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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Sue Foster, Executive Director, Board of Dentistry/MQA, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399-3258

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

Section II
Proposed Rules

DEPARTMENT OF EDUCATION

State Board of Education

RULE TITLE: RULE NO.:

The Dale Hickam Excellent Teaching Program 6A-10.060

PURPOSE AND EFFECT: This amendment is to amend one of the qualifications for who may be certified as eligible for the fee subsidies, incentives and bonuses under Section 1012.72, Florida Statutes. The qualification relating to discipline of a teacher certificate will now only exclude those whose certificate has been disciplined within the five years prior to certification by the district pursuant to Section 1012.72(2)(c), Florida Statutes.

SUMMARY: This amendment is to amend one of the qualifications for who may be certified as eligible for the fee subsidies, incentives and bonuses under Section 1012.72, Florida Statutes. The qualification relating to discipline of a teacher certificate will now only exclude those whose certificate has been disciplined within the five years prior to certification by the district pursuant to Section 1012.72(2)(c), Florida Statutes.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None.

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

SPECIFIC AUTHORITY: 1012.72(4), 1001.02(2)(n) FS.

LAW IMPLEMENTED: 1012.72 FS.

A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 9:00 a.m., May 17, 2005

PLACE: 325 West Gaines Street, Tallahassee, Florida 32399

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Michael Kooi, Assistant General Counsel, Department of Education, 325 West Gaines Street, Room 1242, Tallahassee, Florida, (850)245-0442

THE FULL TEXT OF THE PROPOSED RULE IS:

6A-10.060 The Dale Hickam Excellent Teaching Program.

(1) Eligibility for payment(s) of the certification fee subsidy, teaching salary bonus, and mentoring salary bonus, pursuant to Section 1012.72, Florida Statutes, requires the following:

(a) through (e) No change.

(f) Holding a valid Florida educator's certificate that has not ~~never~~ been subject to discipline as the result of a final order of the Education Practices Commission after a formal, informal, or show cause hearing or settlement agreement within the five (5) years immediately prior to the district's certification pursuant to Section 1012.72(2)(c), Florida Statutes.

(2) through (8) No change.

Specific Authority 1012.72 FS. Law Implemented 1012.72 FS. History–New 7-12-99, Amended 5-29-00, 5-25-04,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Michael Kooi, Assistant General Counsel, Department of Education

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Jim Warford, Chancellor K-12 Education, Department of Education

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: April 4, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: February 25, 2005

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND

Pursuant to Chapter 2003-145, Laws of Florida, all notices for the Board of Trustees of the Internal Improvement Trust Fund are published on the Internet at the Department of Environmental Protection's home page at http://www.dep.state.fl.us/ under the link or button titled "Official Notices."

STATE BOARD OF ADMINISTRATION

RULE TITLE: RULE NO.:

Reimbursement Premium Formula 19-8.028

PURPOSE AND EFFECT: This rule is promulgated to implement Section 215.555, Florida Statutes, regarding the Florida Hurricane Catastrophe Fund, for the 2005-2006 contract year.

SUMMARY: Proposed amended Rule 19-8.028, F.A.C., establishes the premium formula and adopts the rates for the 2005-2006 contract year.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: The Board has prepared a statement and found the cost to be minimal.

Any person who wishes to provide information regarding the statement of estimated 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: 215.555(3) FS.

LAW IMPLEMENTED: 215.555(2),(3),(4),(5),(6),(7) FS.

REGARDLESS OF WHETHER OR NOT REQUESTED, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 9:00 a.m. – 12:00 Noon, Eastern Standard Time, Thursday, May 12, 2005

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

Any person requiring special accommodations to participate in this proceeding is asked to advise Patti Elsbernd, P. O. Box 13300, Tallahassee, FL 32317-3300, (850)413-1346, at least five (5) calendar days before such proceeding.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Jack E. Nicholson, Senior FHCF Officer of the Florida Hurricane Catastrophe Fund, State Board of Administration, P. O. Box 13300, Tallahassee, FL 32317-3300, (850)413-1340

THE FULL TEXT OF THE PROPOSED RULE IS:

19-8.028 Reimbursement Premium Formula.

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

(k) New Participants. The term means all Companies which are granted a certificate of authority by the Department of Financial Services after the beginning of the FHCF's Contract Year on June 1 and which write Covered Policies, or which already have a certificate of authority and begin writing Covered Policies on or after the beginning of the FHCF's Contract Year on June 1 and did not or was not required to enter into a contract on June 1 of the Contract Year. A Company that enters into an assumption agreement with Citizens that includes Covered Policies and is effective after on or after June 1 and had written no other Covered Policies on or before June 1 is also considered a New Participant.

(l) through (n) No change.

(3)(a) through (g) No change.

(h) For the 2005-2006 Contract Year, the Formula developed by the Board's Independent Consultant, "Florida Hurricane Catastrophe Fund: 2005 Ratemaking Formula Report to the State Board of Administration of Florida, March 16, 2005" is hereby adopted and incorporated by reference. The basic premium rates developed in accordance with the Premium Formula methodology approved by the Board on April 5, 2005, are hereby adopted and incorporated by reference in Form FHCF-Rates 2005, "Florida Hurricane Catastrophe Fund Proposed 2005 Rates, March 16, 2005." The forms may be obtained from the Fund's Administrator at the address stated in ~~this~~ subsection (5).

(4)(a) No change.

(b) Forfeiture or Surrender of Certificates of Authority.

1. through (c)4. No change.

5. For purposes of paragraph ~~subsubparagraph~~ (4)(c), the requirement that a report is due on a certain date means that the report shall be in the physical possession of the Fund's Administrator in Minneapolis no later than 5 p.m., Central Time, on the due date applicable to the particular report. If the applicable due date is a Saturday, Sunday or legal holiday, then the applicable due date will be the day immediately following the applicable due date which is not a Saturday, Sunday or legal holiday. For purposes of the timeliness of the submission, neither the United States Postal Service postmark nor a postage meter date is in any way determinative. Reports sent to the Board in Tallahassee, Florida, will be returned to the sender. Reports not in the physical possession of the Fund's Administrator by 5:00 p.m., Central Time, on the applicable due date are late.

(d) No change.

(5) All the forms adopted and incorporated by reference in this rule may be obtained from: Administrator, Florida Hurricane Catastrophe Fund, Paragon Strategic Solutions, Inc., 3600 American Boulevard West, Suite 700, Minneapolis, Minnesota 55431.

Specific Authority 215.555(3) FS. Law Implemented 215.555(2),(3),(4),(5),(6),(7) FS. History–New 9-20-99, Amended 7-3-00, 9-17-01, 7-17-02, 7-2-03, 7-29-04, ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Jack E. Nicholson, Senior FHCF Officer, Florida Hurricane Catastrophe Fund, State Board of Administration of Florida

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: The Trustees of the State Board of Administration of Florida

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: April 5, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: December 17, 2004, Vol. 30, No. 51

DEPARTMENT OF CORRECTIONS

RULE TITLE:	RULE NO.:
Canteen Operations	33-203.101

PURPOSE AND EFFECT: The purpose and effect of the proposed rule is to delete obsolete language. Reference to the Department's cashless canteen system is being deleted as the contracted vendor provides their own cashless system.

SUMMARY: Reference to the Department's cashless canteen system is being deleted as the contracted vendor provides their own cashless system.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None.

Any person who wishes to provide information regarding the statement of estimated 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: 20.315, 944.09, 945.215 FS.

LAW IMPLEMENTED: 20.315, 944.09, 945.215, 946.002 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Perri King Dale, Office of the General Counsel, Department of Corrections, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500

THE FULL TEXT OF THE PROPOSED RULE IS:

33-203.101 Canteen Operations.

(1) through (2) No change.

(3) ~~A standard mark-up policy implemented through the department's cashless canteen system will be used to price canteen resale items.~~ Current price lists will be posted in the proximity of the canteen for inmate viewing purposes.

(4) through (8) No change.

Specific Authority 20.315, 944.09, 945.215 FS. Law Implemented 20.315, 944.09, 945.215, 946.002 FS. History–New 1-20-86, Formerly 33-3.035, Amended 11-22-91, 5-25-95, 11-13-95, 5-28-96, 2-12-97, Formerly 33-3.0035, Amended 11-18-02, 12-3-03, 12-14-04,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Millie Seay

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: James V. Crosby, Jr.

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: March 8, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 18, 2005

DEPARTMENT OF CORRECTIONS

RULE TITLE: RULE NO.:

Rules of Prohibited Conduct and Penalties for Infractions 33-601.314

PURPOSE AND EFFECT: The purpose and effect of the proposed rule is to renumber disciplinary charges for consistency with the Department's database, and to provide a specific disciplinary charge for making a threatening gesture.

SUMMARY: The proposed rule renumbers disciplinary charges for consistency with the Department's database, and provides a specific disciplinary charge for making a threatening gesture.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None.

Any person who wishes to provide information regarding the statement of estimated 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: 944.09 FS.

LAW IMPLEMENTED: 20.315, 944.09, 944.14, 944.279, 944.28 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Perri King Dale, Office of the General Counsel, Department of Corrections, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500

THE FULL TEXT OF THE PROPOSED RULE IS:

33-601.314 Rules of Prohibited Conduct and Penalties for Infractions.

The following table shows established maximum penalties for the indicated offenses. As used in the table, "DC" means the maximum number of days of disciplinary confinement that may be imposed and "GT" means the maximum number of days of gain time that may be taken. Any portion of either penalty may be applied.

		Maximum Disciplinary Actions
SECTION 1 – ASSAULT, BATTERY, THREATS, AND DISRESPECT		
1-1 through 1-2 No change.		
1-3	Spoken, ~~or~~ written, or gestured threats	30 DC + 90 GT
1-4 through 1-5 No change.		
SECTION 2 – No change.		
SECTION 3 – CONTRABAND – ANY ARTICLE NOT SOLD IN THE CANTEEN, OR ISSUED BY THE INSTITUTION, OR FOR WHICH YOU DO NOT HAVE A SPECIFIC PERMIT AUTHORIZED BY THE INSTITUTION WHERE PRESENTLY HOUSED		
3-1 through 3-12 No change.		
3-13	Introduction of any contraband	60 DC + All GT
3-14~~3~~	Possession or use of a cellular telephone or any other type of wireless communication device	60 DC + All GT
~~3-14~~	~~Introduction of any contraband~~	~~60 DC + All GT~~
SECTION 4 through SECTION 11 – No change.		

