Section I
Notices of Development of Proposed Rules and Negotiated Rulemaking

DEPARTMENT OF STATE

Division of Cultural Affairs

RULE TITLE: RULE NO.:
Division of Cultural Affairs 1T-1.001

PURPOSE AND EFFECT: The purpose of these amendments are to incorporate program changes to the Cultural Support Grants Program and revisions to forms used in administration of program-based grants to organizations.

SUBJECT AREA TO BE ADDRESSED: The Cultural Support Grants Program and administrative and reporting requirements for organizations.

SPECIFIC AUTHORITY: 255.043(4), 265.284(5)(d), 265.285(1)(c), 265.286(1),(4),(6), 265.2861(2)(b), 265.2865(6), 265.51, 265.605(1), 265.608, 265.609(1),(4),(6), 265.701(4) FS.

LAW IMPLEMENTED: 215.97, 255.043, 265.284, 265.285, 265.286, 265.2861, 265.2865, 265.51-.56, 265.601-.607, 265.608, 265.609, 265.701, 286.011, 286.012, 286.25 FS.

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

TIME AND DATE: 9:00 a.m., Monday, April 28, 2003

PLACE: Division of Cultural Affairs, 1001 DeSoto Park Drive, 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 7 days before the workshop/meeting by contacting Linda Downey, (850)245-6481. If you are hearing or speech impaired, please contact the Division by using the Florida Relay Service, which can be reached by calling 711.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT, IF AVAILABLE, IS: Linda Downey, Bureau Chief, Grants Services, Division of Cultural Affairs, 1001 DeSoto Park Drive, Tallahassee, Florida 32301

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

DEPARTMENT OF INSURANCE

Division of State Fire Marshal

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Fire Extinguishers and Preengineered Systems 4A-21

RULE TITLE: RULE NO.:
Training Requirements for Servicing Fire Extinguishers and Preengineered Systems 4A-21.115

PURPOSE AND EFFECT: This facilitated rulemaking involves Section 633.061(1), Florida Statutes, relating to training of persons permitted to service fire extinguishers and preengineered systems. The pertinent language in the subject statute states: "All fire extinguishers and preengineered systems required by statute or by rule must be serviced by an organization or individual licensed under the provisions of this chapter. A licensee who receives appropriate training shall not be prohibited by a manufacturer from servicing any particular brand of fire extinguisher or preengineered system." (Emphasis supplied). The facilitated rulemaking affects fire extinguisher dealers and preengineered systems dealers, licensed under Chapter 633, Florida Statutes, manufacturers of fire extinguishers and preengineered systems, fire chiefs, fire marshals, firesafety inspectors licensed under Section 633.081, Florida Statutes, other local fire officials, and owners of fire extinguishers and preengineered systems.

SUBJECT AREA TO BE ADDRESSED: Training for servicing of fire extinguishers and preengineered systems. The specific issue involves:

A. Whether a licensee must be trained by the manufacturer to inspect, service, or maintain any particular brand of fire extinguisher or preengineered system, or

B. Whether a licensee, not trained by the manufacture, may inspect, service, or maintain any particular fire extinguisher or preengineered system provided that the licensee inspects, services, and maintains the equipment in accordance with the manufacturer's maintenance procedures and with the applicable National Fire Protection Association standards, as required by Section 633.065, Florida Statutes.

SPECIFIC AUTHORITY: 633.01(1) FS.

LAW IMPLEMENTED: 633.061(1) FS.

Section 120.54(2)(c), Florida Statutes, provides: "The workshop may be facilitated or mediated by a neutral third person, or the agency may employ other types of dispute resolution alternatives for the workshop that are appropriate for rule development." The workshops will be facilitated by a representative of the Florida Conflict Resolution Consortium, The Florida Atlantic University, 777 Glades Road, Boca Raton, Florida 33431-0991.

The division will conduct a series of at least two facilitated rule development workshops and, if deemed necessary, a third facilitated rule development workshop, to solicit input from affected interests for developing a rule to clarify provisions in Section 633.061, Florida Statutes, as indicated above, regarding "appropriate training" as related to fire extinguisher and preengineered systems.

These facilitated workshops are designed to be interactive among all participants, narrow in scope, and each workshop will build on the results of the previous workshop. For this reason, it is important for all substantially affected persons to attend, or send a representative with full authority to make decisions in their place to, all of the workshops.

A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE FOLLOWING TIMES, DATES AND PLACES SHOWN BELOW:

TIME AND DATE: 10:00 a.m., April 30, 2003

PLACE: 3804 Coconut Palm Drive, Tampa, Florida

TIME AND DATE: 10:00 a.m., May 20, 2003

PLACE: 3804 Coconut Palm Drive, Tampa, Florida

IF DEEMED NECESSARY, A WORKSHOP WILL BE HELD AT THE FOLLOWING TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 10:00 a.m., June 10, 2003

PLACE: 3804 Coconut Palm Drive, Tampa, Florida

IF A THIRD WORKSHOP IS NOT DEEMED NECESSARY, A NOTICE OF CANCELLATION OF THE WORKSHOP ON JUNE 10, 2003, WILL BE PUBLISHED IN THE MAY 30, 2003, EDITION OF THE FLORIDA ADMINISTRATIVE WEEKLY, AND POSTED ON THE DIVISION OF STATE FIRE MARSHAL WEBSITE AT: http://www.fldfs.com/SFM/

In accordance with the Americans with Disabilities Act and Section 286.26, Florida Statutes, persons needing a special accommodation to participate in this workshop should contact Millicent King, (850)413-3171, no later than 48 hours prior to the workshop.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT, IF AVAILABLE, IS: Jim Goodloe, Chief, Bureau of Fire Prevention, 200 East Gaines Street, Tallahassee, Florida 32399-0342, (850)413-3171

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS AVAILABLE AT NOT CHARGE FROM THE CONTACT PERSON LISTED ABOVE.

DEPARTMENT OF INSURANCE

Division of State Fire Marshal

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Firefighter Death Benefits	4A-64
RULE TITLE:	RULE NO.:
Adjustments to Reflect Consumer Price Index	4A-64.006

PURPOSE AND EFFECT: To adopt price level changes relating to firefighter death benefits in Section 112.191, Florida Statutes, for the year 2003-2004.

SUBJECT AREA TO BE ADDRESSED: Firefighter death benefits in Section 112.191, Florida Statutes.

SPECIFIC AUTHORITY: 112.191 FS.

LAW IMPLEMENTED: 112.191 FS.

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

TIME AND DATE: 9:00 a.m., April 28, 2003

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

Pursuant to the provisions of the Americans with Disabilities Act and Section 286.26, Florida Statutes, any person requiring special accommodations to participate in this program, please advise the Department at least 48 hours before the program by contacting: Kimberly Riordan, (850)413-3170.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Harriett Abrams, Assistant Director, Division of State Fire Marshal, 200 East Gaines Street, Tallahassee, Florida 32399-0340, (850)413-3170, Fax (850)922-1235

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

4A-64.006 Adjustments to Reflect Consumer Price Index.

(1) Section 112.191, Florida Statutes, requires that the Division adjust the statutory amount payable based on the Consumer Price Index for all urban consumers published by the United States Department of Labor. The adjustment is to be effective on July 1 of each year using the most recent month for which data is available as of the time of the adjustment ~~as of July 1 of each year~~. The amounts payable for the period from July 1, 2003, through June 30, 2004, using the Consumer Price Index for all urban consumers published by the United States Department of Labor for March, 2003, which is the most recent month for which data is available as of the time of the adjustment, are ~~Since the effective date of the act is July 1, 2002, the statutory amount for the period from July 1, 2002 to June 30, 2003, shall be~~:

(a) For those benefits paid or to be paid under paragraph (a) of subsection (2) of Section 112.191, Florida Statutes: [specific amount to be inserted when the CPI is received for March, 2003, which will be published in the Notice of Hearing] ~~$50,000~~.

(b) For those benefits paid or to be paid under paragraph (b) of subsection (2) of Section 112.191, Florida Statutes: [specific amount to be inserted when the CPI is received for March, 2003, which will be published in the Notice of Hearing] ~~$50,000~~.

(c) For those benefits paid or to be paid under paragraph (c) of subsection (2) of Section 112.191, Florida Statutes: [specific amount to be inserted when the CPI is received for March, 2003, which will be published in the Notice of Hearing] ~~$150,000~~.

(2) No change.

Specific Authority 112.191 FS. Law Implemented 112.191 FS. History–New 3-13-03, Amended ________.

PUBLIC SERVICE COMMISSION

DOCKET NO: Undocketed

RULE TITLE: RULE NO.:

Establishment of Price Index, Adjustment of Rates; Requirement of Bond; Filings After Adjustment; Notice to Customers 25-30.420

PURPOSE AND EFFECT: Pursuant to Section 367.081(4)(a), Florida Statutes, the Commission must make a determination of quality of service as part of a water and/or wastewater utility's request for an index price increase. The amendment to the rule would require a statement on quality of service. The statement would provide the Commission with the information necessary to investigate and make a determination regarding the utility's service.

SUBJECT AREA TO BE ADDRESSED: Water and/or Wastewater Price Index.

SPECIFIC AUTHORITY: 350.127(2), 367.081(4)(a), 367.121(1)(c), (f) FS.

LAW IMPLEMENTED: 367.081(4), 367.121(1)(c), (g) FS.

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

TIME AND DATE: 9:30 a.m., Thursday, May 8, 2003

PLACE: Betty Easley Conference Center, Room 152, 4075 Esplanade Way, Tallahassee, Florida

Any person requiring some accommodation at this workshop because of a physical impairment should call the Division of the Commission Clerk and Administrative Services at (850)413-6770 at least 48 hours prior to the hearing. Any person who is hearing or speech impaired should contact the Florida Public Service Commission by using the Florida Relay Service, which can be reached at: 1(800)955-8771 (TDD).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Troy Rendell, Florida Public Service Commission, 2540 Shumard Oak Blvd., Tallahassee, FL 32399-0862, (850)413-6934

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

25-30.420 Establishment of Price Index, Adjustment of Rates; Requirement of Bond; Filings After Adjustment; Notice to Customers.

(1) through (2)(g) No change.

(h) A statement that the utility does not have any active complaints, corrective orders, or outstanding citations with the Department of Environmental Protection (DEP), the County Health Departments, or the Public Service Commission or that the utility does have active complaints, corrective orders, or outstanding citations with the DEP, the County Health Departments, or the Public Service Commission.

(i) A copy of any active complaints, corrective orders, or outstanding citations with the Department of Environmental Protection (DEP), the County Health Departments, or the Public Service Commission.

(3) through (7) No change.

Specific Authority 350.127(2), 367.081(4)(a), 367.121(1)(c), 367.121(1)(f) FS. Law Implemented 367.081(4), 367.121(1)(c), 367.121(1)(g) FS. History–New 4-5-81, Amended 9-16-82, Formerly 25-10.185, Amended 11-10-86, 6-5-91, 4-18-99,________.

DEPARTMENT OF CORRECTIONS

RULE TITLES:	RULE NOS.:
Offender Grievance Procedures	33-302.101
Offender Orientation	33-302.109

PURPOSE AND EFFECT: The purpose and effect of the proposed rules is to provide for an administrative complaint process for submission of offender complaints alleging violation of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with 45 C.F.R. 164.530, and to provide notice to offenders as to the department's maintenance of the privacy of protected health information in accordance with 45 C.F.R. 164.520.

SUBJECT AREA TO BE ADDRESSED: Application of HIPAA privacy regulations to offenders.

SPECIFIC AUTHORITY: 944.09 FS., 45 CFR 164.520, 164.530 FS.

LAW IMPLEMENTED: 20.315, 944.09 FS., 45 CFR Part 160, 164.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Perri King Dale, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

33-302.101 Offender Grievance Procedures.

(1) through (4) No change.

(5) All grievances concerning Health Insurance Portability and Accountability Act (HIPAA) compliance shall be submitted by the offender to the Director of Community Corrections, as described in subsection (4). The Director of Community Corrections shall respond to the grievance within thirty days of receipt of the grievance.

(6) No action shall be taken against an offender as the result of the offender's submission of a grievance.

Specific Authority 944.09 FS., 45 CFR 164.530. Law Implemented 944.09 FS., 45 CFR Part 160, 164. History–New 5-28-86, Amended 10-1-89, 9-30-91, 2-15-98, Formerly 33-24.005, Amended 3-4-01, 7-30-01, 2-4-02, 5-12-02, _______.

33-302.109 Offender Orientation.

(1) through (6) No change.

(7) The correctional probation officer shall instruct on and review the information contained in the Notice of Privacy Practices, Form DC3-2006. Form DC3-2006 is hereby incorporated by reference. Copies of this form are available from the Forms Control Administrator, Office of the General Counsel, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500. The effective date of this form is ________. The correctional probation officer and the offender shall sign and date Form DC3-2006, Notice of Privacy Practices, certifying that the offender has received a copy of the privacy notice. The original executed Form DC3-2006 shall be placed in the offender file and a copy shall be provided to the offender.

Specific Authority 944.09 FS., 45 CFR 164.520. Law Implemented 20.315, 944.09 FS., 45 CFR Part 160, 164. History–New 7-19-01, Amended 9-15-02, ________.

DEPARTMENT OF CORRECTIONS

RULE TITLE: RULE NO.:
Confidential Records 33-601.901

PURPOSE AND EFFECT: The purpose and effect of the proposed rules is to provide for the privacy of protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164.

SUBJECT AREA TO BE ADDRESSED: Application of HIPAA privacy regulations to inmate and offender records.

