(a) through (b) No change.

(2) No change.

Specific Authority 478.43 FS. Law Implemented 478.42(5), 478.43(3), 478.50 FS. History–New 10-3-00, Amended _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Electrolysis Council

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Medicine

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: August 5, 2000

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 24, 2001

DEPARTMENT OF HEALTH

Board of Medicine

RULE TITLE: RULE NO.:
Mediation 64B8-55.004

PURPOSE AND EFFECT: The proposed rule will set forth the requirements for mediation.

SUMMARY: The proposed rule is to identify the meaning of mediation.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated 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: 456.078, 478.43 FS.

LAW IMPLEMENTED: 456.078 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE NEXT AVAILABLE ISSUE OF THE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Kaye Howerton, Executive Director, Electrolysis Council/MQA, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399

THE FULL TEXT OF THE PROPOSED RULE IS:

64B6-55.004 Mediation.

(1) "Mediation" means a process whereby a mediator appointed by the Department acts to encourage and facilitate resolution of a legally sufficient complaint. It is an informal and nonadversarial process with the objective of assisting the parties to reach a mutually acceptable agreement.

(2) For purposes of Section 456.078, F.S., the Board designates as being appropriate for mediation, failure to respond timely to a continuing education audit.

Specific Authority 456.078, 478.43 FS. Law Implemented 456.078 FS. History–New _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Electrolysis Council

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Medicine

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: August 5, 2000

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 24, 2001

Section III
Notices of Changes, Corrections and Withdrawals

DEPARTMENT OF BANKING AND FINANCE

Division of Securities and Finance

RULE NO.: RULE TITLE:
3E-500.017 Compensatory Benefit Plan Exemption

NOTICE OF CHANGE

Notice is hereby given that the Department has made the following changes to the above referenced rule, which was published in the July 20, 2001, Vol. 27, No. 29, issue of the Florida Administrative Weekly, based on public comments received by the Department.

The rule has been changed to read:

(1) Transactions involving the offer or sale of a security pursuant to a written ~~pension plan, stock plan, profit sharing plan,~~ compensatory benefit plan (or a written compensation contract) or similar plan established by the issuer, its parents, its majority-owned subsidiaries or majority-owned subsidiaries of the issuer's parent, for the participation of their employees, directors, general partners, trustees, officers, or consultants and advisors, and their family members who acquire such securities from such persons through gifts or domestic relations orders, are exempt from the registration provisions of Section 517.07, F.S., if:

(a) through (c) No change.

(2) through (4) No change.

(a) All sales of securities are made by a partner, officer, director, trustee of the issuer, its parents, its majority-owned subsidiaries or majority-owned subsidiaries of the issuer's parent, or any person employed by any of the foregoing ~~the issuer~~ who primarily performs substantial duties for, or on behalf of any of the foregoing, ~~the issuer~~ other than in connection with transactions in securities; and

(b) No change.

DEPARTMENT OF INSURANCE

RULE NOS.: RULE TITLES:
4-186.001 Disclosure; Mortgage Policyholders
4-186.002 Approved Form

4-186.003	Title Insurance Rates
4-186.006	Usury of Claims of Usury Excluded from Title Insurance Overages
4-186.008	Escrow Requirements
4-186.012	Independent Searcher/Abstractor Coverage
4-186.014	Insurer Reporting for Non-Licensed Agents

NOTICE OF WITHDRAWAL

Notice is hereby given that the above rule(s), as noticed in Vol. 27, No. 34, August 24, 2001 of the Florida Administrative Weekly, have been withdrawn.

DEPARTMENT OF COMMUNITY AFFAIRS

Division of Housing and Community Development

RULE CHAPTER NO.:	RULE CHAPTER TITLE:
9B-3	Florida Building Commission: Operational Procedures
RULE NO.:	RULE TITLE:
9B-3.047	State Building Code Adopted

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 27, No. 31, August 3, 2001 issue of the Florida Administrative Weekly:

9B-3.047 State Building Code Adopted.

(1) The Florida Building Code as revised by the Florida Building Commission on _____, is hereby adopted and incorporated by reference as the building code for the State of Florida.

(2) No change.

Specific Authority 553.73(1),(7), FS. Law Implemented 553.72, 553.73(3),(7),(9) FS. History–New 7-18-90, Amended 3-30-93, 10-17-93, 8-28-95, 9-24-96, 12-26-96, 4-27-97, 10-5-97, 10-14-97, 9-7-00, 11-28-00, 2-7-01,_____.

