Section I
Notice of Development of Proposed Rules and Negotiated Rulemaking

NONE

Section II
Proposed Rules

DEPARTMENT OF FINANCIAL SERVICES
Division of Insurance Fraud

RULE NO.:	RULE TITLE:
69D-2.005	Compliance and Enforcement

PURPOSE AND EFFECT: The purpose of this amendment is to clarify and correct Rule 69D-2.005, F.A.C., which provides that the Office of Insurance Regulation shall conduct audits to determine insurance company compliance with anti-fraud laws and shall take appropriate administrative action against insurers for failure to comply.

SUMMARY: The amendment changes "shall" to "may" to comply with the law implemented. Thus, the Office of Insurance Regulation may conduct audits to determine insurance company compliance and may take appropriate administrative action against insurers for failure to comply. It also adds a sentence to clarify that the Department of Financial Services also has authority to take appropriate administrative action against insurers for failure to comply with the law.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS AND LEGISLATIVE RATIFICATION: The Agency has determined that this will not have an adverse impact on small business or likely increase directly or indirectly regulatory costs in excess of $200,000 in the aggregate within one year after the implementation of the rule. A SERC has been prepared by the Agency.

The Agency has determined that the proposed rule is not expected to require legislative ratification based on the statement of estimated regulatory costs.

Any person who wishes to provide information regarding a statement of estimated regulatory costs, or provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

RULEMAKING AUTHORITY: 624.308, 626.9891, 626.9891(8) FS.

LAW IMPLEMENTED: 624.307, 626.9891(7) FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

DATE AND TIME: June 4, 2015, 11:00 a.m.

PLACE: 200 E. Gaines Street, Room 139, Larson Building, Tallahassee, FL 32301

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: Nevada Martinez, (850)413-4238. 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 IS: Simon Blank, Director of the Division of Insurance Fraud, Florida Department of Financial Services, 200 E. Gaines Street, Tallahassee, FL 32399-0318 or simon.blank@MyFloridaCFO.com

THE FULL TEXT OF THE PROPOSED RULE IS:

69D-2.005 Compliance and Enforcement.

(1) The Division shall review the filings of SIU descriptions and insurer anti-fraud plans and the Office may ~~shall~~ conduct audits pursuant to Section 624.3161, F.S., to determine compliance with Section 626.9891, F.S., and this rule chapter.

(2) If an insurer fails to timely file an anti-fraud plan or SIU description, fails to implement or follow the provisions of its ~~their~~ anti-fraud plan or SIU description, or in any other way fails to comply with the requirements of Section 626.9891, F.S., and this rule chapter, the Division may take appropriate administrative action as provided in Section 626.9891(7), F.S., and the Office may ~~shall~~ take appropriate administrative action as provided in Sections 626.9891(7) and 624.4211, F.S.

Rulemaking ~~Specific~~ Authority 624.308, 626.9891, 626.9891(8) FS. Law Implemented 624.307, 626.9891(7) FS. History–New 10-5-06, Amended _________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Simon Blank, Director of the Division of Insurance Fraud, Department of Financial Services

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Jeff Atwater, Chief Financial Officer, Department of Financial Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 8, 2015

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAR: March 20, 2015

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Drugs, Devices and Cosmetics

RULE NO.: RULE TITLE:

61N-1.020 Forms

PURPOSE AND EFFECT: To repeal Rule 61N-1.020, F.A.C.

SUMMARY: The proposed rulemaking repeals Rule 61N-1.020, F.A.C.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS AND LEGISLATIVE RATIFICATION: The Agency has determined that this will not have an adverse impact on small business or likely increase directly or indirectly regulatory costs in excess of $200,000 in the aggregate within one year after the implementation of the rule. A SERC has not been prepared by the Agency.

The Agency has determined that the proposed rule is not expected to require legislative ratification based on the statement of estimated regulatory costs or if no SERC is required, the information expressly relied upon and described herein: the economic review conducted by the agency.

Any person who wishes to provide information regarding a statement of estimated regulatory costs, or provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

RULEMAKING AUTHORITY: 499.01, 499.012, 499.0122, 499.013, 499.015, 499.018, 499.028, 499.04, 499.041, 499.05, 499.06, 499.62, 499.63, 499.64, 499.66, 499.67, 499.701 FS.

LAW IMPLEMENTED: 499.01, 499.012, 499.0122, 499.013, 499.015, 499.018, 499.028, 499.04, 499.041, 499.05, 499.06, 499.062, 499.063, 499.064, 499.066, 499.067 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAR.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Brittany B. Griffith, Assistant General Counsel, Department of Business and Professional Regulation, 1940 North Monroe Street, Suite 42, Tallahassee, Florida 32399, (850)488-0062

THE FULL TEXT OF THE PROPOSED RULE IS:

61N-1.020 Forms.

Rulemaking Authority 499.01, 499.012, 499.0122, 499.013, 499.015, 499.018, 499.028, 499.04, 499.041, 499.05, 499.06, 499.62, 499.63, 499.64, 499.66, 499.67, 499.701 FS. Law Implemented 499.01, 499.012, 499.0122, 499.013, 499.015, 499.018, 499.028, 499.04, 499.041, 499.05, 499.06, 499.062, 499.063, 499.064, 499.066, 499.067 FS. History–New 12-12-82, Formerly 10D-45.56, Amended 11-26-86, 2-4-93, 7-1-96, Formerly 10D-45.056, Amended 1-26-99, 1-1-04, Formerly 64F-12.020, Repealed_____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Brittany B. Griffith, Assistant General Counsel, Department of Business and Professional Regulation

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Ken Lawson, Secretary, Department of Business and Professional Regulation

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 1, 2015

DEPARTMENT OF FINANCIAL SERVICES

Division of Worker's Compensation

RULE NOS.:	RULE TITLES:
69L-7.710	Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule
69L-7.720	Forms Incorporated by Reference for Medical Billing, Filing and Reporting
69L-7.730	Health Care Provider Medical Billing and Reporting Responsibilities
69L-7.740	Insurer Authorization and Medical Bill Review Responsibilities
69L-7.750	Insurer Electronic Medical Report Filing to the Division

PURPOSE AND EFFECT: The proposed rules represent a substantial rewrite and reorganization of Rule 69L-7.710, F.A.C., titled, "Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule." Existing Rule 69L-7.710, F.A.C., is rewritten and reorganized into five proposed rules that are intended to replace existing Rule 69L-7.710, F.A.C. The proposed rules incorporate an updated version of Form DFS-F5-DWC-9, which includes revised instructions for the billing of medications by dispensing practitioners and revised instructions for pharmacists when billing on Form DFS-F5-DWC-10. The proposed rules also incorporate revised form completion instructions for pharmacies and pharmacists, hospitals, ambulatory surgical centers, health care providers, work hardening programs, nursing homes and home health agencies. The proposed rules add, revise and delete certain definitions consistent with the implementation of SB 662, Chapter 2013-131, Laws of Florida and, upon federal implementation, the use of the ICD-10 International Classification of Diseases (10th Revision). The proposed rules omit subsection 69L-7.710(3), entitled, "Materials Incorporated by Reference," which is to be transferred for listing under proposed new Rule Chapter 69L-8, F.A.C., titled, "Selected Materials Incorporated by Reference."

SUMMARY: The proposed rulemaking represents a substantial rewrite and reorganization of existing Rule 69L-7.710, F.A.C., which is divided into five rule sections. The rulemaking also incorporates and adopts the ICD-10 medical code sets for use in conjunction with the Florida Medical EDI

Implementation Guide ("MEIG"). The proposed rules also include revised billing forms and accompanying instructions.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS AND LEGISLATIVE RATIFICATION: The Agency has determined that this will not have an adverse impact on small business or likely increase directly or indirectly regulatory costs in excess of $200,000 in the aggregate within one year after the implementation of the rule. A SERC has not been prepared by the Agency.

The Agency has determined that the proposed rule is not expected to require legislative ratification based on the statement of estimated regulatory costs or if no SERC is required, the information expressly relied upon and described herein: The Department has conducted an economic analysis of the proposed rules and determined that there are no adverse impacts or potential regulatory cost associated with any of the proposed rules that exceed the criteria established under paragraphs 120.541(1)(b) or 120.541(2)(a), F.S. The Department bases its economic analysis on its experience in estimating regulatory and transactional costs within the rulemaking process and through survey and consultation with affected entities and industry representatives.

Any person who wishes to provide information regarding a statement of estimated regulatory costs, or provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

RULEMAKING 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), (5), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

DATE AND TIME: Tuesday, June 2, 2015, 9:30 a.m.

PLACE: Room 102, Hartman Building, Hartman Building, 2012 Capital Circle Southeast, Tallahassee

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: Pamela Macon, (850)413-1708 or Pamela.Macon@myfloridacfo.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 IS: Pamela Macon, Chief, Bureau of Monitoring and Audit, Division of Workers' Compensation, Department of Financial Services, 200 E. Gaines Street, Tallahassee, Florida 32399-4232, (850)413-1708, Pamela.Macon@myfloridacfo.com

THE FULL TEXT OF THE PROPOSED RULE IS:

Substantial rewording of Rule 69L-7.710 follows. See Florida Administrative Code for present text.

69L-7.710 Definitions.

(1) As used in this Chapter:

(a) "Accurately Complete" or "Accurately Completed" means the form submitted contains the information necessary to meet the requirements of Chapter 440, F.S., and this rule.

(b) "Adjust" or "Adjusted" means payment is made with modification to the information provided on the bill.

(c) "Ambulatory Surgical Center" or "ASC" is defined in subsection 395.002(3), F.S.

(d) "Average Wholesale Price" or "AWP" is as defined in paragraph 440.13(12)(c), F.S., for medications dispensed on or after July 1, 2013.

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

(f) "Catastrophic Event" means the occurrence of an event outside the control of a claim 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 a claim 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 69L-7.750(4), F.A.C., for requirements to request approval of an alternative method and timeline for medical report filing with the Division due to a catastrophic event.

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

(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.

(i) "Claim Administrator" means any insurer, qualified servicing entity, third party administrator, claims-handling entity, self-serviced self-insured employer or fund, guarantee fund, or managing general agent responsible for adjusting workers' compensation claims.

(j) "Claim Administrator Code Number" means the number the Division assigns to an Insurer, qualified servicing entity, third party administrator, claims-handling entity, self-serviced self-insured employer or fund, guarantee fund, or managing general agent responsible for adjusting workers' compensation claims.

(k) "Claim Administrator File Number" means the number assigned to the claim file by the claim administrator for purposes of internal tracking.

(l) "Current Dental Terminology" (CDT) means the American Dental Association's reference document containing descriptive terms to identify codes for billing and reporting dental procedures, as incorporated by reference in Rule 69L-8.074, F.A.C.

(m) "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, as incorporated by reference in Rule 69L-8.074, F.A.C.

(n) "Date Insurer Paid Bill" and "Date Insurer Paid, Adjusted, Disallowed or Denied" means the date the claim 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 Bill" and "Date Insurer Paid, Adjusted, Disallowed or Denied" means the date the claim 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 subsection 69L-7.750(8), F.A.C., for the requirement to accurately report the "Date Insurer Paid Bill."

(o) "Date Insurer Received Bill" 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 claim administrator or any entity acting on behalf of the insurer. See subsection 69L-7.750(8), F.A.C., for the requirement to accurately report the "Date Insurer Received Bill". If a medical bill meets any of the criteria in paragraph 69L-7.740(11)(g), F.A.C., and possession of the form is relinquished by the claim administrator 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 Bill" shall not apply to the medical bill as submitted.

(p) "Days" means calendar days unless otherwise noted.

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

(r) "Department" means Department of Financial Services (DFS) as defined in subsection 440.02(12), F.S.

(s) "Disallow" or "Disallowed" means payment for a compensable injury or illness is not made because the service rendered has not been substantiated for reasons of medical necessity, insufficient documentation, lack of authorization or billing error.

(t) "Division" means the Division of Workers' Compensation (DWC) as defined in subsection 440.02(14), F.S.

(u) "Electronic Filing" means the computer exchange of medical data from a sender to the Division in the standardized format defined in the MEIG.

(v) "Electronic Form Equivalent" means the record, provided in the Florida Medical EDI Implementation Guide MEIG to be used when a sender 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.

(w) "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.

(x) "Entity" means any party involved in the processing, adjudication or payment of medical bills on behalf of the insurer.

(y) "Explanation of Bill Review" (EOBR) means the document used to provide notice of payment or notice of adjustment, disallowance or denial by a claim 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 69L-7.740(13), F.A.C.

(z) "Explanation of Bill Review Code" (EOBR Code) means a code listed in paragraph 69L-7.740(13)(b), F.A.C., that describes the basis for the reimbursement decision of a claim administrator or any entity acting on behalf of the insurer.

(aa) "Florida Medical EDI Implementation Guide" (MEIG) is the Division's reference document containing the specific electronic formats, data elements, and requirements for insurer reporting of medical data to the Division, as incorporated by reference in Rule 69L-8.074, F.A.C.

(bb) "Healthcare Common Procedure Coding System National Level II Codes" (HCPCS) means the Centers for Medicare and Medicaid Services' reference document listing descriptive codes for billing and reporting professional services, procedures, and supplies provided by health care

providers, as incorporated by reference in Rule 69L-8.074, F.A.C.

(cc) "Health Care Provider" is defined in paragraph 440.13(1)(g), F.S.

(dd) "Home Health Agency" (HHA) is defined in subsection 400.462(12), F.S.

(ee) "Home Medical Equipment Provider," sometimes referred to as durable medical equipment or DME provider, is defined in subsection 400.925(7), F.S.

(ff) "Hospital" is defined in subsection 395.002(12), F.S.

(gg) "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, as incorporated by reference in Rule 69L-8.074, F.A.C.

(hh) "ICD-10 International Classification of Diseases" (ICD-10) is the 10th Revision of the International Classification of Diseases set of diagnosis and inpatient procedure codes, as incorporated by reference in Rule 69L-8.074, F.A.C.

(ii) "Implants" means the surgical implant(s), the associated disposable instrumentation required for use with the surgical implant(s) and the shipping and handling, when listed on the implant invoice.

(jj) "Insurer" is defined in subsection 440.02(38), F.S.

(kk) "Insurer Code Number" means the number the Division assigns to each individual insurer, self-insured employer, self-insured fund, or guaranty fund financially responsible for the claim.

(ll) "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.