Specific Authority 944.09 FS. Law Implemented 20.315, 944.09, 944.14, 944.279, 944.28 FS. History–New 3-12-84, Amended 1-10-85, Formerly 33-22.12, Amended 12-30-86, 9-7-89, 11-22-90, 6-2-94, 10-01-95, 3-24-97, 7-9-98, 8-13-98, Formerly 33-22.012, Amended 9-30-99, 6-7-00, 4-18-02, 10-10-04, 1-9-05,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: George Sapp
NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: James V. Crosby, Jr.
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: April 4, 2005
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 18, 2005

DEPARTMENT OF CORRECTIONS

RULE TITLE: RULE NO.:
Maximum Management 33-601.820

PURPOSE AND EFFECT: The purpose and effect of the proposed rule is to: delete obsolete and unnecessary language; define relevant terms; provide requirements for documentation of actions and decisions related to maximum management; describe the process for maximum management placement, review and release; provide for the imposition of immediate restrictions; reorganize provisions for clarity; and clarify authority and responsibilities associated with maximum management review and decision-making.

SUMMARY: The proposed rule deletes unnecessary language related to general purpose; defines the authority and role of the maximum management review team; includes the regional director in the maximum management decision process; reflects the change to an electronic database; provides for immediate placement of an inmate into maximum management upon recommendation from the shift supervisor; clarifies requirements for restriction of inmate property or privileges for security reasons; requires approval by the Deputy Assistant Secretary of Operations before an inmate is released from maximum management; and deletes the prohibition against maximum management inmates checking out library books.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None.

Any person who wishes to provide information regarding the statement of estimated 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: 944.09 FS.

LAW IMPLEMENTED: 944.09 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Perri King Dale, Office of the General Counsel, Department of Corrections, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500

THE FULL TEXT OF THE PROPOSED RULE IS:

33-601.820 Maximum Management.

~~(1) General. Maximum Management is a temporary status for an inmate who, through a recent incident or a series of recent incidents, has been identified as being an extreme security risk to the Department and requires an immediate level of control beyond that available in close management or death row.~~

(1)~~(2)~~ Definitions.

(a) No change.

(b) Institutional Classification Team (ICT) ~~for Maximum Management Review~~ – refers to the team consisting of the Warden or Assistant Warden, Classification Supervisor, a correctional officer chief, and other members as necessary when appointed by the Warden or designated by rule. ~~The ICT is responsible for making work, program, housing and inmate status decisions at a facility and for making other recommendations to the State Classification Office (SCO).~~

(c) Maximum Management ~~(MM)~~ – refers to a temporary status for an inmate who, through a recent incident or series of recent incidents, has been identified as being an extreme security risk to the Department and requires an immediate level of control beyond that available in close management or death row. The Secretary shall designate which institutions are authorized to house maximum management inmates, based upon the needs of the Department.

(d) No change.

(e) Maximum Management Review Team – refers to the committee in Central Office that has approval authority for placement in maximum management and the modification of conditions and restrictions imposed at the time an inmate is initially placed in maximum management. The Maximum Management Review Team shall consist of the following staff or those acting in that capacity:

1. Deputy Assistant Secretary of Operations (Chairperson);

2. Chief, Bureau of Classification and Central Records;

3. Chief, Bureau of Security Operations; and

4. Deputy Director of Health Services (clinical).

(f)~~(e)~~ Shift Supervisor – the ~~highest-ranking~~ c~~C~~orrectional o~~O~~fficer in charge of security on any work shift ~~on-duty~~.

(g)~~(f)~~ No change.

(2)~~(3)~~ Maximum Management Placement Criteria.

~~(a)~~ An inmate shall have, at a minimum, met the criteria for placement in Close Management I or death row and participated in a recent incident or series of recent incidents which demonstrate:

1. through 4. renumbered (a) through (d) No change.

(3) Initial Placement in Maximum Management Housing.

(a)~~(b)~~ Whenever an inmate has met at least one of the conditions above, ~~and~~ the Shift Supervisor ~~believes that the inmate cannot be controlled in a status less than maximum management, the Shift Supervisor~~ shall recommend immediate placement in maximum management on the electronic ~~by completing Section 1 of Form DC6-101,~~ r~~R~~eferral for m~~M~~aximum m~~M~~anagement in the Offender Based Information System (OBIS). ~~Form DC6-101 is incorporated by reference in subsection (6) of this rule. Approval from the warden or duty warden shall be received prior to placement of the inmate in maximum management.~~

(b)~~(c)~~ The Warden or Duty Warden shall document this decision on the electronic referral for maximum management in OBIS. Approval from the Warden or Duty Warden shall be received prior to placement of the inmate in maximum management pending completion of the hearing process in subsection (5) ~~approve or disapprove the immediate placement of an inmate in maximum management by signing Form DC6-101, Referral for Maximum Management~~.

(c) The Shift Supervisor who recommended placing an inmate in maximum management shall ensure delivery of the electronic notice of referral for maximum management to the inmate prior to being relieved of duty. The written notice will provide the inmate the reason for the placement and inform the inmate that a hearing will be held no sooner than 24 hours to review the recommendation for placement in maximum management. The inmate may waive the 24 hour period or appearance at the hearing by signing the Waiver of Right to Appear/Waiver of 24 Hour Period, Form DC6-104. Form DC6-104 is hereby incorporated by reference. Copies of this form are available from the Forms Control Administrator, Office of Research, Planning and Support Services, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500. The effective date of this form is December 7, 2000.

~~(d) Whenever an inmate has met at least one of the conditions in subsection 33-601.820(3), F.A.C., and the Shift Supervisor believes that the inmate should be reviewed for but not immediately placed in maximum management at the present time, then the Shift Supervisor shall recommend placement by completing Section 1 of Form DC6-101, Referral for Maximum Management. The Shift Supervisor shall notify the Classification Supervisor in writing of the recommendation no later than the following administrative workday.~~

(d)~~(e)~~ No change.

(4) Initial Conditions at time of Placement in Maximum Management Housing.

(a) During initial placement of an inmate into maximum management the following will be provided:

1. through 2. No change.

3. Cell with a Solid Door ~~Should an inmate's behavior require that the solid door be closed for security reasons, the Shift Supervisor may authorize this immediate restriction. The Shift Supervisor shall notify the ICT the following day and the ICT shall approve, disapprove or modify this restriction. The ICT shall notify the warden for final approval, disapproval or modification of the ICT decision as described in subsection (5) of this rule~~.

4. through 10. No change.

(b) Should an inmate's behavior require that the clothing or bedding be removed or that the solid door be closed for security reasons either upon initial placement or at any time during maximum management status, the Shift Supervisor may authorize this immediate restriction. The Shift Supervisor shall notify the Warden. If in agreement with the action, the Warden shall notify the Regional Director. If the Regional Director agrees with the action, the Deputy Assistant Secretary of Operations will be contacted for final approval no later than the first work day following the Shift Supervisor's action. If an inmate's clothing is removed, a modesty garment shall be immediately given to the inmate. If the inmate chooses not to wear the garment, the garment shall be left in the cell and this action shall be documented. Under no circumstances shall an inmate be left without a means to cover him or herself.

(c)~~(b)~~ No change.

~~(c) The conditions set forth in paragraphs (a) and (b) above shall be reviewed at least weekly by the ICT, and when the ICT determines the inmate has sufficiently demonstrated positive adjustment, consideration shall be given to adjusting the inmate's conditions to the extent authorized for Close Management I inmates. The Institutional Classification Team shall document their justification for adjustment on Form DC6-101, Referral for Maximum Management.~~

(5) ~~Maximum Management Conditions After~~ Initial Placement Hearing and Decision Process. ~~Should the inmate's behavior require alteration of initial placement conditions or previously relaxed conditions as described in paragraphs (4)(a) and (b), the Institutional Classification Team shall make the recommendation to the warden on Form DC6-101, Referral for Maximum Management. The warden shall approve, disapprove or modify the recommendations.~~

~~(6) Inmate Notice of Maximum Management Hearing. The Shift Supervisor who recommends placing an inmate in maximum management shall ensure delivery of the Notice of Referral for Maximum Management, Form DC6-101, to the inmate prior to being relieved of duty. Form DC6-101 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 December 7, 2000. The written notice will provide the inmate with an explanation of the reason for the recommendation or placement and inform the inmate that a hearing will be held no sooner~~

~~than 24 hours of the recommended placement in maximum management. The inmate may waive the 24-hour period or appearance at the hearing by signing the Waiver of Right to Appear/Waiver of 24 Hour Period, Form DC6-104. Form DC6-104 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 December 7, 2000.~~

~~(7) Conducting the Hearing.~~

(a) No change.

(b) The inmate shall be present for the hearing, unless:

1. through 2. No change.

3. If applicable, t~~T~~he reasons the inmate did not appear at the hearing shall be included in the ICT recommendation entered ~~documented~~ on the electronic ~~Form DC6-101,~~ r~~R~~eferral for m~~M~~aximum m~~M~~anagement in OBIS.

(c) through (d) No change.

(e) The Institutional Classification Team chairperson shall have authority to postpone the hearing to gather further information or order an investigation regarding any pertinent issues. If the hearing is postponed, that action and the reasons for it shall be included in the ICT recommendation entered on the electronic referral for maximum management in OBIS.

(f) The Institutional Classification Team shall recommend approval ~~approve~~ or disapproval of ~~disapprove~~ the recommendation for placement in maximum management and changes to the initial conditions of placement as listed in paragraph (4)(a), if appropriate. The initial conditions of placement are intended to be short-term and should be relaxed as soon as the inmate's adjustment to maximum management and the inmate's level of threat to the security of the institution indicate that it is safe and appropriate to do so. These conditions can only be relaxed to the level permitted for Close Management I inmates. The recommendations and the basis for the recommendations shall be documented on the electronic referral for maximum management in OBIS.

~~(g) The inmate shall be informed verbally and in writing of the ICT decision.~~

(g)~~(h) If~~ T~~t~~he Institutional Classification Team's recommendations shall be forwarded to the Warden for review ~~disapproves placement, the inmate shall immediately be reclassified to his original status and removed from the maximum management cell~~. The Warden's recommendation for approval or disapproval of maximum management placement and any changes to the initial conditions and the basis for the recommendations shall be documented on the electronic referral for maximum management in OBIS.

(h) The Warden's recommendations shall be forwarded to the Regional Director for review. The Regional Director's recommendation for approval or disapproval of maximum management placement and any changes to the initial conditions and the basis for recommendations shall be documented on the electronic referral for maximum management in OBIS.