NOTE 1: The following sections of the Florida Building Code were changed as a result of public comments received at the rule making hearing on August 28, 2001, and October 2, 2001:

Volume Building:

Chapter 1, Administration

The following section is amended in the Code:

104.6.2 (Work commencing before permit issuance)

The following section is added in the Code:

104.5.4 (Work starting before permit issuance)

Chapter 4, Special Occupancy

The following sections are amended in the Code:

412 (Special Provisions for Group B and Group R High Rise Buildings);

427 (Crisis Stabilization Units): 427.1, 427.1.1, 427.1.3.2.11, and 427.2;

428 (Manufactured Buildings): 428.3.2.2

Chapter 11, Florida Accessibility Code for Building Construction

The following figure is amended in the Code (Part A):

Figure 30 (e) (Toilet Stall New Construction)

The following Form is amended in the Code (Part C):

Request for Waiver from Accessibility Requirements, Chapter 553, Part V, Florida Statutes.

Chapter 13, Energy Efficiency

The following forms are amended in the Code:

Appendix D Energy Code Compliance Forms 600A-01, North, Central, South. Changes shall be made to the FLA/RES computer program which generates an equivalent of the completed forms.

IF REQUESTED WITHIN 21 DAYS OF THE DATE 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., November 6, 2001

PLACE: Rosen Plaza Hotel, 9700 International Drive, Orlando, Florida

Any person requiring special accommodation at the hearing because of a disability or physical impairment should contact Ila Jones, Community Program Administrator, Department of Community Affairs, 2555 Shumard Oak Boulevard, Sadowski Building, Tallahassee, Florida 32399-2100, (850)487-1824, at least seven days before the date of the hearing. If you are hearing or speech impaired, please contact the Department of Community Affairs using the Florida Dual Party Relay System which can be reached at 1(800)955-8770 (Voice) or 1(800)955-9771 (TDD).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Ila Jones, Community Program Administrator, Department of Community Affairs, 2555 Shumard Oak Boulevard, Sadowski Building, Tallahassee, Florida 32399-2100, (850)487-1824

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND

RULE NOS.:	RULE TITLES:
18-21.003	Definitions
18-21.004	Management Policies, Standards, and Criteria
18-21.007	Applications for Consent of Use
18-21.008	Applications for Lease
18-21.009	Applications for Public Easement
18-21.010	Applications for Private Easement
18-21.900	Forms

NOTICE OF FINAL PUBLIC HEARING

The Department, as staff to the Board of Trustees, announces a final adoption hearing before the Governor and Cabinet, sitting as the Board of Trustees of the Internal Improvement Trust Fund, for consideration and adoption of the final rule amendments regarding sufficient upland interest.

DATE AND TIME: October 30, 2001, 9:00 a.m.

PLACE: The Capitol, Lower Level, Cabinet Meeting Room LL03, Tallahassee, Florida

The Notice of Proposed Rulemaking was published in Vol. 27, No. 24, June 15, 2001, issue and a Notice of Change was published in Vol. 27, No. 36, September 7, 2001, issue of the Florida Administrative Weekly.

A copy of the agenda may be obtained by writing: Jeanese McCree, Department of Environmental Protection, 2600 Blair Stone Road, MS #2500, Tallahassee, FL 32399-2400, by calling (850)921-9901, or e-mail Jeanese.McCree@dep.state.fl.us.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this final adoption hearing is asked to advise the agency at least 48 hours before the hearing by contacting: Personnel Service Specialist, Bureau of Personnel, (850)488-2996. If you are hearing or speech impaired, please contact the agency by calling 1(800)955-8771 (TDD).

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE NO.: RULE TITLE:
59G-6.020 Payment Methodology for Inpatient Hospital Services

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 27, No. 34, August 10, 2001, issue of the Florida Administrative Weekly. Based upon comments received from the Joint Administrative Procedures Committee (JAPC), the Agency is adding the following changes to the proposed rule 59G-6.020, Payment Methodology for Inpatient Hospital Services. The purpose of the proposed amendment is to incorporate changes to the Florida Title XIX Inpatient Hospital Reimbursement Plan (the Plan).

1. Section II.E.6 (page 6), the statutory reference relating to repayments was changed to "Section" 414.41, F.S., instead of "Chapter" 414.41, F.S.