(mm) "Medical Bill" means the document or electronic form equivalent submitted by a health care provider to an Insurer, Service Company/Third Party Administrator 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 Rule 69L-7.730(2), F.A.C.

(nn) "Medically Necessary" or "Medical Necessity" is defined in paragraph 440.13(1)(k), F.S.

(oo) "NDC Number" means the eleven-digit 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. As used in this Rule Chapter, when referring to dispensed drugs, "Original Manufacturer's NDC Number" shall mean the NDC Number assigned by the original manufacturer of the underlying dispensed drug; and, "Repackaged NDC Number" shall mean the NDC Number assigned by the repackager/relabeler of the underlying dispensed drug.

(pp) "Nursing Home Facility" is defined in subsection 400.021(12), F.S.

(qq) "Pay" or "Paid" means payment is made applying the applicable reimbursement formula to the medical bill as submitted.

(rr) "Physician" is defined in paragraph 440.13(1)(p), F.S.

(ss) "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.

(tt) "Recognized Practitioner" means a non-physician health care provider licensed by the Department of Health who works under the protocol of a physician or who, upon referral from a physician, can render direct billable services that are within the scope of the recognized practitioner's license, independent of the supervision of a Physician.

(uu) "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.

(vv) "Service Company/Third Party Administrator (TPA)" means an entity that has contracted with an insurer for the purpose of providing services necessary to adjust workers' compensation claims on the Insurer's behalf.

(ww) "Sender" means an Insurer, Service Company/TPA, entity or any other party acting 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.

(xx) "UB-04 Manual" means the National Uniform Billing Committee Official UB-04 Data Specifications Manual, 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. 2015), as incorporated by reference in Rule 69L-8.074, F.A.C.

Rulemaking 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), (5), 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, 1-12-10, 10-23-12, Formerly 69L-7.602, Amended .

69L-7.720 Forms Incorporated by Reference for Medical Billing, Filing and Reporting.

(1) The following forms, including form completion instructions, are incorporated for use with rules adopted under this Rule Chapter.

(a) Form DFS-F5-DWC-9 CMS-1500 Health Insurance Claim Form, Rev. 02/12,

Completion Instructions for the DFS-F5-DWC-9 are comprised of three sets.

1. Form DFS-F5-DWC-9-A, Completion Instructions for Physicians and Recognized Practitioners, Rev. 01/01/2015;

2. Form DFS-F5-DWC-9-B, Completion Instructions for Work Hardening and Pain Management Programs, Rev. 01/01/2015;

3. Form DFS-F5-DWC-9-C, Completion Instructions for Ambulatory Surgical Centers, Rev. 01/01/2015 (only for dates of services prior to July 8, 2010);

(b) Form DFS-F5-DWC-10, Statement of Charges for Drugs and Medical Equipment & Supplies Form, Rev. 01/01/2015, Form DFS-F5-DWC-10-A, Completion Instructions for Pharmacies And Home Medical Equipment Providers/Suppliers, Rev. 01/01/2015;

(c) Form DFS-F5-DWC-11, American Dental Association Dental Claim Form, Rev. 2012; Form DFS-F5-

DWC-11-A Completion Instructions for Dentists, Rev. 01/01/2015;

(d) Form DFS-F5-DWC-25, Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form, Rev. 1/31/2008, Form DFS-F5-DWC-25-A, Completion Instructions for Physicians and Recognized Practitioners, Rev. 01/01/2015.

(e) Form DFS-F5-DWC-90 (UB-04/CMS-1450), Uniform Bill, Rev. 11/03/2006; Completion Instructions for the DFS-F5-DWC-90 are comprised of four sets:

1. Form DFS-F5-DWC-90-A (UB-04), Completion Instructions for Hospitals, Rev. 01/01/2015;

2. Form DFS-F5-DWC-90-B (UB-04), Completion Instructions for Ambulatory Surgical Centers, Rev. 01/01/2015 (for dates of service on and after 07/08/2010);

3. Form DFS-F5-DWC-90-C (UB-04), Completion Instructions for Home Health Agencies, Rev. 01/01/2015;

4. DFS-F5-DWC-90-D (UB-04), Completion Instructions for Nursing Home Facilities, Rev. 01/01/2015.

(2) Obtaining Copies of Forms and Instructions.

(a) A copy of the Form DFS-F5-DWC-9 can be obtained from the AMA web site: https://commerce.ama-assn.org/store/. Completion instructions for the DFS-F5-DWC-9 can be obtained from the Department of Financial Services/Division of Workers' Compensation (DFS/DWC) web site:

http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.

htm.

(b) A copy of the Form DFS-F5-DWC-10 and completion instructions for the form can be obtained from the DFS/DWC website:

http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.

htm.

(c) A copy of the Form DFS-F5-DWC-11 can be obtained from the American Dental Association web site: http://www.ada.org/. Completion instructions for the form can be obtained from the DFS/DWC web site: http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm.

(d) 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/Division/WC/PublicationsFormsManualsReports/Forms/Default.

htm.

(e) A copy of the instructions for completion of Form DFS-F5-DWC-90 (Rev. 2006), Form DFS-F5-DWC-90 (UB-04)-A (for Hospitals) (Rev. 01/01/2015), Form DFS-F5-DWC-90 (UB-04)-B (for ASCs) (Rev. 01/01/2015), Form DFS-F5-DWC-90 (UB-04)-C (for Home Health Agencies) (Rev. 01/01/2015), Form DFS-F5-DWC-90 (UB-04)-D (for Nursing Home Facilities), (Rev. 01/01/2015), can be obtained from the DFS/DWC web site: http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm.

(3) Alternate Billing Forms for Use in Lieu of DFS-F5-DWC-10.

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

(a) An insurer has approved the alternate billing form(s) prior to submission by a health care provider, and

(b) The form provides all information required to be submitted to the Division, pursuant to the 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 for the DFS-F5-DWC-10.

Rulemaking 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), (5), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS. History–New ______. Editorial Note: Formerly 69L-7.602 and 69L-7.710, F.A.C.

69L-7.730 Health Care Provider Medical Billing and Reporting Responsibilities.

(1) Bill Submission/Filing and Reporting Requirements.

(a) All health care providers are responsible for meeting their obligations, under this rule, regardless of any business arrangement with any entity under which claims are prepared, processed or submitted to the insurer.

(b) Each health care provider is responsible for submitting any form completion information and supporting documentation requested by the insurer that is in addition to the requirements of this rule and the applicable reimbursement manual, when it is requested, in writing, by the insurer at the time of authorization or upon receipt of notification of emergency care.

(c) 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 based on the provider's failure to submit requested documentation with the medical bill.

(d) 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 other reporting forms may be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

1.The Form DFS-F5-DWC-25 does not replace physician notes, medical records or Division-required medical reports.

2. All information submitted on physician notes, medical records or Division-required medical reports shall be consistent with information documented on the Form DFS-F5-DWC-25.

3. The DFS-F5-DWC-25, submitted to address the physical limitation(s), permanent impairment rating or maximum medical improvement date, shall be signed by the physician performing the physical examination upon which the physical limitation(s), permanent impairment or maximum medical improvement date is based.

(e) All medical claim form(s) or medical bill(s) related to authorized services shall be coded by the health care provider at the highest level of specificity and submitted to the claim administrator or any entity acting on behalf of the insurer, as a requirement for billing.

(f) Medical claim form(s) or medical bill(s) may be electronically filed or submitted via facsimile by a health care provider to the claim administrator or any entity acting on behalf of the insurer, provided the insurer agrees.

(g) When requested by the claim administrator or any entity acting on behalf of the insurer, a health care provider shall send documentation that supports the medical necessity of the specific services rendered and any other required documentation pursuant to subsection 69L-7.730(2), F.A.C., and the applicable reimbursement manual.

(h) Each health care provider is responsible for correcting and resubmitting any billing forms returned by a claim administrator or any entity acting on behalf of the insurer pursuant to paragraph 69L-7.740(11)(g), F.A.C.

(i) Each hospital and ASC shall maintain its charge master and shall produce relevant portions when requested for the purpose of verifying its usual charges pursuant to paragraph 440.13(12)(d), F.S.

(j) A health care provider shall bill multiple services, rendered on the same date of service, on a contiguous bill; provided however, nothing herein shall prevent a physician from selling, assigning or otherwise factoring a claim for the provision of pharmacy related services to a third party billing entity.

(2) Special Billing Requirements.

(a) When anesthesia services are billed on a Form DFS-F5-DWC-9, completion of the form shall 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.

(b) When a certified registered nurse anesthetist provides anesthesia services, the individual shall bill on a Form DFS-F5-DWC-9 for the services rendered and enter their Florida Department of Health Advanced Registered Nurse Practitioner license number in Field 33b, regardless of the employment arrangement under which the services were rendered, or the party submitting the bill.

(c) Recognized practitioners, except physician assistants, advanced registered nurse practitioners, certified registered nurse anesthetists, who are salaried employees of an authorized treating physician and who render direct billable services for which reimbursement is sought from a claim administrator or any entity acting on behalf of the claim administrator shall report and bill for such services on a Form DFS-F5-DWC-9 under the employing physician's name and license number.

(d) For hospital billing, the following special requirements apply:

1. Inpatient billing – Hospitals shall, in addition to filing a Form DFS-F5-DWC-90:

a. Attach an itemized statement with charges based on the facility's charge master; and

b. Submit all specifically requested and additional documentation requested at the time of authorization; and

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

d. In Form Locator 80 - "Remarks"- make written entry "implant(s)" followed by the certification amount or the reimbursement amount calculated pursuant to Rule 69L-7.501, F.A.C.

2. Outpatient billing – Hospitals shall in addition to filing a Form DFS-F5-DWC-90:

a. Enter the CPT®, HCPCS or workers' compensation unique code and the applicable CPT® or HCPCS modifier code in Form Locator 44 on the Form DFS-F5-DWC-90, when required pursuant to the UB-04 Manual; and

b. Make written entry "scheduled" or "non-scheduled" in Form Locator 80 of Form DFS-F5-DWC-90 – "Remarks" on the DFS-F5-DWC-90 when billing outpatient surgery or outpatient surgical services; and

c. Attach an itemized statement with charges based on the facility's charge master; and

d. Submit all applicable documentation required pursuant to Rule 69L-7.501, F.A.C.; and

e. Bill professional services provided by a physician or recognized practitioner on the Form DFS-F5-DWC-9, regardless of employment arrangement.

(e) A certified, licensed physician 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 shall enter the individual's Florida Department of Health license number in Field 33b.

(f) ASCs shall bill as follows:

1. For dates of service up to and including 07/07/2010, ASCs shall bill on Form DFS-F5-DWC-9 using the American Medical Association's CPT® procedure codes, or using the workers' compensation unique procedure code 99070 with required modifiers, and shall bill charges based on the ASC's charge master except when billing for procedure code 99070.

2. For dates of service on and after 07/08/2010, ASCs shall bill on Form DFS-F5-DWC-90 and shall enter the CPT®, HCPCS, or workers' compensation unique code and the applicable CPT® or HCPCS modifier code in Form Locator 44 for each service rendered. ASCs shall bill charges based on the ASC's charge master except when billing for surgical implants, associated disposable instrumentation and applicable shipping and handling. ASCs shall use revenue center code 0278 and workers' compensation unique code(s) with required modifier(s), as defined in the MEIG and pursuant to Rule 69L-7.100, F.A.C., when billing for surgical implants, 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.

(g) HHAs shall bill on Form DFS-F5-DWC-90.

1. For dates of service up to and including 07/07/2010, HHAs shall bill on letterhead or invoice.

2. For dates of service on or after 07/08/2010, HHAs shall bill on Form DFS-F5-DWC-90 and shall enter the CPT®, HCPCS or workers' compensation unique codes and the applicable CPT® or HCPCS modifier code in Form Locator 44 for each service rendered.

(h) Nursing home facilities shall bill on Form DFS-F5-DWC-90.

1. For dates of service up to and including 07/07/2010, nursing home facilities shall bill on letterhead or invoice.

2. For dates of service on or after 07/08/2010, nursing home facilities shall bill on Form DFS-F5-DWC-90 and shall enter the CPT®, HCPCS or workers' compensation unique code and the applicable CPT® or HCPCS modifier code in Form Locator 44 for each service rendered.

(i) Federal facilities shall bill on their usual form.

(j) Out-of-state health care providers shall bill on the applicable medical bill form pursuant to subsection 69L-7.730(3), F.A.C.

(k) Dental services.

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

2. 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.

(l) Pharmaceutical(s), DME and home medical equipment or supplies.

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

a. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the 11 digit original manufacturer's NDC number in Field 9a. When the dispensed drug is a repackaged/relabeled drug, the provider shall, in addition to the above, enter the repackaged NDC number in Field 9b of Form DFS-F5-DWC-10.

b. Physicians (including oral surgeons), physician assistants, advanced registered nurse practitioners, and any other recognized practitioner registered to dispense medications pursuant to Section 465.0276, F.S., shall bill on Form DFS-F5-DWC-9. Subsection 440.13(12)(c), F.S, requires the original manufacturer's NDC number to be included in the claim when repackaged or re-labeled medications have been dispensed. See the DFS-F5-DWC-9 Form Completion Instructions in Rule 69L-7.720, F.A.C.

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

d. Dentists registered to dispense medications pursuant to Section 465.0276, F.S., shall bill on Form-DFS-F5-DWC-11. Paragraph 440.13(12)(c), F.S., requires the original manufacturer's NDC number to be included in the claim when repackaged or re-labeled medications have been dispensed.

See the DFS-F5-DWC-11 Form Completion Instructions in Rule 69L-7.720, F.A.C.

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

a. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the workers' compensation unique code COMPD, as defined in the MEIG, in Field 9a.

b. Physicians, physician assistants or advanced registered nurse practitioners shall bill on Form DFS-F5-DWC-9 and shall enter the workers' compensation unique code COMPD, as defined in the MEIG, in Field 24D.

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

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

a. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the 11 digit NDC number in form Field 9a.

b. Physicians (including oral surgeons), physician assistants or advanced registered nurse practitioners shall bill on Form DFS-F5-DWC-9, shall enter the 11 digit NDC number in the shaded portion above Field 24. See the DFS-F5-DWC-9 Form Completion Instructions in Rule 69L-7.720, F.A.C.

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

4. When administering or dispensing injectable drugs:

a. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the 11 digit NDC number in Field 9a.

b. Physicians, physician assistants or advanced registered nurse practitioners 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 11 digit NDC number, preceded by the alpha-numeric qualifier (N4), in the shaded portion above Field 24. See the DFS-F5-DWC-9 Form Completion Instructions in Rule 69L-7.720, F.A.C.