(i) The Regional Director's recommendations shall be forwarded to the Maximum Management Review Team for review and final approval or disapproval of the maximum management placement and any changes to the initial conditions. The Maximum Management Review Team's decisions shall be documented on the electronic referral for maximum management in OBIS. ~~If the Institutional Classification Team approves placement, the decision will be forwarded to the warden who will review the recommendation.~~

(j) If the Maximum Management Review Team's decision is to disapprove the maximum management placement, the inmate shall immediately be reclassified to his original status and removed from the maximum management cell.

(k) The Classification Supervisor at the maximum management facility shall ensure that Form DC6-229A, Daily Record of Segregation, is documented with any status or condition changes approved by the Maximum Management Review Team. The Classification Supervisor shall also ensure that the inmate is informed verbally and in writing of the Maximum Management Review Team's decision. Form DC6-229A is incorporated by reference in Rule 33-601.800, F.A.C.

(l) The ICT at the maximum management facility is responsible for ensuring that staff adheres to any time frames approved in reference to inmate conditions.

(m) An inmate shall not be released from maximum management status or be subjected to changes in initial conditions until the actions are approved by the Maximum Management Review Team except as allowed in paragraph (4)(b) above.

~~(8) Final Review of Placement.~~

~~(a) The warden shall approve or disapprove the ICT recommendation based on the criteria in paragraph (3)(a). If the ICT recommendation is incomplete or additional data is needed, the warden shall return the recommendation to the ICT for additional information.~~

~~(b) If the warden disapproves placement, the inmate shall immediately be reclassified to his original status.~~

(6)~~(9)~~ Review of Maximum Management Status and Conditions.

(a) The Institutional Classification Team shall review the inmate's maximum management status, the conditions set forth in paragraphs (4)(a) and (b) above, and previously modified conditions, weekly for the first sixty days ~~two months~~ from the date of placement, and at least monthly thereafter.

1. Weekly reviews by the ICT during the first sixty days of maximum management status and monthly thereafter shall be documented on Form DC6-229A, Daily Record of Segregation

~~A recommendation for release from maximum management shall be set forth in memorandum and forwarded to the State Classification Office for review~~.

2. If the ICT recommends the inmate's release from maximum management or a change in the inmate's conditions during the first sixty days, the ICT shall also document their recommendation on the electronic classification contact log in OBIS. ~~An inmate shall not be released from maximum management status until authorized by a member of the State Classification Office.~~

3. All reviews conducted at least monthly by the ICT after the first sixty days of maximum management status shall be documented on the electronic classification contact log in OBIS. This documentation shall include any recommendations for changes in the inmate's conditions.

(b) All ICT reviews documented on the electronic classification contact log in OBIS shall be reviewed by the Warden. The Warden shall document the reason for approval, disapproval or modification of the ICT recommendations on the classification contact log in OBIS.

(c) The Warden's recommendations for approval, disapproval or modification of the inmate's status or conditions shall be reviewed by the Regional Director. The Regional Director shall document approval, disapproval or modification of the Warden's recommendation on the classification contact log in OBIS.

(d) If the Regional Director approves the inmate for continuation of maximum management status, no further review of the placement or change of conditions is required. An inmate shall not be subjected to changes in conditions until those actions are approved by the Regional Director, except as allowed in paragraph (4)(b) above.

(e) If the Regional Director recommends release from maximum management status, the recommendation must be forwarded for review and final decision to the Deputy Assistant Secretary of Operations. The Deputy Assistant Secretary of Operations shall document approval, disapproval, or modification of the Regional Director's recommendations on the classification contact log in OBIS.

(f) The Classification Supervisor at the maximum management facility shall ensure that Form DC6-229A, Daily Record of Segregation, is documented with any status or condition changes approved by the Regional Director or Deputy Assistant Secretary of Operations.

(g) The ICT at the maximum management facility shall ensure that staff adhere to any time frames approved in reference to inmate conditions.

(h) An inmate shall not be released from maximum management status until that action is approved by the Deputy Assistant Secretary of Operations.

(7) On-Site Review of Maximum Management.

(a)~~(b)~~ If an inmate remains in maximum management status for 90 days ~~or more~~, the Regional Director or designee ~~a member of the State Classification Office~~ shall conduct an on-site review of the inmate's maximum management status and conditions in conjunction with the monthly review of the Warden's recommendations. This on-site review shall take place after every 90 day~~s~~ period of continued maximum management status ~~from the date of placement~~. The Regional Director's designee shall be a Regional Assistant Warden, Regional Classification Administrator, or State Classification Officer.

(b)~~1.~~ The Institutional Classification Team shall participate in the review of the inmate's adjustment with the Regional Director or his designee ~~State Classification Office member~~.

~~2. The State Classification Office member is authorized to reclassify an inmate from maximum management status at any point during the reviews.~~

~~3. The Institutional Classification team shall be authorized to appeal the decision to reclassify the inmate to the State Classification Office chairperson.~~

~~4. The inmate shall not be released from maximum management status until the State Classification Office chairperson rules upon the appeal. The ruling of the State Classification Office chairperson is final.~~

(c) The Regional Director's recommendations following this on-site review will be documented on the classification contact log in OBIS.

(8)~~(10)~~ No change.

(9)~~(11)~~ Other Conditions Of Confinement.

~~(a) Inmates in maximum management shall not be allowed to check out books from the library.~~

(b) through (d) renumbered (a) through (c) No change.

(d)~~(e)~~ Inmates who are housed in maximum management will have mental health and medical care services to the same extent as all close management inmates. Monitoring of inmates will be as described in Rule 33-601.800, F.A.C.

Specific Authority 944.09 FS. Law Implemented 944.09 FS. History–New 12-7-00, Amended 11-23-03, 4-1-04, ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: George Sapp

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: James V. Crosby, Jr.

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: April 4, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 18, 2005

DEPARTMENT OF CORRECTIONS

RULE TITLE: RULE NO.:
Use of Committed Name 33-603.101

PURPOSE AND EFFECT: The purpose and effect of the proposed rule is to clarify that an inmate may use his or her true or legal name on mail or documents, so long as the committed name and DC number appear first.

SUMMARY: The proposed rule provides that an inmate may use his or her true or legal name on mail or documents, so long as the committed name and DC number appear first.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None.

Any person who wishes to provide information regarding the statement of estimated 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: 20.315, 944.09 FS.

LAW IMPLEMENTED: 944.09 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Perri King Dale, Office of the General Counsel, Department of Corrections, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500

THE FULL TEXT OF THE PROPOSED RULE IS:

33-603.101 Use of Committed Name.

(1)(a) No change.

(b) The department shall register any known aliases on the inmate's record and shall also designate on the record which name is the inmate's true or legal name if this information is available. <u>If an inmate's true name is not the committed name, the inmate shall be permitted to use the true name on documents and mail so long as the committed name and DC number appear first, followed by the true name.</u>

(c) through (4) No change.

Specific Authority 20.315, 944.09 FS. Law Implemented 944.09 FS. History–New 9-30-93, Formerly 33-6.012, Amended 4-29-02, 5-20-03,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: George Sapp

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: James V. Crosby, Jr.

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: March 2, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 18, 2005

AGENCY FOR HEALTH CARE ADMINISTRATION

Certificate of Need

RULE TITLE: RULE NO.:
Certificate of Need Application
Review Procedures 59C-1.010

PURPOSE AND EFFECT: The agency is proposing to amend the rule currently used to describe the time frames and the certificate of need (CON) application process. The amended rule removes requirements for CON filing with Local Health Councils and clarifies what is required for applicant to certify that they will license and operate a health care facility or hospice. A preliminary draft of the rule amendments is included in this Notice.

SUMMARY: The proposed rule eliminates local health council reporting requirements and specifies the requirements of applicants prior to notifying the Agency of its intentions.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None prepared.

Any person who wishes to provide information regarding the statement of estimated 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: 408.034(6), 408.15(8) FS.

LAW IMPLEMENTED: 408.040 FS.

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: 2:00 p.m. (EST), May 10, 2005

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Rommel Bain, Certificate of Need, 2727 Mahan Drive, Building 1, MS 28, Tallahassee, Florida 32308

THE FULL TEXT OF THE PROPOSED RULE IS:

59C-1.010 Certificate of Need Application Review Procedures.

(1) No change.

(2) General Provisions.

(a) Applications subject to comparative or expedited review shall be submitted to the agency ~~and the Local Health Council~~ on AHCA Form CON-1, as referenced in paragraph 59C-1.008(1)(f), F.A.C.

(b) Applications for projects involving an existing health care facility shall be filed by the current license holder as listed on the current agency license in effect at the time of the applicant omission deadline specified in subparagraph (3)(a)3. or (4)(d)3. of this rule, or the application shall be withdrawn from consideration. <u>Applications submitted by corporations required to have filed incorporation papers or foreign</u>

corporation papers in order to do business in Florida must be able to do business in Florida prior to notifying the Agency of its intentions in a comparative review cycle or by the time it files an expedited application, if the project is subject to expedited review.

(c) No change.

(3) No change.

(a) No change.

1. through 2. No change.

3. If an applicant does not provide the specific additional information required by statute and rule in writing to the agency within 21 calendar days of the receipt of the agency's request, the application shall be deemed withdrawn from consideration. The applicant's response must be received by the agency no later than 5:00 p.m. local time on or before the omissions due date promulgated under paragraph 59C-1.008(1)(g), F.A.C. ~~The Local Health Council must receive a copy of the additional information bearing a postmark or shipping date that is no later than the omissions due date.~~

(b) The agency shall deem the application complete or withdrawn within 7 calendar days of the receipt of the requested information. Subsequent to an application being deemed complete or withdrawn by the agency, no further application information or amendment will be accepted by the agency.

(c) through (d) No change.

(4) No change.

(a) through (d) No change.

1. through 2. No change.

3. If an applicant does not provide the specific additional information required by statute and rule in writing to the agency within 21 calendar days of the receipt of the agency's request, the application shall be deemed withdrawn from consideration. ~~The Local Health Council must receive a copy of the additional information bearing a postmark or shipping date that is no later than the omissions due date.~~

(e) through (g) No change.

(5) through (7) No change.

