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Architecture and Interior Design

RULE NOS.:	RULE TITLES:
61G1-22.002	Schedule for Award of Interior Design Professional Experience
61G1-22.003	Education Requirements for Interior Designers

PURPOSE AND EFFECT: The Board proposes to review the existing language in these rules to determine whether changes are necessary.

SUBJECT AREA TO BE ADDRESSED: Schedule for Award of Interior Design Professional Experience; Education Requirements for Interior Designers.

SPECIFIC AUTHORITY: 481.203(8), 481.209(2), 481.2055 FS.

LAW IMPLEMENTED: 481.203(8), 481.209(2), 481.2055 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Juanita Chastain, Executive Director, Board of Architecture and Interior Design, 1940 North Monroe Street, Tallahassee, Florida 32399-0750

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF ENVIRONMENTAL PROTECTION

Notices for the Department of Environmental Protection between December 28, 2001 and June 30, 2006, go to http://www.dep.state.fl.us/ under the link or button titled "Official Notices."

DEPARTMENT OF HEALTH

Board of Hearing Aid Specialists

RULE NO.:	RULE TITLE:
64B6-5.001	Continuing Education as a Condition for Renewal

PURPOSE AND EFFECT: The proposed changes will require in person attendance at all continuing education courses and will require HIV/AIDS for the first renewal only.

SUBJECT AREA TO BE ADDRESSED: Continuing Education as a Condition for Renewal.

SPECIFIC AUTHORITY: 456.013(6), (8), 484.044, 484.047(1), (4) FS.

LAW IMPLEMENTED: 456.013(6), (8), 484.044, 484.047(1), (4) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Sue Foster, Executive Director, Board of Hearing Aid Specialists, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399-3253

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF HEALTH

Board of Hearing Aid Specialists

RULE NO.: RULE TITLE:

64B6-5.002 Continuing Education Programs

PURPOSE AND EFFECT: The proposed changes will require in person attendance at all continuing education courses.

SUBJECT AREA TO BE ADDRESSED: Continuing Education Programs.

SPECIFIC AUTHORITY: 456.013(7)-(9), 484.044, 484.047(4) FS.

LAW IMPLEMENTED: 456.013(7)-(9), 484.047(4) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Sue Foster, Executive Director, Board of Hearing Aid Specialists, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399-3253

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF HEALTH

Board of Hearing Aid Specialists

RULE NO.: RULE TITLE:

64B6-6.004 Certified Testing Room

PURPOSE AND EFFECT: The proposed changes would adopt and incorporate the waiver form in rule, indicate a website where the form may be obtained, and required, if applicable, the executed waiver to be attached to the clients copy of the contract and a copy to be retained by the licensee.

SUBJECT AREA TO BE ADDRESSED: Certified Testing Room.

SPECIFIC AUTHORITY: 484.044, 484.0501(6) FS.

LAW IMPLEMENTED: 484.047, 484.0501 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Sue Foster, Executive Director, Board of Hearing Aid Specialists, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399-3253

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF HEALTH

Board of Hearing Aid Specialists

RULE NO.: RULE TITLE:

64B6-8.002 Qualifications for Trainees, Sponsors and Designated Hearing Aid Specialists

PURPOSE AND EFFECT: The proposed changes will adopt and incorporate by reference the form in rule and indicate a website where the form may be obtained.

SUBJECT AREA TO BE ADDRESSED: Qualifications for Trainees, Sponsors and Designated Hearing Aid Specialists.

SPECIFIC AUTHORITY: 484.044, 484.0445 FS.

LAW IMPLEMENTED: 484.0445 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Sue Foster, Executive Director, Board of Hearing Aid Specialists, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399-3253

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF HEALTH

Board of Hearing Aid Specialists

RULE NO.: RULE TITLE:

64B6-8.003 Trainee Stages, Minimum Training Requirements, and Training Program

PURPOSE AND EFFECT: The proposed changes will require a hearing aid specialists trainee to complete Stage I, the International Hearing Society Home Study Course, before beginning Stage II of the training program.

The rule adopts and incorporates by reference the Sponsor Report Form and Training Program Continuation Request

Form and provides a website to obtain the forms.

SUBJECT AREA TO BE ADDRESSED: Trainee Stages, Minimum Training Requirements, and Training programs.

SPECIFIC AUTHORITY: 484.044, 484.0445(1) FS.

LAW IMPLEMENTED: 484.0445, 484.045 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Sue Foster, Executive Director, Board of Hearing Aid Specialists, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399-3253

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF HEALTH

Board of Medicine

RULE NO.: RULE TITLE:

64B8-1.007 List of Approved Forms; Incorporation

PURPOSE AND EFFECT: The Board proposes the development of rule amendments to address revised forms in the rule.

SUBJECT AREA TO BE ADDRESSED: Incorporation of revised forms.

SPECIFIC AUTHORITY: 120.55(1)(a), (4), 456.013, 456.036(5), 456.048(1), 458.309, 458.311, 458.3124(6), 458.313(4), 458.3145, 458.315(2), 458.320(8), 458.321(2), 458.347(13), 458.3475, 458.351(6) FS.

LAW IMPLEMENTED: 456.013, 456.035, 4456.036, 456.048, 456.073, 458.309, 458.311, 458.3124, 458.313, 458.3145, 458.315, 458.316, 458.317, 458.319, 458.320, 458.321, 458.345, 458.347, 458.3475, 458.348, 458.351, 465.0276 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Larry McPherson, Jr., Executive Director, Board of Medicine/MQA, 4052 Bald Cypress Way, Bin #C03, Tallahassee, Florida 32399-3253

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF HEALTH

Board of Medicine

RULE NO.: RULE TITLE:

64B8-4.009 Applications

PURPOSE AND EFFECT: The Board proposes the development of rule amendments to incorporate revised licensure applications in the application rule.

SUBJECT AREA TO BE ADDRESSED: Various application forms for licensure.

SPECIFIC AUTHORITY: 120.53, 456.031, 456.033, 458.309, 458.311, 458.3137 FS.

LAW IMPLEMENTED: 120.53, 456.013(7), 456.031, 456.033, 458.311, 458.3124, 458.313, 458.3145, 458.315, 458.316, 458.3165, 458.317 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Larry McPherson, Jr., Executive Director, Board of Medicine/MQA, 4052 Bald Cypress Way, Bin #C03, Tallahassee, Florida 32399-3253

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF HEALTH

Division of Family Health Services

RULE NO.: RULE TITLE:

64F-22.001 Definitions

PURPOSE AND EFFECT: Establish rules necessary for the implementation of Section 1004.435, Florida Statutes.

SUBJECT AREA TO BE ADDRESSED: Financial aid for cancer patients in selected hospitals and clinics.

SPECIFIC AUTHORITY: 1004.435(5)(c), (d) FS.

LAW IMPLEMENTED: 1004.435 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Sue

Middleton, M.H.A., Executive Director, H. Lee Moffitt Cancer Center & Research Institute, 129202 Magnolia Drive, Tampa, Florida 33612

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

FISH AND WILDLIFE CONSERVATION COMMISSION

Freshwater Fish and Wildlife

RULE NO.: RULE TITLE:
68A-12.011 Regulations Governing the Establishment and Operation of Game Farms

PURPOSE AND EFFECT: The purpose and effect of this rule development effort is to promulgate a new rule pertaining to the establishment and operation of game farms in Florida. The proposed rule will replace the substantive portions of existing statute, Section 379.302, Florida Statutes. That statute is expected to be repealed by the Legislature after this replacement rule is adopted. The proposed rule also clarifies the requirements for lawful operation of game farms in Florida.

SUBJECT AREA TO BE ADDRESSED: Establishment and operation of game farms in Florida.

SPECIFIC AUTHORITY: Art. IV, Sec. 9, Florida Constitution.

LAW IMPLEMENTED: Art. IV, Sec. 9, Florida Constitution, 379.3711 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Captain Linda E. Harrison, Division of Law Enforcement, Fish and Wildlife Conservation Commission, 620 South Meridian Street, Tallahassee, Florida 32399-1600, (850)488-6253

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF FINANCIAL SERVICES

Division of Workers' Compensation

RULE NO.: RULE TITLE:
69L-7.602 Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule

PURPOSE AND EFFECT: To amend the rule to adopt revised reference manuals for medical billing, filing, and reporting, including the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2008; the 2008 ICD-9-CM Professional for Hospitals, Volumes 1, 2 and 3, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2007, Ingenix, Inc. (American Medical Association); the Physician ICD-9-CM 2008, Volumes 1 & 2, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2007, Ingenix, Inc. (American Medical Association); the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2009, version 3.00, July 2008; and the Current Procedural Terminology (CPT®), 2008 Professional Edition, Copyright 2007, American Medical Association. The proposed amendment also transfers ambulatory surgical centers billing from Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form) to Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill), effective 04/01/2009, incorporates by reference a revised hospital billing instruction form, Form DFS-F5-DWC-90-B (Completion Instructions for Form DFS-F5-DWC-90 for use by hospitals) and a new ambulatory surgical center billing instruction form, Form DFS-F5-DWC-90-C (Completion Instructions for Form DFS-F5-DWC-90, for use by ambulatory surgical centers), both of which supply guidance regarding the completion of Form DFS-F5-DWC-90. The proposed amendment also adds statutory definitions for "Home Health Agency" and "Nursing Homes", and provides new billing forms and completion instructions for each respective application. Form DFS-F5-DWC-90-D (for Home Health Agencies) and Form DFS-F5-DWC-90-E (for Nursing Homes), including their respective completion instructions, Form DFS-F5-DWC-90-D (Completion Instructions for Home Health Agencies), and Form DFS-F5-DWC-90-E (Completion Instructions for Nursing Homes), have been incorporated by reference. The proposed amendment further clarifies the meaning of "Recognized Provider" and changes "Principal Physician" to "Primary Physician" when referring to the treating physician responsible for oversight of medical care, treatment and referrals for injured employees. A definition for "Explanation of Bill Review Code" has also been added. The electronic record layout for form DFS-F5-DWC-90 in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2008, also adds new fields for the submission of a facility's Florida Agency for Health Care Administration ambulatory surgical center number and National Provider Identifier (NPI) number. New fields are also provided for the submission of data regarding procedures, service and supply codes, and code modifiers, as paid by the insurer. These changes, in conjunction with the introduction of refined edits, provide enhanced medical data submission and facilitate the Department's ability to monitor and promote compliance by insurers and submitters with the requirements associated with electronic submission, filing, and reporting of data to the Division of Workers' Compensation. The proposed amendment deletes subsection (7), "Insurer Administrative Penalties and Administrative Fines for Untimely Health Care Provider-Payment of Medical Bills". That subsection shall be consolidated into Rule Chapter 69L-24, F.A.C., "Workers'

Compensation Insurers' Standards and Practices", as part of a restructuring and realignment of rules that consolidates disparate rule elements into their most appropriate chapter. The proposed amendment also provides new language which clarifies billing instructions for dentists and oral surgeons who dispense medications, as well as for those entities that are neither physicians nor recognized health care providers. New language is also added which emphasizes that insurers, or entities acting on behalf of insurers, are responsible for correcting and resubmitting previously accepted data later deemed inadequate by the Division. Finally, the proposed amendment deletes obsolete references and language, renumbers the rule, and makes ministerial changes where necessary.

SUBJECT AREA TO BE ADDRESSED: Health care provider, insurer, and submitter responsibilities for medical billing, filing, and reporting.

SPECIFIC AUTHORITY: 440.13(4), 440.15(3)(b), (d), 440.185(5), 440.525(2), 440.591, 440.593(5) FS.

LAW IMPLEMENTED: 440.09, 440.13(2)(a), (3), (4), (6), (11), (12), (14), (16), 440.15(3)(b), (d), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS.

A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME, AND PLACE SHOWN BELOW:

DATE AND TIME: Wednesday, January 14, 2009, 10:00 a.m.

PLACE: 104J Hartman Bldg., 2012 Capital Circle S. E., Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Sam Willis, Office of Medical Services, Division of Workers' Compensation, Department of Financial Services, 200 East Gaines Street, Tallahassee, Florida 32399-4225, (850)413-1898.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this program, please advise the Department at least 5 calendar days before the program by contacting the person listed above.

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT

69L-7.602 Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule

(1) Definitions. As used in this rule:

(a) through (b) No change.

~~(c) "Agency" means the Agency for Health Care Administration as defined in Section 440.02(3), F.S.~~

(c)~~(d)~~ "Ambulatory Surgical Center" is defined in Section 395.002(3), F.S.

(d)~~(e)~~ "Billing" means the process by which a health care provider submits a medical claim form or medical bill to an insurer, service company/third party administrator or any entity acting on behalf of the insurer, to receive reimbursement for medical services, goods or supplies provided to an injured employee.

(e)~~(f)~~ "Catastrophic Event" means the occurrence of an event outside the control of an insurer, submitter, service company/third party administrator or any entity acting on behalf of the insurer, such as an electronic data transmission failure due to a natural disaster or an act of terrorism (including but not limited to cyber terrorism), in which recovery time will prevent an insurer, submitter, service company/third party administrator or any entity acting on behalf of the insurer from meeting the filing and reporting requirements of Chapter 440, F.S., and this rule. Programming errors, system malfunctions or electronic data interchange transmission failures that are not a direct result of a catastrophic event are not considered to be a catastrophic event as defined in this rule. See subsection (6)(d) for requirements to request approval of an alternative method and timeline for medical report filing with the Division due to a catastrophic event.

(f)~~(g)~~ "Charges" means the dollar amount billed.

(g)~~(h)~~ "Charge Master" means for hospitals a comprehensive listing of all the goods and services for which the facility maintains a separate charge, with the facility's charge for each of the goods and services, regardless of payer type and means for ASCs a listing of the gross charge for each CPT®~~®~~ procedure for which an ASC maintains a separate charge, with the ASC's charge for each CPT®~~®~~ procedure, regardless of payer type.

(h)~~(i)~~ "Claims-Handling Entity File Number" means the number assigned to the claim file by the insurer or service company/third party administrator for purposes of internal tracking.

(i)~~(j)~~ "Current Dental Terminology" (CDT) means the American Dental Association's reference document containing descriptive terms to identify codes for billing and reporting dental procedures.

(j)~~(k)~~ "Current Procedural Terminology" (CPT®~~®~~) means the American Medical Association's reference document (HCPCS Level I) containing descriptive terms to identify codes for billing and reporting medical procedures and services.

(k)~~(l)~~ "Date Insurer Paid" or "Date Insurer Paid, Adjusted, Disallowed or Denied" means the date the insurer, service company/third party administrator or any entity acting on behalf of the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. If payment is disallowed or denied, "Date Insurer Paid" or "Date Insurer Paid, Adjusted, Disallowed or Denied" means the date the insurer, service company/third party administrator or any entity acting on behalf of the insurer mails, transfers or electronically transmits the appropriate

notice of disallowance or denial to the health care provider or the health care provider representative. See paragraph (5)(1) for the requirement to accurately report the "date insurer paid".

(l)~~(m)~~ "Date Insurer Received" means the date that a Form DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-90 or the electronic form equivalent is in the possession of the insurer, service company/third party administrator or any entity acting on behalf of the insurer. See paragraph (5)(l) for the requirement to accurately report the "date insurer received". If a medical bill meets any of the critiera in paragraph (5)(j) of this rule and possession of the form is relinquished by the insurer, service company/TPA or any entity acting on behalf of the insurer by returning the medical bill to the provider with a written explanation for the insurer's reason for return, then "date insurer received" shall not apply to the medical bill as submitted.

(m)~~(n)~~ "Deny" or "Denied" means payment is not made because the service rendered is treatment for a non-compensable injury or illness.

(n)~~(o)~~ "Department" means Department of Financial Services (DFS) as defined in Section 440.02(12), F.S.

(o)~~(p)~~ "Disallow" or "Disallowed" means payment is not made because the service rendered has not been substantiated for reasons of medical necessity, insufficient documentation, lack of authorization or billing error.

(p)~~(q)~~ "Division" means the Division of Workers' Compensation (DWC) as defined in Section 440.02(14), F.S.

(q)~~(r)~~ "Electronic Filing" means the computer exchange of medical data from a submitter to the Division in the standardized format defined in the Florida Medical EDI Implementation Guide (MEIG).

(r)~~(s)~~ "Electronic Form Equivalent" means the format, provided in the Florida Medical EDI Implementation Guide (MEIG) to be used when a submitter electronically transmits required data to the Division. Electronic form equivalents do not include transmission by facsimile, data file(s) attached to electronic mail, or computer-generated paper-forms.

(s)~~(t)~~ "Electronically Filed with the Division" means the date an electronic filing has been received by the Division and has successfully passed structural and data-quality edits.

(t)~~(u)~~ "Entity" means any party involved in the provision of or the payment for medical services, care or treatment rendered to the injured employee, excluding the insurer, service company/third party administrator or health care provider as identified in this section.

(u)~~(v)~~ "Explanation of Bill Review" (EOBR) means the written notice of payment or notice of adjustment, disallowance or denial sent by an insurer, service company/third party administrator or any entity acting on behalf of an insurer to a health care provider containing code(s) and code descriptor(s), in conformance with subsection ~~paragraph~~ (5)~~(o)~~ of this rule.

(v) "Explanation of Bill Review Code" (EOBR Code) means a code listed in paragraph (5)(o)2. of this rule that describes the basis for the reimbursement decision of an insurer, service company/TPA or any entity acting on behalf of the insurer.

(w) through (y) No change.