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

5. When dispensing DME:

a. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on Form DFS-F5-DWC-10.

b. Physicians and recognized practitioners shall bill on Form DFS-F5-DWC-9 and shall enter the applicable HCPCS code in Field 24D of the form and attach documentation indicating the actual cost of the supply.

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

d. Home medical equipment providers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on Form DFS-F5-DWC-10.

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

a. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on Form DFS-F5-DWC-10.

b. Physicians and recognized practitioners shall bill on Form DFS-F5-DWC-9 and shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply.

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

d. Home medical equipment providers shall bill on Form DFS-F5-DWC-10 for DME supplies prescribed by a physician or recognized practitioner, and shall enter the applicable HCPCS code in Field 21 on Form DFS-F5-DWC-10.

7. 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) 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.

8. 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.

(m) 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 worker's compensation unique code 99456-CN on the DFS-F5-DWC-9.

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

(o) Parties that are not physicians or recognized practitioners but are authorized by an insurer to render services reimbursable under workers' compensation shall bill on their invoice or letterhead. These parties 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.

(p) Only a physician as defined in paragraph 440.13(1)(p), F.S., can bill workers' compensation unique codes 99455, 99456, 99457 when reporting services to address maximum medical improvement and permanent impairment.

(3) Bill Completion.

(a) Bills shall be legibly and accurately completed by all health care providers, regardless of location or reimbursement methodology, as set forth in this subpart and in subsection 69L-7.730(2), F.A.C.

(b) Billing elements required by the Division to be completed by a health care provider are identified in Form DFS-F5-DWC-9-B Completion Instructions, Rev. 01/01/2015, and are available at the following websites:

1. http://www.myfloridacfo.com/Division/WC/pdf/DWC-9instrHCP.pdf, when submitted by licensed health care providers;

2.http://www.myfloridacfo.com/Division/WC/provider/DWC-9instrWHPM.pdf, when submitted by work hardening and pain management programs.

3.http://www.myfloridacfo.com/Division/WC/provider/DWC-9instrASC.pdf, when submitted by an ASC for dates of service before 07/08/2010.

(c) Billing elements required by the Division to be completed for pharmaceutical or medical supplier billing are identified in Form DFS-F5-DWC-10 Completion Instructions, Rev.1/01/2015, are available at the following website: http://www.myfloridacfo.com/Division/WC/pdf/DFS-F2-DWC-10instr.pdf.

(d) Billing elements required by the Division to be completed for dental billing are identified in Form DFS-F5-DWC-11-B Completion Instructions, Rev.01/01/2015, are available at website: http://www.myfloridacfo.com/Division/WC/provider/DWC-11instr_1-1-07.pdf.

(e) Billing elements required by the Division to be completed by facilities are identified in Form DFS-F5-DWC-90 (UB-04) Completion Instructions, Rev. 01/01/15, and are available at the following websites:

1. http://www.myfloridacfo.com/Division/WC/provider/DWC-90(UB-04)-A (Rev. 01/01/2015), when submitted by a hospital.

2.http://www.myfloridacfo.com/Division/WC/provider/DWC-90 (UB-04)-B (Rev. 01/01/2015), when submitted by an ASC for dates of service on or after 7/8/2010.

3.http://www.myfloridacfo.com/Division/WC/provider/DWC-90 (UB-04)-C (Rev. 01/01/2015), when billed by a HHA.

4.http://www.myfloridacfo.com/Division/WC/provider/DWC-90(UB-04) –D, (Rev. 01/01/2015), when billed by a nursing home facility.

(f) A health care provider shall submit additional data elements or supporting documentation required for the adjudication of a bill upon receipt of a written request from the insurer/claim administrator pursuant to subsection 69L-7.740(2), F.A.C.

(g) A health care provider may bill consistent with the requirements of ICD-10 beginning on the implementation date specified for use of ICD-10 in section 62.1002 of Title 45 of the Code of Federal Regulations. Under no circumstance may a health care provider utilize both ICD-9 and ICD-10 coding on the same bill.

Rulemaking 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), (5), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS. History–New ________. Editorial Note: Formerly 69L-7.602 and 69L-7.710, F.A.C.

69L-7.740 Insurer Authorization and Medical Bill Review Responsibilities.

(1) An insurer is responsible for meeting its obligations under this rule regardless of any business arrangements with any claim administrator or any entity acting on behalf of an insurer under which medical bills are paid, adjusted, disallowed, denied, or otherwise processed or submitted to the Division.

(2)(a) At the time of authorization for medical service(s) or upon receipt of notification of emergency care, an insurer shall notify each health care provider, in writing, of data elements or supporting documentation necessary for reimbursement determinations that are in addition to the requirements of this rule and the applicable reimbursement manual.

(b) This subpart applies to dates of injury occurring on or after October 1, 2003. At the time of authorization for medical service(s), or upon receipt of notification of emergency care, an insurer shall issue a written or electronic notice to each health care provider stating whether the insurer will, when paying reimbursement for the medical service(s) for a compensable injury, apportion out the percentage of need for the care attributable to a pre-existing condition pursuant to subsection 440.15(5), F.S. If the insurer decides to apportion out the percentage of need for the care attributable to the pre-existing condition after authorization, the insurer shall issue a written or electronic notice to each health care provider stating that the insurer will apply such apportionment, pursuant to subsection 440.15(5), F.S., to the reimbursement for the authorized medical service(s). Compliance with this subpart is independent of and does not satisfy the notification requirement pursuant to Rule 69L-3.017, F.A.C.

(3) At the time of authorization for medical service(s), or upon receipt of notification of emergency care, an insurer shall inform out-of-state health care providers of the specific reporting, billing and submission requirements contained in Rule 69L-7.730, F.A.C. (Health Care Provider Responsibilities), and provide in-state and out-of-state health care providers the specific address for submitting a reimbursement request.

(4) Claim administrators 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 and for requesting approval of a treatment plan. No other reporting forms may be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

(5) Required data elements on each electronic form equivalent of 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 days of when the medical bill is paid, adjusted, disallowed or denied by the insurer, claim administrator or any entity acting on behalf of the insurer. The 45 day filing requirement includes initial submission and correction and re-submission of all errors identified in the "Medical Bill Acknowledgement," as defined in the MEIG.

(6) An Insurer shall be responsible for accurately completing required data filed with the Division, pursuant to the MEIG and Rule 69L-7.750, F.A.C. 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 monitoring, auditing, investigation or analysis, and resubmitting the corrected and accurate data in accordance with the requirements set forth in the MEIG and subsection 69L-7.750(5), F.A.C.

(7) When an injured employee does not have a social security number or a previously assigned division-assigned number, the claim administrator or entity acting on behalf of the insurer shall contact the Division via email at DWCAssignedNumber@myfloridacfo.com to obtain a division-assigned number prior to submitting the medical report to the Division.

(8) An insurer, claim administrator or any entity acting on behalf of an insurer shall report to the Division the procedure code(s), number of line-items billed, diagnosis code(s), modifier code(s), NDC number(s) and amount(s) charged, as billed by the health care provider when reporting these data to the Division. However, the insurer, claim administrator or any entity acting on behalf of an insurer may correct the procedure code(s) or modifier code(s) or NDC number(s) to effect payment and shall report both the provider billed code(s) and insurer adjusted code(s) pursuant to the MEIG. The insurer, claim administrator 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.

(9) An insurer, claim administrator 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 Bill" as defined in paragraph 69L-7.710(1)(o), F.A.C.

(10) When utilizing the option(s) available under paragraph 69L-7.750(8)(a), F.A.C., the insurer shall document the following:

(a) The option(s) selected, and

(b) The specific effective date for each option selected, and

(c) The specific role of each "entity" acting on the insurers behalf in the option selected.

The insurer shall make this written documentation available to the Division for audit purposes pursuant to Section 440.525, F.S. The insurer shall maintain written documentation from the "entity" acknowledging its responsibilities concerning "Date Insurer Received Bill" and "Date Insurer Paid Bill" for each option when the insurer selects options 2., 3., or 4. from paragraph 69L-7.750(8)(a), F.A.C., and shall also maintain written documentation identifying the applicability of the options selected in sufficient detail to allow verification of the coding of each medical bill under paragraph 69L-7.750(8)(c), F.A.C.

(11) An insurer, claim administrator or any entity acting on behalf of the insurer shall comply as indicated below to ensure the timely and correct reimbursement of properly completed medical bills:

(a) When adjudicating practitioner-dispensed medication bills, an insurer/claim administrator or any entity acting on behalf of an insurer shall use the Medi-Span Master Drug Database®, pursuant to paragraph 440.13(12)(c), F.S., to determine whether or not the dispensed medication is repackaged.

(b) When a medical bill is submitted for reimbursement by a health care provider, the insurer, claim administrator or entity acting on behalf of the insurer shall review the medical bill to determine if any of the criteria in paragraph 69L-7.740(11)(e), F.A.C., are present.

(c) If a medical bill is deficient according to the criteria listed in paragraph 69L-7.740(11)(g), F.A.C., and the applicable form completion instructions incorporated by reference in Rule 69L-7.720, F.A.C., the insurer, claim administrator or entity acting on behalf of the insurer shall either:

1. Secure and/or correct the information on the medical bill and proceed to make a reimbursement decision to pay, adjust, disallow or deny billed charges within 45 days from the "Date Insurer Received Bill"; or

2. Return the medical bill to the provider within twenty-one (21) days of the "Date Insurer Received Bill" with a written statement identifying the deficiency criteria under which the medical bill is being returned. 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."**

(d) If the insurer returns a medical bill to the provider pursuant to paragraph 69L-7.740(11)(g), F.A.C., the written statement, which shall accompany the returned bill shall include all deficiency criteria upon which the return of the medical bill are based.

(e) If the deficiency criteria upon which the return of the medical bill is based includes any of the deficiency criteria in subparagrahs 69L-7.740(11)(g)4-7, F.A.C., and the applicable form completion instructions, the written statement shall identify the information that is illegible, incorrect, or omitted.

(f) An insurer may return a medical bill to a provider without issuance of an EOBR only on the basis of the deficiency criteria set forth in paragraph 69L-7.740(11)(e), F.A.C., and the applicable form completion instructions.

(g) The deficiency criteria upon which a medical bill is to be reviewed by the insurer, claim administrator or entity acting on behalf of the insurer for return to the provider pursuant to this sub-part of subsection 69L-7.740(11), F.A.C., are:

1. Services are billed on an incorrect medical billing form; or

2. The medical bill has been submitted to the incorrect insurer; or

3. The medical bill has been submitted to the incorrect claim administrator or entity acting on behalf of the insurer; or

4. Injured employee identification information required by this rule and the applicable form completion instructions is illegible on the medical bill; or

5. Injured employee identification information required by this rule and the applicable form completion instructions is incorrect on the medical bill; or

6. Billing information required by this rule and the applicable form completion instructions is illegible on the medical bill; or

7. Billing information required by this rule and the applicable form completion instructions is omitted or incomplete on the medical bill.

(h) An insurer, claim administrator or entity acting on behalf of the insurer shall establish and maintain a process by which medical bills that have been returned and written statements identifying the reason for return are compiled. The compiled information shall be sufficiently detailed to allow verification and review by the Division.

(12) A claim administrator or any entity acting on behalf of the insurer shall pay, adjust, disallow or deny billed charges within 45 days from the "Date Insurer Received Bill," pursuant to paragraph 440.20(2)(b), F.S.

(13) In completing an EOBR, a claim administrator shall, for each line item billed, select the EOBR code(s) from the list below which identifies(y) the reason(s) for the reimbursement decision for each line item.

(a) The claim administrator may utilize up to three EOBR codes for each line item billed. When utilizing more than one EOBR code, the claim administrator shall list the EOBR codes that describe the basis for the claim administrator's reimbursement decision in descending order of importance.

(b) The EOBR code list is as follows:

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

10 – Payment denied: total denial: total compensability denied or the injury or illness for which service was rendered is not compensable.

11 - Payment denied: partial denial: diagnosis or procedure code for the line item service is not related to the compensable condition. (Insurer must specify the non-compensable condition).

21 – Payment disallowed: medical necessity: medical records reflect no physician's order was given for service rendered or supply provided.

22 – Payment disallowed: medical necessity: medical records reflect no physician's prescription was given for service rendered or supply provided.

23 – Payment disallowed: medical necessity: diagnosis does not support the service rendered.

24 – Payment disallowed: medical necessity: service rendered was not therapeutically appropriate.

25 – Payment disallowed: medical necessity: service rendered was experimental, investigative or research in nature.

26 – Payment disallowed: service rendered by healthcare practitioner outside scope of practitioner's licensure.

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

34 – Payment disallowed: no modification to the information provided on the medical bill. No payment made pursuant to contractual arrangement.

38 – Payment disallowed: insufficient documentation: documentation does not support this supply was dispensed to the patient.

39 – Payment disallowed: insufficient documentation: documentation does not support this medication was dispensed to the patient.

40 – Payment disallowed: insufficient documentation: documentation does not substantiate the service billed was rendered.

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

42 – Payment disallowed: insufficient documentation: intensity of physical medicine and rehabilitation service not supported by documentation.

43 – Payment disallowed: insufficient documentation: frequency of service not supported by documentation.

44 – Payment disallowed: insufficient documentation: duration of service not supported by documentation.

45 – Payment disallowed: insufficient documentation: fraud statement not provided pursuant to subsection 440.105(7), F.S.

46 – Payment disallowed: insufficient documentation: required itemized statement not submitted with the medical bill.

47 – Payment disallowed: insufficient documentation: invoice or certification not submitted for implant.

48 – Payment disallowed: insufficient documentation: invoice not submitted for supplies.

49 – Payment disallowed: insufficient documentation: invoice not submitted for medication.

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

51 – Payment disallowed: insufficient documentation: required DFS-F5-DWC-25 not submitted.

52 – Payment disallowed: insufficient documentation: supply(ies) incidental to the procedure. (Incidental supply shall be specified.)

53 – Payment disallowed: insufficient documentation: required operative report not submitted with the medical bill.

54 – Payment disallowed: insufficient documentation: required narrative report not submitted with the medical bill.

58 – Payment disallowed: billing error: omitted or incorrect/invalid original manufacturer's NDC number.