SPECIFIC AUTHORITY: 20.315, 944.09, 945.10, 945.25 FS., 45 CFR Part 160, 164.

LAW IMPLEMENTED: 944.09, 945.10, 945.25, 947.13 FS., 45 CFR Part 160, 164.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Perri King Dale, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

33-601.901 Confidential Records.

(1) Inmate and offender access to records or information.

(a) Inmate and offender access to non-medical records or information.

1. No inmate or offender under jurisdiction of the department shall have unlimited or routine access to any information contained in the records of the department. Section 945.10(3), F.S., authorizes the Department of Corrections to permit limited access to information if the inmate or offender makes a written request and demonstrates an exceptional need for information contained in the department's records and the information is otherwise unavailable. Such information shall be provided by the department when the inmate or offender has met the above requirements and can demonstrate that the request is being made under exceptional circumstances as set forth in s. 945.10(3), F.S.

2. It shall be the responsibility of the inmate or offender to maintain such information, and repeated requests for the same information shall not be honored.

~~(2)~~ Copies of documents which have been previously provided to the inmate or offender under other rules of the department will not be provided unless the inmate or offender can demonstrate that exceptional circumstances exist.

3.~~(3)~~ No change.

4.~~(4)~~ An inmate desiring access to non-medical information shall submit the written request to his or her classification officer or officer-in-charge of a community facility; a supervised offender shall submit the request to his or her supervising officer. If the request does not meet the requirements specified in s. 945.10(3), F.S., the request shall be denied in writing. If the request meets the requirements specified in s. 945.10(3), F.S., the request shall be approved without further review. If the request meets the requirements specified in s. 945.10(3), F.S., but details exceptional circumstances other than those listed, the classification officer or officer-in-charge shall review the request and make a recommendation to the classification supervisor who shall be the final authority for approval or disapproval of requests from inmates; for supervised offenders, the recommendation shall be submitted to the correctional probation circuit administrator or designee who shall be the final authority for approval or disapproval.

(b) Inmate and offender access to their own medical or substance abuse clinical records.

1. Definitions.

a. "Medical record" as used in this rule means the inmate's medical file maintained by the department.

b. "Protected health information" or "PHI" as used in this rule means individually identifiable health information about an inmate or offender.

c. "Psychotherapy notes" as used in this rule means notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private or group session. The term does not include medication prescription and monitoring, session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

d. "Substance abuse clinical record" as used in this rule means the department inmate file containing all written documents and records, including department forms compiled to detail an inmate's substance abuse history, substance abuse

screening, assessment, intervention, and other substance abuse services, including the results of urinalysis testing, program participation, and admission and discharge summaries.

2. An inmate shall be allowed to have access to his own medical record and, if such exists, his own substance abuse clinical record. An inmate desiring access to his own medical record shall submit a written request to the health services administrator; an inmate desiring access to his own substance abuse clinical record shall submit a written request to the substance abuse program manager.

3. The department does not maintain medical records or substance abuse clinical records on offenders under community supervision. Access to records maintained by treatment providers under contract with the department should be requested by contacting the treatment provider.

4. Inmates shall have no access to psychotherapy notes maintained in the department's records. Inmates and offenders shall have no access to health information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

5. The request for access shall be denied in whole or in part due to any of the following reasons:

a. The request is for records or information identified in subparagraph 4. above.

b. The request is for PHI that was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would with reasonable likelihood reveal the source of the information.

c. The request is for information not maintained or no longer maintained by the department in its files.

d. There has been a determination by a licensed health care professional that:

I. The requested access is reasonably likely to endanger the life or physical safety of the inmate or another person;

II. The requested access is to PHI that makes reference to another person (other than a health care provider) and such access is reasonably likely to cause substantial harm to such other person; or

III. The access is requested by a personal representative of the inmate and such access is likely to cause substantial harm to the inmate.

6. All requests shall be granted, including providing access or copies or both, or denied, in whole or in part, by the health services administrator or substance abuse program manager in writing within 30 days of the date of receipt of the request, except that where the requested records are not maintained on-site, the department shall provide or deny access, in whole or in part, within 60 days from receipt of the request. If the department is unable to grant or deny, in whole or in part, the request for access within the 30 or 60 day time periods, the department is authorized to extend the time for such action an additional 30 days by providing the inmate a written statement that the time period has been extended for 30 days and the reason(s) for the extension. This extension is available only one time.

7. Denials must provide:

a. The basis for the denial;

b. Information on where the requested information is maintained if sub-subparagraph 5.c. applies, and the department knows where the information is maintained;

c. Notification that the inmate may request a review of the denial by submitting a written request to the health services administrator in the case of medical records, or the substance abuse program manager in the case of substance abuse clinical records; and

d. That the inmate may grieve the denial through the inmate grievance process pursuant to Chapter 33-103, F.A.C.

8. Upon written request of the inmate to the staff member designated above, denials based on sub-subparagraph 5.d. shall be reviewed by a licensed health care professional who is designated by the health services administrator or substance abuse program manager, and who did not participate in the original decision to deny the request. Review of the denial must be completed within a reasonable time after receipt of the request for review. Immediately upon determination on review, the inmate shall be notified in writing of the decision. The determination on review shall be followed by the department.

9. Where a request for access to an inmate's medical record or substance abuse clinical record is denied in part, the department shall provide access to the requested record after excluding the information for which access was denied.

(d) Copies will be provided upon receipt of payment as provided in subsection (2) of this rule, except that when providing the inmate a copy of the requested information would jeopardize either the health, safety, security, custody of the inmate or of other inmates; or the safety of any officer, employee, or other person at the correctional institution or a person responsible for the transporting of the inmate, no copies shall be provided. A denial of copies on this basis shall not be subject to review under subparagraph (c)8. Above.

(2)~~(5)~~ If the information being requested requires duplication, the cost of duplication shall be paid by the inmate or offender, and the inmate or offender will sign a receipt for such copies. The cost for copying is $0.15 per page for single-sided copies. Only one-sided copies will be made for inmates; two-sided copies will not be made for inmates. Additionally, a special service charge will be assessed for providing information when the nature or volume of the records requested requires extensive clerical or supervisory assistance by department personnel. "Extensive" means that it will take more than 15 minutes to locate, review for confidential information, copy and refile the requested material. The special service charge will be computed to the nearest quarter of an hour exceeding 15 minutes based on the current rate of pay for the paygrade of the person who

performed the service~~, but not to exceed paygrade 18~~. Exceptions will not be made for indigent inmates or offenders; indigent inmates will be required to pay for copies.

(3)~~(6)~~ The following records or information contained in department files shall be confidential and shall be released for inspection or duplication only as authorized in this rule:

(a) Medical reports, opinions, memoranda, charts or any other medical record of an inmate or offender, including dental and medical classification reports as well as clinical drug treatment and assessment records; letters, memoranda or other documents containing opinions or reports on the description, treatment, diagnosis or prognosis of the medical or mental condition of an inmate or offender; the psychological screening reports contained in the admission summary; the psychological and psychiatric evaluations and reports on inmates or offenders; health screening reports; Mentally Disordered Sex Offender Status Reports. Other persons may review medical records only when necessary to ensure that the inmate's or offender's overall health care needs are met, or upon a specific written authorization from the inmate or offender whose records are to be reviewed, or as provided by law. If a request for inmate or offender medical records is submitted upon consent or authorization given by the patient inmate or~~/~~offender, the department's Consent and Authorization for Inspection and~~/or~~ Release of Confidential Information, Form DC4-711B must be utilized in order to obtain inmate medical records held by the department. Form DC4-711B is hereby incorporated by reference. Copies of this form are available from the Forms Control Administrator, Office of the General Counsel, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500. ~~Requests for forms to be mailed must be accompanied by a self-addressed stamped envelope.~~ The effective date of this form is ________ ~~September 19, 2000~~. Offenders under supervision, or previously under supervision, who desire information from their own records, shall be referred to the agency or office originating the report or document to obtain such information. ~~Inmates desiring access to information in their own medical records shall submit a written request to the health information specialist/supervisor. If the request does not meet the requirements specified in subsection (1), the request shall be denied. If the request meets the requirements specified in subsection (1) and falls within exceptions (a) through (e) of s. 945.10(3), F.S., the request shall be approved without further review. The records will be provided upon receipt of payment. If the request meets the requirements specified in s. 945.10(3), F.S., but details exceptional circumstances other than those listed in (a) through (e) or falls within (f), the health information specialist/supervisor shall review the request and make a recommendation to the chief health officer who shall be the final authority for approval or disapproval.~~

(b) Preplea, pretrial intervention, presentence and post-sentence investigation reports including supplements, addenda and updates, except as provided in s. 960.001(1)(g), F.S.

(c) No change.

(d) Florida Parole Commission records which are confidential or exempt from public disclosure by law.

(e) through (h) No change.

(4)~~(7)~~ Blueprints, detailed physical diagrams, photographs of institutions and facilities and computer printouts containing information on inmates or offenders except those printouts specifically designated for public use are confidential and can be released only as provided in paragraph (5)~~(8)~~(d) of this rule.

(5)~~(8)~~ Unless expressly prohibited by federal law, the following confidential records or information may be released to the Office of the Governor, the Legislature, the Parole Commission, the Department of Legal Affairs, the Department of Children and Family Services, a private correctional facility or program that operates under a contract, ~~the Department of Legal Affairs,~~ a state attorney, the court, or a law enforcement agency:

(a) Preplea, pretrial intervention, presentence and postsentence investigations along with attachments to such reports, except as provided in s. 960.001(1)(g), F.S.;

(b) Florida Parole commission records;

(c) through (d) No change.

(6)~~(9)~~ After victim information has been redacted, access to preplea, pretrial intervention, presentence or postsentence investigations is authorized as follows:

(a) To any other state or local government agency not specified in subsection (5)~~(8)~~ upon receipt of a written request which includes a statement demonstrating a need for the records or information;

(b) through (c) No change.

(d) Written requests under paragraphs (b) and (c) above must be submitted to the Bureau Chief of Classification and Central Records or designee for approval if the request pertains to an inmate record. If the request pertains to a report in a supervision file, the request shall be submitted to the correctional probation circuit administrator or designee of the office where such record is maintained. If ~~the request pertains to~~ confidential health information is included in the presentence or postsentence investigation, authorization for release must be obtained from the inmate or offender~~, the request shall be submitted to the institutional chief health officer~~.

(7)~~(10)~~ Parties establishing legitimate research purposes who wish to review preplea, pretrial intervention, presentence and postsentence investigation reports in the records of current or prior inmates or offenders must obtain prior approval from the Bureau Chief of Research and Data Analysis. Parties seeking to review records pursuant to this section shall be required to submit a written request to the Bureau Chief of

Classification and Central Records or designee if the report pertains to an inmate, or to the correctional probation circuit administrator or designee of the office where the record is located if the report pertains to a supervised offender. The written request must disclose the name of the person who is to review the records; the name of any organization, corporation, business, school or person for which the research is to be performed; the purpose of the research; any relationship to inmates or offenders or the families of inmates or offenders; and a confidentiality agreement must be signed. After submitting the required written request, research parties must receive written approval as described in this section prior to starting the project.

(8)~~(11)~~ Any information, whether recorded or not, concerning the identity, diagnosis, prognosis or treatment of any inmate or offender which is maintained in connection with the performance of any alcohol or drug abuse prevention or treatment function shall be confidential and shall be disclosed only as follows:

(a) With the prior written consent of the inmate or offender. The written consent shall include the following information:

1. through 8. No change.

9. The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given. If a request for inmate medical records is submitted upon consent given by the patient inmate/offender, the department's Consent and Authorization for Inspection and~~/or~~ Release of Confidential Information, Form DC4-711B, must be utilized in order to obtain medical records held by the department.

(b) Pursuant to 42 C.F.R. Part 2, the department is authorized to disclose information about an inmate or offender to those persons within the criminal justice system who have made participation in the program a condition of the disposition of any criminal proceedings against the inmate or offender or of the inmate or offender's parole or other release from custody if:

1. No change.

2. The inmate or offender has signed Form DC4-711B meeting the requirements of subsection (8)~~(11)~~(a) except for the revocation provision in (8)~~(11)~~(a)8. This written consent shall state the period during which it remains in effect. This period shall be reasonable, taking into account:

a. through c. No change.

(c) A disclosure may not be made on the basis of a consent which:

1. No change.

2. On its face substantially fails to conform to any of the requirements set forth in (8)~~(11)~~(a) above:

3. through 4. No change.

(d) No change.

(e) Whether or not the inmate or offender has given written consent, 42 C.F.R. Part 2 permits disclosure of information as follows:

1. through 4. No change.

5. ~~To~~ R~~r~~eports of suspected child abuse and neglect;

6. No change.

(9) Each employee of the Department of Corrections shall maintain as confidential all medical and mental health information regarding any inmate or offender that the employee obtains in conjunction with his or her duties and responsibilities, and shall not disseminate the medical information or discuss the medical or mental health condition of the inmate or offender with any person except persons directly necessary to the performance of the employee's duties and responsibilities. An employee who has been designated as a member of the healthcare transfer team or is part of a mental health treatment team shall not disseminate inmate medical information or discuss the medical or mental health condition of an inmate with any person except other members of the healthcare transfer team, medical and mental health staff, upper level management at the institution or facility level, regional level and central office level, inspectors from the Inspector General's Office, or department attorneys. Breach of this confidentiality shall subject the employee to disciplinary action. Each employee shall acknowledge receipt and review of Form DC2-813, Acknowledgement of Responsibility to Maintain Confidentiality of Medical/Mental Health Information, indicating that he understands the medical confidentiality requirements. Form DC2-813 is hereby incorporated by reference. Copies of this form are available from the Forms Control Administrator, Office of the General Counsel, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500. The effective date of this form is ________.