(z) "Home Health Agency" is defined in Section 400.462(12), F.S. ~~"Hospital" is defined in Section 395.002(13), F.S.~~

(aa) "Home Medical Equipment Provider" is defined in Section 400.925(7), F.S. ~~"ICD-9-CM International Classification of Diseases" (ICD-9) is the U.S. Department of Health and Human Services' reference document listing the official diagnosis and inpatient procedure code sets.~~

(bb) "Hospital" is defined in Section 395.002(12), F.S. ~~"Insurer" is defined in Section 440.02(38), F.S.~~

(cc) "ICD-9-CM International Classification of Diseases" (ICD-9) is the U.S. Department of Health and Human Services' reference document listing the official diagnosis and inpatient procedure code sets. ~~"Insurer Code Number" means the number the Division assigns to each individual insurer, self-insured employer or self-insured fund.~~

(dd) "Insurer" is defined in Section 440.02(38), F.S. ~~"Itemized Statement" means a detailed listing of goods, services and supplies provided to an injured employee, including the quantity and charges for each good, service or supply.~~

(ee) "Insurer Code Number" means the number the Division assigns to each individual insurer, self-insured employer of self-insured fund. ~~"Medical Bill" means the document or electronic equivalent submitted by a health care provider to an insurer, service company/TPA or any entity acting on behalf of the insurer for reimbursement for services or supplies (e.g. DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, DFS-F5-DWC-90 or the provider's usual invoice or business letterhead) as appropriate pursuant to paragraph (4)(b) of this rule.~~

(ff) "Itemized Statement" means a detailed listing of goods, services and supplies provided to an injured employee, including the quantity and charges for each good, service or supply ~~"Medically Necessary" or "Medical Necessity" is defined in Section 440.13(1)(l), F.S.~~

(gg) "Medical Bill" means the document or electronic equivalent submitted by a health care provider to an insurer, service company/TPA or any entity acting on behalf of the insurer for reimbursement for services or supplies (e.g. DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, DFS-F5-DWC-90 or the provider's usual invoice or business letterhead) as appropriate pursuant to paragraph (4)(b) of this rule. ~~"NDC Number" means the National Drug Code (NDC) number, assigned under Section 510 of the Federal Food, Drug, and Cosmetic Act, which identifies the drug product labeler/vendor, product, and trade package size. The NDC~~

~~number is an eleven-digit number that is expressed in the universal 5-4-2 format and included on all applicable reports with each of the three segments separated by a dash (-).~~

(hh) "Medically Necessary" or "Medical Necessity" is defined in Section 440.13(1)(l), F.S. ~~"Pay" or "Paid" means payment is made applying the applicable reimbursement formula to the medical bill as submitted.~~

(ii) "NDC Number" means the National Drug Code (NDC) number, assigned under Section 510 of the Federal Food, Drug, and Cosmetic Act, which identifies the drug product labeler/vendor, product, and trade package size. The NDC number is an eleven-digit number that is expressed in the universal 5-4-2 format and included on all applicable reports with each of the three segments separated by a dash (-). ~~"Physician" is defined in Section 440.13(1)(q), F.S.~~

(jj) "Nursing Home Facility" is defined in Section 400.021(12), F.S. ~~"Principal Physician" means the treating physician responsible for the oversight of medical care, treatment and attendance rendered to an injured employee, to include recommendation for appropriate consultations or referrals.~~

(kk) "Pay" or "Paid" means payment is made applying the applicable reimbursement formula to the medical bill as submitted. ~~"Report" means any form related to medical services rendered, in relation to a workers' compensation injury, that is required to be filed with the Division under this rule.~~

(ll) "Physician" is defined in Section 440.13(1)(q), F.S. ~~"Service Company/Third Party Administrator (TPA)" means a party that has contracted with an insurer for the purpose of providing services necessary to adjust workers' compensation claims on the insurer's behalf.~~

(mm) "Primary Physician" means the treating physician responsible for the oversight of medical care, treatment and attendance rendered to an injured employee, to include recommendation for appropriate consultations or referrals. ~~"Service Company/Third Party Administrator (TPA) Code Number" means the number the Division assigns to a service company, adjusting company, managing general agent or third party administrator.~~

(nn) "Recognized Practioner" means a non-physician health care provider licensed by the Department of Health who, upon referral from a physician, can render direct billable services independent of the direct supervision of a physician. ~~"Submitter" means an insurer, service company/TPA, entity or any other party acting as an agent on behalf of an insurer, service company/TPA or any entity to fulfill any insurer responsibility to electronically transmit required medical data to the Division.~~

(oo) "Report" means any form related to medical services rendered, in relation to a workers' compensation injury, that is required to be filed with the Division under this rule. ~~"UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee, November 2006" (UB-92 Manual) is the reference document providing billing and reporting completion instructions for the Form DFS-F5-DWC-90 (UB-92 HCFA-1450, Uniform Bill, Rev. 1992).~~

(pp) "Service Company/Third Party Administrator (TPA)" means a party that has contracted with an insurer for the purpose of providing services necessary to adjust workers' compensation claims on the insurer's behalf. ~~"UB-04 Manual" means the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2007, which is the reference document providing billing and reporting completion instructions for the Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2007).~~

(qq) "Service Company/Third Party Administrator (TPA) Code Number" means the number the Division assigns to a service company, adjusting company, managing general agent or third party administrator.

(rr) "Submitter" means an insurer, service company/TPA, entity or any other party acting as an agent on behalf of an insurer, service company/TPA or any entity to fulfill any insurer responsibility to electronically transmit required medical data to the Division.

(ss) "UB-04 Manual" means the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2009, which is the reference document providing billing and reporting completion instructions for the Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2006).

(2) Forms Incorporated by Reference for Medical Billing, Filing and Reporting.

~~(a)1. Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form, Rev. 12/90); Form DFS-F5-DWC-9-A (Completion Instructions for Form DFS-F5-DWC-9: comprised of three sets of completion instructions for use by health care providers, ambulatory surgical centers, and work hardening and pain management programs), Rev. 5/26/05. Effective to bill for dates of service up to and including 03/31/07.~~

(a)~~2.~~ Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form, Rev. 08/05); Form DFS-F5-DWC-9-B (Completion Instructions for Form DFS-F5-DWC-9: comprised of three sets of completion instructions for use by health care providers, ambulatory surgical centers, and work hardening and pain management programs), Rev. 1/1/07. ~~May be used to bill for dates of service up to and including 3/31/07 and shall be used to bill for dates of service on and after 4/1/07.~~

(b)1. Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form), Rev. 2/14/06. Effective to bill for dates of service up to and including 3/31/07.

~~2. Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form), Rev. 1/1/07. May be used to bill for dates of service up to and including 3/31/07 and shall be used to bill for dates of service on and after 4/1/07.~~

~~(c)1. Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2002); Form DFS-F5-DWC-11-A (Completion Instructions for Form DFS-F5-DWC-11), Rev. 5/26/05. Effective to bill for dates of service up to and including 3/31/07.~~

(c)~~2.~~ Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2006); Form DFS-F5-DWC-11-B (Completion Instructions for Form DFS-F5-DWC-11), Rev. 1/1/07. ~~May be used to bill for dates of service up to and including 3/31/07 and shall be used to bill for dates of service on and after 4/1/07.~~

(d) Form DFS-F5-DWC-25 (Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form), Rev. 1/31/08 ~~2/14/06~~.

~~(e)1. Form DFS-F5-DWC-90 (UB-92 HCFA 1450, Uniform Bill, Rev. 1992). Effective for submissions up to and including 5/22/07.~~

(e)~~2.~~ Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2006); Form DFS-F5-DWC-90-B (Completion Instructions for Form DFS-F5-DWC-90 for use by hospitals), Rev. 1/1/09; ~~1/1/07.~~ Form DFS-F5-DWC-90-C (Completion Instructions for Form DFS-F5-DWC-90 for use by Ambulatory Surgical Centers), Form DFS-F5-DWC-90-D (Completion Instructions for Form DFS-F5-DWC-90 for use by Home Health Agencies), Form DFS-F5-DWC-90-E (Completion Instructions for Form DFS-F5-DWC-90 for use by Nursing Homes), New 1/1/09. ~~May be used to bill for submissions between 3/1/07 and 5/22/07 and shall be used to bill for submissions on and after 5/23/07.~~

(f) Obtaining Copies of Forms and Instructions.

1. A copy of ~~either revision of~~ the Form DFS-F5-DWC-9 can be obtained from the CMS web site: http://www.cms.hhs.gov/forms/. Completion instructions for ~~either revision of~~ the form can be obtained from the Department of Financial Services/Division of Workers' Compensation (DFS/DWC) web site: http://www.myfloridacfo.com/WC/forms.html ~~http://www.fldfs.com/WC/forms.html#7~~.

2. A copy of ~~either revision of~~ the Form DFS-F5-DWC-10 and completion instructions for ~~either revision of~~ the form can be obtained from the DFS/DWC web site: http://www.myfloridacfo.com/WC/forms.html ~~http://www.fldfs.com/WC/forms.html#7~~.

3. A copy of ~~either revision of~~ the Form DFS-F5-DWC-11 can be obtained from the American Dental Association web site: http://www.ada.org/. Completion instructions for ~~either revision of~~ the form can be obtained from the DFS/DWC web site: http://www.myfloridacfo.com/WC/forms.html ~~http://www.fldfs.com/WC/forms.html#7~~.

4. A copy of the Form DFS-F5-DWC-25 and completion instructions can be obtained from the DFS/DWC web site: http://www.myfloridacfo.com/WC/forms.html ~~http://www.fldfs.com/WC/forms.html#7~~.