NOTE: If a valid original manufacturer's NDC number for prescription medication is billed alone, it should be reimbursed and reported under EOBR code 98.

59 - Payment disallowed: billing error: omitted or incorrect/invalid repackaged NDC number.

NOTE: If a valid original manufacturer's NDC number for prescription medication is billed alone, it should be reimbursed and reported under EOBR code 98.

60 – Payment disallowed: billing error: line item service previously billed and reimbursement decision previously rendered.

NOTE: Use EOBR code 61 when all lines on bill are disallowed as duplicates. Do not transmit bill electronically to the Division.

61 – Payment disallowed: billing error: duplicate bill.

NOTE: Do not transmit bill electronically to the Division.

62 – Payment disallowed: billing error: incorrect procedure, modifier, units, supply code.

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

64 – Payment disallowed: billing error: service "not reimbursable" under applicable workers' compensation reimbursement manual.

65 – Payment disallowed: billing error: multiple providers billed on the same form.

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

67 – Payment disallowed: billing error: Same service billed multiple times on same date of service.

68 – Payment disallowed: billing error: Rental value has exceeded purchase price per written fee agreement.

71 – Payment adjusted: insufficient documentation: level of evaluation and management service not supported by documentation.

72 – Payment adjusted: insufficient documentation: intensity of physical medicine and rehabilitation service not supported by documentation.

73 – Payment adjusted: insufficient documentation: frequency of service not supported by documentation.

74 – Payment adjusted: insufficient documentation: duration of service not supported by documentation.

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

80 – Payment adjusted: billing error: correction of procedure, modifier, supply code, units, or original manufacturer's NDC number (shall identify correction).

NOTE: Shall not be used with repackaged medications.

81 – Payment adjusted: billing error: payment modified pursuant to a charge audit.

83 – Payment adjusted: medical benefits paid apportioning out the percentage of the need for such care attributable to preexisting condition pursuant to paragraph 440.15(5)(b), F.S.

84 – Payment adjusted: co-payment applied pursuant to paragraph 440.13(13)(c), F.S.

85 – Payment adjusted: no modification to the information provided on the medical bill. Payment made pursuant to a fee agreement between the health care provider and the carrier.

86- Payment adjusted: billing error; repackaged medication; correction of NDC number dispensed or reimbursed pursuant to paragraph 440.13(12)(c), F.S. (Insurer shall indicate the corrected NDC number dispensed or reimbursed).

90 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Health Care Provider Reimbursement Manual.

91 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers.

92 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Reimbursement Manual for Hospitals.

93 – Paid: no modification to the information provided on the medical bill: payment made pursuant to written contractual arrangement (network or preferred provider organization name required).

94 – Paid: Out-of-state provider: payment made pursuant to the out-of-state provider section of the applicable Florida reimbursement manual.

95 – Paid: Reimbursement dispute resolution: payment made pursuant to receipt of a determination or final order on a petition for resolution of reimbursement dispute, pursuant to subsection 440.13(7), F.S.

96 – Paid: Payment made pursuant to a write-off by a health care provider self-insured employer.

97 – Paid: no modification to the information provided on the medical bill; repackaged medication; reimbursed at repackaged methodology pursuant to paragraph 440.13(12)(c), F.S.

98 - Paid: no modification to the information provided on the medical bill; dispensed medication; billed original manufacturer's NDC number only; reimbursed pursuant to paragraph 440.13(12)(c), F.S.

(14) A claim administrator or any entity acting on behalf of the insurer to pay, adjust, disallow or deny a filed bill shall send to the health care provider an EOBR detailing the adjudication of the submitted bill by line item, utilizing only the EOBR codes and code descriptors per line item, as set forth in Rule 69L-7.740(13), F.A.C., and shall include the insurer name, Division issued insurer code number and corresponding insurer mailing address. However, an insurer may choose to append an internal reason code to the EOBR it submits to the health care provider, when utilizing an EOBR code set forth in Rule 69L-7.740(13), F.A.C., that includes a code descriptor requiring the insurer to provide additional specification. A claim administrator 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 subsection 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 paragraph 440.13(7)(a), F.S. The requirements of this subpart do not apply to adjudication of a bill for pharmaceutical services provided by a pharmacist or pharmacy licensed under Chapter 465, F.S., and billed on a Form DFS-F5-DWC-10 or its electronic equivalent, where, prior to the services being rendered, a binding contract exists between the claim administrator or any entity acting on behalf of the insurer, and the pharmacist or pharmacy or its representative that governs and specifies the amount to be paid by or on behalf of the insurer for the services.

(15) Copies of hospital medical records shall be subject to charges allowed pursuant to Section 395.3025, F.S. and Section 440.13, F.S.

Rulemaking 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), (5), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS. History–New ________.

Editorial Note: Formerly 69L-7.602 and 69L-7.710, F.A.C.

69L-7.750 Insurer Electronic Medical Report Filing to the Division.

(1) Effective 3/16/05, all required medical reports shall be electronically filed with the Division by all insurers.

(2) Required data elements shall be submitted in compliance with the MEIG.

(3) The Division will notify the Sender on the "Medical Bill Acknowledgement" of the corrections necessary for rejected medical reports to be electronically re-filed with the Division. An insurer shall ensure all rejected medical reports are corrected and resubmitted successfully to meet the filing requirements of subsection 69L-7.750(5), F.A.C.

(4) Any Sender who experiences a catastrophic event resulting in the insurer's failure to meet the reporting requirements in subsection 69L-7.740(5), F.A.C., shall submit a written or electronic request within 15 business days after the catastrophic event to the Division for approval to submit in an alternative reporting method and an alternative filing timeline. The request shall contain a detailed explanation of the nature of the event, date of occurrence, and measures

being taken to resume electronic submission. The request shall also provide an estimated date by which electronic submission of affected electronic data interchange or EDI filings, as defined in the MEIG, will be resumed. Approval shall be obtained from the Division's Bureau of Data Quality and Collection, 200 East Gaines Street, Tallahassee, Florida 32399-4226. Approval to submit in an alternative reporting method and an alternative filing timeline shall be granted by the Division if a catastrophic event prevents electronic transmission.

(5) When filing any medical report replacement that corrects or replaces a previously accepted medical report, the sender shall use the same control number as the original transaction using bill submission reason code "03". The replacement report shall contain all information necessary to process the medical report including all services and charges from the medical bill as billed by the health care provider and all payments made by a claim administrator or entity acting on behalf of an insurer to the health care provider. Additionally, after being notified by the Division that data has been accepted with errors or that data previously accepted has been deemed inaccurate, a claim administrator or entity acting on behalf of an insurer shall correct or replace the inaccurate data, using the same control number as the original transaction and using bill submission reason code "03". The insurer or the entity acting on behalf of the insurer shall respond 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.

(6) Each insurer shall be responsible for ensuring the accurate completion of the Medical EDI Bill Record Layouts Revision F for Records 09, 10, 11 and 90 as defined in and in accordance with the MEIG's phase-in schedule, as denoted below.

(a) Senders with Sender FL ID numbers 001 – 199, as defined in the MEIG, shall begin testing 150 days after the effective date of this rule and shall complete the testing process with the new Revision "F" record layouts within 195 days after the effective date of this rule.

(b) Senders with Sender FL ID numbers 200 – 899, as defined in the MEIG, shall begin testing 195 days after the effective date of this rule and shall complete the testing process with the new Revision "F" record layouts within 240 days after the effective date of this rule.

(c) Senders with Sender FL ID numbers 900 and above, as defined in the MEIG, shall begin testing 240 days after the effective date of this rule and shall complete the testing process with the new Revision "F" record layouts within 285 days after the effective date of this rule.

(d) The Division will, resources permitting, allow senders that volunteer to complete the test transmission processes earlier than the schedule denoted above. Each voluntary sender shall still have 45 days from the start date of testing to complete the test transmission to production transmission processes, for all Medical EDI Bill Records, that comply with requirements set forth and defined in the MEIG.

(7) Senders who do not accurately complete the testing requirements in accordance with the MEIG shall not submit Revision F medical Reports electronically until having been approved for reporting production data with the Division as necessary to meet the filing requirements of subsection 69L-7.750(5), F.A.C.

(8)(a) In the medical bill claims-handling process, the receipt of medical bills may be based upon receipt by the insurer or "entity" acting on behalf of an insurer. Likewise, the payment of medical bills may be based upon payment by the insurer or "entity" acting on behalf of an insurer. Therefore, to properly reflect "Date Insurer Received Bill" and "Date Insurer Paid Bill," the insurer or entity acting on behalf of the insurer, shall be limited to the receipt and payment options of this subpart for the reporting of a medical bill:

1. Both receipt and payment of medical bills are handled by the insurer. This option may be utilized only when the "Date Insurer Received Bill" is the date the insurer gained possession of the health care provider's medical bill, and the "Date Insurer Paid Bill" is the date the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. This option may not be utilized when a health care provider is required by the insurer to submit medical billings to any "entity" other than the insurer.

2. Both receipt and payment of medical bills are handled by any "entity" acting on behalf of the insurer. This option may be utilized only when the "Date Insurer Received Bill" is the date the "entity" acting on behalf of the insurer gained possession of the health care provider's medical bill, and the "Date Insurer Paid Bill" is the date an entity acting on behalf of the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. This option may not be utilized when a health care provider is required by the insurer to submit medical billings directly to the insurer.

3. Receipt of medical bills is handled by the insurer and payment of medical bills is handled by the "entity" acting on behalf of the insurer. This option may be utilized only when the "Date Insurer Received Bill" is the date the insurer gained possession of the health care provider's medical bill, and the "Date Insurer Paid Bill" is the date an entity acting on behalf of the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider

representative. This option may not be utilized when a health care provider is required by the insurer to submit medical billings to any "entity" other than the insurer.

4. Receipt of medical bills is handled by any "entity" acting on behalf of the insurer and payment of medical bills is handled by the insurer. This option may be utilized only when the "Date Insurer Received Bill" is the date the "entity" acting on behalf of the insurer gained possession of the health care provider's medical bill, and the "Date Insurer Paid Bill" is the date the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. This option may not be utilized when a health care provider is required by the insurer to submit medical billings directly to the insurer.

(b) An insurer and entity may select multiple options for medical bill claims handling between the insurer and the entity based on business practices or whether medical bills are submitted to the insurer electronically or on paper.

(c) The option in paragraph 69L-7.750(8)(a), F.A.C., selected by the insurer shall be identified on each medical report electronic submission to the Division and shall utilize the following coding methodology:

1. If the "Date Insurer Received Bill" is the date the insurer gains possession of the health care provider's medical bill and the "Date Insurer Paid Bill" is the date the health care provider's payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code "x" 1, as defined in the MEIG, shall be transmitted on each individual electronic form equivalent transaction. ("x" shall equal 'R', 'M' or 'C' as denoted in the data dictionary of the MEIG. When submitting Payment Code "x" 1 to the Division, the insurer is declaring that no "entity," as defined in paragraph 69L-7.710(1)(x), F.A.C., is involved in the medical bill claims-handling processes related to "Date Insurer Received Bill" or "Date Insurer Paid Bill".

2. If the "Date Insurer Received Bill" 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 Bill" 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, as defined in the MEIG, shall be transmitted on each individual electronic form equivalent transaction. ("x" shall equal 'R', 'M' or 'C' as denoted in the data dictionary of the MEIG. When submitting Payment Code "x" 2 to the Division, the insurer is declaring that the specified "entity" as defined in subsection 69L-7.710(1)(x), F.A.C., is acting on behalf of the insurer for purposes of the medical bill claims-handling processes related to "Date Insurer Received Bill" and "Date Insurer Paid Bill".

3. If the "Date Insurer Received Bill" is the date the insurer gains possession of the health care provider's medical bill and "Date Insurer Paid Bill" 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, as defined in the MEIG, shall be transmitted on each individual electronic form equivalent transaction. ("x" shall equal 'R', 'M' or 'C' as denoted in the data dictionary of the MEIG. When submitting Payment Code "x" 3 to the Division, the insurer is declaring that no "entity" as defined in paragraph 69L-7.710(1)(x), F.A.C., is involved in the medical bill claims-handling process related to "Date Insurer Received Bill."

4. If the "Date Insurer Received Bill" 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 Bill" is the date the health care provider's payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code "x" 4, as defined in the MEIG, shall be transmitted on each individual form electronic form equivalent transaction. ("x" shall equal 'R', 'M' or 'C' as denoted in the data dictionary of the MEIG. When submitting Payment Code "x" 4 to the Division, the insurer is declaring that no "entity" as defined in paragraph 69L-7.710(1)(x), F.A.C., is involved in the medical bill claims-handling processes related to "Date Insurer Paid Bill."

(9) A Claim administrator or any entity acting on behalf of the insurer, when reporting paid medical claims data to the Division, shall report the dollar amount paid by the insurer or reimbursed to the employee, the employer or other insurer for healthcare service(s) or supply(ies). When reporting disallowed or denied charges, the dollar amount paid shall be reported as $0.00.

(10) A claim administrator 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 federal facilities billing on their usual form, for duplicate medical bills, for medical bills outside the authority of Florida's workers' compensation system, or for health care providers in Rule 69L-7.730(2)(o), F.A.C., who bill on their invoice or letterhead.

(11) A claim administrator or any entity acting on behalf of the insurer, filing electronically, shall submit to the Division the EOBR code(s) relating to the adjudication of each line item billed and:

(a) Maintain the EOBR in a format that can be legibly reproduced, and

(b) When reporting production data in accordance with the MEIG as required in subsection 69L-7.750(6), F.A.C., the insurer shall comply with the EOBR instructions contained in subsection 69L-7.740(13), F.A.C.

(12) A claim administrator, sender or any entity acting on behalf of the insurer shall make available to the Division, upon request and without charge, a legibly reproduced copy of the electronic form equivalents of 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 subsection 69L-7.740(10), F.A.C.

(13) When a claim administrator or any entity acting on behalf of the insurer renders reimbursement following receipt of a determination or final order in response to a petition to resolve a reimbursement dispute filed pursuant to subsection 440.13(7), F.S., the insurer shall:

(a) Submit the required data elements to the Division within 45 days of rendering reimbursement; and

(b) Submit the data as a replacement submission pursuant to the MEIG; and

(c) Submit the cumulative, not the supplemental, payment information at the line-item level utilizing EOBR code 95 for each line-item reflecting a payment amount differing from the payment amount reported on the original submission; and

(d) Report the "Date Insurer Received Bill" as 22 days after the date the determination was received by certified mail, in instances where the insurer has waived its rights under Chapter 120, F.S., or report the "Date Insurer Received Bill" as the date the insurer received the final order by certified mail, in instances where the insurer has invoked its rights pursuant to Chapter 120, F.S., whichever occurs first.