Specific Authority 20.315, 944.09, 945.10, 945.25 FS., 45 CFR Parts 160 and 164. Law Implemented 944.09, 945.10, 945.25, 947.13 FS. 42 USCS 290 ee-3, 45 CFR Parts 160 and 164. History–New 10-8-76, Amended 6-10-85, Formerly 33-6.06, Amended 1-12-89, 7-21-91, 9-30-91, 6-2-92, 8-4-93, 6-12-96, 10-15-97, 6-29-98, Formerly 33-6.006, Amended 9-19-00, ________.

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Regulation of Wells	40D-3
RULE TITLE:	RULE NO.:
Rules and Publications Incorporated by Reference	40D-3.037

PURPOSE AND EFFECT: The purpose of the amendment is to adopt updated versions of the Florida Department of Environmental Protection's Water Well Contractor Disciplinary Guidelines and Procedures Manual (October 2002), and the Florida Unified Citations Dictionary for Water Well Construction (October 2002).

SUBJECT AREA TO BE ADDRESSED: Rules and publications incorporated by reference pertaining to the construction of water wells pursuant to Chapter 40D-3, F.A.C.

SPECIFIC AUTHORITY: 373.044, 373.113, 373.309 FS.

LAW IMPLEMENTED: 373.046, 373.308, 373.309, 373.323, 373.324, 373.333 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Karen E. West, Deputy General Counsel, Office of General Counsel, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, Extension 4651

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

40D-3.037 Rules and Publications Incorporated by Reference.

(1) The regulations promulgated by the Department governing the construction of water wells as set forth in Chapter 62-532, the construction of water wells in delineated areas as set forth in Chapter 62-524, F.A.C., the licensing requirements for Water Well Contractors as set forth in Chapter 62-531 and the construction of public supply water wells as set forth in Chapter 62-555, F.A.C., are hereby incorporated by reference and made a part of this rule and shall apply to all water wells constructed, repaired, modified or abandoned in the District.

(2) The Department's Water Well Contractor Disciplinary Guidelines and Procedures Manual (October 2002) and the Department's Florida Unified Citations Dictionary for Water Well Construction (October 2002) are hereby incorporated by reference and made a part of this rule.

(3) Well Construction Forms are incorporated by reference into Rule 40D-1.659, F.A.C., and are available from the District upon request.

Specific Authority 373.044, 373.113, 373.309 FS. Law Implemented 373.046, 373.308, 373.309, 373.323, 373.324, 373.333 FS. History–New 7-1-90, Amended 12-31-92, 4-11-94, 6-27-94, 9-22-94, 7-5-95, 10-19-95, 7-15-99, ________.

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Individual Environmental Resource Permits	40D-4
RULE TITLE:	RULE NO.:
Publications and Agreements Incorporated by Reference	40D-4.091

PURPOSE AND EFFECT: Rule 40D-4.042, Florida Administrative Code (F.A.C.) has been amended to provide that a petitioner seeking a formal determination of wetlands or other surface waters may publish notice of the agency action in accordance with Rule 40D-1.1010, F.A.C. This amendment made the process for noticing petitions for formal wetland determinations consistent with the processes for noticing water use and environmental resource permit applications. The purpose of this proposed amendment is to conform the language in the Basis of Review for Environmental Resource Permits to the language contained within Rule 40D-4.042, F.A.C.

SUBJECT AREA TO BE ADDRESSED: Section 3.4.1 of the Basis of Review of the Environmental Resource Permit Information Manual.

SPECIFIC AUTHORITY: 373.044, 373.046, 373.113, 373.171, 373. 414 FS.

LAW IMPLEMENTED: 373.0361, 373.114, 373.171, 373.403, 373.413, 373.416, 373.429, 373.411 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Jack R. Pepper, Senior Attorney, Office of General Counsel, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, Extension 4651

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

40D-4.091 Publications and Agreements Incorporated by Reference.

The following documents are hereby incorporated into this chapter and Chapters 40D-40 and 40D-400, F.A.C.

(1) "Basis of Review for Environmental Resource Permit Applications with the Southwest Florida Water Management District, ________ ~~September 26, 2002~~. This document is available from the District upon request.

(2) through (4) No change.

Specific Authority 373.044, 373.046, 373.113, 373.171, 373.414 FS. Law Implemented 373.0361, 373.114, 373.171, 373.403, 373.413, 373.414, 373.416, 373.429, 373.441 FS. History–New 4-2-87, Amended 3-1-88, 9-11-88, 10-1-99, 4-1-91, 11-16-92, 1-30-94, 10-3-95, 12-26-95, 5-26-96, 7-23-96, 4-17-97, 4-12-98, 7-2-98, 12-3-98, 7-28-99, 8-3-00, 9-20-00, 6-12-01, 10-11-01, 2-27-02, 7-29-02, 9-26-02, 3-26-03, ________.

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Individual Environmental Resource Permits	40D-4

RULE TITLE: RULE NO.:
Transfer of Permits 40D-4.351

PURPOSE AND EFFECT: Rule 40D-4.351(1), Florida Administrative Code (F.A.C.), provides for the transfer of an Environmental Resource Permit in the event there is sale or other transfer of the permitted surface water management system or the real property on which such system is located. The District routinely transfers Environmental Resource Permits for projects that are still in the construction phase and for projects that have been turned over to the operation phase. The purpose of this proposed rulemaking is to clarify that the District will transfer the Environmental Resource Permit for a project in the event of a change in ownership or control regardless of whether the project is in the construction or the operation phase.

SUBJECT AREA TO BE ADDRESSED: This proposed rulemaking will amend subparagraph (1)(b) of Rule 40D-4.351, F.A.C. which addresses the transfer of Environmental Resource Permits.

SPECIFIC AUTHORITY: 373.044, 373.113 FS.

LAW IMPLEMENTED: 373.413, 373.416(2), 403.805 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Jack R. Pepper, Senior Attorney, Office of General Counsel, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, Extension 4651

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

40D-4.351 Transfer of Permits.

(1) Transfer of Ownership.

(a) A permittee shall notify the District within 30 days of any sale, conveyance or any other transfer for a permitted surface water management system or the real property at which the system is located.

(b) The District will transfer the surface water management system construction permit or operation and maintenance permit provided the land use remains the same.

(c) The permittee transferring the permit shall continue to remain liable for any corrective actions that may be required as a result of any permit violations prior to such sale, conveyance or other transfer.

(2) Conversion to Operation Phase.

(a) In order to convert an environmental resource permit from the construction phase to the operational phase, the permittee shall submit the following:

1. The Statement of Completion and Request for Transfer to Operation Entity form identified in Chapter 40D-1, F.A.C.; and

2. Documentary evidence of satisfaction of permit conditions, other than long-term monitoring.

(b) A conversion to the operational phase shall not occur until a responsible entity meeting the requirements in the "Basis of Review for Environmental Resource Permit Applications with the Southwest Florida Water Management District – October 3, 1995" has been established to operate and maintain the system. The entity must be provided with sufficient ownership, legal or equitable interest so that it has control over all water management facilities authorized by the permit.

Specific Authority 373.044, 373.113 FS. Law Implemented 373.413, 373.416(2), 403.805 FS. History–New 10-1-84, Amended 6-29-93, 10-3-95, ________.

COMMISSION FOR THE TRANSPORTATION DISADVANTAGED

RULE TITLE: RULE NO.:
Definitions 41-2.002

PURPOSE AND EFFECT: The Commission proposes the rule amendments to update the definitions of transportation providers.

SUBJECT AREA TO BE ADDRESSED: The proposed rule amendments add definitions of commercial transportation providers.

SPECIFIC AUTHORITY: 427.013(9) FS.

LAW IMPLEMENTED: 427.011-.017 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE SCHEDULED FOR THE BOARDS NEXT MEETING ON APRIL 25, 2003, IN ORLANDO, FLORIDA.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Jo Ann Hutchinson, Executive Director, Commission for the Transportation Disadvantaged, 605 Suwannee Street, MS-49, Tallahassee, Florida 32399-0450

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

41-2.002 Definitions.

For purposes of this rule chapter, the following definitions will apply:

(1) through (19) No change.

(20) "Common Carrier" means a public transportation provider that is regulated by a federal, state or local government agency to provide for-hire service to the public and include only: Commercial Bus Operators regulated by the Department of Transportation at the state or federal level;

Commercial Airlines; Ferries; Fixed Route Bus and Rail systems regulated by FTA; and, qualified taxi service providers.

(21) "Qualified taxi service provider" means any taxi company with over 60 cabs which is regulated by city or county ordinance, and is providing 24 hour service including wheelchair accessible taxi cabs. At a minimum, said qualifying city or county ordinance must address local government created standards for: local government monitoring and enforcement; annual driver background checks; bi-annual vehicle mechanical inspections; insurance requirements; and, approved taxi meter rates for the general public. A qualified taxi service provider must have at least one wheelchair accessible taxi for each 40, or portion thereof, non-wheelchair accessible cabs.

Specific Authority 427.013(9) FS. Law Implemented 427.011-.017 FS. History–New 5-2-90, Amended 6-17-92, 1-4-94, 7-11-95, 5-1-96, 10-1-96, 3-10-98,________.

COMMISSION FOR THE TRANSPORTATION DISADVANTAGED

RULE TITLE: RULE NO.:

Grants Program 41-2.014

PURPOSE AND EFFECT: The Commission proposes the rule amendments to provide flexibility in the grant process.

SUBJECT AREA TO BE ADDRESSED: The proposed rule amendments update the amount and the allocation of grant funds.

SPECIFIC AUTHORITY: 427.013(9) FS.

LAW IMPLEMENTED: 427.013, 427.0159, 427.016 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL SCHEDULED FOR THE BOARDS NEXT MEETING ON APRIL 25, 2003, IN ORLANDO, FLORIDA.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Jo Ann Hutchinson, Executive Director, Commission for the Transportation Disadvantaged, 605 Suwannee Street, MS-49, Tallahassee, Florida 32399-0450

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

41-2.014 Grants Program.

(1) No change.

(2) Types of Grants.

(a) No change.

(b) Planning Related. Planning related grant funds may be used by an eligible Metropolitan Planning Organization or Designated Official Planning Agency to assist the Commission in their responsibilities at the local level as identified in Chapter 427, Florida Statutes, including support to the local Coordinating Board ~~and capital equipment limited to no more than 15% of the Commission participation~~.

(3) Match Requirement. Eligible grant recipients for the trip and equipment grants only, must provide at least 10% of the total project cost as a local match. The match must be cash generated from local sources~~, except voluntary dollar collections~~. Voluntary dollar collections do not require a match ~~will be matched with in-kind sources~~.

(4) Distribution of Grant Funds. On or about December 15 of each year, the Commission shall allocate a portion identified as the Grants Program of the Transportation Disadvantaged Trust Fund in the following manner:

(a) An annual amount of $1,372,060 ~~$1,331,060~~ of the Grants Program shall be designated for planning grants to assist the Commission with implementation and maintenance of the program at the local level. Beginning with the 2002/2003 grant cycle, the annual cap will be adjusted by the same percentage increase equivalent to state employees as set by the Legislature.

(b) through (c) No change.

(5) Distribution of Trip and Equipment Related Grant Funds. Each eligible applicant's allocation will be determined for the county or counties within the designated service area for which the applicant provides coordinated transportation disadvantaged services.

(a) In order to maintain system and service stability, the Commission's Fiscal Year 99/00 ~~93/94~~ Allocation of Trip and Equipment Grant Funds, dated February, 2000 ~~12/93~~, incorporated herein by reference, shall be the base allocation for each subsequent year's distribution for trip and equipment related grant funds. No county shall receive less than the base allocation unless the Commission's five year cash-flow forecast falls below the Fiscal Year 99/00 ~~93/94~~ levels allocated to the trip and equipment grant related program.

(b) If the level of funding available for distribution to the trip and equipment grant program falls below the base as stated in paragraph 41-2.014(5)(a), F.A.C., a proportionate adjustment to the base allocation will be made. Such adjustment will be based on the five year cash-flow forecast of the Commission, and each county's share of the Fiscal Year 99/00 ~~93/94~~ trip and equipment related grant allocation.

(c) through (e) No change.

(6) Distribution of Planning Related Grants. Planning related grant funds will be apportioned for distribution to the planning agencies as follows:

(a) No change.

(b) 75% of the planning allocation shall be divided into shares equal to the number of counties ~~coordinating boards~~ throughout the state, with each planning agency receiving no more than one share for each county ~~coordinating board~~ within its jurisdiction. Eligible applicants not requiring the total amount of funding available may recommend to the

Coordinating Board that any excess funds be allocated to the Community Transportation Coordinator for additional non-sponsored trip needs. The Commission shall reallocate any eligible excess funds to that particular county or service area's normal allocation. A local cash match of at least 10% shall be required to obtain this additional allocation.

(7) through (8) No change.

Specific Authority 427.013(9) FS. Law Implemented 427.013, 427.0159, 427.016 FS. History–New 5-2-90, Amended 6-17-92, 7-21-93, 6-26-94, 10-1-96, 3-10-98,________.