5. ~~A copy of either revision of the Form DFS-F5-DWC-90 can be obtained from the CMS web site: http://www.cms.hhs.gov/forms/. Completion instructions for Form DFS-F5-DWC-90 (Rev. 1992) can be obtained from the UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee (Rev. September 2006) and subparagraph (4)(b)4. of this rule.~~ A copy of the ~~Completion~~ instructions for completion of Form DFS-F5-DWC-90 (Rev. 2006), Form DFS-F5-DWC-90-B (for hospitals) (Rev. 1/1/09 ~~1/1/07~~), Form DFS-F5-DWC-90-C (for ASCs) (New 1/1/09), Form DFS-F5-DWC-90-D (for Home Health Agencies), Form DFS-F5-DWC-90-E (for Nursing Homes), can be obtained from the DFS/DWC web site: http://www.myfloridacfo.com/WC/forms.html ~~http://www.fldfs.com/WC/forms.html#7~~.

(g) In lieu of submitting a Form DFS-F5-DWC-10, when billing for drugs or medical supplies, alternate billing forms are acceptable if:

1. No change.

2. The form provides all information required to be submitted to the Division, pursuant to the ~~date-applicable~~ Florida Medical EDI Implementation Guide (MEIG), on the Form DFS-F5-DWC-10. Form DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be submitted as an alternate form.

(3) Materials Adopted by Reference. The following publications are incorporated by reference herein:

~~(a) UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee (Rev. September 2006). A copy of this manual can be obtained from the Florida Hospital Association by calling (407) 841-6230.~~

~~(b) The Florida Medical EDI Implementation Guide (MEIG), 2006, applicable for data submission until 7/1/07. The Florida Medical EDI Implementation Guide (MEIG), 2006 can be obtained from the DFS/DWC web site: http://www.fldfs.com/WC/edi_med.html.~~

(a)~~(c)~~ The American Medical Association Healthcare Common Procedure Coding System, Medicare's National Level II Codes (HCPCS), as adopted in Rule 69L-7.020, F.A.C.

(b)~~(d)~~ The Current Procedural Terminology (CPT®~~®~~), as adopted in Rule 69L-7.020, F.A.C.

(c)~~(e)~~ The Current Dental Terminology (CDT~~-2005~~), as adopted in Rule 69L-7.020, F.A.C.

(d)~~(f)~~ The 2009~~7~~ ICD-9-CM Professional for Hospitals, Volumes 1, 2 and 3, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2008~~6~~, Ingenix, Inc. (American Medical Association).

(e)~~(g)~~ The Physician ICD-9-CM 2009~~7~~, Volumes 1 & 2, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2008~~6~~, Ingenix, Inc. (American Medical Association).

(f)~~(h)~~ The American Medical Association's Guide to the Evaluation of Permanent Impairment, as adopted in Rule 69L-7.604, F.A.C.

(g)~~(i)~~ The Minnesota Department of Labor and Industry Disability Schedule, as adopted in Rule 69L-7.604, F.A.C.

(h)~~(j)~~ The Florida Impairment Rating Guide, as adopted in Rule 69L-7.604, F.A.C.

(i)~~(k)~~ The 1996 Florida Uniform Permanent Impairment Rating Schedule, as adopted in Rule 69L-7.604, F.A.C.

(j)~~(l)~~ National Uniform Billing Committee Official UB-04 Data Specifications Manual 2009~~7~~, version 3~~1~~.00, July 2008 ~~September 2006~~, as adopted by the National Uniform Billing Committee. A copy of this manual can be obtained from the National Uniform Billing Committee web site: http://www.nubc.org/UB-04%20SUBSCRIPTION%20ORDER%20FORM.doc

(k)~~(m)~~ The Florida Medical EDI Implementation Guide (MEIG), 2009~~7~~~~, applicable for data submission on or after 4/2/07 and required for all data submission on or after 8/9/07~~. The Florida Medical EDI Implementation Guide (MEIG), 2009~~7~~ can be obtained from the DFS/DWC web site: http://www.myfloridacfo.com/WC/edi_med.html ~~http://www.fldfs.com/WC/edi_med.html~~.

(l)~~(n)~~ Current Procedural Terminology (CPT®~~®~~), 2009~~7~~ Professional Edition, Copyright 2008~~6~~, American Medical Association.

(4) No change.

(a) No change.

1. No change.

2. Each health care provider is responsible for submitting any additional form completion information and supporting documentation, when it is requested, in writing, by the insurer at the time of authorization ~~or at the time a reimbursement request is received~~.

3. Each health care provider shall resubmit a medical claim form or medical bill with insurer requested documentation when the EOBR provides an explanation for the disallowed service ~~disallowance~~ based on the lack of documentation submitted with the medical bill.

4. Insurers and health care providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of the injured employee's medical treatment/status. No ~~Any~~ other reporting forms may ~~not~~ be used in lieu of or supplemental to the Form DFS-F5-DWC-25. Provider failure to accurately complete and submit the DFS-F5-DWC-25, in accordance with the Form DFS-F5-DWC-25 Completion/Submission Instructions adopted in this rule, may result in the Department ~~Agency~~ imposing sanctions or penalties pursuant to subsection 440.13(8), F.S. or subsection 440.13(11), F.S.

a. through b. No change.

5. through 9. No change.

10. A health care provider shall bill multiple services, rendered on the same date of service, on a single bill.

(b) Special Billing Requirements.

1. When anesthesia services are billed on a Form DFS-F5-DWC-9, completion of the form must include the CPT®~~®~~ code and the "P" code (physical status modifier), which correspond with the procedure performed, in Field 24D. Anesthesia health care providers shall enter the date of service and the 5-digit qualifying circumstance code, which correspond with the procedure performed, in Field 24D on the next line, if applicable.

2. through 3. No change.

a. t.hrough c. No change

4. For hospital billing, the following special requirements apply:

a. No change.

I. through III. No change.

IV. Make written entry "implant(s)" followed by the reimbursement amount calculated pursuant to Rule 69L-7.501, F.A.C., in Form Locator 80 of Form revision 2006 – 'Remarks' on the DFS-F5-DWC-90. ~~When entering the CPT®, HCPCS or unique workers' compensation codes in Form Locator 44 on the Form DFS-F5-DWC-90, the hospital shall utilize CPT®, HCPCS or unique workers' compensation codes provided in the Florida Workers' Compensation Health Care Provider Reimbursement Manual adopted in Rule 69L-7.501, F.A.C.~~

b. No change.

I. Enter the CPT®~~®~~, HCPCS or ~~unique~~ workers' compensation unique code ~~(provided in the Florida Workers' Compensation Health Care Provider Reimbursement Manual as incorporated for reference in Rule 69L-7.501, F.A.C.)~~ in Form Locator 44 on the Form DFS-F5-DWC-90, where applicable ~~to bill outpatient radiology, clinical laboratory and physical, occupational or speech therapy charges~~; and

II. Make written entry "scheduled" or "non-scheduled" in ~~Form Locator 84 of Form revision 1992 and in~~ Form Locator 80 of Form revision 2006 – 'Remarks' on the DFS-F5-DWC-90, when billing outpatient surgery or outpatient surgical services; and

~~III. Make written entry "implant(s)" followed by the reimbursement calculation made pursuant to Rule 69L-7.501, F.A.C., in Form Locator 84 of Form revision 1992 and in Form Locator 80 of Form revision 2006 – 'Remarks' on the DFS-F5-DWC-90, directly after entry of "scheduled" or "non-scheduled", when present;~~

III.~~IV.~~ Attach an itemized statement with charges based on the facility's Charge Master if there is no line item detail shown on the Form DFS-F5-DWC-90; and

IV.~~V.~~ Submit all applicable documentation ~~or certification~~ required pursuant to Rule 69L-7.501, F.A.C.;

V.~~VI.~~ Bill professional services provided by a physician or recognized practitioner~~, physician assistant, advanced registered nurse practitioner, or registered nurse first assistant~~ on the Form DFS-F5-DWC-9, regardless of employment arrangement;

5. A certified, licensed physician assistant, anesthesia assistant and registered nurse first assistant who provides services as a surgical assistant, in lieu of a second physician, shall bill on a Form DFS-F5-DWC-9 entering the CPT®~~®~~ code(s) plus modifier(s), which represent the service(s) rendered, in Field 24D, and must enter his/her Florida Department of Health license number in Field 33b.

6. Ambulatory Surgical Centers (ASCs) shall bill as follows:

a. For dates of service up to and including 9/17/09, ASCs shall bill on ~~a~~ Form DFS-F5-DWC-9 using the American Medical Association's CPT® procedure codes, or using the ~~unique~~ workers' compensation unique procedure code 99070 with required modifiers and shall bill~~ing~~ charges based on the ASC's Charge Master except when billing for procedure code 99070.

b. For dates of service on or after 9/18/09, Ambulatory Surgical Centers shall bill on Form DFS-F5-DWC-90 and shall enter the CPT®, HCPCS or workers' compensation unique code in Form Locator 44 for each service rendered. ASCs shall use revenue code 0278 when billing for implant devices, associated disposable instrumentation, and applicable shipping and handling pursuant to Rule 69L-7.100, F.A.C., ASC medical bills shall be accompanied by all applicable documentation or certification required pursuant to Rule 69L-7.100, F.A.C.