(14) When a claim administrator or any entity acting on behalf of the insurer has reported medical claims data to the Division which were not required, the claim administrator or any entity acting on behalf of the insurer shall withdraw the previously reported data, as described in the MEIG.

(15) When an insurer, claim administrator, or 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 Bill" and "Date Insurer Paid Bill", submitted by the health care provider and shall not combine multiple bills received from a health care provider into a single medical bill transaction.

Rulemaking 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), (5), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS. History–New ______.

Editorial Note: Formerly 69L-7.602 and 69L-7.710, F.A.C.

NAME OF PERSON ORIGINATING PROPOSED RULE: Pamela Macon, Chief, Bureau of Monitoring and Audit, Division of Workers' Compensation, Department of Financial Services

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Jeff Atwater, Chief Financial Officer, Department of Financial Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 6, 2015

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAR: June 3, 2014

DEPARTMENT OF FINANCIAL SERVICES

Division of Worker's Compensation

RULE NOS.:	RULE TITLES:
69L-8.071	Materials for use with the Workers' Compensation Health Care Provider Reimbursement Manual
69L-8.072	Materials for use with the Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers
69L-8.073	Materials for use with the Workers' Compensation Hospital Reimbursement Manual
69L-8.074	Materials for use throughout Rule Chapter 69L-7, F.A.C.

PURPOSE AND EFFECT: The purpose of the proposed new rule chapter and rule sections is to create a more efficient and transparent means of identifying, organizing and updating the incorporated resource materials utilized in conjunction with rule sections listed under Rule Chapter 69L-7, F.A.C., entitled, "Workers' Compensation Medical Reimbursement and Utilization Review." The proposed new rule chapter and rule sections will assist the Department in providing timely updates to the manuals, forms and other materials utilized by the rules listed above.

SUMMARY: The proposed rules reorganize incorporated materials that are utilized in conjunction with DWC medical reimbursement manuals and throughout Rule Chapter 69L-7, F.A.C., entitled, "Workers' Compensation Medical Reimbursement and Utilization Review."

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS AND LEGISLATIVE RATIFICATION: The Agency has determined that this will not have an adverse impact on small business or likely increase directly or indirectly regulatory costs in excess of $200,000 in the aggregate within one year after the implementation of the rule. A SERC has not been prepared by the Agency.

The Agency has determined that the proposed rule is not expected to require legislative ratification based on the statement of estimated regulatory costs or if no SERC is required, the information expressly relied upon and described herein: The Department performed an analysis of the economic impact or regulatory costs for each of the proposed rules and determined that none of the proposed rules will result in costs exceeding the economic analysis criteria set for in paragraphs 120.541(1)(b) or (2)(a), F.S.

Any person who wishes to provide information regarding a statement of estimated regulatory costs, or provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

RULEMAKING AUTHORITY: 440.13(4), 440.15(3)(b), (d), (f), 440.185(5), 440.20(6)(b), 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), (f), (5), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

DATE AND TIME: Tuesday, June 2, 2015 (immediately following the 9:30 AM hearing of Rule Chapter 69L-7, F.A.C.)

PLACE: Room 102, Hartman Building, 2012 Capital Circle Southeast, 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: Pamela Macon, (850)413-1708 or Pamela.Macon@MyFloridaCFO.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 IS: Pamela Macon, Chief, Bureau of Monitoring and Audit, Division of Workers' Compensation, Department of Financial Services, 200 E. Gaines Street, Tallahassee, Florida 32399-4232, (850)413-1708 or Pamela.Macon@MyFloridaCFO.com

THE FULL TEXT OF THE PROPOSED RULE IS:

69L-8.071 Materials for use with the Florida Workers' Compensation Health Care Provider Reimbursement Manual.

(1) The Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2015 Edition (HCP RM), as formerly incorporated by reference in Rule 69L-7.020, F.A.C., adopts all reference materials, as incorporated by reference herein. The incorporated reference materials are as follows:

(a) The CPT® 2014 Current Procedural Terminology Professional Edition, Copyright 2013, American Medical Association;

(b) The Current Dental Terminology, CDT-2014, Copyright 2013, American Dental Association;

(c) The Healthcare Common Procedure Coding System, 2014 HCPCS Level II, Professional Edition, Twenty-fourth Edition, Copyright 2013, Elsevier Inc.(American Medical Association);

(d) The Physician ICD-9-CM®, Volumes 1 & 2, International Classifications of Disease, 9th Revision, Clinical Modification (ICD-9); Copyright 2009, Ingenix, Inc. (American Medical Association);

(e) The 2014 ICD-10-CM: The Complete Official Draft Code Set, Copyright 2013, OptumInsight, Inc., and

(f) The 2014 ICD-10-PCS: The Complete Official Draft Code Set, Copyright 2013, OptumInsight, Inc

(2) When a health care provider performs a procedure or provides a service which is not listed in the HCP RM, 2015 Edition, formerly incorporated by reference as part of Rule 69L-7.020, F.A.C., the provider must use a code contained in materials listed in Rule 69L-8.071(1), F.A.C.

Rulemaking Authority 440.13(13)(b), 440.591 FS. Law Implemented 440.13(12), (13)(b) FS. History – New______.

Editorial Note: Materials were formerly incorporated in Rule 69L-7.602 and 69L-7.710, F.A.C.

69L-8.072 Materials for use with the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers.

(1) The Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2015 Edition, as formerly incorporated by reference in Rule 69L-7.100, F.A.C., adopts all reference materials, as incorporated by reference herein. The incorporated reference materials are as follows:

(a) The CPT® 2010 Current Procedural Terminology Professional Edition, Copyright 2009, American Medical Association;

(b) The Current Dental Terminology, CDT-2009/2010, Copyright 2008, American Dental Association;

(c) The HCPCS Level II, A resourceful compilation of HCPCS codes 2010, Copyright 2009, Ingenix Publishing Group;

(d) The 2010 ICD-9-CM for Hospitals, Volumes 1, 2 and 3, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2009, Ingenix, Inc;

(e) The Physician ICD-9-CM 2010, Volumes 1 & 2, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2009, Ingenix, Inc.; and

(f) CPT® Assistant, Copyright American Medical Association.

Rulemaking Authority 440.13(4), (13), 440.591, FS. Law Implemented 440.13(12), (13) FS. History – New______.

Editorial Note: Materials were formerly incorporated in Rule 69L-7.602 and 69L-7.710, F.A.C.

69L-8.073 Materials for use with the Florida Workers' Compensation Hospital Reimbursement Manual.

(1) The Florida Workers' Compensation Hospital Reimbursement Manual, 2014 Edition (HRM), as formerly incorporated by reference in Rule 69L-7.501, F.A.C., adopts all of the reference materials listed below and incorporated by reference herein. The incorporated reference materials are as follows:

(a) The Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2015 Edition (HCP RM), a s formerly incorporated by reference into Rule 69L-7.020, F.A.C.;

(b) Rule 69L-7.710, F.A.C;

(c) Rule 69L-7.720, F.A.C.;

(d) Rule 69L-7.730, F.A.C.;

(e) Rule 69L-7.740, F.A.C.;

(f) Rule 69L-7.750, F.A.C.;

(g) The 2014 ICD-9-CM for Hospitals, Volumes 1, 2 & 3, Professional Edition, Copyright 2014, Elsevier Saunders, American Medical Association;

(h) The 2014 ICD-10-CM: The Complete Official Draft Code Set, American Medical Association, Copyright 2013, OptumInsight, Inc.;

(i) The 2014 ICD-10-PCS: The Complete Official Draft Code Set, Americn Medical Association, Copyright 2013, OptumInsight, Inc.;

(j) The CPT® 2014 Current Procedural Terminology Professional Edition, Copyright 2013, American Medical Association;

(k) The Current Dental Terminology, CDT-2014, Copyright 2013, American Dental Association; and

(l) The "2014 HCPCS Level II Professional Edition", American Medical Association, Copyright 2014, Elsevier Saunders.

Rulemaking Authority 440.13(12), (13), 440.591 FS., Law Implemented 440.13(12), (13) FS. History – New______.

Editorial Note: Materials were formerly incorporated in Rule 69L-7.602 and 69L-7.710, F.A.C.

69L-8.074 Materials for use throughout Rule Chapter 69L-7, F.A.C.

(1) The Workers' Compensation Medical Reimbursement and Utilization Review, Chapter Rule 69L-7, adopts all reference materials that are incorporated by reference herein. The incorporated reference materials are as follows:

(a) The American Medical Association Healthcare Common Procedure Coding System, Medicare's National Level II Codes (HCPCS), as adopted in Rules 69L-8.071, 69L-8.072 and 69L-8.073, F.A.C.

(b) The Current Procedural Terminology (CPT®), as adopted in Rules 69L-8.071, 69L-8.072 and 69L-8.073, F.A.C.

(c) The Current Dental Terminology (CDT), as adopted in Rules 69L-8.071, 69L-8.072 and 69L-8.073, F.A.C.

(d) The Physician ICD-9-CM, as adopted in Rules 69L-8.071, 69L-8.072 and 69L-8.073, F.A.C.

(e) The ICD-9-CM for Hospitals, as adopted in Rules 69L-8.072 and 69L-8.073, F.A.C.

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

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

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

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

(j) National Uniform Billing Committee Official UB-04 Data Specifications Manual 2015, version 9.00, July 2014, 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/subscriber/index.dhtmll.

(k) The Florida Medical EDI Implementation Guide (MEIG), 2015. The MEIG, 2015 can be obtained from the DFS/DWC web site: http://www.myfloridacfo.com/WC/edi_med.html.

(l) The 2014 ICD-10-CM, as adopted in Rules 69L-8.071 and 69L-8.073, F.A.C.; and

(m) The 2014 ICD-10-PCS, as adopted in Rules 69L-8.071 and 69L-8.073, F.A.C.

Rulemaking Authority 440.13(4), 440.15(3)(b), (d), (f), 440.185(5), 440.20(6)(b), 440.525(2), 440.591, 440.593(5) FS. Law Implemented 440.09, 440.13(2)(a), (3), (4), (6), (11), (12), (13), (16), 440.15(3)(b), (d), (f), (5), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS. History – New______.

Editorial Note: Materials were formerly incorporated in Rule 69L-7.602 and 69L-7.710, F.A.C.

NAME OF PERSON ORIGINATING PROPOSED RULE: Pamela Macon, Chief, Bureau of Monitoring and Audit, Division of Workers' Compensation, Department of Financial Services

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Jeff Atwater, Chief Financial Officer, Department of Financial Services
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: April 30, 2015
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAR: June 3, 2014

Section III
Notice of Changes, Corrections and Withdrawals

AGENCY FOR HEALTH CARE ADMINISTRATION
Health Facility and Agency Licensing

RULE NOS.: RULE TITLES:
59A-5.021 Plans Submission and Fee Requirements
59A-5.022 Physical Plant Requirements for Ambulatory Surgical Centers

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 41 No. 28, February 11, 2015 issue of the Florida Administrative Register.

The following sections of the proposed rule should be changed to read:

59A-5.021 Plans Submission and Fee Requirements.

(1) No construction work, including demolition, shall be started until prior written approval has been given by the Office of Plans and Construction. This includes all construction of new facilities and any and all additions, modifications, renovations, or refurbishment of the site, building, equipment or systems of all existing facilities. Approval to start construction will be granted by the Agency when the design complies with all applicable codes and standards as evidenced by a thorough examination of the documents submitted to the Agency as required for Stage III construction documents.

(2) Approval to start construction limited to demolition, site work, foundation, and building structural frame may be obtained prior to ~~construction document~~ the approval of Stage III construction documents when the following is submitted for review and approval:

(a) A Preliminary Stage II approval letter from the Office of Plans and Construction granted by the Agency when the design complies with applicable life safety code requirements, flood requirements and the layout will accommodate all required functional spaces as evidenced by a thorough examination of the documents submitted to the Agency as required in this rule for Stage II preliminary plans.

(2)(b) through (2)(c) No change.

(d) An infection control risk assessment (ICRA) and a life safety plan indicating temporary egress and detailed phasing plans indicating how the area(s) to be demolished or constructed is to be separated from all occupied areas shall be submitted ~~for review and approval~~ when demolition or construction in and around occupied buildings is to be undertaken. Submissions that fail to provide an ICRA or depict the safety measures prescribed by the ICRA will not be approved.

(3) Construction must commence within 12 months of receiving approval from the Office of Plans and Construction to begin construction. Once construction begins construction activities should be continuous until the completion of the project. Failure to commence construction within 12 months of plan approval or periods of construction inactivity exceeding 12 months following commencement of construction will result in termination of the project. Restarting a terminated project will require resubmission of the construction documents accompanied by a new plan review application and will be subject to all fees prescribed by Section 395.0163, F.S. Projects which have not received approval to begin construction will be considered abandoned following 12 months of inactivity and the project will be terminated. ~~Projects which have not received approval to begin construction will be considered abandoned following 12 months of inactivity and the project will be terminated.~~

(4) No change.

(5) The initial submission of plans to the Office of Plans and Construction for any new project shall include a completed Application for Plan Review, AHCA Form 3500-0011, June 2014, incorporated by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-XXXXX , and a valid Certificate of Need if required by the agency. This information shall accompany the initial submission, ~~and approval will not be granted for any project without a certificate of need if required by the agency~~. Projects requiring a Certificate of Need will not be approved to begin construction without a valid Certificate of Need. Applications for Plan Review are available from the Agency for Health Care Administration, Office of Plans and Construction, 2727 Mahan Drive, Mail Stop #24, Tallahassee, Florida 32308, or at the web address at: ~~http://ahca.myflorida.com/MCHQ/PlansandConstruction.shtml.~~ http://ahca.myflorida.com/MCHQ/Plans/Forms_Rules_Presentations.shtml

(6) No change.

(7) Plans and specifications may be submitted for review at any of the three stages of development described in this rule. ~~Approval of Stage III document is required to begin construction. Limited early construction may be permitted for~~

~~projects with an approved Stage II submission, submission of construction documents limited to the scope of work for early construction, and a letter from the facility holding the Agency for Health Care Administration harmless for any changes require as result of the final construction document review.~~

(7)(a) through (8) No change.