2. Section V.C.6.b.4 (page 18), the reference to "Department" was changed to "AHCA."

3. Section J.1.h. (page 41) referred to two non-existent entities, the Florida Health Care Purchasing Cooperative and the Florida Health Access Corporation, each of which has been disbanded and repealed from statute. These references have been deleted.

4. Section X.H. (page 52), the definition of "Community Hospital Education Program (CHEP) hospitals" referred to the Board of Regents as the administering entity. Chapter 2001-222, Laws of Florida, transferred this responsibility to the Department of Health and therefore the reference to the Board of Regents has been changed to the Department of Health.

5. There was a proposed revision to the definition of "Rural Hospital" in the Outpatient Plan (page 17), to reflect the current statutory definition found in s. 395.602(2)(e), F.S., and s. 408.07(42), F.S. that was inadvertently left out of the Inpatient Plan. We modified the definition in the Inpatient Plan to match the definition in the Outpatient Plan.

6. Section M., Upper Payment Limit (UPL), was slightly reworded to clarify the 100% UPL for privately owned and operated facilities and 150% for non-State government owned and operated facilities.

7. On pages 10 and 16, the new language refers to hospitals "defined" in section V.A. The word "defined" was changed to "included."

IF REQUESTED IN WRITING WITHIN 21 DAYS OF THE DATE 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., November 5, 2001

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: John Owens, Medicaid Cost Reimbursement, Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Room 2120B, Mail Stop 21, Tallahassee, Florida 32308, (850)414-2756

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE NO.: RULE TITLE:
59G-6.030 Payment Methodology for Outpatient Hospital Services

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 27, No. 34, August 10, 2001, issue of the Florida Administrative Weekly. Based upon comments received from the Joint Administrative Procedures Committee (JAPC), the Agency is adding the following changes to the proposed Rule 59G-6.030, Payment Methodology for Outpatient Hospital Services. The purpose of the proposed amendment is to incorporate changes to the Florida Title XIX Outpatient Hospital Reimbursement Plan (the Plan).

1. Section X.D. (page 15), the definition of "Community Hospital Education Program (CHEP) hospitals" referred to the Board of Regents as the administering entity. Chapter 2001-222, Laws of Florida, transferred this responsibility to

the Department of Health and therefore the reference to the Board of Regents has been changed to the Department of Health.

2. On pages 8-9, 11, and 13 the new language refers to hospitals "defined" in section V.A. The word "defined" was changed to "included."

3. Section I.H (page 3) referred to 59G-1.002(13), F.A.C., incorporating ACHA-Med form 1005. It was brought to our attention that 59G-1.002(13) was repealed and replaced with 59G-5.080(2).

IF REQUESTED IN WRITING WITHIN 21 DAYS OF THE DATE 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., November 5, 2001

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: John Owens, Medicaid Cost Reimbursement, Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Room 2120B, Mail Stop 21, Tallahassee, Florida 32308, (850)414-2756

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Division of Pari-Mutuel Wagering

RULE NO.: RULE TITLE:
61D-2.020 Pari-Mutuel Wagering Racing and Game Officials

NOTICE OF WITHDRAWAL

Notice is hereby given that the above-proposed rule as published in Vol. 27, No. 31, August 3, 2001 issue of the Florida Administrative Weekly is withdrawn.

DEPARTMENT OF HEALTH

Board of Opticianry

RULE NO.: RULE TITLE:
64B12-12.008 Reactivation of an Inactive License

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed new rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 26, No. 40, October 6, 2000 issue of the Florida Administrative Weekly. These changes to the new rule are in response to comments received from the Joint Administrative Procedures Committee.

64B12-12.008 Reactivation of an Inactive License.

An inactive status license may change to active status at anytime provided the licensee:

(1) Submits a written request for reactivation,

(2) Demonstrates compliance with the continuing education requirements of Rule 64B12-15.001, F.A.C., for the biennium the license was in inactive status,

(3) Pays the reactivation fee set forth in Rule 64B12-11.010, F.A.C., and

(4) Pays the applicable renewal fee,

(a) If the reactivation request is received during the license renewal cycle, pays the active renewal fee set forth in Rule 64B12-11.003, F.A.C., or

(b) If the reactivation request is received at any other time than at the time of license renewal, pays the difference between the inactive renewal fee and the active renewal fee and the change of status fee set forth in Rule 64B12-11.0105, F.A.C.