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Facility and Agency Licensing

RULE TITLE: RULE NO.:

HMO and PHC Penalty Categories 59A-12.0073

PURPOSE AND EFFECT: The purpose and effect of the rule to be developed is to establish penalty categories that specify varying ranges of monetary fines for willful and nonwillful violations of applicable provisions of Chapter 641, F.S., Parts II and III, or applicable rules promulgated thereunder.

SUBJECT AREA TO BE ADDRESSED: The issuance of penalties against health maintenance organizations and prepaid health clinics for violations of Chapter 641, F.S., Parts II and III, or applicable rules.

SPECIFIC AUTHORITY: 641.56 FS.

LAW IMPLEMENTED: 641.52, 641.511, 641.55, 641.58 FS.

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

TIME AND DATE: 9:30 a.m., Tuesday, May 6, 2003

PLACE: Conference Rooms D & E, Building 3, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Hazel Greenberg, Medical Health Care Program Analyst, Agency for Health Care Administration, Bureau of Managed Health Care, Data Analysis Unit, 2727 Mahan Drive, Bldg. 1, Mail Stop Code 26, Tallahassee, FL 32308, (850)414-9444

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59A-12.0073 HMO and PHC Penalty Categories.

(1) Purpose. The purpose of this rule is to establish penalty categories that specify varying ranges of monetary fines for willful and nonwillful violations of applicable provisions of Chapter 641, F.S., Parts II and III, or rules promulgated thereunder.

(2) Scope. This rule developed by the Agency for Health Care Administration governs the issuance of penalties against health maintenance organizations and prepaid health clinics pursuant to the authority set forth in Chapter 641, F.S. It applies to all violations of the provisions Chapter 641, F.S., Parts II and III, or rules promulgated thereunder.

(3) Definitions. The following terms have the following meanings for purposes of this rule:

(a) "Action" means an event or events leading to the commission of a violation.

(b) "HMO" means a health maintenance organization as defined in Section 641.19(13), F.S., and licensed pursuant to the provisions of Chapter 641, F.S.

(c) "Investigation" means any official Agency review, analysis, inquiry, or research into referrals, complaints, or inquiries to determine the existence of a violation pursuant to Section 641.515, F.S.

(d) "Knowing and willful" means any act or omission, which is committed intentionally as opposed to accidentally and which is committed with knowledge of the act's unlawfulness or with reckless disregard as to the unlawfulness of the act.

(e) "PHC" means a prepaid health clinic as defined in Section 641.02(5), F.S., and licensed pursuant to the provisions of Chapter 641, F.S.

(f) "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state.

(g) "Repeat Violations" means a second or subsequent offense of any given violation under this rule.

(h) "Subscriber" means an individual who has contracted, or on whose behalf a contract has been entered into, with a HMO or PHC for health care services.

(i) "Violation" means any instance of noncompliance by a HMO or PHC with any applicable provisions of Chapter 641, F.S., Parts II and III, rules or orders of the Agency governing HMOs or PHCs.

(4) General Provisions:

(a) Rule Not All-Inclusive. This rule contains illustrative violations. This rule does not, and is not intended to, encompass all possible violations of statute or Agency rule that might be committed by a HMO or PHC. The absence of any violation from this rule shall in no way be construed to indicate that the HMO or PHC is not subject to penalty. In any instance wherein the violation is not listed in this rule, the penalty shall be determined by consideration of:

1. The aggravating and mitigating factors specified in this rule; and

2. Any similar or analogous violation that is listed in this rule, if applicable.

(b) Rule and Statutory Violations Included. This rule applies whether the violation is of an applicable statute or Agency rule, or an order implementing such a statute or rule.

(c) Relationship to Other Rules. The provisions of this rule shall be subordinated in the event that any other rule more specifically addresses a particular violation or violations.

(d) Other Licensees. The imposition of a penalty upon any HMO or PHC in accordance with this rule shall in no way be interpreted as barring the imposition of a penalty upon any agent, or other licensee in connection with the same conduct.

(5) Aggravating Factors. The following aggravating factors are considered in determining penalties for violations not listed in this rule, and, as to listed violations, the placement of the penalty within the range specified. The factors are not necessarily listed in order of importance:

(a) Willfulness and knowledge of the violation.

(b) Actual harm or damage to any recipient, subscriber, claimant, applicant, or other person or entity caused by the violation, as determined by the Agency's examination, inspection, or investigation.

(c) Degree of harm to which any recipient, subscriber, claimant, applicant, or other person or entity was exposed by the violation, as determined by the Agency's examination, inspection, or investigation.

(d) Whether the HMO or PHC reasonably should have known of the action's unlawfulness.

(e) Financial gain or loss to the HMO or PHC or its affiliates from the violation.

(f) Whether the violation is a repeat violation.

(g) The number of occurrences of a violation found during an examination, inspection, or investigation.

(6) Mitigating Factors. The following mitigating factors are considered in determining penalties for violations not listed in this rule, and, as to listed violations, the placement of the penalty within the range specified:

(a) Whether corrective activities were actually and substantially initiated (not just planned) and implemented by the HMO or PHC before the violation was noted by or brought to the attention of the Agency and before the HMO or PHC was made aware that the Agency was investigating the alleged violation. Such corrective activities must be implemented to assure that the violation does not recur and include but are not limited to the following: personnel changes, reorganization or discipline, and making any injured party whole as to harm suffered in relation to the violation.

(b) Destruction of records by fire, hurricane, or other natural disaster.

(c) Death of key personnel.

(7) Penalty Categories and Fines Assessed. Violations are divided into three categories. Category I violations are the most serious and Category III violations are the least serious. Category I violations are violations that will cause harm to the subscriber; Category II violations are violations that have the potential to cause harm to the subscriber; and, Category III violations are violations that would cause no harm to the subscriber. The Agency will use the factors in subsections (5) and (6) above, and any similar or analogous violation listed in this rule, if applicable, to determine, within the penalty ranges specified below, the fine for each violation within a category. The penalty amount does not include any examination or investigative costs that may be assessed in addition to the fine.

(a) CATEGORY I. When a fine is imposed within this category for a knowing and willful violation, the amount shall not exceed $20,000 per violation. Additionally, fines for knowing and willful violations may not exceed an aggregate amount of $250,000 for all such violations arising out of the same action. When a fine is imposed for a nonwillful violation within this category, the fine shall not exceed $2,500 per violation. Additionally fines for non-willful violations may not exceed an aggregate amount of $25,000 for all such violations arising out of the same action.

1. Violation by the HMO or PHC of any lawful rule or order of the Agency.

2. Failure by the HMO or PHC to acquire a health care provider certificate from the Agency pursuant to Section 641.49, F.S.

3. Failure by the HMO or PHC to notify the Agency at least 60 days prior to the date it plans to begin providing health care services in a new geographic area pursuant to Section 641.495, F.S.

4. Failure of the HMO or PHC to provide health care services to subscribers as required by Sections 641.495 and 641.51, F.S.

5. Failure by the HMO or PHC to properly provide referrals to out-of-network specially qualified providers or for ongoing specialty care to subscribers pursuant to Section 641.51(6) and (7), F.S.

6. Failure by the HMO or PHC to allow subscribers access to a grievance process for the purpose of addressing complaints and grievances pursuant to Section 641.511, F.S.

7. Failure by the HMO or PHC to notify subscribers of appeal rights under the plan's grievance process pursuant to Section 641.511(10), F.S.

8. Failure of the HMO or PHC to provide emergency services and care to subscribers pursuant to Section 641.513, F.S.

(b) CATEGORY II. If the violation is knowing and willful, the fine assessed shall not exceed $10,000 per violation. If the violation is nonwillful, the fine assessed shall not exceed $1,000 per violation.

1. Failure by the HMO or PHC to provide to the subscriber the right to a second medical opinion pursuant to Section 641.51(5), F.S.

2. Failure by the HMO or PHC in taking appropriate action whenever inappropriate or substandard services have been provided or services which should have been provided have not been provided as determined under the quality assurance program pursuant to Section 641.51, F.S.

3. Failure by the HMO or PHC to investigate and analyze the frequency and causes of adverse incidents causing injury to patients pursuant to Section 641.55, F.S.

4. Failure by the HMO or PHC to analyze patient grievances relating to patient care and quality of medical services pursuant to Section 641.55, F.S.

(c) CATEGORY III. If the violation is knowing and willful, the fine assessed shall not exceed $2,500 per violation. If the violation is nonwillful, the fine assessed shall not exceed $500 per violation.

1. Failure by the HMO or PHC to timely and accurately submit data to the Agency pursuant to Section 641.51(9), F.S., and Chapter 59B-13.001, Florida Administrative Code. The penalty period will begin on the first day following the due date at $200 a day for purposes of penalty assessments.

2. Failure by the HMO or PHC to resolve a grievance with the statutory requirements pursuant to Section 641.511(5) and (6), F.S.

3. Failure by the HMO or PHC to file with the Agency a copy of the quarterly grievance report pursuant to Section 641.511(7), F.S. The penalty period will begin on the first day following the due date at $200 a day for purposes of penalty assessments.

4. Failure by the HMO or PHC to report to the Agency any adverse or untoward incident within the mandated time frames pursuant to Section 641.55(6), F.S. In addition to any penalty imposed, the Agency may impose an administrative fine not to exceed $5,000 per violation pursuant to Section 641.55(7), F.S.

5. Failure by the HMO or PHC to comply with emergency services and care requirements pursuant to Section 641.513, F.S.

6. Failure by the HMO or PHC to pay a claim pursuant to Section 641.513, F.S. Assignment by the HMO or PHC of claim processing and/or payment to a third party administrator or other entity does not relieve the managed care plan of its responsibilities to pay claims.

7. Failure by a HMO or PHC to timely pay the regulatory assessment as required by Section 641.58, F.S., by April 1. The penalty period will begin on the first day following the due date and continue until such time as the assessment is received by the Agency. During such penalty period the HMO or PHC shall be penalized at a rate of $200 per day for each calendar day during the penalty period. The failure to timely pay will be classified as non-willful for the first 30 days that payment has not been received. Starting with day 31, the failure to pay will be classified as a willful violation.

Specific Authority 641.56 FS. Law Implemented 641.52, 641.511, 641.55, 641.58 FS. History–New ________.

AGENCY FOR HEALTH CARE ADMINISTRATION

Cost Management and Control

RULE TITLES:	RULE NOS.:
Purpose of Ambulatory Patient Data Reporting	59B-9.010
Definitions	59B-9.013
Schedule for Submission of Ambulatory Patient Data and Extensions	59B-9.014
Reporting Instructions	59B-9.015
Ambulatory Patient Data Format – Data Elements and Codes	59B-9.018
Ambulatory Patient Data Format – Record Layout	59B-9.019
Data Standards	59B-9.020

PURPOSE AND EFFECT: The proposed rule amendments require emergency department patient data reporting beginning January 1, 2005. The rule amendments add ambulatory data elements, modify ambulatory data elements and codes, modify ambulatory data formats, and eliminate data elements. The rule amendments require reporting by Internet transmission starting January 1, 2006 for emergency department patient data and ambulatory surgery patient data.

SUBJECT AREA TO BE ADDRESSED: The agency is proposing amendments to Rules 59B-9.010, 59B-9.013, 59B-9.014, 59B-9.015, 59B-9.018, 59B-9.019 and 59B-9.020, F.A.C., that require the reporting of emergency department data and modify ambulatory surgery reporting requirements.

SPECIFIC AUTHORITY: 408.15(8) FS.

LAW IMPLEMENTED: 408.061, 408.15(11) FS.

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

TIME AND DATE: 10:00 a.m., May 7, 2003

PLACE: Agency for Health Care Administration, First Floor Conference Room, Building 3, 2727 Mahan Drive, Tallahassee, Florida 32308

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Beth C. Dye, Bureau Chief, State Center for Health Statistics, Agency for Health Care Administration, Building 3, 2727 Mahan Drive, Tallahassee, Florida 32308

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59B-9.010 Purpose of Ambulatory Patient Data Reporting. The reporting of ambulatory patient data will provide a statewide integrated database that includes ~~of~~ ambulatory surgery ~~surgical procedures~~ and hospital emergency department services for the ~~permit~~ assessment of variations in utilization, disease surveillance ~~practice parameters~~, access to ~~ambulatory~~ care and ~~estimates of~~ cost trends ~~for ambulatory procedures~~. The amendments appearing herein are effective with the reporting period starting January 1, 2005 ~~2003~~.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.010, Amended 6-29-95, 12-28-98, 2-25-02, ________.

59B-9.013 Definitions.

(1) through (4) No change.

(5) "Visit" means a face to face encounter between health care provider and a patient who is not formally admitted as an inpatient in an acute care hospital setting ~~and who is not treated in the emergency room~~. Visits which require the patient to appear in an ambulatory setting prior to the actual procedure (even if this occurs one or more days before the procedure) shall be counted as one visit.

(6) No change.

(7) "Attending Physician" means a licensed physician, dentist or podiatrist who has primary responsibility for the patient's medical care and treatment or who certifies as to the medical necessity of the services rendered. The attending physician may be the ~~referring physician or~~ ~~the~~ operating or performing physician.

(8) "Other ~~Operating or Performing~~ Physician" means a licensed physician other than the attending physician who rendered care to the patient ~~has primary responsibility for the surgery or procedure performed~~.

(9) No change.

Specific Authority 408.15(8) FS. Law Implemented ~~395.002,~~ 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.013, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, ________.

59B-9.014 Schedule for Submission of Ambulatory Patient Data and Extensions.