7. Home Health Agencies (HHA) shall bill on Form DFS-F5-DWC-90. ~~Federal Facilities shall bill on their usual form.~~

a. For dates of service up to and including 9/17/09, HHAs shall bill on letterhead or invoice.

b. For dates of service on or after 9/18/09, HHAs shall bill on Form DFS-F5-DWC-90 and shall enter the CPT®, HCPCS, HIPPS or workers' compensation unique codes in Form Locator 44 for each service rendered.

8. Nursing homes shall bill on Form DFS-F5-DWC-90. ~~Out-of-State health care providers shall bill on the applicable medical bill form pursuant to paragraph (4)(c) of this rule.~~

a. For dates of service up to and including 9/17/09, Nursing Homes shall bill on letterhead or invoice.

b. For dates of service on or after 9/18/09, Nursing Homes shall bill on Form DFS-F5-DWC-90 and shall enter the CPT®, HCPCS, HIPPS or workers' compensation unique codes in Form Locator 44 for each service rendered.

9. Federal Facilities shall bill on their usual form. ~~Dental Services.~~

~~a. Dentists shall bill for services on a Form DFS-F5-DWC-11.~~

~~b. Oral surgeons shall bill for oral and maxillofacial surgical services on a Form DFS-F5-DWC-9. Non-surgical dental services shall be billed on a Form DFS-F5-DWC-11.~~

10. Out-of-State health care providers shall bill on the applicable medical bill form pursuant to paragraph (4)(c) of this rule. ~~Pharmaceutical(s), Durable Medical Equipment and Medical Supplies.~~

~~a. When dispensing commercially available medicinal drugs commonly known as legend or prescription drugs:~~

~~I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format, in Field 9, with each segment separated by a dash (-).~~

~~II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9 and shall enter the NDC number, in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). Optionally, the unique workers' compensation code 96370 may be entered in addition to the NDC number in Field 24D.~~

~~III. Hospitals shall bill on Form DFS F5 DWC 90 using the appropriate revenue codes.~~

~~b. When dispensing medicinal drugs which are compounded and the prescribed formulation is not commercially available:~~

~~I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the unique workers' compensation code 96371 in Field 9.~~

~~II. Physicians, physician assistants or ARNPs shall bill on Form DFS F5 DWC 9 and shall enter the unique workers' compensation code 96371 in form Field 24D.~~

~~III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.~~

~~c. When dispensing over-the-counter drug products:~~

~~I. Pharmacists shall bill on Form DFS F5 DWC 10 and shall enter the NDC number, in the universal 5 4 2 format in form Field 9, with each segment separated by a dash ( ).~~

~~II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the NDC number in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). The requirement to enter the NDC number in Field 24D supersedes the instruction to enter 99070 in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.~~

~~III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.~~

~~d. When administering or dispensing injectable drugs:~~

~~I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format, in form Field 9, with each segment separated by a dash (-).~~

~~II. Physicians, physician assistants or ARNPs shall bill on a Form DFS-F5-DWC-9 and enter the appropriate HCPCS "J" code in form Field 24D. When an appropriate HCPCS "J" code is not available for the injectable drug, enter the NDC number, in the universal 5-4-2 format in form Field 24D with each segment separated by a dash (-).~~

~~III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.~~

~~e. When dispensing durable medical equipment (DME):~~

~~I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on form revision 2/14/06 and in Field 21 on form revision 1/1/07.~~

~~II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply, including applicable manufacturer's shipping and handling.~~

~~III. Hospitals shall bill on Form DFS-F5-DWC-90 using the applicable revenue codes.~~

~~IV. Ambulatory Surgical Centers shall bill for these products on Form DFS-F5-DWC-9 using applicable HCPCS codes.~~

~~V. Medical Suppliers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in form Field 21 on form revision 2/14/06 and in Field 21 on form revision 1/1/07. The requirement to enter the HCPCS code when billing for medical equipment or supplies supersedes the instruction that "the medical supplier is not required to submit codes" in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.~~

~~f. When dispensing medical supplies which are not incidental to a service or procedure:~~

~~I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 16 on form revision 2/14/06 and in Field 21 on form revision 1/1/07.~~

~~II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply, including applicable manufacturer's shipping and handling. The requirement to enter the HCPCS code when billing for medical equipment or supplies supersedes the instruction "under the specific HCPCS code or 99070" in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.~~

~~III. Hospitals shall bill on Form DFS-F5-DWC-90 under the applicable revenue codes.~~

~~IV. Ambulatory Surgical Centers shall bill separately for these products on Form DFS-F5-DWC-9 and shall enter the applicable CPT® code or HCPCS in Field 24D.~~

~~V. Medical Suppliers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 16 on form revision 2/14/06 and in Field 19 on form revision 1/1/07. The requirement to enter the HCPCS code when billing for medical equipment or supplies supersedes the instruction that "the medical supplier is not required to submit codes" in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.~~

~~g. Pharmacists who provide Medication Therapy Management Services shall bill for these services on a Form DFS-F5-DWC-9 by entering the appropriate CPT® code(s) 0115T, 0116T or 0117T that represent the service(s) rendered in form Field 24D, shall enter their Florida Department of Health license number in Field 33b and shall submit a copy of the physician's written prescription with the medical bill.~~

~~h. Pharmacists and medical suppliers may only bill on an alternate to Form DFS-F5-DWC-10 when an insurer has pre-approved use of the alternate form. Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be approved for use as the alternate form.~~

11. Dental Services. ~~Physicians billing for a failed appointment for a scheduled independent medical examination (when the injured employee does not report to the physician office as scheduled) shall bill on their invoice or letterhead. The invoice shall not be a Form DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, or DFS-F5-DWC-90.~~

a. Dentists shall bill for services on Form DFS-F5-DWC-11.

b. Oral surgeons shall bill for oral and maxillofacial surgical services on a Form DFS-F5-DWC-9. Non-surgical dental services shall be billed on Form DFS-F5-DWC-11.

c. When dispensing medications, dentists and oral surgeons shall submit charges on the forms specified in paragraph 11.a. and 11.b. above.

12. Pharmaceutical(s), Durable Medical Equipment and Medical Supplies. ~~Health care providers receiving reimbursement under any payment plan (pre-payment, prospective pay, capitation, etc.) must accurately complete the Form DFS-F5-DWC-9 and submit the form to the insurer.~~

a. When dispensing commercially available medicinal drugs commonly known as legend or prescription drugs:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format, in Field 9, with each segment separated by a dash (-).

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9 and shall enter the NDC number, in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). Optionally, the workers' compensation unique code 96370 may be entered in addition to the NDC number in Field 24D.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

b. When dispensing medicinal drugs which are compounded and the prescribed formulation is not commercially available:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the workers' compensation unique code 96371 in Field 9.

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9 and shall enter the workers' compensation unique code 96371 in form Field 24D.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

c. When dispensing over-the-counter drug products:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format in form Field 9, with each segment separated by a dash (-).

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the NDC number in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-).

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

d. When administering or dispensing injectable drugs:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format, in form Field 9, with each segment separated by a dash (-).

II. Physicians, physician assistants or ARNPs shall bill on a Form DFS-F5-DWC-9 and enter the appropriate HCPCS "J" code in form Field 24D. When an appropriate HCPCS "J" code is not available for the injectable drug, enter the NDC number, in the universal 5-4-2 format in form Field 24D with each segment separated by a dash (-).

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

e. When dispensing durable medical equipment (DME):

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on form revision 1/1/07.

II. Physicians and recognized practitioners shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply, including applicable manufacturer's shipping and handling.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the applicable revenue codes.

IV. Medical Suppliers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in form Field 21 on form revision 1/1/07.

f. When dispensing medical supplies which are not incidental to a service or procedure:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on form revision 1/1/07.

II. Physicians and recognized practitioners shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply, including applicable manufacturer's shipping and handling.

III. Hospitals shall bill on Form DFS-F5-DWC-90 under the applicable revenue codes.

IV. Medical Suppliers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on form revision 1/1/07.

g. Pharmacists who provide Medication Therapy Management Services shall bill for these services on Form DFS-F5-DWC-9 by entering the appropriate CPT® code(s) 99605, 99606 or 99607 that represent the service(s) rendered in form Field 24D, shall enter their Florida Department of Health license number in Field 33b and shall submit a copy of the physician's written prescription with the medical bill.

h. Pharmacists and medical suppliers may only bill on an alternate to Form DFS-F5-DWC-10 when an insurer has pre-approved use of the alternate form. Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be approved for use as the alternate form.

13. Physicians billing for a failed appointment for a scheduled independent medical examination (when the injured employee does not report to the physician office as scheduled) shall bill on their invoice or letterhead. The invoice shall not be Form DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, or DFS-F5-DWC-90. ~~Health care providers and other insurer-authorized providers rendering services reimbursable under workers' compensation, whose billing requirements are not otherwise specified in this rule (e.g. home health agencies, independent, non-hospital based ambulance services, air-ambulance, emergency medical transportation, non-emergency transportation services, translation services, etc.) shall bill on their invoice or business letterhead. These providers shall not submit the Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90 as an invoice.~~

14. Health care providers receiving reimbursement under any payment plan (pre-payment, prospective pay, capitation, etc.) must accurately complete the Form DFS-F5-DWC-9 and submit the form to the insurer.