Specific Authority 456.013(6),(7), 456.036(2),(3),(4), 484.005, 484.008, 484.009 FS. Law Implemented 456.013(6),(7), 456.036(2),(3),(4), 484.008, 484.009 FS. History–New .

DEPARTMENT OF HEALTH

Board of Osteopathic Medicine

RULE NO.: RULE TITLE:
64B15-14.007 Standard of Care for Office Surgery

NOTICE OF CHANGE

The Board of Osteopathic Medicine hereby gives notice that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 27, No. 31, August 3, 2001 issue of the Florida Administrative Weekly. The changes are in response to comments received at a public hearing held on September 21, 2001 in Tampa, Florida.

The rule shall now read as follows:

64B15-14.007 Standard of Care for Office Surgery.

NOTHING IN THIS RULE RELIEVES THE SURGEON OF THE RESPONSIBILITY FOR MAKING THE MEDICAL DETERMINATION THAT THE OFFICE IS AN APPROPRIATE FORUM FOR THE PARTICULAR PROCEDURE(S) TO BE PERFORMED ON THE PARTICULAR PATIENT.

(1) Definitions.

(a) Surgery. For the purpose of this rule, surgery is defined as any operative procedure, including the use of lasers, performed upon the body of a living human being for the purposes of preserving health, diagnosing or curing disease, repairing injury, correcting deformity or defects, prolonging life, relieving suffering or any elective procedure for aesthetic, reconstructive or cosmetic purposes, to include, but not be limited to: incision or curettage of tissue or an organ; suture or other repair of tissue or organ, including a closed as well as an open reduction of a fracture; extraction of tissue including premature extraction of the products of conception from the uterus; insertion of natural or artificial implants; or an endoscopic procedure with use of local or general anesthetic.

(b) Surgeon. For the purpose of this rule, surgeon is defined as a licensed osteopathic physician performing any procedure included within the definition of surgery.

(c) Equipment. For the purpose of this rule, implicit within the use of the term of equipment is the requirement that the specific item named must meet current performance standards.

(d) Office surgery. For the purpose of this rule office surgery is defined as surgery which is performed outside a hospital, an ambulatory surgical center, abortion clinic, or other medical facility licensed by the Department of Health, the Agency for Health Care Administration, or a successor agency. Office surgical procedures shall not be of a type that generally result in blood loss of more than ten percent of estimated blood volume in a patient with a normal hemoglobin; require major or prolonged intracranial, intrathoracic, abdominal, or major joint replacement procedures, except for laparoscopic procedures; directly involve major blood vessels; or are generally emergent or life threatening in nature.

(2) General Requirements for Office Surgery.

(a) The surgeon must examine the patient immediately before the surgery to evaluate the risk of anesthesia and of the surgical procedure to be performed. The surgeon must maintain complete records of each surgical procedure, as set forth in Rule 64B15-15.004, F.A.C., including anesthesia records, when applicable and the records shall contain written informed consent from the patient reflecting the patient's knowledge of identified risks, consent to the procedure, type of anesthesia and anesthesia provider, and that a choice of anesthesia provider exists, i.e., anesthesiologist, another appropriately trained physician as provided in this rule, certified registered nurse anesthetist, or physician assistant qualified as set forth in rule 64B15-6.010(2)(b)6., F. A.C.

(b) The requirement set forth in subsection (2)(a) above for written informed consent is not necessary for minor Level I procedures limited to the skin and mucosa.

(c) The surgeon must maintain a log of all Level II and Level III surgical procedures performed, which must include a confidential patient identifier, the type of procedure, the type of anesthesia used, the duration of the procedure, the type of post-operative care, and any adverse incidents, as identified in Section 459.026, F.S. The log and all surgical records shall be provided to investigators of the Department of Health upon request.

(d) In any liposuction procedure, the surgeon is responsible for determining the appropriate amount of supernatant fat to be removed from a particular patient. A maximum of 4000cc supernatant fat may be removed by liposuction in the office setting. A maximum of 50mg/kg of Lidocaine can be injected for tumescent liposuction in the office setting.

(e) Liposuction may be performed in combination with another separate surgical procedure during a single Level II or Level III operation, only in the following circumstances:

1. When combined with abdominoplasty, liposuction may not exceed 1000 cc of supernatant fat;

2. When liposuction is associated and directly related to another procedure, the liposuction may not exceed 1000 cc of supernatant fat;

3. Major liposuction in excess of 1000 cc supernatant fat may not be performed in a remote location from any other procedure.