(1) ~~All~~ Ambulatory ~~ambulatory~~ centers ~~reporting their ambulatory patient data~~ shall report ambulatory patient data, as described in subsection 59B-9.015(2) and ~~in the format set forth in~~ Rule 59B-9.018 ~~59B-9.019~~, F.A.C., in a quarterly report according to the following schedule:

(a) Each report covering patient visits ending ~~occurring~~ between January 1 and March 31, inclusive of each year, shall be submitted no later than June 1 ~~10~~ of the calendar year during which the visit occurred.

(b) Each report covering patient visits ending ~~occurring~~ between April 1 and June 30, inclusive of each year, shall be submitted no later than September 1 ~~10~~ of the calendar year during which the visit occurred.

(c) Each report covering patient visits ending ~~occurring~~ between July 1 and September 30, inclusive of each year, shall be submitted no later than December 1 ~~10~~ of the calendar year during which the visit occurred.

(d) Each report covering patient visits ending ~~occurring~~ between October 1 and December 31, inclusive of each year, shall be submitted no later than March 1 ~~10~~ of the calendar year following the year in which the visit occurred.

(2) No change.

Specific Authority 408.15(8) FS. Law Implemented 408.006(5), 408.061 FS. History–New 9-6-93, Formerly 59B-7.014, Amended 6-29-95, ________.

59B-9.015 Reporting Instructions.

(1) Ambulatory centers shall submit ambulatory patient data according to Rules~~s~~ 59B-9.018 ~~59B-9.018, 59B-9.019, and 59B-9.020~~, F.A.C.

(2) Ambulatory centers shall report data for:

(a) All ~~for all~~ non-emergency ~~room ambulatory or outpatient~~ visits in which surgery services were performed and the services provided correspond to a Current Procedural Terminology (CPT) code ~~codes~~ 10000 through 69999 or ~~and~~ 93500 through 93599. Codes must be valid in the current ~~or the immediately preceding~~ year's code book to be accepted.

(b) All emergency department visits in which emergency department registration occurs if the patient is not admitted for inpatient care at the reporting entity. The services provided must correspond to a Current Procedural Terminology (CPT) code, 99280 through 99288, unless the patient left against medical advice or discontinued care. Codes must be valid in the current year's code book to be accepted.

(3) Ambulatory centers shall exclude ~~report one record for each patient per visit, excluding~~ records of any patient visit in which the patient was transferred from ambulatory care and admitted to inpatient care within a facility at the same location per Rule 59A-3.203, F.A.C. ~~If more than one visit for the same patient occurs on the same date, report one record which includes all required data for all visits of that patient to the ambulatory center occurring on that date. If more than one visit occurs on different dates by the same patient,~~ Report ~~report~~ one record for each ~~date of~~ visit, except pre-operation visits may be combined with the record of the associated ambulatory surgery visit ~~unless the dates of visits are directly associated to the service~~. See subsection 59B-9.013(5), F.A.C.

(4) For each patient visit, ambulatory centers shall report all services provided using procedural codes specified in subsection 59B-9.018(2), F.A.C. ~~CPT or the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes.~~

(5) Ambulatory ~~Beginning with the report of patient visits occurring between January 1 and March 31, 2002, inclusive, and thereafter, ambulatory~~ centers shall submit ambulatory patient data reports to the agency using one of the following methods described in (a) or in (b) below except that for patient visits ending on or after January 1, 2006 ~~January 1, 2002~~, the methods described in (b) ~~data tapes~~ must not be used.

(a) Internet Transmission. The Internet address established for receipt of ambulatory patient data is www.fdhc.state.fl.us. Reports sent to the Internet address shall be electronically transmitted with the ambulatory data in a text (XML) ~~(ASCII)~~ file using the XML schema corresponding to the report period at www.fdhc.state.fl.us. ~~The file shall contain a complete set of ambulatory patient data for the calendar quarter. Each record of the text file must be terminated with a carriage return (hex '0D') and line feed mark (hex `0A').~~ The data in the text file shall contain the ~~same~~ data elements and codes, ~~the same~~

~~record layout~~ and meet the ~~same~~ data standards required ~~for tapes or diskettes mailed to the agency as described~~ in Rules 59B-9.018 ~~59B-9.018, 59B-9.019 and 59B-9.020~~, F.A.C.

(b) ~~Tapes,~~ CD-ROM or diskettes shall be sent to the agency's mailing address: Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308. Attention: State Center for Health Statistics. Electronic media specifications are:

~~1. Tape:~~

~~a. Density – 1600 or 6250 BPI, 9 track~~

~~b. Collating Sequence – EBCDIC or ASCII~~

~~c. Record Length – 400 Characters, Fixed~~

~~d. Blocking – Unblocked~~

~~e. Labeling – No Label~~

~~2. Diskette and CD-ROM:~~

1.~~a.~~ MS-DOS formatted

2.~~b.~~ PC Text File (XML) with the schema corresponding to the report period described at www.fdhc.state.fl.us ~~(ASCII)~~.

~~c. Record Length: – Header Record – 400 Characters, Ambulatory Data Record – 400 Characters, Trailer Record 400 Characters. Carriage return and line feed are not included in the stated record length.~~

3.~~d.~~ Type: 3.5" diskette, 1.4MB, hd; or CD-ROM.

4.~~e.~~ FILENAME: (e.g., AS10QYY.XML ~~AS10QYY.TXT~~) The 5th position shall ~~should~~ contain the quarter (1-4) and the 6th and 7th position shall contain the year. XML ~~TXT~~ indicates an XML ~~a~~ text file.

~~f. Each record must be terminated with a carriage return of hex '0D' and line feed mark of hex '0OA'.~~

5.~~g.~~ Only one (1) file per diskette set or CD-ROM is allowable. Data requiring more than one diskette shall have the same internal file name. Data requiring more than one (1) diskette shall be externally labeled 1 of x, 2 of x, etc. (x = total number of diskettes).

(6) Ambulatory centers submitting diskettes ~~tapes or diskettes,~~ shall affix the following external identification, or for CD-ROM, use a standard CD-ROM external label with the following information:

(a) Ambulatory center name

(b) AHCA center identification in the AHCA format

(c) Reporting period

(d) Number of records excluding the header record and the trailer record

~~(e) Tape Density: 1600/6250 BPI~~

~~(f) Tape Collating Sequence~~

(e)~~(g)~~ Diskette or CD-ROM Filename as in Rule 59B-9.015, F.A.C., above.

(f)~~(h)~~ The description: "AMBULATORY PATIENT DATA"

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.015, Amended 6-29-95, 12-28-98, 1-4-00, 7-11-01, 2-25-02,________.

59B-9.018 Ambulatory Patient Data Format – Data Elements and Codes.

(1) Header Record: The first record in the data file shall be a header record ~~with a logical record length of 400 characters,~~ containing the ~~following~~ information described below ~~in the prescribed forma~~t. ~~This record must precede any documentation submitted for ambulatory patient data records.~~ If diskettes are submitted, the header record must be placed as the first record on the first diskette of the data set. ~~A header record must accompany each data set and must be placed as the first record on the first diskette of the data set.~~

~~DATA ELEMENT~~ ~~DESCRIPTION~~

(a) Transaction Code – Enter Q for a calendar quarter report or S for a report period other than a calendar quarter where the special report is requested or authorized by the agency to receive data corrections ~~"H" for header record in the first position~~.

(b) Report ~~Reporting~~ Year – Enter ~~A 4 digit field specifying~~ the year of the data in the format YYYY.

(c) Report Reporting Quarter – Enter ~~A 1 digit field specifying~~ the quarter of the data, 1,2,3 or 4, where 1 corresponds to the first quarter of the calendar year, 2 corresponds to the second quarter of the calendar year, 3 corresponds to the third quarter of the calendar year, and 4 corresponds to the fourth quarter of the calendar year. ~~that the data pertains to:~~

~~1 = Jan. 1 through Mar. 31~~

~~2 = Apr. 1 through Jun. 30~~

~~3 = Jul. 1 through Sept. 30~~

~~4 = Oct. 1 through Dec. 31~~

(d) Data Type – Enter ~~A required four character alphanumeric code. Use~~ AS10 for Ambulatory Data.

(e) Submission Type – Enter I, R, or C where I indicates an initial submission of data or resubmission of previously rejected data, R indicates a replacement submission of previously processed and accepted ambulatory patient data, and C indicates an individual record correction or set of individual record corrections where submission of a correction or corrections is requested or authorized by the agency. ~~A 1 character field for submission type: I = Initial. This is the first submisson for the time period. All submissions which are not "I" will be "R" R = re-submission. This code is used to replace previously submitted records for the specified time period. All existing data for the time period will be deleted and replaced with the new data set.~~

(f) Processing Date – Enter ~~MMDDYYYY,~~ the date that the data file was created in the format YYYY-MM-DD where MM represents numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits ~~by the submitter~~.

(g) AHCA Ambulatory Center Number – Enter the eight ~~A 10~~ digit identification number of the ambulatory center as assigned by AHCA for reporting purposes. ~~A numeric field, right justify.~~

~~(h) Florida License Number Zero fill for this header record only.~~

~~(i) Provider Medicaid Number A 10 digit number provided for Medicaid providers. If not a Medicaid provider, zero fill.~~

~~(j) Provider Medicare Number A 10 digit number provided for Medicare providers. If not a Medicare provider, zero fill.~~

(h)~~(k) Provider~~ Organization Name – Enter the name of the ambulatory center that performed the ambulatory services represented by the data, and which is responsible for reporting the data. All questions regarding data accuracy and integrity will be referred to this entity. Up to a forty character field. ~~The name of the health care entity reporting the patient data records.~~

(i)~~(l)~~ Provider Contact Person Name – Enter the name of the ambulatory center contact person preparing and/or submitting the data. Submit name in the Last, First format. Up to a twenty-five character field. ~~The name of the contact person at the health care entity providing the patient data records.~~

(j)~~(m) Provider~~ Contact Person Telephone Number – The area code, business telephone number, and if applicable ~~required~~, extension for the contact person ~~at the health care entity providing the patient data records~~. Enter the contact person telephone number in the format (AAA)XXX-XXXX-EEEE where AAA is the area code, and EEEE is the extension. Zero fill if no extension.

(k) Contact Person E-Mail Address – The e-mail address of the contact person.

(l) Contact Person Address – Enter the mailing address of the contact person. Up to a forty character field.

(m) Mailing Address City – Enter the city of the address of the contact person. Up to a twenty-five character field.

(n) Mailing Address State – Enter the state of the address of the contact person using the U.S. Postal Service state abbreviation in the format XX. Use the abbreviation FL for Florida. ~~Submitter Organization Name The name of the organization that produced the data file that is being submitted.~~

(o) Mailing Address Zip Code – Enter the zip code of the address of the contact person in the format XXXXX-XXXX. ~~Submitter Contact Person Name The name of the person at the submitting organization responsible for submitting the data file.~~

~~(p) Submitter Contact Person Telephone Number The area code, telephone number, and if required, extension for the contact person at the organization submitting the data file.~~

~~(q) Filler A field of 183 spaces, to be left blank.~~

(2) Individual Data Records: All data elements and data element codes listed below shall be reported consistent with the records of the reporting entity. Data elements and codes are listed with a description of the data to be reported and data standards.

~~DATA ELEMENT DESCRIPTION~~

(a) AHCA Ambulatory Center ~~ID~~ Number – An eight ~~8~~ digit ~~ambulatory center~~ identification number assigned by ~~for~~ AHCA for reporting purposes. The number must match the ambulatory center number recorded on the CD-ROM or diskette external label and header record. A required entry.

(b) Record Identification Number – An alpha-numeric code containing standard letters or numbers assigned by the facility ~~at the time of reporting~~ as a unique identifier for each record submitted in the reporting period ~~for each reporting period,~~ to facilitate storage and retrieval of individual case records. Up to seventeen ~~twelve~~ characters. A required entry. Duplicate record identification numbers are not permitted.

(c) Patient Social Security Number – The social security number (SSN) of the patient ~~who received treatment/services~~. A nine ~~9~~ digit field to facilitate retrieval of individual case records, to be used to track multiple patient visits ~~readmissions~~, and for medical ~~epidemiological~~ research. Reporting 000000000 is acceptable for newborns and infants up to 2 years of age who do not have a SSN. For patients not from the United States, use 555555555 if a SSN is not assigned. For those patients where efforts to obtain the SSN have been unsuccessful or where one is unavailable, and the patient is 2 years of age or older and not known to be from a country other than the United States, use 777777777. A required entry.

(d) Patient Race or Ethnicity ~~Racial Background~~ – Self-designated by the patient or patient's parent or guardian except code 8 indicating no response may be reported where efforts to obtain the information have been unsuccessful. A required entry. Must be a ~~A~~ one digit code as follows:

1. 1 – American Indian or Alaska Native ~~1 – American Indian/Eskimo/Aleut.~~

2. 2 – Asian or Pacific Islander.

3. 3 – Black or African American.

4. 4 – White.

5. 5 – White Hispanic.

6. 6 – Black Hispanic.

7. 7 – Other. Use ~~7 – Other (Use~~ if the patient's self-designated racial or ethnicity ~~patient~~ is not described by the above categories. ~~categories.)~~

8. 8 – No response. Use ~~8 – No response (Use~~ if the patient refuses or fails to disclose.~~)~~

(e) Patient Birth Date – The date of birth of the patient. A ten character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. Use 9999-99-99 where efforts to obtain the patient's birth date have been

unsuccessful. Age greater than 120 years is not permitted unless verified by the reporting entity. A birth date after the patient visit ending date is not permitted. A required entry. ~~MMDDYYYY An 8 digit~~ field.