Specific Authority 408.034(5), 408.15(8) FS. Law Implemented 408.033(1), 408.036(2), 408.039(3)(4) FS. History–New 1-1-77, Amended 11-1-77, 9-1-78, 6-5-79, 4-25-80, 2-1-81, 3-31-82, 12-23-82, Formerly 10-5.10, Amended 11-24-86, 11-17-87, 3-23-88, 8-28-88, 1-31-91, 7-1-92, 7-14-92, Formerly 10-5.010, Amended 10-8-97, 12-12-00, 4-2-01, ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Rommel Bain, Health Services and Facilities Consultant

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Karen Rivera, Consultant Supervisor

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 6, 2004

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: October 8, 2004

AGENCY FOR HEALTH CARE ADMINISTRATION

Certificate of Need

RULE TITLE: RULE NO.:

Health Care Facilities Fee Assessments and Fee Collection Procedures 59C-1.022

PURPOSE AND EFFECT: The agency is proposing to amend the rule that outlines the health care facilities fee assessment and collection procedures. The rule incorporates statutory changes to add health care clinics to the list of facilities, updates statutory citations and dishonored check charges. A preliminary draft of the rule amendments is included in this Notice.

SUMMARY: The proposed rule is amended to incorporate statutory changes to the list of health care facilities subject to fee assessment. The rule amends the service charge assessed for dishonored checks.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None prepared.

Any person who wishes to provide information regarding the statement of estimated 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: 408.033(2), 408.034(6), 408.15(8) FS.

LAW IMPLEMENTED: 408.033(2), 215.34(2) FS.

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: 2:00 p.m. (EST), May 11, 2005

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Rommel Bain, Certificate of Need, 2727 Mahan Drive, Building 1, MS 28, Tallahassee, Florida 32308

THE FULL TEXT OF THE PROPOSED RULE IS:

59C-1.022 Health Care Facilities Fee Assessments and Fee Collection Procedures.

(1) Health Care Facilities Subject to Assessment. In accordance with subsection 408.033(2)~~(3)~~, Florida Statutes, the following health care facilities and health care service providers, licensed or certified by the Agency for Health Care Administration, shall be assessed an annual fee to be collected by the agency within the time frames specified in subsection (4):

(a) Abortion clinics licensed under Chapter 390, F.S.

(b) ~~Adult congregate~~ Assisted living facilities licensed under Part III ~~II~~, Chapter 400, F.S.

(c) through (d) No change.

(e) Clinical laboratories licensed under Part I, Chapter 483, F.S., except community nonprofit blood banks and clinical laboratories operated by practitioners for exclusive use regulated under Section 483.035, Florida Statutes.

(f) Health maintenance organizations and prepaid health clinics ~~licensed~~ certified under P~~p~~art III ~~IV~~, Chapter 641, F.S.

(g) Home health agencies licensed under Part IV ~~III~~, Chapter 400, F.S.

(h) Hospices licensed under Part VI ~~I~~, Chapter 400, F.S.

(i) No change.

(j) Intermediate care facilities for developmentally disabled persons ~~the mentally retarded~~ licensed under Part XI, Chapter 400 ~~393~~, F.S.

(k) Nursing homes licensed under Part II ~~I~~, Chapter 400, F.S.

(l) No change.

(m) Health Care Clinics licensed under Part XIII, Chapter 400, F.S.

(2) Health Care Facilities Exempted from Fee Assessments. Facilities operated by the ~~Agency for Health Care Administration~~ Department of Children and Families, the Department of Health or the Department of Corrections, and any hospital which meets the definition of a rural hospital pursuant to subsection 395.~~102(2)~~602, F.S., are exempted from the health care facility assessment.

(3) No change.

(a) Hospitals, nursing homes, and ~~adult congregate~~ assisted living facilities shall be assessed a fee according to the following per bed charges:

1. through 2. No change.

3. ~~Adult congregate~~ Assisted living facilities shall be assessed $1 per bed not to exceed $150 per facility based on a bed inventory established by the agency as of July 1 of each year.

(b) Other health care facilities subject to a health care facility assessment, as specified in paragraph (1)(a), (c), (d), (e), (f), (g), (h), (j), ~~and~~ (l) and (m), shall be assessed an annual fee of $150.

(4) Billing and Collection Process. The agency shall bill each regulated facility not later than August 10 of each year. The agency shall collect annually, by September 1 of each year, an assessment from all facilities listed in paragraph (1)(a) through (m)~~(l)~~ in accordance with the fee schedule specified in paragraphs (3)(a) and (3)(b).

(5) through (6) No change.

(7) Penalties. In accordance with paragraph 408.033(2)~~(3)~~(e), the agency shall impose a fine of $100 per day, not to exceed the total annual assessment amount of $150 and $500, after the assessment becomes delinquent as specified in subsection (5). Refusal by a health care facility to pay the annual assessment or fine shall result in forfeiture procedures. Refusal of payment is defined as non-payment by the provider of the assessment or fine within 60 days of receipt of the delinquency notice.

(8) Dishonored Checks. The agency shall assess a service charge ~~of $10~~ for each returned check of five percent of the face value of the check or $15, whichever is greater.

Specific Authority 408.15(8), 408.033(2)~~(3)(e)~~, 408.034(6)~~(5)~~ FS. Law Implemented 408.033(2)~~(3)~~, 215.34(2) FS. History–New 12-7-88, Amended 11-29-89, 12-5-90, 8-19-91, Formerly 10-5.022, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Rommel Bain, Health Services and Facilities Consultant

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Karen Rivera, Consultant Supervisor

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: February 25, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 5, 2004

AGENCY FOR HEALTH CARE ADMINISTRATION

Hospital and Nursing Home Reporting Systems and Other Provisions Relating to Hospitals

RULE TITLES:	RULE NOS.:
Inpatient Data Reporting and Audit Procedures	59E-7.012
Inpatient Data Format – Data Elements, Codes and Standards	59E-7.014
Public Records	59E-7.015
General Provisions	59E-7.016

PURPOSE AND EFFECT: The rule amendments add inpatient data elements, modify inpatient data elements and codes, and modify inpatient data formats. The new reporting requirements will provide more comprehensive data about inpatient medical conditions for the purpose of medical research, public policy, and public information.

SUMMARY: The Agency is proposing amendments to Rules 59E-7.012, 59E-7.014, 59E-7.015 and 59E-7.016, F.A.C., that modify inpatient data reporting requirements and require the reporting of patient level data by long-term psychiatric hospitals. The rule amendments require reporting by Internet transmission effective with the submission of first quarter 2006 data. The rule amendments modify public record formats consistent with the requirements of the federal Health Insurance Portability and Accountability Act.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None prepared.

Any person who wishes to provide information regarding the statement of estimated 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: 408.15(8) FS.

LAW IMPLEMENTED: 408.061, 408.15(11) FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 10:00 a.m., May 9, 2005

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Lisa Rawlins, Bureau Chief, State Center for Health Statistics, Agency for Health Care Administration, Building 3, 2727 Mahan Drive, Tallahassee, Florida 32308

THE FULL TEXT OF THE PROPOSED RULES IS:

59E-7.012 Inpatient Data Reporting and Audit Procedures.

(1) Hospitals licensed under Chapter 395, F.S. except state-operated hospitals and specialty rehabilitation hospitals as defined in subparagraph 59A-3.252(1)(c)2., F.A.C. ~~All acute care hospitals and all short term psychiatric hospitals,~~ (hereinafter referred to as "hospital/hospitals"), in operation for all or any of the reporting periods described in subsection 59E-7.012(5), F.A.C., below, shall submit hospital inpatient discharge data to the Agency according to the provisions in ~~a format consistent with requirements of~~ Rules 59E-7.011 through 59E-7.016, F.A.C.~~, to the Agency following the provisions of this Rule~~. The amendments appearing herein are effective with the report period starting January 1, 2006 except the provisions in paragraph 59B-7.014(2)(p), F.A.C. are effective with the report period starting January 1, 2007.

~~(2) For purposes of submission of hospital inpatient discharge data, hospital shall be any hospital licensed under Chapter 395, Florida Statutes except state-operated hospitals, long-term psychiatric hospitals with an average length of stay exceeding 60 days and comprehensive rehabilitation hospitals as defined in Rule 59A-3.201, F.A.C. Additionally, long-term psychiatric hospitals are required to submit aggregated data following the format and context as presented in the Psychiatric Reporting Format AHCA PSY III dated 9/12/88 and herein incorporated by reference.~~

(2)~~(3)~~ Each hospital shall submit a separate report for each location per paragraph 59A-3.066(2)(i) ~~Rule 59A-3.203~~, F.A.C.

(3) All acute, intensive care, and psychiatric live discharges and deaths including newborn live discharges and deaths shall be reported. Submit one record per inpatient discharge, to include all newborn admissions, transfers and deaths.

(4) through (5) No change.

(6) Extensions to the initial submission due date will be granted by the Administrator, Office of ~~Hospital~~ Data Collection Section of the Agency staff, for a maximum of 30 days from the initial submission due date in response to a written request signed by the hospital's ~~data contact~~ chief executive officer or chief financial officer. The request must be received prior to the initial submission due date and the delay must be due to unforeseen and unforeseeable factors beyond the control of the reporting hospital. These factors must be specified in the written request for the extension along with documentation of efforts undertaken to meet the filing requirements. Extensions shall not be granted verbally.

(7) No change.

(8) Beginning with the inpatient data report for the 1st Quarter of the year 2006 ~~2000~~ (January 1, 2006 ~~2000~~ through March 31, 2006 ~~2000~~), reporting facilities shall submit inpatient discharge data by Internet according to ~~reports in one of~~ the specifications in (a) through (c) below unless reporting by CD-ROM is approved by the Agency in a case of extraordinary or hardship circumstances. ~~following formats except that on or after January 1, 2002, data tapes must not be used:~~

~~(a) 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. Refer to the Data Elements and Formatting Requirements, Rule 59E-7.014, F.A.C. Electronic media specifications are:~~

~~1. 9-Track Tape:~~

~~IBM label or nonlabel tapes~~

~~Density 1600 or 6250 BPI~~

~~Collating sequence: EBCDIC or ASCII~~

~~d. Record Format: Header Record – 480 characters, Inpatient Discharge Record-480 characters, Trailer Record-480 characters.~~

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

~~Format – MS-DOS text file (ASCII)~~

~~Type 3.5" (1.44mb) diskette or CD-ROM~~

~~c. A header record must accompany each data set and must be placed as the first record on the first diskette of the data set. Each record must be terminated with a carriage return (hex '0D') and line feed mark (hex '0A').~~

~~d. Record length: Header Record 480 characters, Inpatient Discharge Record 480 characters, Trailer Record 480 characters. Carriage return and line feeds are not included in the stated record length.~~

~~e. Only one file per diskette set or CD-ROM is allowable. Data requiring more than one diskette shall be externally labeled 1 or n, 2 or n, etc.~~

~~f. Data reported quarterly shall follow the format: ddddqyy.txt where dddd=data type; q=reporting quarter (1-4); yy=year. EXAMPLE: PD10394.TXT.~~