(f) For elective cosmetic and plastic surgery procedures performed in a physician's office, the maximum planned duration of all surgical procedures combined must not exceed 8 hours. Except for elective cosmetic and plastic surgery, the surgeon shall not keep patients past midnight in a physician's office. For elective cosmetic and plastic surgical procedures, the patient must be discharged within 24 hours of presenting to the office for surgery; an overnight stay is permitted in the office provided the total time the patient is at the office does not exceed 23 hours and 59 minutes including the surgery time. An overnight stay in a physician's office for elective cosmetic and plastic surgery shall be strictly limited to the physician's office. If the patient has not recovered sufficiently to be safely discharged within the timeframes set forth, the patient must be transferred to a hospital for continued post-operative care.

(g) The Board of Osteopathic Medicine adopts the "Standards of the American Society of Anesthesiologists for Basic Anesthetic Monitoring," approved by House Delegates on October 21, 1986 and last amended on October 21, 1998, as the standards for anesthetic monitoring by any qualified anesthesia provider.

1. These standards apply to general anesthetics, regional anesthetics, and monitored anesthesia care (Level II and III as defined by this rule) although, in emergency circumstances, appropriate life support measures take precedence. These standards may be exceeded at any time based on the judgment of the responsible supervising physician or anesthesiologist. They are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice. This set of standards address only the issue of basic anesthesia monitoring, which is one component of anesthesia care.

2. In certain rare or unusual circumstances some of these methods of monitoring may be clinically impractical, and appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual monitoring may be unavoidable. For purpose of this rule, "continual" is defined as "repeated regularly and frequently in steady rapid succession" whereas "continuous" means "prolonged without any interruption at any time."

3. Under extenuating circumstances, the responsible supervising osteopathic physician or anesthesiologist may waive the requirements marked with an asterisk (*); it is recommended that when this is done, it should be so stated

(including the reasons) in a note in the patient's medical record. These standards are not intended for the application to the care of the obstetrical patient in labor or in the conduct of pain management.

a. Standard I

I. Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.

II. OBJECTIVE. Because of the rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care. In the event there is a direct known hazard, e.g., radiation, to the anesthesia personnel which might require intermittent remote observation of the patient, some provision for monitoring the patient must be made. In the event that an emergency requires the temporary absence of the person primarily responsible for the anesthetic, the best judgment of the supervising physician or anesthesiologist will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person left responsible for the anesthetic during the temporary absence.

b. Standard II

I. During all anesthetics, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated.

II. OXYGENATION

(A) OBJECTIVE – To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.

(B) METHODS:

(I) Inspired gas: During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.*

(II) Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as a pulse oximetry shall be employed.* Adequate illumination and exposure of the patient are necessary to assess color.*

III VENTILATION

(A) OBJECTIVE – To ensure adequate ventilation of the patient during all anesthetics.

(B) METHODS:

(I) Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. Qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds are useful. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is strongly encouraged.*

(II) When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.*

(III) When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.

(IV) During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated, at least, by continual observation of qualitative clinical signs.

IV CIRCULATION

(A) OBJECTIVE – To ensure the adequacy of the patient's circulatory function during all anesthetics.

(B) METHODS

(I) Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.*

(II) Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.*

(III) Every patient receiving general anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry.

V. BODY TEMPERATURE

(A) OBJECTIVE – To aid in the maintenance of appropriate body temperature during all anesthetics.

(B) METHODS: Every patient receiving anesthesia shall have temperature monitored when clinically significant changes in body temperature are intended, anticipated or suspected.

(h) The surgeon must assure that the post-operative care arrangements made for the patient are adequate to the procedure being performed as set forth in Rule 64B15-14.006, F.A.C. Management of post-surgical care is the responsibility of the operating surgeon and may be delegated only as set forth in Rule 64B15-14.006(3), F.A.C. If there is an overnight stay at the office in relation to any surgical procedure:

1. The office must provide at least two (2) monitors, one of these monitors must be certified in Advanced Cardiac Life Support (ACLS), and maintain a monitor to patient ratio of at least 1 monitor to 2 patients. Once the surgeon has signed a timed and dated discharge order, the office may provide only one monitor to monitor the patient. The monitor must be

certified in Advanced Cardiac Life Support. The full and current crash cart required below must be present in the office and immediately accessible for the monitors.