(9) For projects involving only equipment changes or system renovations, only Stage III, construction documents will be accepted ~~may be submitted~~. These documents shall include the following:

(a) Life safety plans showing the fire/smoke compartments in the area of renovation.

(b) Detailed phasing plans indicating how the new work will be separated from all occupied areas.

(c) Engineering plans and specifications for all of the required work.

(10) Stage I, Schematic Plans. ~~At a minimum,~~ ~~t~~The following shall be incorporated into the schematic plans:

(10)(a) through (10)(c) No change.

(11) Stage II, Preliminary Plans.

~~At a minimum,~~ ~~t~~The following shall be incorporated into the preliminary plans.

(11)(a) through (c) No change.

(d) Building ~~locating~~ location dimensions.

(11)(e) through (n) No change.

(12) Stage III, Construction Documents.

The Stage III, construction documents shall be an extension of the Stage II, preliminary plan submission and shall provide a complete description of the contemplated construction. Construction documents shall be signed, sealed and dated and submitted for written approval to the Office of Plans and Construction by a Florida-registered architect and Florida-registered professional engineer. These documents shall consist of work related to civil, structural, mechanical, and electrical engineering, fire protection, lightning protection, landscape architecture and all architectural work. ~~At a minimum, and~~ I~~i~~n addition to the requirements for Stage II submission, the following shall be incorporated into the construction documents:

(12)(a) through (d) No changes.

(e) Mechanical engineering plans including fire and smoke control plans. Include all equipment that requires mechanical utilities ~~Show all items of owner furnished equipment requiring mechanical services~~. Provide a clear and concise narrative control sequence of operations for each item of mechanical equipment including but not limited to air conditioning, heating, ventilation, medical gas, plumbing, and fire protection and any interconnection of the equipment of the systems. Mechanical engineering drawings shall depict completely the systems to be utilized, whether new or existing, from the point of system origination to termination. Provide a tabular schedule giving the required air flow (as computed from the information contained on the ventilation rate table) in cubic feet per minute (cfm) for supply, return, exhaust, outdoor, and ventilation air for each space, as applicable, shown on the architectural documents. The schedule shall also contain the HVAC system design air flow rates and the resulting space relative pressures. The schedule or portion of the schedule as applicable shall be placed on each floor plan drawing sheet containing the spaces depicted on the drawing.

(f) Fire protection system layout documents as defined by the Department of Business and Professional Regulation in Rule 61G15-32.002, F.A.C., where applicable, that shall include the existing system as necessary to define the new work. These documents shall be signed and sealed by a Florida-registered professional engineer.

(12)(g) through (13)(a) No change.

(b) The specifications shall require a performance verification test and balance air quantity values report ~~for a minimum of two operating conditions~~ with the specified air filters installed for each air handling unit system~~.~~ ~~One~~ operating ~~condition shall be with the specified air filters installed~~ in the minimum pressure drop condition ~~or~~ (clean filter state)~~. The second operating condition is to be~~ and at the maximum pressure drop condition ~~and/or~~ (dirty filter state).

(14) All construction documents shall be ~~well~~ coordinated to provide consistency of design intent throughout the documents and phasing plans shall be clear and provide continuity of required services. It is specifically required that in the case of additions to existing institutions, the mechanical and electrical, especially existing essential electrical systems and all other pertinent conditions shall be a part of this submission.

(a) All ~~work described in~~ subsequent addenda, change orders, field orders and other documents altering the above ~~must be approved in writing by the Office of Plans and Construction prior to initiation. Documents submitted for approval shall also be signed, sealed and dated~~ shall also be signed, sealed and dated and submitted in advance to the Office of Plans and Construction for review. The Agency will either approve or disapprove the submission based on compliance with all applicable codes and standards and shall provide a listing of deficiencies in writing.

(b) All submissions will be acted upon by the agency within 60 days of the receipt of properly executed construction documents and the initial payment of the plan review fee. The A~~a~~gency will either approve or disapprove the submission and shall provide a listing of deficiencies in writing. ~~Each subsequent resubmission of documents for review on the project will initiate another 60-day response period~~. All deficiencies noted by the agency must be satisfactorily

corrected before final approval~~.~~ will be provided from the Agency.

(15) Additions or revisions that ~~substantially change~~ increase the ~~original~~ scope of the project work greater than fifty percent or change the original scope of the project more than fifty percent will be required to be submitted as a new project.

(16) No change.

Rulemaking Authority 395.1055 FS. Law Implemented ~~395.001,~~ 395.0163, 471.025, 481.221, 553.73, FS. History–New 6-14-78, Formerly 10D-30.21, Amended 2-3-88, 5-6-92, Formerly 10D-30.021, Amended 11-12-96,__________.

59A-5.022 Physical Plant Requirements for Ambulatory Surgical Centers.

(1) The Agency provides technical assistance to the Florida Building Commission and the State Fire Marshal in developing and maintaining standards for the design and construction of ambulatory surgery centers. These standards are included in the following: ~~All construction of new ambulatory surgery centers and all construction of additions, alterations, refurbishing, renovations to and reconstruction of existing ambulatory surgery centers shall be in compliance with the following codes and standards~~

(a) The building codes ~~described~~ in Rule 61G20-1.001, F.A.C.; as adopted by the Florida Building Commission.

(b) The fire codes ~~described~~ in Chapter 69A-60, F.A.C.; as adopted by the State Fire Marshal.

(c) The handicap accessibility standards in Chapter 553, Part V, F.S. and Rule 61G20-4.002, F.A.C; as adopted by the Florida Building Commission.

(2) No building shall be converted to a licensed ambulatory surgery center unless it complies with the standards and codes in effect when the building is converted. ~~set forth herein and with the physical plant standards set forth in the Florida Building Code, adopted pursuant to 61G20-4.002, F.A.C.~~

(3) No change.

~~(4) The fire safety evaluation system NFPA 101A Alternate Approaches to Life Safety shall not be used as design criteria for new construction. The requirements of this rule are the minimum requirements.~~

Rulemaking Authority 395.1055 FS. Law Implemented 395.1055 FS. History–New 6-14-78, Formerly 10D-30.22, Amended 2-3-88, Formerly 10D-30.022, Amended 6-11-97,____________.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

RULE NO.:	RULE TITLE:
61-35.020	Community Association Management Departmental Forms

NOTICE OF CORRECTION

Notice is hereby given that the following correction has been made to the proposed rule in Vol. 41 No. 46, March 9, 2015 issue of the Florida Administrative Register.

The following language is added to the Summary of Statement of Estimated Regulatory Costs and Legislative Ratification:

The agency has determined that the proposed rule is not expected to require legislative ratification based on the statement of estimated regulatory costs or if no SERC is required, the information expressly relied upon and described herein: The economic review conducted by the agency.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Division of Pari-Mutuel Wagering

RULE NO.:	RULE TITLE:
61D-4.002	Evaluating a Permit Application for a Pari-Mutuel Facility

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 41 No. 90, May 8, 2015 issue of the Florida Administrative Register.

61D-4.002 Evaluating a Permit Application for a Pari-Mutuel Facility.

An applicant for a Florida Pari-Mutuel Facility permit shall submit a Form DBPR PMW-3010, Permit Application; https://www.flrules.org/gateway/reference.asp?NO=Ref-01552, a Form DBPR PMW-3030, Personal History Record; https://www.flrules.org/gateway/reference.asp?NO=Ref-01553, and a Form DBPR PMW-3195, Request for Release of Information and Authorization to Release Information; https://www.flrules.org/gateway/reference.asp?NO=Ref-01555, all of which are effective 9-12-12 and adopted herein by reference. The forms can be obtained at www.myfloridalicense.com/dbpr/pmw or by contacting the Division of Pari-Mutuel Wagering at 1940 North Monroe Street, Tallahassee, Florida 32399-1037.

(1) No change.

(a) Financial profitability of the prospective permitholder as derived from the assets and liabilities of the applicant; the existence of any judgment or current litigation, whether civil, criminal, or administrative; the type of pari-mutuel activity to be conducted and desired period of operation; and net income projected over the first three years of operation with the permit. If the applicant is able to show any profitability as outlined in this subsection, the Division will review the following criteria in subsection (b).

(b) No change.

(2) through (3) No change.

Rulemaking Authority 550.0251(3), 550.054(8)(b), 550.1815(5) FS. Law Implemented 550.0251, 550.054, 550.0951, ~~550.155~~ 550.0115, 550.1815 FS. History–New 10-20-96, Amended 12-15-97, 3-4-07, 9-12-12, ________.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Drugs, Devices and Cosmetics

RULE NO.: RULE TITLE:
61N-1.010 Guidelines for Manufacturing Cosmetics

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 41 No. 85, May 1, 2015 issue of the Florida Administrative Register.

61N-1.010 Requirements ~~Guidelines~~ for Manufacturing Cosmetics.

(1) No change.

(2) Buildings and facilities requirements.

Buildings and facilities used for manufacture, processing, packaging, or relabeling of cosmetics must:

(a) Be constructed ~~of suitable size, design, and construction,~~ and maintained in a clean and orderly manner to prevent selection errors (i.e., mix-ups) or cross contamination between consumables, raw materials, intermediate formulations (i.e., in-process materials), and finished products (This applies to containers, closures, labels and labeling materials as well.);

(b) through (e) No change.

(f) Have ~~adequate~~ washing, cleaning, plumbing, toilet, and locker facilities to allow for:

1. through 3. No change.

(g) No change.

(3) Equipment requirements.

Equipment, machinery and utensils used in manufacturing, processing, packaging, or relabeling of cosmetics must be specifically designed and constructed ~~of appropriate design, size, material and workmanship~~ for the intended purpose to prevent corrosion, accumulation of static material, and adulteration with lubricants, coolants, dirt, and sanitizing agents. The equipment must be:

(a) through (b) No change.

(c) Constructed to ensure accurate ~~Of suitable size and accuracy for~~ measuring, mixing, and weighing operations;

(d) Calibrated regularly or checked according to a standard operating procedure with results documented~~, where appropriate~~; and

(e) No change.

(4) Personnel requirements.

(a) through (c) No change.

(d) Eating food, drinking beverages, or using tobacco must be restricted to ~~appropriate~~ designated areas away from storage and processing areas.

(e) All personnel and visitors must be ~~properly~~ supervised while in the manufacturing facility.

(f) No change.

(5) Raw materials requirements.

Raw materials must be identified, stored, examined, tested, inventoried, handled, and controlled ~~to ensure they conform to appropriate standards and specifications~~. In particular, raw materials must be:

(a) through (d) No change.

(e) Specifically ~~Properly~~ identified and controlled to prevent the use of materials that would be injurious to users if such material were incorporated into a cosmetic product and such product were used under the conditions of use prescribed in the labeling or advertisement of the product or under such conditions as are customary or usual ~~fail to meet acceptance specifications~~.

(6) Water requirements.

(a) There must be established procedures for ensuring that the water used as a cosmetic ingredient is being tested or monitored regularly ~~to verify that it meets applicable chemical, physical, and microbiological specifications for quality~~.

(b) The entire system for supplying water used as a cosmetic ingredient must be set up to avoid stagnation and risks of contamination (This system shall ~~should~~ be routinely cleaned and sanitized according to a ~~an appropriate~~ standard operation procedure that ensures no biofilm build-up.).

(7) Product requirements.

Cosmetic manufacturers shall develop and maintain written manufacturing and control standard operating procedures addressing formulations, processing instructions, in-process control methods, packaging instructions, and instructions for operating equipment); the procedures must include provisions to ensure that:

(a) through (b) No change.

(c) There are ~~appropriate~~ measures to prevent contamination with microorganisms, chemicals, filth, or other extraneous material;

(d) through (f) No change.

(g) Finished product packages bear permanent ~~meaningful~~, unique lot or control numbers and there is a coding system that corresponds to these numbers.

(8) Laboratory controls.

Cosmetic manufacturers shall develop and maintain laboratory controls addressing sample collection techniques, product development specifications, test methods, laboratory equipment, and technician qualifications; the laboratory controls shall ~~should~~ include provisions to ensure that:

(a) No change.

(b) Returned cosmetics are examined for deterioration, contamination, and compliance with the manufacturer's product development ~~acceptance~~ specifications.

(9) Internal audit requirements.

Cosmetic manufacturers must have internal audit procedures that ensure:

(a) Internal audits are conducted randomly and ~~occur regularly or~~ on demand for a specific reason;

(b) No change.

(c) All observations made during the internal audit are evaluated and shared with ~~appropriate~~ management, production, quality control, and lab personnel who are responsible for developing and implementing corrective measures; and

(d) Internal audit follow-up confirms the ~~satisfactory~~ completion or implementation of corrective actions.

(10) Complaints, adverse events and recall requirements.

Cosmetic manufacturers must have standard operating procedures sufficient to:

(a) through (c) No change.

(d) Ensure ~~timely~~ notification of adverse incidents and product recalls to ~~the appropriate~~ state and federal regulatory agencies; such notification shall be no later than 30 calendar days of receipt of the adverse incident and no later than 10 calendar days where the manufacturer has declared a product recall.

Rulemaking Authority 499.05 FS. Law Implemented ~~499.002,~~ 499.008, 499.009 FS. History–New 7-1-96, Formerly 10D-45.0505, Formerly 64F-12.010, Amended ____________.

Section IV
Emergency Rules

NONE

Section V
Petitions and Dispositions Regarding Rule Variance or Waiver

DEPARTMENT OF CHILDREN AND FAMILIES

Agency for Persons with Disabilities

RULE NO.: RULE TITLE:

65G-5.004 Selection of Housing.

NOTICE IS HEREBY GIVEN that on May 7, 2015, the Agency for Persons with Disabilities received a petition for a waiver from paragraph 65G-5.004(2)(b), F.A.C., from William Palmer Esq., counsel for the Petitioner. The rule states in part, "Neither the supported living provider nor the immediate family of the supported living provider shall serve as landlord or have any interest in the ownership of the housing unit." Petitioner is seeking a waiver from paragraph 65G-5.004(2)(b), F.A.C., and states that, "[her daughter] has been living in the housing owned by her provider for more than 20 years, and [the provider] has provided intense specialized care for [her] for the same period. It would result in a substantial hardship for [her daughter] to be uprooted to a new environment and to alter the support system to which [her daughter] has become accustomed for such a long period."

Any interested person or other agency may submit written comments within 5 days after the publication of this notice. Comments received will be made a part of the record regarding the petition for rule waiver.