~~g. Data requiring more than one diskette must have the same internal file name.~~

~~h. Compressed, backup, or PKZIP files are not acceptable.~~

~~3. Tapes or diskettes shall be submitted with the following information on an externally affixed label, or for CD-ROM, use a standard CD-ROM external label with the following information:~~

~~"HOSPITAL INPATIENT DISCHARGE DATA"~~

~~Hospital Name: (As on file at AHCA)~~

~~c. Hospital Number: (In the AHCA format)~~

~~d. Reporting Period for Discharges~~

~~e. Number excluding the Header and Trailer records~~

~~Tape Density: 1600 or 6250 BPI~~

~~File Format: (TAPES) EBCDIC or (DISKETTES) ASCII~~

~~h. Filename: Data reported on diskettes or CD-ROM shall be reported in the following format: ddddqyy.txt where dddd=data type; q=quarter (1-4); yy=year FILENAME EXAMPLE: PD10394.TXT~~

~~i. IBM Labeled tapes require the label identifier (name)~~

(a)~~(b)~~ ~~Internet Transmission:~~ The Internet address for the receipt of inpatient data is www.ahca.myflorida.com. ~~reports is~~: ~~Internet transmission specifications are:~~

~~1. The file shall contain a complete set of inpatient discharge data for the reporting quarter.~~

(b)~~2.~~ Data ~~Reports~~ submitted to the Internet address shall be electronically transmitted with the inpatient data in XML ~~a text (ASCII)~~ file using the Inpatient Data XML Schema available at www.ahca.myflorida.com. The Inpatient Data XML Schema is incorporated by reference. ~~Each record of the text file must be terminated with a carriage return (hex '0D') and line feed mark (hex '0A').~~

(c)~~3.~~ The data in the XML ~~text~~ file shall contain the ~~same~~ data elements, ~~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 59E-7.014 and 59E-7.016, F.A.C.

~~(c) All acute, intensive care, and short term psychiatric live discharges and deaths including newborn live discharges and deaths shall be reported.~~

~~(d) Submit one record per inpatient discharge, to include all newborn admissions, transfers, and deaths.~~

(9) through (10) No change.

(11) Changes or corrections to hospital data will be accepted from hospitals to improve their data quality for a period of eighteen (18) months following the initial submission of data. The Administrator, Office of Data Collection, may grant approval for resubmitting previously certified data in response to a written request signed by the hospital's chief executive officer or chief financial officer. The reason for the changes or corrections must be specified in the written request.

(12) No change.

Specific Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061, 408.08(1), 408.08(2), 408.15(11) FS. History–New 12-15-96, Amended 1-4-00, 7-11-02, ________.

59E-7.014 Inpatient Data Format – Data Elements, Codes and Standards ~~Elements and Formatting Requirements~~.

~~(1) Codes for Data Elements. A detailed explanation of each data element is provided in this rule, which provides specific guidance as to the formatting of each data element submitted in each record.~~

(1)~~(a)~~ HEADER RECORD. The first record in the data file shall be a header record containing the information described below. ~~This record must precede any/all documentation submitted for inpatient discharge data records. If the header record is not included in the data file the tape/diskette will not run.~~

(a)~~1.~~ 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. A required field. ~~A required single character alpha identifier used by the hospital to establish the classification of data being submitted. The identifier must be "H". File is rejected if missing or wrong.~~

(b)~~2.~~ Report ~~Reporting~~ Year. Enter the year of the data in the format YYYY where YYYY represents the year in four (4) digits. A required field. ~~A required four digit field to be used for Submission Type (see 5. below) is I or R. File is rejected if missing or wrong.~~

(c)~~3.~~ Report ~~Reporting~~ Quarter. Enter 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. A required field. ~~A required single digit field to be used if Submission Type (see 5. below) is I or R. File is rejected if missing or wrong.~~

(d)~~4.~~ Data Type. Enter PD10 for Inpatient Data. A required field. ~~A required four character alphanumeric code (PD10) which identifies the type of data which follows the header record. Failure to submit, or submitting with zeros present, will result in a report which fails to run or has data assigned to the wrong category of data submission.~~

(e)~~5.~~ Submission Type. Enter I or R where I indicates an initial submission or resubmission of previously rejected data, R indicates a replacement submission of previously processed and accepted inpatient data where resubmission has been requested or authorized by the Agency. A required field. ~~A required single character alpha field which designates the type of inpatient discharge data included on the tape/diskette. Authorized codes for inpatient discharge data are:~~

~~I (Initial). This code is used for the first submission of an inpatient data set for the specified time period. This code should also be used when replacing previously rejected files. All data set Action Codes in subparagraph 59E-7.014(1)(b)2., F.A.C., must be set to "A".~~

~~R (Re-submission). This code is used to replace all accepted or partially accepted records for the specified time period. All data type Action Codes must be 'A'. All existing data for the time period will be deleted and replaced with the new data set.~~

~~M (Maintenance). All submissions which are not "I" or "R" will be considered to be maintenance type of actions. Data set Action Codes can be 'A' or 'D' or 'U'.~~

(f)~~6.~~ Processing Date. Enter the date that the data file was created in the format YYYY-MM-DD where MM represents numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. A required field. ~~An eight digit numeric field which specifies the date when the data on the tape was processed by the hospital. Must be in the MMDDCCYY format (e.g., 05101994). File is rejected if missing or wrong.~~

(g)~~7.~~ AHCA Hospital Number. Enter the identification number of the hospital as assigned by AHCA for reporting purposes. A valid identification number must contain at least eight (8) digits and no more than twelve (12) digits. A required field. ~~Valid for up to ten alphanumeric characters. Report the AHCA approved hospital identification number assigned for AHCA reporting purposes. Right justify, zero fill unused spaces. A required field; file is rejected if missing or wrong.~~

~~8. Florida License Number. A required field. Up to a ten character alphanumeric field for insertion of the hospital license number provided by the AHCA Division of Health Quality Assurance. Left justify, leave unused field spaces blank. File is rejected if the license number is outdated, missing or wrong.~~

~~9. Provider Medicaid Number. Up to a ten character alphanumeric hospital number assigned by the AHCA Medicaid Office. Left justify, leave unused field spaces blank. File is rejected if improperly formatted, missing or wrong.~~

~~10. Provider Medicare Number (MPN). Up to a ten character alphanumeric hospital number assigned by the HCFA Medicare office. Left justify, leave unused field spaces blank. File is rejected if improperly formatted, missing or wrong.~~

(h)~~11. Provider~~ Organization Name. Enter ~~Up to a forty character alphanumeric field containing~~ the name of the hospital that performed the inpatient service(s) represented by the ~~inpatient~~ 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. ~~Left justify, leave unused field spaces blank.~~ A required field.

(i)~~12. Provider~~ Contact Person Name. Enter ~~Up to a twenty-five character alpha field for~~ the name of the ~~designated hospital~~ contact person for the hospital ~~preparing and/or submitting inpatient discharge data~~. Submit name in the Last, First format. Up to a twenty-five-character field. ~~Left justify, leave unused field spaces blank.~~ A required field.

(j)~~13. Provider~~ Contact Phone Number. The area code, business telephone number, and if applicable, extension for the contact person. Enter the contact person's telephone number in the format (AAA)XXXXXXXEEEE where AAA is the area code, XXXXXXX represents the seven (7) digit phone number and EEEE represents the extension. Zero fill if no extension. ~~A ten digit numeric field for entry of the business phone of the hospital contact representative (See 12. above). Include area code (3), phone number (7); e.g., 9041324675. Do not use hyphens. Right justify; fill all spaces.~~ A required field.

~~14. Provider Contact Phone Extension. An optional field up to four numeric digits for including a contact's extension number if applicable. Right justify; fill unused spaces with zeros.~~

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

(l) Contact Person Street or P. O. Box Address. Enter the street or post office box address of the contact person's mailing address. Up to a forty-character field. A required field.

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

(n) Mailing Address State. Enter the state of the contact person's address using the U.S. Postal Service state abbreviation in the format XX. Use the abbreviation FL for Florida. A required field.

(o) Mailing Address Zip Code. Enter the zip code of the contact person's address in the format XXXXX-XXXX.

~~15. Submitter Organization Name. Up to a forty character alphanumeric field for entry of the name of the organization which prepares the hospital's discharge data submittal. Includes outside abstracting service or corporate office data preparers. Can be the hospital. Left justify, leave unused field spaces blank. A required field.~~

~~16. Submitter Contact Person. Up to a twenty five character alphanumeric field for the designated submitting organization's contact person responsible for submitting inpatient discharge data. Submit name in the Last, First format. Left justify, leave unused field spaces blank. A required field.~~

~~17. Submitter Contact Phone. A ten digit numeric field for entry of the business phone of the hospital contact representative. Include area code (3), phone number (7); e.g., 9041235764. Do not use hyphens. Right justify; fill all spaces. A required field.~~

~~18. Submitter Contact Phone Extension. An optional field up to four numeric digits for including a contact's extension number if applicable. Right justify; fill unused spaces with zeros.~~

~~19. Filler Space. A two hundred sixty three character space filled alphanumeric field.~~

~~Only one (1) Header Record per hospital submission is required/acceptable.~~

(2)~~(b)~~ INDIVIDUAL DATA RECORDS ~~INPATIENT DATA ELEMENTS FORMAT AND EDIT CRITERIA~~. 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. ~~This section contains the format for individual inpatient discharge data records required for each hospital discharge. All fields described are required and must be submitted unless otherwise designated as optional/discretionary fields.~~

~~1. Data Type. Four character alphanumeric field specifying the type of data submitted. Must match Field Element 4. in the Header Record. Use PD10. A required field; must be submitted for the hospital data tape/diskette to run.~~

~~2. Action Code. A single character alpha field designating the type of processing action to occur. A required field. Use one of the codes:~~

~~A – Add a new record.~~

~~D – Delete an existing record.~~

~~U – Update an existing record.~~

~~3. Reporting Quarter Code. A single digit numeric field which identifies the calendar quarter in which the discharges occurred using the following codes:~~

~~1 Represents January 1st through March 31st discharges.~~

~~2 Represents April 1st through June 30th discharges.~~

~~3 Represents July 1st through September 30th discharges.~~

~~4 Represents October 1st through December 31st discharges.~~

~~For submission types "I" and "R", the quarter must match Field Number 3 in the Header Record. A required field.~~

~~4. Reporting Year Code. A two digit numeric field which identifies the year in which the discharges occurred as noted in subparagraph 59E-7.014(1)(a)2., F.A.C., above. For submission types "I" and "R", the year must match the Header Record Field Element 2. A required field.~~

(a)~~5.~~ AHCA Hospital Number. Enter the identification number of the hospital as assigned by AHCA for reporting purposes. A valid identification number must contain at least eight (8) digits and no more than twelve (12) digits. A required field. ~~Valid for up to ten alphanumeric characters. Report the AHCA approved hospital identification number assigned for AHCA reporting purposes. Right justified; zero fill unused spaces. A required field; must be submitted for the hospital submission to run.~~

(b)6. Record Identification Number. An alpha-numeric code containing standard letters or numbers assigned by the facility as a unique identifier for each record submitted in the reporting period to facilitate storage and retrieval of individual case records. Up to seventeen (17) characters. Duplicate record identification numbers are not permitted. A required field. ~~A seventeen character alphanumeric code assigned by the hospital at the time of reporting as a unique identifier for each record submitted for each reporting period, to facilitate storage and retrieval of individual case records. Hospital must use standard letters and numbers; no__, #, @, $, *, ^, etc., are authorized. Left justified; space fill unused spaces.~~ The hospital must maintain a key list to locate actual records upon request by AHCA.