15. Entities that are not physicians or recognized practitioners authorized by an insurer to render services reimbursable under workers' compensation shall bill on their invoice or letterhead. These providers shall not bill using Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90 as an invoice.

(c) Bill Completion.

1. No change.

2. Billing elements required by the Division to be completed by a health care provider are identified in ~~specific~~ Form ~~DFS-F5-DWC-9-A or Form~~ DFS-F5-DWC-9-B (completion instructions)~~, as appropriate for the date of the revised form,~~ available at the following websites:

a. http://www.myfloridacfo.com/WC/pdf/DWC-9instrHCP 1-1-07.pdf ~~http://www.fldfs.com/wc/pdf/DWC-9instrHCP.pdf~~ when submitted by Licensed Health Care Providers;

b. http://www.myfloridacfo.com/WC/pdf/DWC-9instrASC 1-1-07.pdf ~~http://www.fldfs.com/wc/pdf/DWC-9instrASC.pdf~~ when submitted by Ambulatory Surgical Centers for dates of service up to and including 9/17/09;

c. http://www.myfloridacfo.com/WC/pdf/DWC-9instrWHPM 1-1-07.pdf ~~http://www.fldfs.com/wc/pdf/DWC-9instrWHPM.pdf~~ when submitted by Work Hardening and Pain Management Programs.

3. Billing elements required by the Division to be completed for Pharmaceutical or Medical Supplier Billing are identified in ~~specific~~ Form DFS-F5-DWC-10 (completion instructions)~~, as appropriate for the date of the revised form,~~ available at website: http://www.myfloridacfo.com/WC/forms.html ~~http://www.fldfs.com/WC/forms.html#7~~.

4. Billing elements required by the Division to be completed for Dental Billing are identified in ~~specific~~ Form DFS-F5-DWC-11~~-A or Form DFS-F5-DWC-9-~~B (completion instructions)~~, as appropriate for the date of the revised form,~~ available at website: http://www.myfloridacfo.com/WC/forms.html ~~http://www.fldfs.com/WC/forms.html#7~~.

5. Billing elements required by the Division to be completed for Form DFS-F5-DWC-90 ~~Hospital Billing~~ are identified in ~~the UB-92 Manual,~~ the UB-04 Manual, and as follows; ~~Form DFS-F5-DWC-90-B (completion instructions) and subparagraph (4)(b)4. of this rule.~~

a. For Hospital billing, Form DFS-F5-DWC-90-B (UB-04) – B Completion Instructions, Rev. 1/1/2009 and subparagraph (4)(b)4. of this rule.

b. For Ambulatory Surgical Center billing, Form DFS-F5-DWC-90-C (UB-04) – C Completion Instructions, New 1/1/2009 and subparagraph (4)(b)6. of this rule.

c. For Home Health Agency billing, Form DFS-F5-DWC-90-D (UB-04) – D Completion Instructions, New 1/1/2009 and subparagraph (4)(b)7. of this rule.

d. For Nursing Home billing, Form DFS-F5-DWC-90-E (UB-04) – E Completion Instructions, New 1/1/2009 and subparagraph (4)(b)8. of this rule.

6. A ~~An insurer can require a~~ health care provider shall submit ~~to complete~~ additional data elements or supporting documentation that are ~~not~~ required by the insurer in writing pursuant to paragraph (5)(b) of this rule. ~~Division on Form DFS-F5-DWC-9 or DFS-F5-DWC-11.~~

(5) Insurer Responsibilities.

(a) An insurer is responsible for meeting its obligations under this rule regardless of any business arrangements with any service company/TPA, submitter or any entity acting on behalf of an insurer under which claims are paid, adjusted and paid, disallowed, denied, or otherwise processed or submitted to the Division.

(b) At the time of authorization for medical service(s) ~~or at the time a reimbursement request is received,~~ an insurer shall notify each health care provider, in writing, of additional form completion requirements or supporting documentation that are necessary for reimbursement determinations.

(c) At the time of authorization for medical service(s), an insurer shall inform in-state and out-of-state health care providers of the specific reporting, billing and submission requirements of this rule and provide the specific address for submitting a reimbursement request.

(d) Insurers, service company/TPAs or entities acting on behalf of insurers and health care providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of an injured employee's medical treatment/status. No ~~Any~~ other reporting forms may ~~not~~ be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

(e) Required data elements on each Form DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, and DFS-F5-DWC-90, for both medical only and lost-time cases, shall be filed with the Division within 45-calendar days of when the medical bill is paid, adjusted, disallowed or denied by the insurer, service company/TPA or any entity acting on behalf of the insurer. The 45-calendar day filing requirement includes initial submission and correction and re-submission of all errors identified in the "Medical Claim Processing Report", as defined in the date-applicable Florida Medical EDI Implementation Guide (MEIG).

(f) An insurer shall be responsible for accurately completing required data filed with the Division, pursuant to the ~~date-applicable~~ Florida Medical EDI Implementation Guide (MEIG) and subparagraphs (4)(c)2.-5. of this rule. Additionally, an insurer or entity acting on behalf of an insurer shall be responsible for correcting previously accepted data that is deemed inaccurate by the Division through audit or analysis, and resubmitting the corrected and accurate data in accordance with the requirements set forth in paragraph (6)(e) of this rule.

(g) When an injured employee does not have a Social Security Number or division-assigned number, the insurer must contact the Division via information provided on the following website: http://www.myfloridacfo.com/WC/organization/odqc.html ~~http://www.fldfs.com/WC/organization/odqc.html~~ (under Records Management) to obtain a division-assigned number prior to submitting the medical report to the Division.

(h) An insurer, service company/TPA or any entity acting on behalf of an insurer must report to the Division the procedure code(s), number of line-items billed, diagnosis

code(s), modifier code(s), NDC number and amount(s) charged, as billed by the health care provider when reporting these data to the Division. However, the insurer, service company/TPA or any entity acting on behalf of an insurer may correct the procedure code(s) or modifier code(s) or NDC number to effect payment and shall report both the provider billed code(s) and insurer adjusted code(s) pursuant to the ~~date-appropriate~~ MEIG. The insurer, service company/TPA or any entity acting on behalf of an insurer shall utilize the EOBR code "80" to notify the health care provider concerning any such billing errors and shall transmit EOBR code "80", in instances when the carrier corrects the provider coding, when reporting to the Division.

(i) An insurer, service company/TPA or any entity acting on behalf of the insurer shall manually or electronically date stamp accurately completed Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-90 or the electronic form equivalent on the "date insurer received" as defined in paragraph (1)(l)~~(m)~~ of this rule.

(j)1. No change.

a. No change.

b. Return the medical bill to the provider within twenty-one (21) days of the "Date Insurer Received" with a written statement identifying the criteria under which the medical bill is being returned ~~within twenty-one (21) days of the "Date Insurer Received"~~. The written statement sent to the provider with the returned medical bill shall bear the following statement CAPITALIZED and in **BOLD** print: **"A HEALTH CARE PROVIDER MAY NOT BILL THE INJURED EMPLOYEE FOR SERVICES RENDERED FOR A COMPENSABLE WORK-RELATED INJURY".**

2. If the insurer returns a medical bill to the provider pursuant to subparagraph (5)(j)5. of this rule, the written statement, which must accompany the returned bill must include all criteria upon which the return of the medical bill are based.

3. If the criterion upon which the return of the medical bill is based includes any of the criteria in sub-subparagraphs (5)(j)5.d.-g.~~-f.~~ of this rule, the written statement must identify the information that is illegible, incorrect, or omitted.

4. No change.

5. No change.

a. through e. No change.

f. Billing information required by this rule is illegible on the medical bill; or

g.~~f.~~ Billing information required by this rule is omitted on the medical bill.

6. No change.

(k) through (l) No change.

1. No change.

a. through d. No change.

2. No change.

a. through f. No change.

3. through 4. No change.

4. No change.

a. If the "date insurer received" is the date the insurer gains possession of the health care provider's medical bill and the "date insurer paid" is the date the health care provider's payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code "x" 1 must be transmitted on each individual form-type electronic submission. ("x" must equal 'R', 'M' or 'C' as denoted in Appendix D of the ~~date-appropriate~~ Florida Medical Implementation EDI Guide (MEIG).) When submitting Payment Code "x" 1 to the Division, the insurer is declaring that no "entity" as defined in paragraph (1)(t)~~(u)~~ of this rule is involved in the medical bill claims-handling processes related to "date insurer received" or "date insurer paid".

b. If the "date insurer received" is the date the "entity" acting on behalf of the insurer gains possession of the health care provider's medical bill and the "date insurer paid" is the date the health care provider's payment is mailed, transferred or electronically transmitted by the "entity" acting on behalf of the insurer, then Payment Code "x" 2 must be transmitted on each individual form-type electronic submission. ("x" must equal 'R', 'M' or 'C' as denoted in Appendix D of the ~~date-appropriate~~ Florida Medical Implementation EDI Guide (MEIG).) When submitting Payment Code "x" 2 to the Division, the insurer is declaring that the specified "entity" as defined in paragraph (1)(t)~~(u)~~ of this rule is acting on behalf of the insurer for purposes of the medical bill claims-handling processes related to "date insurer received" and "date insurer paid".

c. If the "date insurer received" is the date the insurer gains possession of the health care provider's medical bill and "date insurer paid" is the date the health care provider's payment is mailed, transferred or electronically transmitted by the "entity" acting on behalf of the insurer, then Payment Code "x" 3 must be transmitted on each individual form-type electronic submission. ("x" must equal 'R', 'M' or 'C' as denoted in Appendix D of the ~~date-appropriate~~ Florida Medical Implementation EDI Guide (MEIG).) When submitting Payment Code "x" 3 to the Division, the insurer is declaring that no "entity" as defined in paragraph (1)(t)~~(u)~~ of this rule is involved in the medical bill claims-handling process related to "date insurer received".

d. If the "date insurer received" is the date the "entity" acting on behalf of the insurer gains possession of the health care provider's medical bill and the "date insurer paid" is the date the health care provider's payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code "x" 4 must be transmitted on each individual form-type electronic submission. ("x" must equal 'R', 'M' or 'C' as denoted in Appendix D of the ~~date-appropriate~~ Florida Medical

Implementation EDI Guide (MEIG).) When submitting Payment Code "x" 4 to the Division, the insurer is declaring that no "entity" as defined in paragraph (1)(t)~~(u)~~ is involved in the medical bill claims-handling processes related to "date insurer paid".