2. The surgeon must be reachable by telephone and readily available to return to the office if needed. For purposes of this subsection, "readily available" means capable of returning to the office within 15 minutes of receiving a call.

(i) A policy and procedure manual must be maintained in the office, updated annually, and implemented. The policy and procedure manual must contain the following: duties and responsibilities of all personnel, quality assessment and improvement systems comparable to those required by Rule 59A-5.019; cleaning, sterilization, and infection control, and emergency procedures. This applies only to physician offices at which Level II and Level III procedures are performed.

(j) The surgeon shall establish a risk management program that includes the following components:

1. The identification, investigation, and analysis of the frequency and causes of adverse incidents to patients,

2. The identification of trends or patterns of incidents,

3. The development of appropriate measures to correct, reduce, minimize, or eliminate the risk of adverse incidents to patients, and

4. The documentation of these functions and periodic review no less than quarterly of such information by the surgeon.

(k) The surgeon shall report to the Department of Health any adverse incidents that occur within the office surgical setting. This report shall be made within 15 days after the occurrence of an incident as required by Section 497.026, F.S.

(l) A sign must be prominently posted in the office which states that the office is a doctor's office regulated pursuant to the rules of the Board of Osteopathic Medicine as set forth in Rule Chapter 64B15, F.A.C. This notice must also appear prominently within the required patient informed consent.

(3) Level I Office Surgery.

(a) Scope. Level I office surgery includes the following:

1. Minor procedures such as excision of skin lesions, moles, warts, cysts, lipomas and repair of lacerations or surgery limited to the skin and subcutaneous tissue performed under topical or local anesthesia not involving drug-induced alteration of consciousness other than minimal pre-operative tranquilization of the patient.

2. Liposuction involving the removal of less than 4000cc supernatant fat is permitted.

3. Incision and drainage of superficial abscesses, limited endoscopies such as proctoscopies, skin biopsies, arthrocentesis, thoracentesis, paracentesis, dilation of urethra, cysto-scopic procedures, and closed reduction of simple fractures or small joint dislocations (i.e., finger and toe joints).

4. Pre-operative medications not required or used other than minimal pre-operative tranquilization of the patient; anesthesia is local, topical, or none. No drug-induced alteration of consciousness other than minimal pre-operative tranquilization of the patient is permitted in Level I Office Surgery.

5. Chances of complication requiring hospitalization are remote.

(b) Standards for Level I Office Surgery.

1. Training Required. Surgeon's continuing medical education should include: proper dosages; management of toxicity or hypersensitivity to regional anesthetic drugs. Basic Life Support Certification is recommended but not required.

2. Equipment and Supplies Required. Oxygen, positive pressure ventilation device, Epinephrine (or other vasopressor), Corticoids, Antihistamine and Atropine if any anesthesia is used.

3. Assistance of Other Personnel Required. No other assistance is required, unless the specific surgical procedure being performed requires an assistant.

(4) Level II Office Surgery.

(a) Scope.

1. Level II Office Surgery is that in which peri-operative medication and sedation are used intravenously, intramuscularly, or rectally, thus making intra and post-operative monitoring necessary. Such procedures shall include, but not be limited to: hemorrhoidectomy, hernia repair, reduction of simple fractures, large joint dislocations, breast biopsies, colonoscopy, and liposuction involving the removal of up to 4000cc supernatant fat.

2. Level II Office Surgery includes any surgery in which the patient is placed in a state which allows the patient to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal command and/or tactile stimulation. Patients whose only response is reflex withdrawal from a painful stimulus are sedated to a greater degree than encompassed by this definition.

(b) Standards for Level II Office Surgery.

1. Training Required. The surgeon must be able to document satisfactory completion of training such as Board certification or Board eligibility by a Board approved by the American Osteopathic Association, the American Board of Medical Specialties, the Accreditation Council on Graduate Medical Education or any other board approved by the Board of Osteopathic Medicine or must be able to establish comparable background, training, and experience. The surgeon and one assistant must be currently certified in Basic Life Support and the surgeon or at least one assistant must be currently certified in Advanced Cardiac Life Support or have a qualified anesthesia provider practicing within the scope of the provider's license manage the anesthesia.