(c)~~7.~~ Patient ~~Inpatient~~ Social Security Number. Enter the social security number (SSN) of the patient receiving treatment. The SSN is a nine (9) digit number issued by the Social Security Administration. Reporting 000000000 is acceptable for newborns and infants up to two (2) years of age at admission who do not have a SSN. Reporting 777777777 is acceptable for those patients where efforts to obtain the SSN have been unsuccessful and the patient is two (2) years of age or older and not known to be from a country other than the United States (U.S.). Reporting 555555555 is acceptable for non-U.S. citizens who have not been issued SSNs. ~~The social security number (SSN) of the inpatient receiving treatment/services during this hospital stay. A nine digit numeric field to facilitate retrieval of individual case records, to be used to track inpatient readmissions, and for epidemiological or demographic research use. A SSN is required for each inpatient record if the patient is two (2) years of age or older except in cases of very old persons never issued a SSN, foreign visitors (including illegal aliens), and migrant workers (non-citizens).~~ One SSN; one inpatient. DO NOT share SSNs in this field. A required entry. ~~(See also provisions in subparagraph 59E-7.014(3)(b)7., F.A.C.)~~

(d)~~8.~~ Patient Race or Ethnicity ~~Inpatient~~. 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 from the patient or from the patient's parent or guardian have been unsuccessful. A required entry. Must be a ~~A~~ one (1) digit code as follows:

~~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 ~~– White~~

6. 6 – Black Hispanic ~~– Black~~

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

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

(e)~~9.~~ Patient ~~Inpatient~~ Birth Date. The date of birth of the patient. A ten (10)-character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. Age greater than one hundred twenty (120) years is not permitted unless verified by the reporting entity. A birth date

after the discharge date is not permitted. A required entry. An eight digit field in MMDDCCYY format. (e.g., May 10, 1932 = 05101932)

(f)10. Patient Gender Inpatient Sex. The gender of the patient at admission. A required entry. Must be a one digit code as follows: A one digit code as follows:

1. 1 – Male

2. 2 – Female

3. 3 – Unknown – Use where efforts to obtain the information have been unsuccessful or where the patient's gender cannot be determined due to a medical condition. (Use if unknown due to medical condition.)

(g)11. Patient Inpatient Zip Code. The five (5) 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 U.S. Postal Service approved zip code of the inpatient's permanent address (See also Element 11., subsection 59E-7.014(3)(b), F.A.C.

(h)12. Type of Admission. The scheduling priority of the admission. A required entry. Must be a A one digit code as follows:

1. 1 – Emergency – The patient requires immediate medical intervention as a result of severe, life- threatening or potentially disabling conditions.

2. 2 – Urgent – The patient requires attention for the care and treatment of a physical or mental disorder.

3. 3 – Elective – The patient's condition permits adequate time to schedule the availability of a suitable accommodation.

4. 4 – Newborn – Use of this code requires the use of special Source of Admission codes. (See also paragraph 59E-7.014(2)(i) and subsections (10)-(13) F.A.C.)

5. 5 – Trauma Center Other – Trauma activation at a State of Florida designated trauma center.

(i)13. Source of Admission. Must be a A two (2) digit code as follows, where codes 10 through 13 are to be used for newborn admissions, codes 1 through 8 are to be used for any admission that is not a newborn, code 9 is used where the source of admission is not known, and code 14 is used where the Source of Admission is other than code 1 through code 13. A required field. as follows:

Codes for inpatient admissions:

1. 01 – Physician referral – The patient was admitted to this facility upon the recommendation of the patient's personal physician.

2. 02 – Clinic referral – The patient was admitted to this facility upon recommendation of this facility's clinic physician.

3. 03 – HMO referral – The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.

4. 04 – Transfer from a hospital – The patient was admitted to this facility as a transfer from an acute care facility where the patient was an inpatient.

5. 05 – Transfer from a skilled nursing facility – The patient was admitted to this facility from a skilled nursing facility where the patient was at a skilled level of care.

6. 06 – Transfer from another health care facility – The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility.

7. 07 – Emergency Room – The patient was admitted to this facility through the emergency room upon recommendation of an emergency room physician or other physician.

8. 08 – Court/Law Enforcement – The patient was admitted upon the direction of a court of law, or upon the request of a law enforcement agency representative.

9. 09 – Information Not Available – The means by which the patient was admitted to this hospital is not known Other.

Codes required for newborn admissions (Type of Admission=4):

10. 10 – Normal delivery – A baby delivered without complications.

11. 11 – Premature delivery – A baby delivered with time or weight factors qualifying it for premature status.

12. 12 – Sick Baby – A baby delivered with medical complications, other than those relating to premature status.

13. 13 – Extramural – A newborn born in a non-sterile environment.

14. 14 – Other – The source of admission is not described by 1. through 13., above.

(j)14. Admission Date. The date the patient was admitted to the reporting facility. A ten (10)-character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. Admission date must equal or precede the discharge date. A required entry. A six digit field in MMDDYY format.

(k)15. Discharge Date. The date the patient was discharged from the reporting facility. A ten (10)-character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. Discharge date must equal or follow the admission date, and discharge date must occur within the reporting period as shown on the header record. A required entry. A six digit field in MMDDYY format.

(l)16. Patient Inpatient Discharge Status. Patient disposition at discharge. A required entry. Must be a A two (2) digit code as follows:

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

2. 02 – Discharged to a short-term general hospital

3. 03 – Discharged to a skilled nursing facility

4. 04 – Discharged to an intermediate care facility

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

6. 06 – Discharged to home under care of home health care organization

7. 07 – Left this hospital against medical advice (AMA) or discontinued care ~~(AMA)~~

8. 08 – Discharged home under care of home IV provider on IV medications

9. 20 – Expired

10. 50 – Discharged to hospice – home ~~(Required for discharges occurring on or after January 1, 2003.)~~

11. 51 – Discharged to hospice – medical facility ~~(Required for discharges occurring on or after January 1, 2003.)~~

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

13. 63 – Discharged to a Medicare certified long term care hospital.

14. 65 – Discharged to a psychiatric hospital including psychiatric distinct part units of a hospital.

(m)~~17.~~ Principal Payer Code. Describes the expected primary source of reimbursement for services rendered based on the patient's status at discharge or the time of reporting. Report charity as defined in subsection 59E-7.011(2), F.A.C. A required entry. Must be a ~~A~~ one (1) character alpha field using upper case as follows:

1. A – Medicare
2. B – Medicare HMO or Medicare PPO
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
12. L – Self Pay/Under-insured – No ~~(no~~ third party coverage or less than 30% estimated insurance coverage. ~~coverage)~~
13. M – Other
14. N – Charity
15. O – KidCare – Includes ~~(Report~~ Healthy Kids, MediKids and Children's Medical Services. ~~Required for discharges occurring on or after January 1, 2003.)~~

(n)~~18.~~ Principal Diagnosis Code. The code representing the diagnosis established, after study, to be chiefly responsible for occasioning the admission. Principal Diagnosis code must contain a valid ICD-9-CM or ICD-10-CM 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 hospitalization 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. A required entry. ~~The ICD-9-CM code for the principal diagnosis. Up to a five character alphanumeric field. Principal diagnosis is the condition established, after study, to be chiefly responsible for occasioning the inpatient hospitalization. Use acceptable V-codes as appropriate. Left justified, no decimal.~~

(o)~~19. through 27.~~ Other Diagnosis Code (1), Other Diagnosis Code (2), Other Diagnosis Code (3), Other Diagnosis Code (4), Other Diagnosis Code (5), Other Diagnosis Code (6), Other Diagnosis Code (7), Other Diagnosis Code (8), Other Diagnosis Code (9), Other Diagnosis Code (10), Other Diagnosis Code (11), Diagnosis Code (12), Other Diagnosis Code (13), Other Diagnosis Code (14), Other Diagnosis Code (15), Other Diagnosis Code (16), Other Diagnosis Code (17), Other Diagnosis Code (18), Other Diagnosis Code (19), Other Diagnosis Code (20), Other Diagnosis Code (21), Diagnosis Code (22), Other Diagnosis Code (23), Other Diagnosis Code (24), Other Diagnosis Code (25), Other Diagnosis Code (26), Other Diagnosis Code (27), Other Diagnosis Code (28), Other Diagnosis Code (29), and Other Diagnosis Code (30). ~~Codes.~~ A code representing a condition that is related to the services provided during the hospitalization excluding external cause of injury codes. Report external cause of injury codes as described in (ww) below. No more than thirty (30) other diagnosis codes may be reported. Less than thirty (30) entries or no entry is permitted consistent with the records of the reporting entity. Must contain a valid ICD-9-CM code or valid ICD-10-CM code for the reporting period. Inconsistency between the other diagnosis code and patient sex must be verified by the reporting entity. Inconsistency between the other diagnosis code and patient age must be verified by the reporting entity. An other diagnosis code cannot be used more than once as a principal or other diagnosis for each hospitalization 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. ~~Optional fields determined by the presence of additional diagnoses in hospital inpatient records. ICD-9-CM codes describing other factors contributing to the inpatient's stay in the hospital. A three to five character alphanumeric field; left-justified or space filled, no decimal. Cannot duplicate the Principal Diagnosis code. More than one of the same code will not be accepted. Enter E-codes and V-codes in these spaces. E-codes permit classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. Where E-code is~~

~~applicable, it is intended that it shall be used in addition to a code from one of the main Chapters of ICD-9-CM, indicating the nature of the condition. Make certain that blank spaces are not interspersed between consecutive fields with codes.~~

(p) Present at Admission Indicator (1), Present at Admission Indicator (2), Present at Admission Indicator (3), Present at Admission Indicator (4), Present at Admission Indicator (5), Present at Admission Indicator (6), Present at Admission Indicator (7), Present at Admission Indicator (8), Present at Admission Indicator (9), Present at Admission Indicator (10), Present at Admission Indicator (11), Present at Admission Indicator (12), Present at Admission Indicator (13), Present at Admission Indicator (14), Present at Admission Indicator (15), Present at Admission Indicator (16), Present at Admission Indicator (17), Present at Admission Indicator (18), Present at Admission Indicator (19), Present at Admission (20), Present at Admission Indicator (21), Present at Admission Indicator (22), Present at Admission Indicator (23), Present at Admission Indicator (24), Present at Admission Indicator (25), Present at Admission Indicator (26), Present at Admission Indicator (27), Present at Admission Indicator (28), Present at Admission Indicator (29), and Present at Admission Indicator (30). A code differentiating whether the condition represented by the corresponding other diagnosis code (o) (1) through (30) was present at admission or whether the condition developed after admission as determined by the physician, medical record, or nature of the condition. A required entry if the corresponding other diagnosis code is reported. Must be a one digit code as follows:

1. 1 – Yes – The condition was present at admission including chronic conditions diagnosed during the hospitalization, an outcome of delivery, or a reason for admission.