(f) Patient Sex – The gender of the patient. A required entry. Must be a ~~A~~ one digit code as follows:

1. 1 – Male.

2. 2 – Female or patient's sex cannot be determined due to a medical condition.

3. 3 – Unknown shall be reported where efforts to obtain the information have been unsuccessful and type of service is "2" indicating an emergency department visit and patient status is "07" indicating the patient left against medical advice or discontinued care. ~~(Use if unknown due to medical condition.)~~

(g) Patient Zip Code – The five digit United States Postal Service ZIP Code of the patient's permanent residence. Use 00009 for foreign residences. Use 00007 for homeless patients. Use 00000 where efforts to obtain the information have been unsuccessful. A required entry. ~~A five digit zip code of the patient's permanent address: XXXXX.~~

(h) Patient Visit Beginning Date – The date at the beginning of the patient's visit for ambulatory surgery or the date at the time of registration in the emergency department. A ten character field in the format YYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYY represents the year in four digits. Patient visit beginning date must equal or precede the patient visit ending date. A required entry. ~~MMDDYYY An 8 digit field.~~

(i) Principal Payer Code – Describes the primary source of expected reimbursement for services rendered. A required entry. A blank field is permitted if type of service is "2" and patient status is "07" consistent with the records of the reporting entity. Must be a ~~A~~ one character field using upper case as follows:

1. A – Medicare.

2. B – Medicare HMO.

3. C – Medicaid.

4. D – Medicaid HMO.

5. E – Commercial Insurance.

6. F – Commercial HMO.

7. G – Commercial PPO.

8. H – Workers' Compensation.

9. I - CHAMPUS.

10. J – VA.

11. K – Other State/Local Government ~~Govt.~~

12. L – Self Pay. No third party coverage. ~~Self Pay (No third party coverage).~~

13. M – Other.

14. N – Charity.

15. O – KidCare. Includes ~~KidCare (Report~~ Healthy Kids, MediKids and Children's Medical Services. ~~Required for ambulatory visits occurring on or after January 1, 2003.)~~

(j) Principal Diagnosis Code – The code representing the diagnosis chiefly responsible for the services performed during the visit. Must contain a valid ICD-9-CM or ICD-10-CM diagnosis code if type of service is "1" indicating ambulatory surgery. Must contain a valid ICD-9-CM or ICD-10-CM diagnosis code if type of service is "2" indicating an emergency department visit unless patient status is "07" indicating that the patient left against medical advice or discontinued care. A blank field is permitted if type of service is "2" and patient status is "07" consistent with the records of the reporting entity. If not space filled, must contain a valid ICD-9-CM diagnosis code or valid ICD-10-CM diagnosis code for the reporting period. Inconsistency between the principal diagnosis code and patient sex must be verified by the reporting entity. Inconsistency between the principal diagnosis code and patient age must be verified by the reporting entity. A diagnosis code cannot be used more than once as a principal or other diagnosis for each visit reported. The code must be entered with a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code. ~~The ICD-9-CM codes(s). Enter the primary diagnosis related to the services provided. Left justified, space filled, no decimal. Make certain that blank spaces are not interspersed between codes.~~

(k) ~~through (n)~~ Other Diagnosis Code (1), Other Diagnosis (2), Other Diagnosis (3), Other Diagnosis (4), Other Diagnosis (5), Other Diagnosis (6), Other Diagnosis (7), Other Diagnosis (8), Other Diagnosis (9) ~~Codes~~ – A code representing a diagnosis related to the services provided during the visit. If no principal diagnosis code is reported, other diagnosis code must not be reported. No more than nine other diagnosis codes may be reported. Less than nine entries or no entry is permitted consistent with the records of the reporting entity. If not space filled, must contain a valid ICD-9-CM code or valid ICD-10-CM code for the reporting period. Inconsistency between the diagnosis code and patient sex must be verified by the reporting entity. Inconsistency between the diagnosis code and patient age must be verified by the reporting entity. A diagnosis code cannot be used more than once as a principal or other diagnosis for each visit reported. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code. ~~The ICD-9-CM codes(s). Enter all other diagnoses related to the services provided. Left-justified, space filled, no decimal, includes E-codes. Make certain that blank spaces are not interspersed between codes.~~

(l)~~(o)~~ Principal ~~Primary~~ CPT Procedure Code – The code representing the procedure or service most related to the principal diagnosis. Must contain a valid CPT code between 10000 and 69999, inclusive, or between 93500 and 93599,

inclusive if type of service is "1" indicating ambulatory surgery. Must contain a valid CPT code between 99280 and 99288, inclusive if type of service is "2" indicating an emergency department visit and patient status is not "07." Must contain a valid CPT code between 99280 and 99289, inclusive, or a blank field, consistent with the records of the reporting entity, if type of service is "2" indicating an emergency department visit and patient status is "07" indicating that the patient left against medical advice or discontinued care. If not space filled, must contain a valid ICD-9-CM or ICD-10-CM procedure code. Inconsistency between the principal procedure code and patient sex must be verified by the reporting entity. Inconsistency between the principal procedure code and patient age must be verified by the reporting entity. The code must be five digits and valid for the reporting period. ~~The CPT codes(s). Enter the primary procedure codes for services provided. Enter five digits. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted. This code is directly related to the primary diagnosis.~~

~~(p) Primary Procedure Modifier Code (Optional) The CPT modifier code. Enter primary procedure modifier.~~

~~(q) Primary Procedure Modifier Code (Optional) The CPT modifier code. Enter primary procedure modifier.~~

(m)~~(r)~~ Other CPT Procedure Code (1), Other CPT Procedure Code (2), Other CPT Procedure Code (3), Other CPT Procedure Code (4), Other CPT Procedure Code (5), Other CPT Procedure Code (6), Other CPT Procedure Code (7) Other CPT Procedure Code (8), Other CPT Procedure Code (9) – A code representing a procedure or service provided during the visit. If no principal CPT procedure is reported, other CPT procedure code must not be reported. No more than nine other CPT procedure codes may be reported. Less than nine entries or no entry is permitted consistent with the records of the reporting entity. If not space filled, must be a valid CPT or HCPCS code. Inconsistency between the procedure code and patient sex must be verified by the reporting entity. Inconsistency between the procedure code and patient age must be verified by the reporting entity. The code must be five digits and valid for the reporting period. ~~The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(s) Other Procedure Modifer Code (Optional) The CPT modifier code. Enter other procedure (r) modifier.~~

~~(t) Other Procedure Modifer Code (Optional) The CPT modifier code. Enter other procedure (r) modifier.~~

~~(u) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(v) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (u) modifier.~~

~~(w) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (u) modifier.~~

~~(x) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(y) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (x) modifier.~~

~~(z) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (x) modifier.~~

~~(aa) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(bb) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (aa) modifier.~~

~~(cc) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (aa) modifier.~~

~~(dd) Other Procedure Code. The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(ee) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (dd) modifier.~~

~~(ff) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (dd) modifier.~~

~~(gg) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(hh) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (gg) modifier.~~

~~(ii) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (gg) modifier.~~

~~(jj) Other Procedure Code. The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed~~

~~between codes. CPT codes mustbe recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(kk) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (jj) modifier.~~

~~(ll) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (jj) modifier.~~

~~(mm) Other Procedure Code. The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes mustbe recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(nn) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (mm) modifier.~~

~~(oo) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (mm) modifier.~~

~~(pp) Other Procedure Code. The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(qq) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (pp) modifier.~~

~~(rr) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (pp) modifier.~~

~~(ss) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(tt) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (ss) modifier.~~

~~(uu) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (ss) modifier.~~

~~(vv) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(ww) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (vv) modifier.~~

~~(xx) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (vv) modifier.~~

~~(yy) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(zz) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (yy) modifier.~~

~~(aaa) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (yy) modifier.~~

~~(bbb) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(ccc) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (bbb) modifier.~~

~~(ddd) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (bbb) modifier.~~

~~(eee) Other Procedure Code The CPT or HCPCS code. Enter all procedure codes for services provided. Enter five characters. Make certain that blank spaces are not interspersed between codes. CPT codes must be recent. Codes must be valid in the current or immediately preceding year's code book to be accepted.~~

~~(fff) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (eee) modifier.~~

~~(ggg) Other Procedure Modifier Code (Optional) The CPT modifier code. Enter other procedure (eee) modifier.~~

(n)~~(hhh)~~ Attending ~~Ordering~~ Physician Identification Number – The Florida license number of the attending physician, dentist or podiatrist. Report the physician who had primary responsibility for the patient's care during the visit. ~~ID # Enter the Florida license number of the attending physician, beginning with "FL".~~ An ~~eleven character~~ alpha-numeric field of up to eleven characters ~~(e.g., FLME1234567). If out-of-state physician, fill with the physician's state two letter abbreviation and 9's (e.g., NY999999999 for a physician from New York). For non-U.S. physicians (a physician licensed and practicing in another country and not licensed in the U.S.), fill with "XX" and 9's (e.g., XX999999999).~~ For military physicians not licensed in Florida, use US ~~fill with "US" and 9's (e.g., US999999999)~~. Use NA if the patient was not treated by a physician, dentist or podiatrist. A required entry.

~~(iii) Blank Field A six character alpha-numeric field to be left blank.~~

(o)~~(jjj)~~ Other ~~Operating or Performing~~ Physician Identification Number – The Florida license number of a physician, dentist, or podiatrist who rendered care to the patient other than the physician, dentist, or podiatrist reported in (n) above. ~~ID # Enter the Florida license number of the operating or performing physician, beginning with "FL".~~ An ~~eleven character~~ alpha-numeric field of up to eleven characters ~~(e.g., FLME1234567)~~. No entry is permitted consistent with the records of the reporting entity.

~~(kkk) Blank Field A six character alpha-numeric field to be left blank.~~

(p)~~(lll)~~ Pharmacy Charges – Charges for medication, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no pharmacy charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect total pharmacy charges.~~

(q) Medical and Surgical Supply Charges – Charges for supply items required for patient care, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no medical and surgical supply charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

~~(mmm) Med./Surgical Supp. Charges Enter up to 6 digits to reflect total medical and surgical supply charges.~~

~~(nnn) Radiation Oncology Charges Enter up to 6 digits to reflect total oncology charges.~~

(r)~~(ooo)~~ Laboratory Charges – Charges for the performance of diagnostic and routine clinical laboratory tests, reported in dollars or commas, excluding cents numerically without dollar signs. Report 0 (zero) if there are no laboratory charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect total laboratory charges.~~

(s) Radiology and Computed Tomography Charges – Charges for the performance of diagnostic radiology services including computed tomography, reported in dollars or commas, excluding cents. Report 0 (zero) if there are no radiology or computed tomography charges.

~~(ppp) CT Scan Charges Enter up to 6 digits to reflect total computerized axial tomography (CAT) scan charges.~~

(s)~~(qqq)~~ Operating Room Charges – Charges for the use of the operating room, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no operating room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect total operating room charges.~~

~~(rrr) Anesthesia Charges – Enter up to 6 digits to reflect total anesthesia charges.~~

~~(sss) MRI Charges – Enter up to 6 digits to reflect total magnetic resonance imaging (MRI) charges.~~

(t) Emergency Room Charges – Charges for medical examinations and emergency treatment, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no emergency room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

~~(ttt) Recovery Room Charges – Enter up to 6 digits to reflect total recovery room charges.~~

(u)~~(uuu)~~ Treatment or Observation Room Charges – Charges for use of a treatment room or for the room charge associated with observation services, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no treatment or observation room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect total treatment or observation room charges.~~

(v)~~(vvv)~~ Other Charges – Other facility charges not included in (p) to (u) above, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no other charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~Enter up to 6 digits to reflect any other charges that do not fall into any of the categories above.~~

(w)~~(www)~~ Total Gross Charges – The total of undiscounted ~~A required field. Enter up to 8 digits. Total~~ billed charges to the patient for services rendered ~~for the visit~~ by the reporting entity, reported in dollars numerically without dollar signs or commas, excluding cents. Include charges for services rendered by the ambulatory center excluding professional fees. Zero (0) or negative amounts are not permitted unless verified separately by the reporting entity. Amounts exceeding 50000 must be verified separately by the reporting entity if type of service is "1" indicating ambulatory surgery. Amounts exceeding 500000 must be verified separately by the reporting entity if type of service is "2" indicating an emergency department visit. The sum of pharmacy charges, medical and surgical supply charges, laboratory charges, operating room charges, emergency room charges, treatment or observation room charges, and other charges must equal total charges, plus or minus 10. A required entry. ~~Include charges for the standard package of surgical procedure services as defined by CPT and charges for all other technical services and professional radiological services if facility bills globally, provided for this encounter. Round to the nearest dollar. No negative numbers.~~

(x) Type of Service Code – A code designating the type of service, etiher ambulatory surgery or emergency department visit. A required entry. Must be a one digit code as follows:

1. 1 – Ambulatory surgery, as described in paragraph 59B-9.015(2)(a), F.A.C.
2. 2 – Emergency department visit, as described in paragraph 59B-9.015(2)(b), F.A.C.