A copy of the Petition for Variance or Waiver may be obtained by contacting: David De La Paz, Agency for Persons with Disabilities, 4030 Esplanade Way, Suite 380, Tallahassee, Florida 32399-0950, david.delapaz@apdcares.org.

Section VI
Notice of Meetings, Workshops and Public Hearings

DEPARTMENT OF LEGAL AFFAIRS

The Florida Commission on the Status of Women announces a telephone conference call to which all persons are invited.

DATE AND TIME: May 21, 2015, 1:00 p.m.

PLACE: Please call (850)414-3300 for instructions on participation

GENERAL SUBJECT MATTER TO BE CONSIDERED: Annual Report Committee.

NOTE: In the absence of a quorum, items on this agenda will be discussed as workshop, and notes will be recorded although no formal action will be taken. If you have any questions, please call (850)414-3300.

A copy of the agenda may be obtained by contacting: Florida Commission on the Status of Women at the Office of the Attorney General, The Capitol, Tallahassee, FL 32399-1050, (850)414-3300, fax: (850)921-4131.

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 3 days before the workshop/meeting by contacting: Florida Commission on the Status of Women at the Office of the Attorney General, The Capitol, Tallahassee, FL 32399-1050, (850)414-3300, fax: (850)921-4131. 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).

If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.

For more information, you may contact: Florida Commission on the Status of Women at the Office of the Attorney General, The Capitol, Tallahassee, FL 32399-1050, (850)414-3300, fax: (850)921-4131.

DEPARTMENT OF LEGAL AFFAIRS

Division of Victim Services and Criminal Justice Programs

The Florida Council on the Social Status of Black Men and Boys announces a telephone conference call to which all persons are invited.

DATE AND TIME: June 1, 2015, 11:00 a.m. – 12:00 Noon

PLACE: Toll-free dial-in number: 1(888)670-3525, conference code: 8519855825

GENERAL SUBJECT MATTER TO BE CONSIDERED: Discussions will include organizing a meeting with Deans of education on recruiting men of color to major in education.

A copy of the agenda may be obtained by contacting: http://www.cssbmb.com.

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: Bureau of Criminal Justice Programs at (850)414-3300. 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).

For more information, you may contact: Bureau of Criminal Justice Programs at (850)414-3300.

DEPARTMENT OF EDUCATION

The Florida Rehabilitation Council for the Blind announces a telephone conference call to which all persons are invited.

DATE AND TIME: Tuesday, May 19, 2015, 3:00 p.m.

PLACE: Phone number: 1(888)670-3525, participant code: 1242528392, then #

GENERAL SUBJECT MATTER TO BE CONSIDERED: This meeting is to discuss the further development of a Children's Camp.

A copy of the agenda may be obtained by contacting: Alise Fields, Division of Blind Services, 325 W. Gaines Street, Room 1114, Tallahassee, FL 32399, (850)245-0300.

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 7 days before the workshop/meeting by contacting: Alise Fields, Division of Blind Services, 325 W. Gaines Street, Room 1114, Tallahassee, FL 32399, (850)245-0300. 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).

For more information, you may contact: Alise Fields, Division of Blind Services, 325 W. Gaines Street, Room 1114, Tallahassee, FL 32399, (850)245-0300.

DEPARTMENT OF HIGHWAY SAFETY AND MOTOR VEHICLES

The Department of Highway Safety and Motor Vehicles announces a public meeting to which all persons are invited.

DATE AND TIME: May 12 2015, 8:00 a.m. – 12:00 Noon, ET - CANCELLED

PLACE: 2900 Apalachee Parkway, Conference Room A427, Tallahassee Florida 32399

GENERAL SUBJECT MATTER TO BE CONSIDERED: The above scheduled meeting has been CANCELLED.

For more information, you may contact: Terrence Samuel, 2900 Apalachee Parkway, Room D312, Tallahassee, FL 32399, (850)617-2100, terrencesamuel@flhsmv.gov.

DEPARTMENT OF CITRUS

The Florida Department of Citrus announces a workshop to which all persons are invited.

DATE AND TIME: May 27, 2015, 9:00 a.m.

PLACE: Florida Department of Citrus, 605 E. Main Street, Bartow, Florida 33830

GENERAL SUBJECT MATTER TO BE CONSIDERED: The Commission will convene for the purpose of exploring the possibilities of a Federal Research and Promotion Order.

A copy of the agenda may be obtained by contacting: Alex Cutts, Florida Department of Citrus, P.O. Box 9010, Bartow, Florida 33831 or acutts@citrus.myflorida.com.

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: Dianne Screws at dscrews@citrus.myflorida.com or (863)537-3984. 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).

If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.

DEPARTMENT OF CITRUS
The Florida Department of Citrus announces a workshop to which all persons are invited.
DATE AND TIME: May 27, 2015, at conclusion of 9:00 a.m. FRPP workshop but no earlier than 1:00 p.m.
PLACE: Florida Department of Citrus, 605 E. Main Street, Bartow, Florida 33830
GENERAL SUBJECT MATTER TO BE CONSIDERED: The Commission will convene for the purpose of codifying in Rules 20-3 and 20-100.004, F.A.C., the processes and procedures used to collect data and disseminate reports of processing statistics.
A copy of the agenda may be obtained by contacting: Alex Cutts, Florida Department of Citrus, P.O. Box 9010, Bartow, Florida 33831 or acutts@citrus.myflorida.com.
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: Dianne Screws at dscrews@citrus.myflorida.com or (863)537-3984. 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).
If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.

EXECUTIVE OFFICE OF THE GOVERNOR
The Governor's Commission on Community Service - Volunteer Florida announces a telephone conference call to which all persons are invited.
DATE AND TIME: June 2, 2015, 9:00 a.m. until all business is complete
PLACE: Telephone conference call: 1(888)670-3525, pass code: 3360784946#
GENERAL SUBJECT MATTER TO BE CONSIDERED:
Communication Committee, 9:00 a.m. – 10:00 a.m.
Emergency Management Committee, 10:00 a.m. – 11:00 a.m.
Finance and Audit Committee, 11:00 a.m. – 12:00 Noon
Legislative Committee, 1:00 p.m. – 2:00 p.m.
National Service Committee, 2:00 p.m. – 3:00 p.m.
Executive Committee, 3:00 p.m. – 4:00 p.m.
Volunteer Services, 4:00 p.m. – 5:00 p.m.
A copy of the agenda may be obtained by contacting: Marcia Warfel, (850)414-7400.
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 3 days before the workshop/meeting by contacting: Marcia Warfel, (850)414-7400. 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).
If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.
For more information, you may contact: Marcia Warfel, (850)414-7400.

EXECUTIVE OFFICE OF THE GOVERNOR
The Governor's Commission on Community Service - Volunteer Florida Foundation announces a telephone conference call to which all persons are invited.
DATE AND TIME: June 3, 2015, 2:00 p.m. until all business is complete
PLACE: Telephone conference call: 1(888)670-3525, pass code: 3360784946#
GENERAL SUBJECT MATTER TO BE CONSIDERED: Nominating Committee, 2:00 p.m. – 3:00 p.m.
A copy of the agenda may be obtained by contacting: Marcia Warfel, (850)414-7400.
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 3 days before the workshop/meeting by contacting: Marcia Warfel, (850)414-7400. 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).
If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.
For more information, you may contact: Marcia Warfel, (850)414-7400.

EXECUTIVE OFFICE OF THE GOVERNOR
The Governor's Commission on Community Service - Volunteer Florida Foundation announces a telephone conference call to which all persons are invited.
DATE AND TIME: June 5, 2015, 2:00 p.m. until all business is complete

PLACE: Telephone conference call: 1(888)670-3525, pass code: 3360784946#

GENERAL SUBJECT MATTER TO BE CONSIDERED: General Business Meeting, 2:00 p.m. – 3:00 p.m.

A copy of the agenda may be obtained by contacting: Marcia Warfel, (850)414-7400.

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 3 days before the workshop/meeting by contacting: Marcia Warfel, (850)414-7400. 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).

If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.

For more information, you may contact: Marcia Warfel, (850)414-7400.

EXECUTIVE OFFICE OF THE GOVERNOR

The Governor's Commission on Community Service - Volunteer Florida announces a telephone conference call to which all persons are invited.

DATE AND TIME: June 10, 2015, 1:00 p.m. until all business is complete

PLACE: Telephone conference call: 1(888)670-3525, pass code: 3360784946#

GENERAL SUBJECT MATTER TO BE CONSIDERED: General Business Meeting, 1:00 p.m. – 4:00 p.m.

A copy of the agenda may be obtained by contacting: Marcia Warfel, (850)414-7400.

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 3 days before the workshop/meeting by contacting: Marcia Warfel, (850)414-7400. 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).

If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.

For more information, you may contact: Marcia Warfel, (850)414-7400.

REGIONAL PLANNING COUNCILS

Central Florida Regional Planning Council

The Central Florida Regional Planning Council announces a public meeting to which all persons are invited.

DATE AND TIME: May 28, 2015, 9:30 a.m.

PLACE: Hardee County Health Department, 115 K.D. Revell Road, Wauchula, FL 33873

GENERAL SUBJECT MATTER TO BE CONSIDERED: Regular quarterly meeting of the Local Emergency Planning Committee (LEPC) and/or its subcommittees, to discuss the provision of the Emergency Planning Community Right-to-Know Program. Items pertaining to the State Emergency Response Commission (SERC) may be discussed.

A copy of the agenda may be obtained by contacting: Chuck Carter at (863)534-7130, ext. 107 or at ccarter@cfrpc.org.

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 3 days before the workshop/meeting by contacting: Chuck Carter at (863)534-7130, ext. 107 or at ccarter@cfrpc.org. 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).

If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.

WATER MANAGEMENT DISTRICTS

South Florida Water Management District

The South Florida Water Management District announces a public meeting to which all persons are invited.

DATE AND TIME: Wednesday, May 20, 2015, 10:00 a.m.

PLACE: South Florida Water Management District, B-1 Auditorium, 3301 Gun Club Road, West Palm Beach, FL, 33406

GENERAL SUBJECT MATTER TO BE CONSIDERED: Public Meeting to discuss regulatory matters.

All or part of these meetings will be video-conferenced in order to permit maximum participation from the South Florida Water Management District Service Centers located at:

- Lower West Coast Service Center, 2301 McGregor Blvd., Fort Myers, FL 33901
- Orlando Service Center, 1707 Orlando Central Parkway Suite 200, Orlando, FL 32809
- Okeechobee Service Center, 3800 NW 16th Boulevard, Okeechobee, FL 34972

The meeting will also be webcast.

Agendas are available 7 days prior to the meeting date. You may obtain a copy of the agenda by going to our website at: www.sfwmd.gov:

Hold mouse over the "Topics" tab, scroll down to "Permits" and click

Under "Upcoming Events" on the right-hand column, click the "Monthly Regulatory Meetings" link

or subscribe to ePermitting/eNoticing: www.sfwmd.gov/epermitting

For additional information, you may also call our information line: (561)682-6207 or Florida toll-free: 1(800)432-2045, ext. 6207.

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: District Clerk's Office, (561)682-2087. 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).

For more information, you may contact: District Clerk's Office, (561)682-2087.

DEPARTMENT OF MANAGEMENT SERVICES

Division of Purchasing

The Department of Management Services announces a public meeting to which all persons are invited.

DATE AND TIME: Tuesday, May 19, 2015, 2:01 p.m., EDT

PLACE: 4050 Esplanade Way, Tallahassee, Florida 32399-0950

GENERAL SUBJECT MATTER TO BE CONSIDERED: In accordance with Section 120.525, Florida Statutes, a bid opening is hereby noticed for the following ITB (Number: 20-21100000-C) for Agriculture and Lawn Equipment. The Department reserves the right to issue amendments, addenda, and changes to the timeline and specifically to the meeting notice listed above. The Department will post notice of any changes or additional meetings within the Vendor Bid System (VBS) in accordance with Section 287.042(3), Florida Statutes, and will not re-advertise notice in the Florida Administrative Register (FAR). Access the VBS at: http://vbs.dms.state.fl.us/vbs/main_menu.

A copy of the agenda may be obtained by contacting: Leslie Gallegos at (850)488-4946, leslie.gallegos@dms.myflorida.com.

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: Leslie Gallegos. 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).

For more information, you may contact: Leslie Gallegos at (850)488-4946, leslie.gallegos@dms.myflorida.com.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Cosmetology

The Board of Cosmetology announces a telephone conference call to which all persons are invited.

DATE AND TIME: Tuesday, June 16, 2015, 3:00 p.m.

PLACE: Conference number: 1(888)670-3525, participant code: 7335214083

GENERAL SUBJECT MATTER TO BE CONSIDERED: General board business.

A copy of the agenda may be obtained by contacting: Board of Cosmetology, 1940 North Monroe Street, Tallahassee, Florida 32399, (850)487-1395.

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: Board of Cosmetology, 1940 North Monroe Street, Tallahassee, Florida 32399, (850)487-1395. 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).

If any person decides to appeal any decision made by the Board with respect to any matter considered at this meeting or hearing, he/she will need to ensure that a verbatim record of the proceeding is made, which record includes the testimony and evidence from which the appeal is to be issued.

For more information, you may contact: Board of Cosmetology, 1940 North Monroe Street, Tallahassee, Florida 32399, (850)487-1395.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Accountancy

The Board of Accountancy announces a public meeting to which all persons are invited.

DATE AND TIME: May 21, 2015, 3:15 p.m. until all business is concluded

PLACE: 1940 North Monroe Street, Tallahassee, Florida 32399

GENERAL SUBJECT MATTER TO BE CONSIDERED: The Budget Task Force will meet to discuss the board's quarter financials.

A copy of the agenda may be obtained by contacting: Denise Graves, (352)313-6607.

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 2 days before the workshop/meeting by contacting: Denise Graves. 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).
For more information, you may contact: Denise Graves.

DEPARTMENT OF CHILDREN AND FAMILIES
The Collier County Community Alliance announces a public meeting to which all persons are invited.
DATE AND TIME: May 19, 2015, July 21, 2015, September 15, 2015, November 17, 2015, 12:00 Noon
PLACE: Collier County Government Complex, 3301 Tamiami Trail East, Building L, 5th Floor, Naples, FL
GENERAL SUBJECT MATTER TO BE CONSIDERED: Ongoing Collier County Alliance business.
Members recommended bylaw changes (i.e., term limits) on July 31, 2014 to commence on January 20, 2015.
A copy of the agenda may be obtained by contacting: Stephanie Jones at (239)895-0257.
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: Stephanie Jones at (239)895-0257. 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).