2. 2 – No – The condition was not present at admission such as an acute condition that develops after admission or an exacerbation of a chronic condition that develops after admission.

3. 3 – Uncertain – The status of the condition cannot be determined from the medical record, nature of the condition, or after requesting a determination from the patient's physician.

(q)~~28.~~ Principal Procedure Code. The code representing the procedure most related to the principal diagnosis. No entry is permitted consistent with the records of the reporting entity. Must contain a valid ICD-9-CM or ICD-10-CM procedure code for the reporting period. If a principal procedure date is reported, a valid principal procedure code must be reported. 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. ~~An optional field dependent upon the presence of procedures during the episode of care. Must be a valid ICD-9-CM which describes the procedure most related to the principal diagnosis. A three or four character alphanumeric field; left-justified or space filled, no decimal. Field must be coded if a date is present in element 29.~~

(r)~~29.~~ Principal Procedure Date. The date when the principal procedure was performed. If a principal procedure is reported, a principal procedure date must be reported. No entry is permitted if no principal procedure is reported. A ten (10)-character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. The principal procedure date must be less than four (4) days prior to the admission date and not later than the discharge date. ~~A required six digit field in MMDDYY format if a principal procedure code is present in element 28.~~

(s)~~30. through 38.~~ Other Procedure Code (1), Other Procedure Code (2), Other Procedure Code (3), Other Procedure Code (4), Other Procedure Code (5), Other Procedure Code (6), Other Procedure Code (7), Other Procedure Code (8), Other Procedure Code (9), Other Procedure Code (10), Other Procedure Code (11), Other Procedure Code (12), Other Procedure Code (13), Other Procedure Code (14), Other Procedure Code (15), Other Procedure Code (16), Other Procedure Code (17), Other Procedure Code (18), Other Procedure Code (19), Other Procedure Code (20), Other Procedure Code (21), Other Procedure Code (22), Other Procedure Code (23), Other Procedure Code (24), Other Procedure Code (25), Other Procedure Code (26), Other Procedure Code (27), Other Procedure Code (28), Other Procedure Code (29) and Other Procedure Code (30) Codes. A code representing a procedure provided during the hospitalization. If no principal procedure is reported, an other procedure code must not be reported. No more than thirty (30) other procedure codes may be reported. Less than thirty (30) or no entry is permitted consistent with the records of the reporting entity. 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. ~~Entry is optional dependent upon the presence of multiple operative procedures. ICD-9-CM codes describing other procedures which may have been performed on the inpatient. A Principal Procedure must be recorded, or Other Procedures will not be accepted. A three to four character alphanumeric field; left-justified, no decimal. Make certain that blank spaces are not interspersed between consecutive fields with codes.~~

(t) Other Procedure Code Date (1), Other Procedure Code Date (2), Other Procedure Code Date (3), Other Procedure Code Date (4), Other Procedure Code Date (5), Other Procedure Code Date (6), Other Procedure Code Date (7), Other Procedure Code Date (8), and Other Procedure Code Date (9), Other Procedure Code Date (10), Other Procedure Code Date (11), Other Procedure Code Date (12), Other Procedure Code Date (13), Other Procedure Code Date (14), Other Procedure Code Date (15), Other Procedure Code Date (16), Other Procedure Code Date (17), Other Procedure Code Date (18), Other Procedure Code Date (19), Other Procedures Code (20), Other Procedure Code (21), Other Procedure Code (22), Other Procedure Code (23), Other Procedure Code (24), Other Procedure Code (25), Other Procedure Code Date (26), Other Procedure Code Date (27), Other Procedure Code Date (28), Other Procedure Code Date (29), and Other Procedure Code Date (30). The date when the procedure was performed. A required entry if a corresponding procedure code (s) (1) through (30) is reported. No entry is permitted if no procedure is reported consistent with the records of the reporting entity. A ten (10)-character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. The procedure date must be less than four (4) days prior to the admission date and not later than the discharge date.

(u)~~39.~~ Attending Physician Identification ~~ID~~ Number. The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner who had primary responsibility for the patient's medical care and treatment or who certified as to the medical necessity of the services rendered. For military physicians not licensed in Florida, use US. A required entry. ~~An eleven character alphanumeric field. A required physician identification number, using the State of Florida AHCA issued license number; e.g., FLME1298465. The prefix abbreviation "FL" must be included for it to be a valid identifier. The attending physician is normally that physician having primary responsibility for the inpatient's admission, care and treatment plan, or who certifies to medical necessity.~~

~~40. Blank Field. A six character alpha-numeric field to be left blank.~~

(v)~~41.~~ Operating or Performing Physician Identification ~~ID~~ Number. The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner who had primary responsibility for the principal procedure performed. The operating or performing physician may be the attending physician. For military physicians not licensed in Florida, use US. No entry is permitted if no principal procedure is reported consistent with the records of the reporting entity. ~~An eleven character alphanumeric field. An optional field depending on the presence of a principal procedure, using the physician identification code issued by the State of Florida; the AHCA issued license number; e.g., FLME1368143. The abbreviation prefix "FL" must be included for a valid identifier. The physician ID is required anytime that an operative procedure is performed on the inpatient. The operating physician is normally the surgeon scheduling surgery and/or the principal surgeon responsible. Can also be the attending physician.~~

~~42. Blank Field. A six character alphnumeric field to be left blank.~~

(w) Other Operating or Performing Physician Identification Number – The Florida license number of a medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner who assisted the operating or performing physician or performed a secondary procedure. The other operating or performing physician must not be reported as the operating or performing physician. The other operating or performing physician may be the attending physician. For military physicians not licensed in Florida, use US. No entry is permitted consistent with the records of the reporting entity.

(x) Room and Board Charges. Routine service charges incurred for accommodations. Report charges for revenue codes 11X through 16X as used in the UB-92 or UB-04. Charges to be reported in dollars numerically, without dollar signs or commas, excluding cents. Report zero (0) if there are no Room and Board Charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(y) Nursery Charges. Accommodation charges for nursing care to newborn and premature infants in nursery. Report charges for revenue code 17X as used in the UB-92 or UB-04 excluding Level III charges. Charges to be reported in dollars numerically, without dollar signs or commas, excluding cents. Report zero (0) if there are no Nursery Charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(z) Level III Nursery Charges. Accommodation charges for nursing care to newborn and premature infants for Level III nursery charges. Report charges for revenue code 173 (Level III) as used in the UB-92 or UB-04. Charges to be reported in dollars numerically, without dollar signs or commas, excluding cents. Report zero (0) if there are no Level III Nursery Charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(aa) Intensive Care Charges. Routine service charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit. Exclude neonatal intensive care charges reported as a Level III Nursery Charge. Report charges for revenue code 20X as used in the UB-92 or UB-04. Reported in dollars numerically, without dollar signs or commas, excluding cents. Report zero (0) if there are no

intensive cares charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(bb) Coronary Care Charges. Routine service charges for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical unit. Report charges for revenue code 21X as used in the UB-92 or UB-04. Reported in dollars numerically, without dollar signs or commas, excluding cents. Report zero (0) if there are no Coronary care charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(cc) Pharmacy Charges. Charges for medication. Report charges for revenue codes 25X and 63X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no pharmacy charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(dd) Medical and Surgical Supply Charges. Charges for supply items required for patient care. Report charges for revenue codes 27X and 62X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no medical and surgical supply charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(ee) Laboratory Charges. Charges for the performance of diagnostic and routine clinical laboratory tests and for diagnostic and routine tests in tissues and culture. Report charges for revenue codes 30X and 31X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no laboratory charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(ff) Radiology or Other Imaging Charges. Charges for the performance of diagnostic and therapeutic radiology services including computed tomography, mammography, magnetic resonance imaging, nuclear medicine, and chemotherapy administration of radioactive substances. Report charges for revenue codes 32X through 35X, 40X and 61X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no radiology or other imaging charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(gg) Cardiology Charges. Facility charges for cardiac procedures rendered such as, but not limited to, heart catheterization or coronary angiography. Reported in dollars numerically without dollar signs or commas, excluding cents. Report charges for revenue code 48X as used in the UB-92 or UB-04. Report zero (0) if there are no cardiology charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(hh) Respiratory Services or Pulmonary Function Charges. Charges for administration of oxygen, other inhalation services, and tests that evaluate the patient's respiratory capacities. Report charges for revenue codes 41X and 46X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no respiratory service or pulmonary function charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(ii) Operating Room Charges. Charges for the use of the operating room. Report charges for revenue code 36X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no operating room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(jj) Anesthesia Charges. Charges for anesthesia services by the facility. Report charges for revenue code 37X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no anesthesia charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(kk) Recovery Room Charges. Charges for the use of the recovery room. Report charges for revenue code 71X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no recovery room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(ll) Labor Room Charges. Charges for labor and delivery room services. Report charges for revenue code 72X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no labor room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(mm) Emergency Room Charges. Charges for medical examinations and emergency treatment. Report charges for revenue code 45X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no emergency room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(nn) Trauma Response Charges. Charges for a trauma team activation. Report charges for revenue code 68X used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no trauma response charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(oo) Treatment or Observation Room Charges. Charges for use of a treatment room or for the room charge associated with observation services. Report charges for revenue code 76X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no treatment or observation room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(pp) Behavioral Health Charges. Charges for behavioral health treatment and services. Report charges for revenue codes 90X though 91X and 100X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(qq) Oncology. Charges for treatment of tumors and related diseases. Excludes therapeutic radiology services reported in radiology and other imaging services (ff). Report charges for revenue code 28X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no oncology charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(rr) Physical and Occupational Therapy Charges. Report charges for physical, occupational or speech therapy in revenue codes 42X through 44X as used in the UB-92 or UB-04. Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