(y) Patient Visit Ending Date æ The date at the end of the patient's visit. A ten character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. Patient visit ending date must equal or follow the patient visit beginning date. Patient visit ending data must occur within the calendar quarter recorded on the CD-ROM or

diskette external label and header record. A visit exceeding 3 days as determined by the patient visit beginning date and patient visit ending date must be verified by the reporting entity. A blank field is not permitted unless type of service is "2" indicating an emergency department visit and patient status is "07" indicating the patient left against medical advice or discontinued care. ~~MMDDYYYY An 8 digit field.~~

(z) Hour of Arrival – The hour on a 24-hour clock during which the patient's visit for ambulatory surgery began or during which registration in the emergency department occurred. A required entry. Use 99 where efforts to obtain the information have been unsuccessful. Must be two digits as follows:

1. 00 – 12:00 midnight to 12:59
2. 01 – 01:00 to 01:59
3. 02 – 02:00 to 02:59
4. 03 – 03:00 to 03:59
5. 04 – 04:00 to 04:59
6. 05 – 05:00 to 05:59
7. 06 – 06:00 to 06:59
8. 07 – 07:00 to 07:59
9. 08 – 08:00 to 08:59
10. 09 – 09:00 to 09:59
11. 10 – 10:00 to 10:59
12. 11 – 11:00 to 11:59
13. 12 – 12:00 noon to 12:59
14. 13 – 01:00 to 01:59
15. 14 – 02:00 to 02:59
16. 15 – 03:00 to 03:59
17. 16 – 04:00 to 04:59
18. 17 – 05:00 to 05:59
19. 18 – 06:00 to 06:59
20. 19 – 07:00 to 07:59
21. 20 – 08:00 to 08:59
22. 21 – 09:00 to 09:59
23. 22 – 10:00 to 10:59
24. 23 – 11:00 to 11:59
25. 99 – Unknown.

(aa) Hour of Departure – The hour on a 24-hour clock during which the patient's visit ended. A required entry. Use 99 where efforts to obtain the information have been unsuccessful. Must be two digits as follows:

1. 00 – 12:00 midnight to 12:59
2. 01 – 01:00 to 01:59
3. 02 – 02:00 to 02:59
4. 03 – 03:00 to 03:59
5. 04 – 04:00 to 04:59
6. 05 – 05:00 to 05:59
7. 06 – 06:00 to 06:59
8. 07 – 07:00 to 07:59
9. 08 – 08:00 to 08:59
10. 09 – 09:00 to 09:59
11. 10 – 10:00 to 10:59
12. 11 – 11:00 to 11:59
13. 12 – 12:00 noon to 12:59
14. 13 – 01:00 to 01:59
15. 14 – 02:00 to 02:59
16. 15 – 03:00 to 03:59
17. 16 – 04:00 to 04:59
18. 17 – 05:00 to 05:59
19. 18 – 06:00 to 06:59
20. 19 – 07:00 to 07:59
21. 20 – 08:00 to 08:59
22. 21 – 09:00 to 09:59
23. 22 – 10:00 to 10:59
24. 23 – 11:00 to 11:59
25. 99 – Unknown.

(bb) Mode of Arrival Code – The mode of arrival of the patient indicating transportation or other circumstances. A required entry. Use 3 if type of service is "1" indicating ambulatory surgery. If type of service is "2" indicating an emergency department visit, use a one digit code as follows:

1. 1 – Ambulance by air transportation.
2. 2 – Ambulance by ground transportation.
3. 3 – Public service (police, social services) intervention excluding ambulance.
4. 4 – Walk-in or self-transportation (car, bus, taxi or other motor vehicle excluding ambulance).
5. 5 – Unknown. Use if the information not available and efforts to obtain the information have been unsuccessful.

(cc) Patient's Reason for Visit (Admitting Diagnosis) – The code representing the patient's diagnosis or reason for visit at the time of registration. Must contain a valid ICD-9-CM code or valid ICD-10-CM code for the reporting period if type of service is "2" indicating an emergency department visit unless the patient fails to disclose or the information is unavailable. A blank field is permitted if the patient fails to disclose or efforts to obtain the information have been unsuccessful consistent with the records of the reporting entity. If not space filled, must contain a valid ICD-9-CM or ICD-10-CM diagnosis code. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code. Space fill if type of service is "1" indicating ambulatory surgery.

~~(xxx) Radiology Professional Fees Indicator – A required field. A one digit code. 1 = Yes. 2 = No. "Yes" means total charges reported in the data field (www) include professional fees for radiology. "No" means total charges in data field (www) do not include professional fees for radiology services.~~

~~(yyy) Blank Field – A two character alpha-numeric field to be left blank.~~

(dd)(zzz) Principal ICD Procedure Code (Optional) – The code representing the procedure or service most related to the principal diagnosis. A blank field is permitted if type of service is "1" indicating ambulatory surgery. Must contain a valid ICD-9-CM or ICD-10-CM procedure code if type of service is "2" indicating an emergency department visit unless patient status is "07" indicating the patient left against medical advice or discontinued care. No entry is permitted consistent with the records of the reporting entity if type of service is "2" and patient status is "07." If not space filled, must contain a valid ICD-9-CM or ICD-10-CM procedure code for the reporting period. Inconsistency between the principal procedure code and patient sex must be verified by the reporting entity. Inconsistency between the principal procedure code and patient age must be verified by the reporting entity. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code. The ICD-9-CM code. Enter the principal procedure code related to the primary procedure. Left-justified, space filled, no decimal.

(ee) Other ICD Procedure Code (1), Other ICD Procedure Code (2), Other ICD Procedure Code (3), Other ICD Procedure Code (4) – A code representing a procedure or service provided during the visit. If no principal ICD procedure is reported, other ICD procedure code must not be reported. No more than four other ICD procedure codes may be reported. No entry is permitted if type of service is "1." Less than four or no entry is permitted if type of service is "2" consistent with the records of the reporting entity. If not space filled, must be a valid ICD-9-CM or ICD-10-CM procedure code for the reporting period. Inconsistency between the procedure code and patient sex must be verified by the reporting entity. Inconsistency between the procedure code and patient age must be verified by the reporting entity. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code.

(ff) Principal Diagnosis External Cause of Injury Code – A code representing circumstances or conditions as the cause of injury, poisoning, and other adverse effects recorded as the principal diagnosis. Use of this field is not permitted unless a valid principal diagnosis is reported. No entry is permitted consistent with the records of the reporting entity. If not space filled, must be a valid ICD-9-CM or ICD-10-CM cause of injury code for the reporting period. An external cause of injury code cannot be used more than once for each visit reported. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code.

(gg) Other External Cause of Injury Code (1) and Other External Cause of Injury Code (2) – A code representing circumstances or conditions as the cause of injury, poisoning, and other adverse effects recorded as a diagnosis. No more than two other external cause of injury codes may be reported. Less than two or no entry is permitted consistent with the records of the reporting entity. If not space filled, must be a valid ICD-9-CM or ICD-10-CM cause of injury code for the reporting period. An external cause of injury code cannot be used more than once for each visit reported. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code.

(hh)(aaaa) Patient Status – Patient disposition at end of visit. A required entry. Must be a Required for ambulatory visits occurring on or after January 1, 2003 – A two digit code indicating patient disposition as follows:

1. 01 – Released home or self care (with or without planned outpatient medical care). 01 Home

2. 02 – Transferred to To a short-term general hospital. hospital

3. 03 – Transferred to To a skilled nursing facility. facility

4. 04 – Transferred to an intermediate care facility. 04 Other

5. 05 – Transferred to another type of institution (psychiatric, cancer or children's hospital or distinct part unit).

6. 06 – Home under care of home health care organization.

7. 07 – Left against medical advice or discontinued care.

8. 08 – Home under care of home IV provider.

9. 20 – Expired.

10. 50 – Discharged to hospice – home.

11. 51 – Discharged to hospice – medical facility.

12. 62 – Transferred to an inpatient rehabilitation facility including distinct part units of a hospital.

(bbbb) Data Type Enter "AS10" for ambulatory patient data.

(cccc) Filler – A blank field of 66 spaces.

(3) Trailer Record: The last record in the data file shall be a trailer record and must accompany each data set. If diskettes are submitted, the trailer record must be placed as the last record on the last diskette of the data set. One data element, number of records, must be entered in the trailer record. Report the total number of patient data records contained in the file, excluding header and trailer records. The number entered must equal the number of records processed. This record must follow any documentation submitted for ambulatory patient data records. This record is entered into the file once. All fields are required unless otherwise specified.

DATA ELEMENT DESCRIPTION

(a) Transaction Code "T" for the trailer record.

(b) AHCA Number – A 10 digit identification number assigned by AHCA for reporting purposes. A numeric field, right justify.

(c) Florida License Number Zero fill for the trailer record only.

~~(d) Provider Medicaid Number – A 10 digit number provided for Medicaid providers. If not a Medicaid provider, zero fill.~~

~~(e) Provider Medicare Number – A 10 digit number provided for Medicare providers. If not a Medicare provider, zero fill.~~

~~(f) Provider Mailing Address – The address of the health care entity providing the patient data records.~~

~~(g) Provider Mailing Address City – The city of the address of the health care entity providing the patient data records.~~

~~(h) Provider Mailing Address State – The mailing address of the health care entity providing the patient data records.~~

~~(i) Provider Mailing Address Zip Code – The zip code of the health care entity providing the patient data records.~~

~~(j) Submitter Mailing Address – The address of the organization that is submitting the data file.~~

~~(k) Submitter Mailing Address City – The city of the organization that is submitting the data file.~~

~~(l) Submitter Mailing Address State – The state of the organization submitting the data file.~~

~~(m) Submitter Mailing Address Zip Code – The zip code of the organization submitting the data file.~~

~~(n) Number of Records – The total number of patient data records contained in the file, excluding header and trailer records. Must equal the number of records processed.~~

~~(o) Filler – A blank field of 206 spaces.~~

~~(4) The effective date of all data reporting changes in Rule 59B-9.018, F.A.C., as amended after 12-28-98, shall be for discharges occurring on or after January 1, 2002 unless a later date is indicated in Rule 59B-9.018, F.A.C.~~

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.018, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, ________.

59B-9.019 Ambulatory Patient Data Format — Record Layout.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.019, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, Repealed ________.

59B-9.020 Data Standards.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.020, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, Repealed ________.

AGENCY FOR HEALTH CARE ADMINISTRATION

Certificate of Need

RULE TITLE: RULE NO.:

Nursing Home Subdistricts 59C-2.200

PURPOSE AND EFFECT: The agency proposes to amend paragraphs (2)(d) and (3)(c) of Rule 59C-2.002, F.A.C., revising the description of nursing home subdistricts for agency District 3. In the current rule, the entire 16-county area is defined as one subdistrict for purposes of certificate of need (CON) planning and review. By action of the North Central Florida Health Planning Council, which is the Local Health Council serving District 3, the 16 counties have recently been grouped into seven defined subdistricts. The proposed amendments to Rule 59C-2.200, F.A.C., reflect this change.

SUBJECT AREA TO BE ADDRESSED: Nursing home subdistricts for agency District 3.

SPECIFIC AUTHORITY: 408.034(6), 408.15(8) FS.

LAW IMPLEMENTED: 408.033(1)(b) FS.

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

TIME AND DATE: 2:00 p.m., April 29, 2003

PLACE: Agency for Health Care Administration, Conference Room C, Building 3, 2727 Mahan Drive, Tallahassee, Florida 32308

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: John Davis, Certificate of Need, 2727 Mahan Drive, Building 1, Mail Stop 28, Tallahassee, Florida 32308

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59C-2.200 Nursing Home Subdistricts.

(1) No change.

(2) Definitions.

(a) “Agency.” The Agency for Health Care Administration.

(b) “District.” A health service planning district of the agency defined in subsection 408.032(5), Florida Statutes.

(c) “Local Health Council.” The council referenced in section 408.033, Florida Statutes.

(d) "Subdistrict." A group of counties, a county, or a portion of a county which forms a subdivision of a district. For purposes of this rule, ten ~~nine~~ of the eleven districts of the agency are divided into subdistricts; ~~District 3 and~~ District 10 is ~~are~~ not divided.

(3) Nursing Home Subdistricts. The nursing home subdistricts are defined and numbered as follows:

(a) through (b) No change.

(c) Subdistricts for District 3.

1. Subdistrict 3-1 consists of Columbia, Hamilton and Suwannee Counties.

2. Subdistrict 3-2 consists of Alachua, Bradford, Dixie, Gilchrist, Lafayette, Levy and Union Counties.

3. Subdistrict 3-3 consists of Putnam County.

4. Subdistrict 3-4 consists of Marion County.

5. Subdistrict 3-5 consists of Citrus County.

6. Subdistrcit 3-6 consists of Hernando County.

7. Subdistrict 3-7 consists of Lake and Sumter Counties ~~all of District 3. For purposes of need determination under rule 59C-1.036, District 3 is treated in the same manner as a subdistrict~~.

(d) through (k) No change.

Specific Authority 408.15(8), 408.034(6)~~(5)~~ FS. Law Implemented 408.033(1)(b)~~, 408.034(3)~~ FS. History–New 2-12-96, Amended 10-31-96, ________.

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE TITLE: RULE NO.:

Nursing Facility Services 59G-4.200

PURPOSE AND EFFECT: The purpose of this rule amendment is to incorporate by reference the Florida Medicaid Provider Reimbursement Handbook, Institutional 021, October 2003. The handbook contains changes required by the Health Insurance Portability and Accountability Act (HIPAA) and other billing information changes. The effect will be to incorporate by reference in the rule the current Florida Medicaid Provider Reimbursement Handbook, Institutional 021, October 2003.

SUBJECT AREA TO BE ADDRESSED: Nursing Facility Services.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 400 Part II, 409.905, 409.908 FS.

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

TIME AND DATE: April 29, 2003, 9:00 a.m. – 11:00 a.m.