ABLE TRUST
The JP PAS Oversight Group announces a public meeting to which all persons are invited.
DATE AND TIME: Thursday, May 21, 2015, 11:00 a.m.
PLACE: Hilton Garden Inn Central, 1330 Blairstone Road, Tallahassee, FL 32301
GENERAL SUBJECT MATTER TO BE CONSIDERED: Policies & procedures, financial reports, program support, and any other business that may come before the committee.
A copy of the agenda may be obtained by contacting: Natalie Alden at (850)488-9071.
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 4 days before the workshop/meeting by contacting: Natalie Alden. 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).
For more information, you may contact: Natalie Alden at (850)488-9071.

ATKINS - BARTOW
The Florida Department of Transportation (FDOT), District One, will hold a public hearing about the design of State Road (SR) 542 in Polk County, Florida. All members of the public are invited to attend.
DATE AND TIME: Thursday, May 21, 2015, 6:00 p.m., open house; 7:00 p.m., formal presentation
PLACE: Saint Matthew Catholic Church Parish Center, 1991 Overlook Drive, Winter Haven, FL 33884
GENERAL SUBJECT MATTER TO BE CONSIDERED: The FDOT is presenting proposed design changes for a 3.5-mile segment of SR 542 from east of Buckeye Loop Road to east of US 27 in Polk County, FL. FDOT sent notices of the public hearing to all property owners located within 300 feet on either side of SR 542 within the project limits. Draft project reports and design plans are available for public review through June 1, 2015, at Winter Haven Public Library, 325 Avenue A NW, Winter Haven, FL. Library hours are Monday and Wednesday 9:00 a.m. to 6:00 p.m., Tuesday and Thursday 10:00 a.m. to 7:00 p.m., and Friday and Saturday 9:00 a.m. to 5:00 p.m.
The FDOT solicits public participation without regard to race, color, national origin, age, sex, religion, disability or family status. People who require special accommodations under the Americans with Disabilities Act or who require translation services (free of charge) should contact Jamie Schley, District One Title VI Coordinator, (863)519-2573, jamie.schley@dot.state.fl.us at least seven days prior to the public hearing. If you are hearing or speech impaired, please contact the FDOT using the Florida Relay Service, 1 (800)955-8771 (TDD) or 1 (800)955-8770 (Voice).
For more information about the project or the public hearing, please contact Amy Setchell, FDOT project manager, (863)519-2609, amy.setchell@dot.state.fl.us or visit the project website: www.sr542design.com.

Section VII
Notice of Petitions and Dispositions Regarding Declaratory Statements

DEPARTMENT OF FINANCIAL SERVICES
Division of State Fire Marshal
NOTICE IS HEREBY GIVEN that the Department of Financial Services has issued an order disposing of the petition for declaratory statement filed by Richard Coates on February 9, 2015. The following is a summary of the agency's disposition of the petition:
The Notice of Petition for Declaratory Statement was published February 19, 2015, in Vol. 41, No. 34 of the Florida Administrative Register. The Petitioner sought a determination by the Department as to whether a boatyard located in Punta Gorda, Florida, complied with Florida Fire Protection Code during an incident that burned Petitioner's boat. The Notice of Denial of Declaratory Statement determined that the Petition is not the appropriate means for determining whether the

conduct of another person/entity, Gator Creek Marina, is in violation of the FFPC. Therefore, the Petition was denied on May 8, 2015.

A copy of the Order Disposing of the Petition for Declaratory Statement may be obtained by contacting: Melissa E. Dembicer, Assistant General Counsel, Department of Financial Services, 200 E. Gaines Street, Tallahassee, Florida 32399-0333 or by email: Melissa.dembicer@myfloridacfo.com.

Section VIII Notice of Petitions and Dispositions Regarding the Validity of Rules

Notice of Petition for Administrative Determination has been filled with the Division of Administrative Hearings on the following rules:

NONE

Notice of Disposition of Petition for Administrative Determination has been filled with the Division of Administrative Hearings on the following rules:

NONE

Section IX Notice of Petitions and Dispositions Regarding Non-rule Policy Challenges

NONE

Section X Announcements and Objection Reports of the Joint Adminstrative Procedures Committee

NONE

Section XI Notices Regarding Bids, Proposals and Purchasing

DEPARTMENT OF EDUCATION

University of Florida

Commissioning Services For UAA-35 UF Indoor Football Practice Facility

NOTICE TO PROFESSIONAL CONSULTANTS:

The University Of Florida Board Of Trustees and the University Athletic Association announces that Professional Services in the disciplines of engineering for Building Systems Commissioning will be required for the project listed below:

Project: UAA-35 Indoor Football Practice Facility (Gainesville FL)

The project includes the construction of a new indoor football practice facility including restrooms, storage, and a satellite training facility. The scope of services shall include construction inspections and testing; completion and maintenance of the Owner's Project Requirements (OPR) document; and construction phase pre-functional, functional, and performance testing for mechanical, electrical, building automation systems. The consultant shall also support project efforts to achieve higher-than-normal energy efficiency and attain Silver LEED certification.

Blanket professional liability insurance will be required for this project in the amount of $1,000,000.

INSTRUCTIONS:

Firms desiring to apply for consideration shall submit a proposal only after thoroughly reviewing the facilities program, Project Fact Sheet for Commissioning Consultants, and other background information. The proposal shall be limited to 20 single-sided pages OR 10 double-sided, consecutively-numbered pages and shall include:

1. A Letter of Application that concisely illustrates the applicant's understanding of the scope of services.
2. A completed, project-specific Commissioning proposal form with signed certification. Applications on any other form will not be considered.
3. Resumes, LEED accreditation, and other pertinent credentials for all proposed staff (applicant and consultants).
4. Proof of the applicant's corporate status in Florida (if applicable) and copies of current licenses for the applicant and its consultants from the appropriate governing board.
5. Proof of the applicant's ability to be insured for the level of professional liability coverage demanded for this project.

At the time of application, the applicant must possess current design Professional Registration Certificate(s) from the appropriate governing board; must be properly registered to practice its profession in the State of Florida; and, if the applicant is a corporation, must be chartered by the Florida Department of State to operate in Florida. As required by Section 287.133, Florida Statutes, an applicant may not submit a proposal for this project if it is on the convicted vendor list for a public entity crime committed within the past 36 months. The selected applicant must warrant that it will neither utilize the services of, nor contract with, any supplier, subcontractor, or consultant in excess of $15,000.00 in connection with this

project for a period of 36 months from the date of their being placed on the convicted vendor list.

Incomplete proposals will be disqualified. Submittal materials will not be returned.

The Commissioning Services Proposal Form and Instructions, Project Fact Sheet, UF Design Services Guide, UF Design & Construction Standards, PD&C non-technical specifications, standard University of Florida Owner-Commissioning Consultant agreement, and other project and process information can be found on the Planning, Design & Construction website. Finalists may be provided with supplemental interview requirements and criteria as needed.

Provide the electronic submittal as prescribed in the Project Fact Sheet. Submittals must be received by 3:00 p.m. local time, on Tuesday, June 9, 2015. Facsimile (FAX) submittals are not acceptable and will not be considered.

Planning, Design & Construction
Ben Hill Griffin Stadium
245 Gale Lemerand Drive
P.O. Box 115050
Gainesville, FL 32611-5050
Telephone: (352)273-4000
Internet: www.facilities.ufl.edu

Section XII
Miscellaneous

EXECUTIVE OFFICE OF THE GOVERNOR

Division of Emergency Management

NOTICE OF FUNDING OPPORTUNITY (NOFO)
Florida Division of Emergency Management Releases
Funding Opportunity for Citizen Corps/Community
Emergency Response Team (CERT) Programs

The Division of Emergency Management is providing you with notification of its intent to open the Fiscal Year 2015-2016 application cycle for competitive awards from the Emergency Management Performance Grant to support the Citizen Corps and Community Emergency Response Team (CERT) Program.

The applications will be available online May 18, 2015, at the Florida Citizen Corps/CERT website, which can be accessed at www.floridadisaster.org/CitizenCorps The submission deadline for all grants is July 20, 2015. If there are no pending appeals, funds provided under the Fiscal Year 2015-2016 cycle will be available to award recipients no earlier than September 1, 2015.

The Citizen Corps mission is to bring community and government leaders together to coordinate the involvement of community members and organizations in emergency preparedness, planning, mitigation, response, and recovery. The participation of community leaders in developing emergency plans is critical to the success of a comprehensive planning process. Community-based planning that involves the whole community will reflect an accurate composite of that community and establish a viable, fully integrated and coordinated plan that emergency officials will execute when an incident occurs.

Specific emphasis should be placed on community preparedness practices that increase the inclusion of people with disabilities into community planning initiatives. Effective preparedness activities will include strategies, projects, and tools for meeting the access and functional needs of workers with disabilities, as well as citizens with disabilities through increased physical, programmatic, and communications access for people who have physical, sensory, intellectual, cognitive, and mental health disabilities in compliance with applicable laws that require inclusive preparedness, response, recovery, and mitigation.

The funds will be available to any regional or local government in the State of Florida. Eligible applicants also include Fire Tax Districts and Native American Tribes or nations of Florida. The total funds for the Citizen Corps/CERT sub-grants are $300,000.

The Division of Emergency Management will accept sub-grant applications to perform the following activities as described hereinafter:

> CERT Program – These funds are for CERT Training and start-up programs in areas of the State where CERT is not currently constituted and/or expansion of current programs. Awarded contracts for a start up or an expansion CERT program will be made available in the range of up to $15,000. There is a match requirement. Certain restrictions on what these grants can be used for do apply.
>
> Citizen Corps Program – These funds are to support the formation of Citizen Corps Councils, to enhance existing Citizen Corps Councils and to carryout Citizen Corps goals and objectives of education, training, recruiting, screening and referring volunteers to the four federally chartered Citizen Corps Programs and other Citizen Corps partners.
>
> *(Please see application instructions for more details)*

All Citizen Corps/CERT grant recipients must register their Citizen Corps Council and/or CERT program and receive approval on the Citizen Corps website at http://www.citizencorps.gov/. In addition, all grant recipients must update/validate their Citizen Corps and/or CERT information, activity, and contacts located on the Citizen Corps and national program websites twice a year. Also, there

will be timely financial reports due quarterly beginning at the start of the grant performance period not the execution date.

All applications must be submitted by 5:00 p.m. (Eastern Time), on July 20, 2015 in a sealed envelope to:

Chanda Jenkins
Florida Division of Emergency Management
Domestic Preparedness Section
2555 Shumard Oak Boulevard
Tallahassee, Florida 32399-2100

Any application received after July 20, 2015, will not be considered for funding. All Sub-grants must be prepared in conformance with the Citizen Corps/CERT Program Application package Instructions found at www.floridadisaster.org/CitizenCorps.

Requests for hard copies of the Citizen Corps/CERT Application Package, questions or other inquiries should be directed to Ms. Chanda Jenkins, State Citizen Corps/CERT Coordinator.

Contact information: (850)414-8538 or preferably by email at Chanda.Jenkins@em.myflorida.com.

DEPARTMENT OF ENVIRONMENTAL PROTECTION
Office of the Secretary

Notice of Project Solicitation: Florida Greenways and Trails Acquisition Cycle Opens

The Department of Environmental Protection, Office of Greenways and Trails, will accept applications for land acquisition funding under the Florida Greenways and Trails Program between July 1, 2015 and August 31, 2015. Applicants must apply for and receive a "Certificate of Eligibility" prior to submittal of an application. Once eligible, an applicant must submit an original "Application for Acquisition of Land" to the Office of Greenways and Trails at the address listed below by 5:00 p.m. EDT August 31, 2015. When possible, please submit application packages (including maps) on 8.5" x 11" paper. You must also provide a copy of the completed application and all attachments on a CD in PDF format. Faxes cannot be accepted.

The Florida Greenways and Trails Program is funded through the sale of bonds authorized under the Florida Forever Act. At present, approximately $2 million is available for acquisition projects. Further program funding is unknown and is contingent upon the Florida Legislature's allocation of additional funds from the Florida Forever Trust Fund. For an application or copy of the rule containing detailed program requirements, call (850)245-3069, visit our website at www.floridagreenwaysandtrails.com or write the Office of Greenways and Trails at: Department of Environmental Protection, Office of Greenways and Trails, 3900 Commonwealth Blvd., MS 795, Tallahassee, FL 32399-3000.

DEPARTMENT OF HEALTH
Board of Medicine

Notice of Emergency Action

On May 8, 2015, State Surgeon General issued an Order of Emergency Suspension of License with regard to the license of Mitchell S. Cohen, P.A., License #: PA 3332. This Emergency Suspension Order was predicated upon the State Surgeon General's findings of an immediate and serious danger to the public health, safety and welfare pursuant to Sections 456.073(8) and 120.60(6), Florida Statutes (2014). The State Surgeon General determined that this summary procedure was fair under the circumstances, in that there was no other method available to adequately protect the public.

DEPARTMENT OF HEALTH
Board of Nursing

Notice of Emergency Action

On May 8, 2015, the State Surgeon General issued an Order of Emergency Suspension of Certification with regard to the certificate of Joleen R. Kennedy, C.N.A., Certificate #: CNA 81172. This Emergency Suspension Order was predicated upon the State Surgeon General's findings of an immediate and serious danger to the public health, safety and welfare pursuant to Sections 456.073(8) and 120.60(6), Florida Statutes (2014). The State Surgeon General determined that this summary procedure was fair under the circumstances, in that there was no other method available to adequately protect the public.

DEPARTMENT OF HEALTH
Board of Nursing

Notice of Emergency Action

On May 8, 2015, the State Surgeon General issued an Order of Emergency Restriction of License with regard to the license of Melissa Ann Camacho, R.N., License #: RN 9313584. This Emergency Restriction Order was predicated upon the State Surgeon General's findings of an immediate and serious danger to the public health, safety and welfare pursuant to Sections 456.073(8) and 120.60(6), Florida Statutes (2014). The State Surgeon General determined that this summary procedure was fair under the circumstances, in that there was no other method available to adequately protect the public.

Section XIII
Index to Rules Filed During Preceeding Week

NOTE: The above section will be published on Tuesday beginning October 2, 2012, unless Monday is a holiday, then it will be published on Wednesday of that week.