(m) No change.

(n) An insurer, service company/TPA or any entity acting on behalf of the insurer is not required to report electronically as medical payment data to the Division, those payments made for failed appointments for scheduled independent medical examinations, for federal facilities billing on their usual form, for duplicate medical bills, for medical bills outside Florida jurisdiction, or for health care providers in subparagraph (4)(b)15.~~13.~~ who bill on their invoice or letterhead.

(o) No change.

1. No change.

~~2. Use the EOBR codes and code descriptors as follows up through the date for reporting production data with the Medical Data System in the Claim Record Layout-Revision "D" as required in subparagraph (6)(f) of this rule:~~

~~a. 01 Services not authorized, as required.~~

~~b. 02 Services denied as not related to the compensable work injury.~~

~~c. 03 Services related to a denied work injury: Form DFS-F2-DWC-12 on file with the Division.~~

~~d. 04 Services billed are listed as not covered or non-covered ("NC") in the applicable reimbursement manual.~~

~~e. 05 Documentation does not support the level, intensity, frequency, duration or provision of service(s) billed. (Insurer must specify to the health care provider.)~~

~~f. 06 Location of service(s) is not consistent with the level of service(s) billed.~~

~~g. 07 Reimbursement equals the amount billed.~~

~~h. 08 Reimbursement is based on the applicable reimbursement fee schedule.~~

~~i. 09 Reimbursement is based on any contract.~~

~~j. 10 Reimbursement is based on charges exceeding the stop-loss point.~~

~~k. 11 Reimbursement is based on insurer re-coding. (Insurer must specify to the health care provider.)~~

~~l. 12 Charge(s) are included in the per diem reimbursement.~~

~~m. 13 Reimbursement is included in the allowance of another service. (Insurer must specify procedure to the health care provider.)~~

~~n. 14 Itemized statement not submitted with billing form.~~

~~o. 15 Invalid code. (Use only when other valid codes are present.)~~

~~p. 16 Documentation does not support that services rendered were medically necessary.~~

~~q. 17 Required supplemental documentation not filed with the bill. (Insurer must specify required documentation to the health care provider.)~~

~~r. 18 Duplicate Billing: Service previously paid, adjusted and paid, disallowed or denied on prior claim form or multiple billing of service(s) billed on same date of service.~~

~~s. 19 Required Form DFS-F5-DWC-25 not submitted within three business days of the first treatment pursuant to Section 440.13(4)(a), F.S.~~

~~t. 20 Other: Unique EOBR code descriptor. Use of EOBR code "20" is restricted to circumstances when an above-listed EOBR code does not explain the reason for payment, adjustment and payment, disallowance or denial of payment. When using EOBR code "20", an insurer must reflect code "20" and include the specific explanation of the code on the EOBR sent to the health care provider. The insurer, service company/TPA or any entity acting on behalf of the insurer must maintain a standardized EOBR code descriptor list.~~

2.~~3.~~ When reporting production data with the Medical Data System in the Claim Record Layout-Revision "E" ~~"D"~~ as required in subparagraph (6)(f) of this rule, the insurer shall comply with the following instructions pertaining to EOBRs: In completing an Explanation of Bill Review (EOBR) an insurer shall, for each line item billed, select the EOBR code(s) from the list below which identifies(y) the reason(s) for the insurer's reimbursement decision for each line item. The insurer may utilize up to three EOBR codes for each line item billed. When utilizing more than one EOBR, the insurer shall list the EOBR codes that describe the basis for its reimbursement decision in descending order of importance. An insurer, service company/TPA or any entity acting on behalf of the insurer shall submit to the Division the Explanation of Bill Review (EOBR) code, relating to the adjudication of each line item billed, in descending order of importance. The EOBR code list is as follows:

06 – Payment disallowed: location of service(s) is not consistent with the level of service(s) billed.

10 – No change.

21 – No change.

22 – No change.

23 – No change.

24 – No change.

25 – No change.

26 – No change.

30 – Payment disallowed: lack of authorization: no authorization given for service rendered or notice provided for emergency treatment pursuant to Section 440.13(3), F.S.

40 – No change.

41 – Payment disallowed: insufficient documentation: level of evaluation and management service not supported by documentation. (Insurer must specify missing components of evaluation and management code description.)

42 – No change.

43 – No change.

44 – No change.

45 – No change.

46 – No change.

47 – No change.

48 – No change

49 – No change.

50 – Payment disallowed: insufficient documentation: specific ~~requested~~ documentation requested in writing at the time of authorization not submitted with the medical bill. (Insurers must specify omitted documentation.)

51 – No change.

52 – Payment disallowed: insufficient documentation: supply(ies) incidental to the procedure. (Insurer must specify which supply is incidental to which procedure.)

53 – No change.

54 – No change.

60 – Payment disallowed: billing error: line item service previously billed and reimbursement decision previously rendered ~~processed on prior medical bill~~.

61 – Payment disallowed: billing error: duplicate bill. (Shall not be transmitted electronically to the Division.) ~~same service billed multiple times on same date of service.~~

62 – Payment disallowed: billing error: incorrect procedure, modifier, NDC number, or supply code.

63 – Payment disallowed: billing error: service billed is integral component of another procedure code. (Insurer must specify inclusive procedure code.)

64 – No change.

65 – No change.

66 – Payment disallowed: billing error: omitted procedure, modifier or supply code or NDC number.

71 – No change.

72 – No change.

73 – No change.

74 – No change.

75 – Payment adjusted: insufficient documentation: specific ~~requested~~ documentation requested in writing at the time of authorization not submitted with the medical bill.

80 – Payment adjusted: billing error: correction of procedure, modifier, NDC number or supply code.

81 – No change.

~~82 – Payment adjusted: payment modified pursuant to carrier charge analysis.~~

83 – No change.

84 – No change.

90 – No change.

91 – No change.

92 – No change.

93 – No change.

94 – No change

95 – No change.

(p) An insurer, service company/TPA, submitter or any entity acting on behalf of the insurer shall make available to the Division ~~and to the Agency~~, upon request and without charge, a legibly reproduced copy of the electronic form equivalents or Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-25, DFS-F5-DWC-90, supplemental documentation, proof of payment, EOBR and the insurer written documentation required in subparagraphs (5)(j)6. and (5)(l)2. of this rule.

(q) An insurer, service company/TPA or any entity acting on behalf of the insurer to pay, adjust, disallow or deny a filed bill shall submit to the health care provider an Explanation of Bill Review, utilizing only the EOBR codes and code descriptors, as set forth in paragraph (o) of this section, and shall include the insurer name and specific insurer contact information. An insurer, service company/TPA or any entity acting on behalf of the insurer shall notify the health care provider of notice of payment or notice of adjustment, disallowance or denial only through an EOBR. An EOBR shall specifically state that the EOBR constitutes notice of disallowance or adjustment of payment within the meaning of Section 440.13(7), F.S. An EOBR shall specifically identify the name and mailing address of the entity the carrier designates to receive service on behalf of the "carrier and all affected parties" for the purpose of receiving the petitioner's service of a copy of a petition for reimbursement dispute resolution by certified mail, pursuant to Section 440.13(7)(a), F.S.

(r) through (t) No change.

1. No change.

2. Submit the data as a replacement submission pursuant to the ~~date-appropriate~~ MEIG; and

3. No change.

4. Report the "Date Insurer Received" as 22 days after the date the Determination was received by certified mail, in instances where the insurer has waived its rights under Chapter ~~Section~~ 120, F.S., or report the "Date Insurer Received" as the date the carrier received the Final Order by certified mail, in instances where the insurer has invoked its rights pursuant to Chapter ~~Section~~ 120, F.S., whichever occurs first.

(u) No change.

(v) When an insurer, service company/TPA, any entity acting on behalf of the insurer renders reimbursement for multiple bills received from a health care provider, the insurer shall report required data elements to the Division for each individual bill, including "Date Insurer Received" and "Date Insurer Paid", submitted by the health care provider and shall not combine multiple bills received from a health care provider into a single medical bill data submission ~~(i.e. a single bill equals a single datum transmission)~~.