PLACE: 2727 Mahan Drive, Building 3, Conference Room D, Tallahassee, FL 32308

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Kris Russell, Medicaid Services, 2727 Mahan Drive, Building 3, Mail Stop 20, Tallahassee, Florida 32308-5407, (850)922-7353

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59G-4.200 Nursing Facility Services.

(1) No change.

(2) All participating nursing facility services providers must comply with the provisions of the Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook, August, 2000 and the corresponding Florida Medicaid Provider Reimbursement Handbook, Institutional 021, October 2003, ~~September 1996~~ which are incorporated by reference. Both handbooks are available from the Medicaid fiscal agent.

Specific Authority 409.919 FS. Law Implemented 400 Part II, 409.905, 409.908 FS. History–New 1-1-77, Amended 6-13-77, 10-1-77, 1-1-78, 2-1-78, 12-28-78, 2-14-80, 4-5-83, 1-1-84, 8-29-84, 9-1-84, 9-5-84, 7-1-85, Formerly 10C-7.48, Amended 8-19-86, 6-1-89, 7-2-90, 6-4-92, 8-5-92, 11-2-92, 7-20-93, Formerly 10C-7.048, Amended 11-28-95, 5-9-99, 10-15-00, 10-4-01, ________.

DEPARTMENT OF HEALTH

Board of Massage Therapy

RULE TITLE: RULE NO.:

Definitions 64B7-26.001

PURPOSE AND EFFECT: The Board proposes to review the language in this rule to determine if any amendments are necessary.

SUBJECT AREA TO BE ADDRESSED: Definitions.

SPECIFIC AUTHORITY: 480.035(7) FS.

LAW IMPLEMENTED: 480.043(7) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Pamela King, Executive Director, Board of Massage Therapy, 4052 Bald Cypress Way, Bin #C06, Tallahassee, Florida 32399

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

DEPARTMENT OF HEALTH

Board of Medicine

RULE TITLE: RULE NO.:

Disciplinary Guidelines 64B8-55.001

PURPOSE AND EFFECT: The Board proposes to revise the existing rule to add completion of all incomplete continuing education credits to the penalty for failure to comply with continuing education requirements.

SUBJECT AREA TO BE ADDRESSED: Disciplinary Guidelines.

SPECIFIC AUTHORITY: 456.072, 456.079, 478.52(4) FS.

LAW IMPLEMENTED: 456.072, 456.073, 456.079, 478.52(4) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Kaye Howerton, Executive Director, Board of Medicine, Electrolysis Council/MQA, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3253

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

DEPARTMENT OF HEALTH

Board of Medicine

RULE TITLE: RULE NO.:

Citations 64B8-55.002

PURPOSE AND EFFECT: The Board proposes to amend the existing rule to change the penalty for a first time violation of failure to comply with continuing education requirements to $500.00 and completion of all incomplete continuing education credits.

SUBJECT AREA TO BE ADDRESSED: Citations.

SPECIFIC AUTHORITY: 456.077(1),(2) FS.

LAW IMPLEMENTED: 456.072(3)(b), 456.077(1),(2), 478.51, 478.52 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Kaye Howerton, Executive Director, Board of Medicine, Electrolysis Council/MQA, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3253

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

DEPARTMENT OF HEALTH

Board of Osteopathic Medicine

RULE TITLE: RULE NO.:

Requirements for Osteopathic Physician Office Registration; Inspection or Accreditation 64B15-14.0076

PURPOSE AND EFFECT: The Board proposes the rule amendment to incorporate a new office registration form required for osteopathic physicians who perform office surgery.

SUBJECT AREA TO BE ADDRESSED: The proposed rule adds a required registration form for osteopathic physicians who perform Level II or Level III office surgeries.

SPECIFIC AUTHORITY: 459.005(1),(2) FS.

LAW IMPLEMENTED: 459.069, 459.005(2) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE SCHEDULED AT THE BOARD'S NEXT MEETING TO BE HELD ON JUNE 7, IN MIAMI, FLORIDA.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Pam King, Executive Director, Board of Osteopathic Medicine/MQA, 4052 Bald Cypress Way, Bin #C06, Tallahassee, Florida 32399-3256

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

64B15-14.0076 Requirement for Osteopathic Physician Office Registration; Inspection or Accreditation.

(1) Registration.

(a) Every Florida licensed osteopathic physician who holds an active Florida license and performs Level II surgical procedures in Florida with a maximum planned duration of five (5) minutes or longer or any Level III office surgery, as fully defined in Rule 64B15-14.007, F.A.C., shall register with the Board of Osteopathic Medicine on application form DH-MQA 1071, 1/03, effective ________. It is the osteopathic physician's responsibility to ensure that every office in which he or she performs Levels II or III surgical procedures as described above is registered, regardless of whether other physicians are practicing in the same office or whether the office is non-physician owned.

(b) through (d) No change.

(2) through (3) No change.

Specific Authority 459.005(1),(2) FS. Law Implemented 456.069, 459.005(2) FS. History–New 2-12-02, Amended ________.

DEPARTMENT OF HEALTH

Board of Pharmacy

RULE TITLES:	RULE NOS.:
Active License Renewal	64B16-26.1001
Inactive License Renewal	64B16-26.1011
Delinquent License Reinstatement	64B16-26.1021

PURPOSE AND EFFECT: The Board proposes new rules to update licensure renewal requirements and fees.

SUBJECT AREA TO BE ADDRESSED: The new proposed rules address the requirements and the fees for renewal of license from active, inactive, or delinquent status.

SPECIFIC AUTHORITY: 465.005, 465.012 FS.

LAW IMPLEMENTED: 465.008, 465.012, 456.036(3),(4), (7), (8), 456.065(3) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Lucy C. Gee, Acting Executive Director, Board of Pharmacy/MQA, 4052 Bald Cypress Way, Bin #C04, Tallahassee, Florida 32399-3254

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

64B16-26.1001 Active License Renewal.

The biennial license renewal fee for an active pharmacist license shall be $250.00, which includes an additional $5.00 unlicensed activity fee pursuant to Section 456.065(3), F.S.

Specific Authority 465.005 FS. Law Implemented 465.008, 456.036(3), 456.065(3) FS. History–New ________.

64B16-26.1011 Inactive License Renewal.

(1) A licensee may elect at the time of license renewal to place the license on inactive status by submitting a written request with the board for inactive status and submitting the inactive status fee of $250.00, which includes an additional $5.00 unlicensed activity fee pursuant to Section 456.065(3), F.S.

(2) A licensee on inactive status may elect at the time of renewal to continue the license on inactive status by submitting a written request with the board for inactive status and submitting the inactive status fee of $250.00, which includes an additional $5.00 unlicensed activity fee pursuant to Section 456.065(3), F.S.

(3) A licensee on inactive status may elect at the time of renewal to change the inactive status license to active status, provided the licensee meets the continuing education requirements of Rule 64B16-26.103, F.A.C., for each biennium the license was on inactive status, submits the reactivation fee of $70.00, and the current active renewal fee set forth in Rule 64B16-26.1001, F.A.C.

(4) A licensee on inactive status may elect to change the inactive status license to active status at any time other than at the beginning of a licensure renewal cycle, provided the licensee meets the continuing education requirements of Rule 64B16-26.103, F.A.C., for each biennium the license was on inactive status, submits the reactivation fee of $70.00, the current renewal fee set forth in Rule 64B16-26.1001, F.A.C., and a change of status fee of $25.00.

Specific Authority 465.005, 465.012 FS. Law Implemented 465.012, 456.036(3), (4), (8), 456.065(3) FS. History–New ________.

64B16-26.1021 Delinquent License Reinstatement.

(1) An active or inactive license that is not renewed by midnight of the expiration date of the license shall automatically revert to delinquent status.

(2) A licensee may request that a delinquent license be reinstated to active or inactive status by submitting the delinquent fee of $245.00 plus the current fee for an active status or inactive status license set forth in Rule 64B16-26.1001, F.A.C., or Rule 64B16-26.1011, F.A.C.

(3) An active or inactive status license in delinquent status that is not renewed prior to midnight of the expiration date of the current licensure cycle shall render the license null without any further action by the board or the Department.

Specific Authority 465.005, 465.012 FS. Law Implemented 465.012, 456.036(3), (4), (7), 456.065(3) FS. History–New ________.

DEPARTMENT OF HEALTH

Board of Pharmacy

RULE TITLE: RULE NO.:

Examination and Initial Licensure Fees 64B16-26.2035

PURPOSE AND EFFECT: The Board proposes the rule amendments to update the fees for initial licensure application by examination.

SUBJECT AREA TO BE ADDRESSED: The proposed rule amendments address the requirements for initial licensure and examination fees.

SPECIFIC AUTHORITY: 465.005, 456.013(2) FS.

LAW IMPLEMENTED: 465.007, 456.013(2) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Lucy C. Gee, Acting Executive Director, Board of Pharmacy/MQA, 4052 Bald Cypress Way, Bin #C04, Tallahassee, Florida 32399-3254

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

64B16-26.2035 Examination and Initial Licensure Fees.

(1) The ~~examination~~ fees for licensure by examination shall include~~s~~ a non-refundable application fee of $100 and a refundable initial licensure fee of $190 payable to the Board~~,~~ ~~and component examination fees of $360 for the National Practice Examination and $130 for the jurisprudence examination. Component examination fees may be paid directly to the examination vendor. All fees collected under this section are non-refundable~~.

(2) Examination fees for the National Practice Examination and jurisprudence examination are payable to the examination vendor.

Specific Authority 465.005, 456.013(2) FS. Law Implemented 465.007, 456.013(2) FS. History–New 9-19-94, Amended 3-10-96, Formerly 59X-26.2035, Amended 3-22-99, 10-30-00, ______.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Economic Self-Sufficiency Program

RULE TITLE: RULE NO.:

Income and Resource Criteria 65A-1.716

PURPOSE AND EFFECT: Rule 65A-1.716, F.A.C., is amended to revise the monthly poverty income guidelines used in the Medicaid program for applicants and recipients to the level of federal guidelines for 2003.

SUBJECT AREA TO BE ADDRESSED: This proposed amendment will bring the federal poverty guidelines used in the Medicaid program to a current status.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.902, 409.903, 409.904, 409.906, 409.919 FS.

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

TIME AND DATE: 2:00 p.m., April 28, 2003

PLACE: Building 3, Room 100, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT, IF AVAILABLE, IS: Audrey Mitchell, Program Administrator, Building 3, Room 421, 1317 Winewood Boulevard, Tallahassee, FL 32399-0700, (850)488-3090

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

Section II
Proposed Rules

DEPARTMENT OF INSURANCE

Division of State Fire Marshal

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Rules of the Bureau of Fire and Arson Investigations 4A-61

RULE TITLE: RULE NO.:
Initial Investigations of Fires 4A-61.001

PURPOSE AND EFFECT: These rules clarify the roles of the Division of State Fire Marshal and the local fire officials or law enforcement officers on conditions that necessitate the engagement and assistance of the State Fire Marshal resources upon the occurrence of a fire or explosion pursuant to the investigative authority in Sections 633.03 and 633.801-633.821, Florida Statutes.

SUMMARY: Provides criteria for local fire officials and any law enforcement officers to perform initial investigations to determine whether probable cause exists for an investigation by the Bureau of Fire and Arson Investigations pursuant to Section 633.03, Florida Statutes, or an investigation should be made pursuant to Sections 633.801-633.821, Florida Statutes.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: No Statement of Regulatory Costs was prepared.

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

SPECIFIC AUTHORITY: 633.01, 633.806, 633.808 FS.

LAW IMPLEMENTED: 633.01, 633.03, 633.806, 633.808 FS.

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

TIME AND DATE: 9:00 a.m., May 6, 2003

PLACE: Room 143, Larson Building, Tallahassee, Florida

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this program, please advise the Department at least 5 calendar days before the program by contacting Jenny Cooley, (850)413-3173.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Eric Miller, Chief, Bureau of Fire and Arson Investigations, Division of State Fire Marshal, 200 East Gaines Street, Tallahassee, Florida 32399-0340, (850)413-3173

THE FULL TEXT OF THE PROPOSED RULE IS:

4A-61.001 Initial Investigation of Fires.

(1)(a) PURPOSE.

The purpose of this rule is to assist local fire officials and law enforcement officers in determining the established responsibilities with respect to the initial or preliminary assessment of fire scenes, and the determination of whether probable cause exists to refer such scenes to the Division for an investigation pursuant to Section 633.03, Florida Statutes. Experience shows that the most effective deterrent to arson lies in the effective investigation of suspicious and incendiary fires. This requires a commitment of fire officials, law enforcement, and the Division to direct investigative resources to those fires that are of a suspicious nature, or are believed to be incendiary, to more effectively prosecute offenders that commit the crime of arson. This rule imposes no additional or new obligations on local fire officials or law enforcement, but serves solely to clarify the conditions that necessitate the engagement and assistance of State Fire Marshal, Bureau of Fire and Arson Investigations' resources upon the occurrence of a fire or explosion.

(b) SCOPE.

Pursuant to Section 633.03, Florida Statutes, the State Fire Marshal is required to investigate any fire in which property has been damaged or destroyed and where there is probable cause to believe that the fire was the result of carelessness or design. The Bureau of Fire and Arson Investigations of the Division of State Fire Marshal is a law enforcement agency whose personnel are sworn law enforcement officers pursuant to Chapter 943, Florida Statutes. The State Fire Marshal is charged with enforcing all laws and rules adopted pursuant thereto for purposes of the prevention of fire and explosion through the regulation of conditions which could cause fire or explosion, pursuant to Section 633.01(2)(a), Florida Statutes.