2. Equipment and Supplies Required.

a. Full and current crash cart at the location the anesthetizing is being carried out. The crash cart must include, at a minimum, the following resuscitative medications:

I. Adrenalin (epinephrine) 1:10,000 dilution; 10ml

II. Adrenalin (epinephrine) 1:1000 dilution; 1ml

III. Atropine 0.1mg/ml; 5ml

IV. Benadryl (diphenhydramine)

V. Calcium chloride 10%; 10ml

VI. Dextrose 50%;

VII. Dilantin (phenytoin)

VIII. Dopamine

IX. Heparin

X. Inderal (propranolol)

XI. Isuprel

XII. Lanoxin (digoxin)

XIII. Lasix (furosemide)

XIV. Xylocaine (lidocaine)

XV. Magnesium sulfate 50%

XVI. Narcan (naloxone)

XVII. Pronestyl (procainamide)

XVIII. Sodium bicarbonate 50mEq/50ml

XIX. Solu-medrol (methylprednisolone)

XX. Verapamil hydrochloride

XXI. Romazicon

b. Suction devices, endotracheal tubes, laryngoscopes, etc.

c. Positive pressure ventilation device (e.g., Ambu) plus oxygen supply.

d. Double tourniquet for the Bier block procedure.

e. Monitors for blood pressure/EKG/Oxygen saturation.

f. Emergency intubation equipment.

g. Adequate operating room lighting.

h. Emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours.

i. Appropriate sterilization equipment.

j. IV solution and IV equipment.

3. Assistance of Other Personnel Required. The surgeon must be assisted by a qualified anesthesia provider as follows: An Anesthesiologist, Certified Registered Nurse Anesthetist, or Physician Assistant qualified as set forth in Rule 64B15-6.010(2)(b)6., Florida Administrative Code, or a registered nurse may be utilized to assist with the anesthesia, if the surgeon is ACLS certified. An assisting anesthesia provider cannot function in any other capacity during the procedure. If additional assistance is required by the specific procedure or patient circumstances, such assistance must be provided by a physician, osteopathic physician, registered nurse, licensed practical nurse, or operating room technician. A physician licensed under Chapter 458 or 459, a licensed physician assistant, a licensed registered nurse with post-anesthesia care unit experience or the equivalent, credentialed in Advanced Cardiac Life Support or, in the case of pediatric patients, Pediatric Advanced Life Support, must be available to monitor the patient in the recovery room until the patient is recovered from anesthesia.

(5) Level IIA Office Surgery.

(a) Scope. Level IIA office surgeries are those Level II office surgeries with a maximum planned duration of 5 minutes or less and in which chances of complications requiring hospitalization are remote.

(b) Standards for Level IIA Office Surgery.

1. The standards set forth in 64B15-14.006(4), Florida Administrative Code must be met except for the requirements set forth in section 64B15-14.006(4)(b)4., Florida Administrative Code regarding assistance of other personnel.

2. Assistance of Other Personnel Required. During the procedure, the surgeon must be assisted by a physician or physician assistant who is licensed pursuant to Chapter 458 or 459, F.S., or by a licensed registered nurse or a licensed practical nurse. Additional assistance may be required by specific procedure or patient circumstances. Following the procedure, a physician or physician assistant who is licensed pursuant to Chapter 458 or 459, F.S., or a licensed registered nurse must be available to monitor the patient in the recovery room until the patient is recovered from anesthesia. The monitor must be certified in Advanced Cardiac Life Support, or, in the case of pediatric patients, Pediatric Advanced Life Support.

(6) Level III Office Surgery.

(a) Scope.

1. Level III Office Surgery is that surgery which involves, or reasonably should require, the use of a general anesthesia or major conduction anesthesia and pre-operative sedation. This includes the use of:

a. Intravenous sedation beyond that defined for Level II office surgery;

b. General Anesthesia: loss of consciousness and loss of vital reflexes with probable requirement of external support of pulmonary or cardiac functions; or

c. Major Conduction anesthesia.

2. Only patients classified under the American Society of Anesthesiologist's (ASA) risk classification criteria as Class I or II are appropriate candidates for Level III office surgery.

(a) All Level III surgeries on patient classified as ASA III and higher are to be performed only in a hospital or ambulatory surgery center.

(b) For all ASA II patients above the age of 40, the surgeon must obtain, at a minimum, an EKG and a complete workup performed prior to the performance of Level III surgery in a physician office setting. If the patient is deemed to be a complicated medical patient, the patient must be referred to an appropriate consultant for an independent medical clearance. This requirement may be waived after evaluation by the patient's anesthesiologist.