(6) No change.

(a) No change.

(b) Required data elements shall be submitted in compliance with the instructions and formats as set forth in the ~~date-appropriate~~ Florida Medical EDI Implementation Guide (MEIG).

(c) through (d) No change.

(e) When filing any medical report replacement that corrects a rejected medical report ~~bill~~ or replaces a previously accepted medical report ~~bill~~, the submitter shall use the same control number as the original submission. The replacement report submission shall contain all information necessary to process the medical report ~~bill~~ including all services and charges from the claim as billed by the health care provider and all payments made by the insurer to the health care provider. Additionally, an insurer or entity acting on behalf of an insurer shall follow the EDI medical bill replacement methodology specified in the 2008 Florida Medical EDI Implementation Guide (MEIG) after being notified by the Division that data previously accepted has been deemed inaccurate and responding to a written request from the Division to review, correct, and re-submit accurate data. Each Division written request shall have a specified timeline to which the insurer or entity acting on behalf of an insurer shall adhere. ~~Information contained on the original submission is deemed independent and is not considered as a supplement to information contained in the replacement submission.~~

(f) Each ~~Additionally, an~~ insurer shall be responsible for accurately completing the electronic record-layout programming requirements for the reporting of the Form DFS-F5-DWC-9 Claim Detail Record Layout – Revision "E" ~~"D"~~, Form DFS-F5-DWC-10 Claim Detail Record Layout – Revision "E" ~~"D"~~, Form DFS-F5-DWC-11 Claim Detail Record Layout – Revision "E" ~~"D"~~ and Form DFS-F5-DWC-90 Claim Detail Record Layout – Revision "E" ~~"D"~~ in accordance with the Florida Medical EDI Implementation Guide (MEIG), 2009~~7~~, to the Division in accordance with the phase-in schedule as denoted below in subparagraphs 1., 2., and 3. of this section. The electronic record layout for Form DFS-F5-DWC-90 in the MEIG 2009 adds the new fields for facility name, facility address, Florida Agency for Health Care Administration facility license number, procedure, service or supply code as paid by the insurer, procedure, service or supply code modifier as paid by the insurer, and the line item amount paid by the insurer. ~~The electronic record layout for Form DFS-F5-DWC-9 in the MEIG, 2007, adds the new fields for gender, date of birth, up to three new modifiers and a maximum of three EOBR codes per line item from the revised code set. The electronic record layout for Form DFS-F5-DWC-10 in the MEIG, 2007, adds the new fields for gender, date of birth, pharmacist's Florida Department of Health license number, and, medical supply and equipment HCPCS code(s), quantity, purchase or rental date, usual charge, amount paid, prescriber's license number and a maximum of three EOBR codes per line item from the revised code set. The electronic record layout for Form DFS-F5-DWC-11 in the MEIG, 2007, adds the new fields for gender, date of birth and a maximum of three EOBR codes per line item from the revised code set. The electronic record layout for Form DFS-F5-DWC-90 in the MEIG, 2007, adds the new form locators for gender, date of birth, designation of surgery as scheduled or unscheduled, implant amount, up to three External Cause of Injury codes, four additional ICD-9 diagnostic codes, four other procedure codes, operating physician's Florida DOH license number and a maximum of three EOBR codes per line item from the revised code set. The conversion implementation schedule is as follows:~~

1. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision "D" ~~"C"~~), between 04/01/2007 ~~12/5/05~~ and 06/15/2007 ~~2/24/06~~ shall begin testing on 05/18/2009 ~~4/2/07~~ and shall complete the testing process with the new Revision "E" ~~"D"~~ record layouts no later than 06/26/2009 ~~5/14/07~~.

2. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision "D" ~~"C"~~), between 06/16/2007 ~~2/25/06~~ and 08/07/2007 ~~3/31/06~~ shall begin testing on 06/29/2009 ~~5/15/07~~ and shall complete the testing process with the new Revision "E" ~~"D"~~ record layouts no later than 08/07/2009 ~~6/26/07~~.

3. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision "D" ~~"C"~~), between 08/08/2007 ~~4/1/06~~ and the effective date of this rule shall begin testing on 08/10/2009 ~~6/27/07~~ and shall complete the testing process with the new Revision "E" ~~"D"~~ record layouts no later than 09/18/2009 ~~8/8/07~~.

4. The Division will, resources permitting, allow submitters that volunteer to complete the test transmission processes earlier than the schedule denoted above. Each voluntary submitter shall have six weeks to complete test transmission to production transmission processes, for all electronic form equivalents, that comply with requirements set forth in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2009~~7~~.

(g) All submitters shall be in production with the new Revision "E" ~~"D"~~ record layouts on 09/18/2009 ~~8/9/07~~. ~~Optionally, after successful completion of the testing process and continuing up to and including 8/8/07, submitters may elect to submit all required medical reports as required in the new Revision "D" record layouts, as required in the current Revision "C" record layouts, or, as required in the Revision "C" record layouts for billings on the current medical claim forms and as required in the Revision "D" record layouts for billings on the new medical claim forms.~~

(h) Submitters who do not accurately complete and maintain electronic record-layout programming requirements of this rule shall not submit medical reports electronically until the submitter has been approved for reporting production data with the Medical Data System as necessary to meet the filing requirements of paragraph (5)(e) of this rule.

~~(7) Insurer Administrative Penalties and Administrative Fines for Untimely Health Care Provider Payment or Disposition of Medical Bills.~~

~~(a) The Department shall impose insurer administrative penalties for failure to comply with the payment, adjustment, disallowance or denial requirements pursuant to Section 440.20(6)(b), F.S. Timely performance standards for timely payments, adjustments and payments, disallowances or denials, reported on Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 and DFS-F5-DWC-90, shall be calculated and applied on a monthly basis for each separate form category that was received within a specific calendar month.~~

~~(b) Pursuant to Section 440.185(9), F.S., the Department shall impose insurer administrative fines for failure to comply with the submission, filing or reporting requirements of this rule. Insurer administrative fines shall be applied as follows:~~

~~1. Calculated on a monthly basis for each separate form category (Forms DFS F5 DWC 9, DFS F5 DWC 10, DFS F5 DWC 11 and DFS F5 DWC 90) received and accepted by the Division within a specific calendar month; and~~

~~2. Insurers are required to report all medical reports timely pursuant to paragraph (5)(e) of this rule. Insurers that fail to submit a minimum of 95% of all medical reports timely are subject to an administrative fine. Each untimely filed medical report which falls below the 95% requirement is subject to the following penalty schedule:~~

~~a. 1 – 30 calendar days late $5.00;~~

~~b. 31 – 60 calendar days late $10.00;~~

~~c. 61 – 90 calendar days late $25.00;~~

~~d. 91 or greater calendar days late $100.00.~~

~~3. Each medical report that does not pass the electronic reporting edits shall be rejected by the Division and considered not filed pursuant to paragraph (5)(e) of this rule. If the medical report remains rejected and not corrected, resubmitted and accepted by the Division for greater than 90 days, an administrative fine shall be assessed in the amount of $100.00 for each such medical report. Rejected and not resubmitted medical reports will not be included in the 95% timely reporting requirement.~~

~~4. Untimely filed medical reports for a given month will be excluded from the administrative fine set forth in subparagraph (7)(b)3. above as falling within the performance standard between 100% and 95% in the following order:~~

~~a. Medical Reports filed 1 – 30 calendar days late; then~~

~~b. Medical Reports filed 31 – 60 calendar days late; then~~

~~c. Medical Reports filed 61 – 90 calendar days late; then~~

~~d. Medical Reports filed 91+ calendar days late.~~

Specific Authority 440.13(4), 440.15(3)(b), (d), 440.185(5), 440.525(2), 440.591, 440.593(5) FS. Law Implemented 440.09, 440.13(2)(a), (3), (4), (6), (11), (12), (14), (16), 440.15(3)(b), (d), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS. History–New 1-23-95, Formerly 38F-7.602, 4L-7.602, Amended 7-4-04, 10-20-05, 6-25-06, 3-8-07, _____.

FINANCIAL SERVICES COMMISSION

OIR – Insurance Regulation

RULE NOS.:	RULE TITLES:
69O-149.205	Indemnity Standard Risk Rate
69O-149.207	Health Maintenance Organization Standard Risk Rates

PURPOSE AND EFFECT: To comply with the statutory mandates of Section 627.6675(3), F.S., relating to the creation of standard risk rates.

SUBJECT AREA TO BE ADDRESSED: The creation of standard risk rates.

SPECIFIC AUTHORITY: 624.308, 627.6675(3)(c) FS.

LAW IMPLEMENTED: 624.307(1), 627.6498(4), 627.6675(3), 641.3922(3) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:

DATE AND TIME: January 5, 2009, 2:00 p.m.

PLACE: 116 Larson Building, 200 East Gaines Street, Tallahassee, Florida

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 5 days before the workshop/meeting by contacting: Dan Keating, Office of Insurance Regulation, E-mail dan.keating@floir.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Dan Keating, Office of Insurance Regulation, E-mail dan.keating@floir.com

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.