(b) Standards for Level III Office Surgery. In addition to the standards for Level II Office Surgery, the surgeon must comply with the following:

1. Training Required.

a. The surgeon must be able to document satisfactory completion of training such as Board certification or Board qualification by a Board approved by the American Osteopathic Association, the American Board of Medical Specialties, the Accreditation Council on Graduate Medical Education or any other board approved by the Board of Osteopathic Medicine or must be able to demonstrate to the accrediting organization or to the Department comparable background, training and experience. In addition, the surgeon must have knowledge of the principles of general anesthesia.

b. The surgeon and one assistant must be currently certified in Basic Life Support and the surgeon or at least one assistant must be currently certified in Advanced Cardiac Life Support.

2. Emergency procedures related to serious anesthesia complications should be formulated, periodically reviewed, practiced, updated, and posted in a conspicuous location.

3. Equipment and Supplies Required.

a. Equipment, medication, including at least 36 ampules of dantrolene on site, and monitored post-anesthesia recovery must be available in the office.

b. The office, in terms of general preparation, equipment, and supplies, must be comparable to a free standing ambulatory surgical center, including, but not limited to, recovery capability, and must have provisions for proper recordkeeping.

c. Blood pressure monitoring equipment; EKG; end tidal CO2 monitor; pulse oximeter, precordial or esophageal stethoscope, emergency intubation equipment and a temperature monitoring device.

d. Table capable of trendelenburg and other positions necessary to facilitate the surgical procedure.

e. IV solutions and IV equipment.

4. Assistance of Other Personnel Required. An Anesthesiologist, Certified Registered Nurse Anesthetist, or Physician Assistant qualified as set forth in Rule 64B15-6.010(2)(c)6., Florida Administrative Code, must administer the general or regional anesthesia and an M.D., D.O., Registered Nurse, Licensed Practical Nurse, Physician Assistant, or Operating Room Technician must assist with the surgery. The anesthesia provider cannot function in any other capacity during the procedure. A physician licensed under Chapter 458 or 459, F.S., a licensed physician assistant, or a licensed registered nurse with post-anesthesia care unit experience or the equivalent, and credentialed in Advanced Cardiac Life Support, or in the case of pediatric patients, Pediatric Advanced Life Support, must be available to monitor the patient in the recovery room until the patient has recovered from anesthesia.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Karen Eaton, Executive Director, Board of Osteopathic Medicine, 4052 Bald Cypress Way, Bin #C06, Tallahassee, Florida 32399-3256

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Economic Self-Sufficiency Program

RULE NOS.:	RULE TITLES:
65A-2.022	Rights and Responsibilities of Applicants and Recipients
65A-2.032	General Eligibility Criteria
65A-2.036	Amount of Optional State Supplementation Payments

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rules identified above in accordance with subparagraph 120.54(3)(d)1., F.S., published in the Vol. 27, No. 33, August 17, 2001, issue of the Florida Administrative Weekly. These changes are the result of potential objections raised by the Joint Administrative Procedures Committee in a letter dated August 28, 2001.

In Rule paragraph 65A-2.022(1), F.A.C., following the second sentence, insert, "OSS payments are made to individuals residing in facilities covered by Rule 65A-2.032(7) and within the coverage groups specified in Rules 65A-2.033(1) through (4), F.A.C."

In Rule paragraph 65A-2.022(4), F.A.C., the single sentence is changed as follows, "The department is responsible for providing prompt action in accordance with Rule 65A-2.023(1) and (2), equitable treatment in accordance with Rules 65A-1.204 and 65A-2.031 and timely notification in accordance with Rule 65A-2.023(2) of any decision regarding an individual's payment or eligibility status."

In Rule paragraph 65A-2.032(4), F.A.C., add at the end of the single sentence, "in Rule 65A-2.036(3)".

In Rule paragraph 65A-2.032(6), F.A.C., add at the end of the single sentence, "as required by federal regulation 20 CFR s. 416.210 for the SSI program and by federal regulation 42 CFR s. 435.608 for the Medicaid program".

In Rule paragraph 65A-2.036(1), F.A.C., the first sentence is changed to read, "The department establishes the base provider rates for specialized living arrangements (the amount the individual is to pay the facility) specified in rule 65A-2.036(4) wWithin ~~the~~ funds appropriated by the Legislature~~, the department will establish base provider rates for specialized living arrangements (the amount the individual is to pay the facility)~~."