~~43. through 65. Charges grouped by revenue code as used in the UB-92. A required field up to eight digits, right justified. If inpatient accounts contain billing charges in matching revenue code fields, data for each specific revenue code must be submitted. Zero fill only if no charges exist in the respective revenue code field. All decimals rounded to the nearest dollar. Negative amounts are not accepted. Codes utilized will be aggregated under the categories listed in the UB-92 manual (e.g., Revenue code 112 is reported in the (11X) group; code 303 is reported in the (30X) group; and so forth).~~

(ss)~~66.~~ Other ~~"Other" Revenue~~ Charges. Other facility charges not included in (x) to (rr) above. Include charges that ~~A required field up to eight digits containing an aggregate dollar amount charged to the inpatient account~~ are not reflected in any of the preceding specific revenue accounts in the UB-92 or UB-04. ~~(Field Elements 43.-65.). Total is rounded to the nearest dollar. Right justify; no negative amounts.~~ DO NOT include charges from revenue codes 96X, 97X, 98X, or 99X in the UB-92 or UB-04 for ~~because these charges are~~ professional fees and personal convenience items ~~not carried in all hospital billing information~~. ~~Zero fill if "Other" charges do not exist.~~ Reported in dollars numerically without dollar signs or commas, excluding cents. Report zero (0) if there are no other charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(tt)~~67.~~ Total Gross Charges. The total of undiscounted charges for services rendered by the hospital. Include charges for services rendered by the hospital excluding professional fees. The sum of all charges reported above (x) through (ss) must equal total charges, plus or minus ten (10) dollars. Reported in dollars numerically without dollar signs or commas, excluding cents. Zero (0) or negative amounts are not permitted unless verified separately by the reporting entity. A required entry. ~~A required field up to ten digits, right justified. Displays the total inpatient charges (dollars) before any discounts, rounded to the nearest dollar. No negative numbers. Must equal the sum of all of the Charges By Revenue Code reported; Fields 43 through 66.~~

(uu)~~68.~~ Infant Linkage Identifier. The social security number of the patient's birth mother where the patient is less than two (2) years of age. A nine (9) digit field to facilitate retrieval of individual case records, to be used to link infant and mother records, and for medical research. Reporting 777777777 for the mother's SSN is acceptable for those patients where efforts to obtain the mother's SSN have been unsuccessful and the mother is not known to be from a country other than the United States. Reporting 555555555 is acceptable if the infant's mother is not a U.S. Citizen and has not been issued a SSN. Infants in the custody of the State of Florida or adoptions, use 333333333 if the birth mother's SSN is not available. A required field for patients whose age is less than two (2) years of age at admission. If the patient is two (2) years of age or older, the field is zero filled. A required entry. ~~A required field for patients less than two (2) years of age. A nine digit numeric field. Use the birth mother's (preferred) or father's (acceptable) SSN. CAUTION: If the patient is two (2) years of age or older, this field is zero filled.~~ ~~To be used only for research purposes to link infants with their respective mother. (Linkage identifiers for infants one year of age and older and less than two years are required beginning with discharges occurring on or after January 1, 2003.)~~

(vv) Admitting Diagnosis. The diagnosis provided by the admitting physician at the time of admission, which describes the patient's condition upon admission or purpose of admission. Must contain a valid ICD-9-CM code or valid ICD-10-CM code for the reporting period. Inconsistency between the admitting diagnosis code and patient sex must be verified by the reporting entity. Inconsistency between the admitting diagnosis 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. A required entry.

(ww) External Cause of Injury Code (1), External Cause of Injury Code (2), and External Cause of Injury Code (3). A code representing circumstances or conditions as the cause of the injury, poisoning, or other adverse effects recorded as a diagnosis. No more than three (3) external cause of injury codes may be reported. Less than three (3) or no entry is permitted consistent with the records of the reporting entity. Entry 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 hospitalization 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.

(xx) Emergency Department Hour of Arrival. The hour on a 24-hour clock during which the patient's registration in the emergency department occurred. A required entry. Use 99 where the patient was not admitted through the emergency department or where efforts to obtain the information have been unsuccessful. Must be two (2) 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.

~~69. Filler. A sixty-two character space filled alpha field.~~

(3)~~(c)~~ TRAILER RECORD. The last record in the data file shall be a trailer record and must accompany each data set. Report only 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/all documentation submitted for hospital inpatient discharge data records as described in paragraph 59E-7.014(1)(b), F.A.C. Elements 2. through 5. must match their counterpart elements in the Header Record, paragraph 59E-7.014(1)(a), F.A.C., else the file will reject. Failure to include will cause the data file to fail and be rejected.~~

~~1. Transaction Code. A required single character alpha identifier used by the hospital to establish the end of the file, and to set up a program check for accuracy of file input. The authorized identifier for the filed is "T". File is rejected if missing or wrong.~~

~~2. AHCA Hospital Number. Up to ten character alphanumeric field which specifies the hospital number now in effect and/or as assigned by the AHCA. Must be either the 100xxx or 11xxxx format or as specified by AHCA. A required field. File is rejected if missing, wrong, or does not match Header Record.~~

~~3. Florida License Number. Up to a ten character alphanumeric field for insertion of the hospital license number provided by the AHCA Division of Health Quality Assurance. Left justify, leave unused field spaces blank. Must match counterpart field in Header file. A required field. File is rejected if the license number is invalid, outdated, missing or wrong.~~

~~4. Provider Medicaid Number. Up to a ten character alphanumeric hospital number assigned by the AHCA Medicaid office. A required field. File is rejected if improperly formatted, missing or wrong.~~

~~5. Provider Medicare Number (MPN). Up to a ten character alphanumeric hospital number assigned by the HCFA Medicare office. A required field. Must match counterpart field in Header file. Left justify, leave unused field spaces blank. File is rejected if improperly formatted, missing or wrong.~~

~~6. Provider Street Address. Up to a forty character alphanumeric field containing the address of the Provider Hospital. Left justify, leave unused field spaces blank. A required field.~~

~~7. Provider City Address. Up to twenty-five character alphanumeric field for the city in which the hospital is located. A required field.~~

~~8. Provider State. A two character alpha field designating the state in which the hospital is located using the approved U.S. Postal Service state abbreviation; use the abbreviation "FL". A required field.~~

~~9. Provider Zip Code. A five digit numeric field for recording the hospital zip code. A required field.~~

~~10. Submitter Street Address. Up to a forty character alphanumeric field containing the address of the data submitter. A required field.~~

~~11. Submitted City Address. Up to twenty-five character alphanumeric field for the city in which the data submitter is located. A required field.~~

12. Submitter State. A two character alpha field designating the state in which the data submitter is located using the approved U.S. Postal Service state abbreviation; use the abbreviation, for example, "FL". A required field.

13. Submitter Zip Code. A five digit numerical field for recording the submitting organization's zip code. A required field.

14. Number of Records. A required nine digit numerical field recording the total number of records included in the file, excluding Header and Trailer records.

15. Filler Space. A two hundred eighty six character space filled alpha field.

(2) Layout for Reporting. The required inpatient discharge record data reporting layout is presented in 3 sections.

(a) HEADER RECORD. A required record inserted at the beginning of the tape/diskette. Must be present for the tape to run. Contains 480 characters with the following layout of fields:

NUMBER DATA ELEMENT	TYPE	JUST	SIZE	FIELD POSITIONS
1. TRANSACTION CODE (H)	A	L	1	1
2. REPORTING YEAR	N	R	4	2-5
3. REPORTING QUARTER	N	R	1	6
4. DATA TYPE (PD10)	A/N	L	4	7-10
5. SUBMISSION TYPE	A	L	1	11
6. PROCESSING DATE	N	R	8	12-19
7. AHCA HOSPITAL NUMBER	A/N	R	10	20-29
8. FLORIDA LICENSE NUMBER	A/N	L	10	30-39
9. PROVIDER MEDICAID NUMBER	A/N	L	10	40-49
10. PROVIDER MEDICARE NUMBER	A/N	L	10	50-59
11. PROVIDER ORGANIZATION	A/N	L	40	60-99
12. PROVIDER CONTACT NAME	A	L	25	100-124
13. CONTACT PERSON TELEPHONE #	N	R	10	125-134
14. CONTACT TELEPHONE EXTENSION	N	R	4	135-138
15. SUBMITTER ORGANIZATION NAME	A/N	L	40	139-178
16. SUBMITTER CONTACT NAME	A/N	L	25	179-203
17. SUBMITTER CONTACT TELEPHONE #	N	R	10	204-213
18. CONTACT TELEPHONE EXTENSION	N	R	4	214-217
19. FILLER SPACE	A/N	L	263	218-480

(b) HOSPITAL INPATIENT DISCHARGE DATA RECORDS. Contains the required record layout of Inpatient Discharge Data elements which make up each inpatient discharge record, having an individual record length of 480 characters.

NUMBER DATA ELEMENT	TYPE	JUST	SIZE	FIELD POSITIONS
1. DATA TYPE (PD10)	A/N	L	4	1-4
2. ACTION CODE	A	L	1	5
3. REPORTING QUARTER	N	R	1	6
4. REPORTING YEAR	N	R	2	7-8
5. AHCA HOSPITAL NUMBER	A/N	R	10	9-18
6. RECORD ID NUMBER	A/N	L	17	19-35
7. INPATIENT SOCIAL SECURITY NUMBER	N	R	9	36-44
8. INPATIENT RACE	N	R	1	45
9. INPATIENT BIRTHDATE	N	R	8	46-53
10. INPATIENT SEX	N	R	1	54
11. INPATIENT ZIP CODE	N	R	5	55-59
12. TYPE OF ADMISSION	N	R	1	60
13. SOURCE OF ADMISSION	N	R	2	61-62
14. ADMISSION DATE	N	R	6	63-68
15. DISCHARGE DATE	N	R	6	69-74
16. INPATIENT DISCHARGE STATUS	N	R	2	75-76
17. PRINCIPAL PAYER CODE	A	L	1	77
18. PRINCIPAL DIAGNOSIS CODE	A/N	L	5	78-82
19. OTHER DIAGNOSIS CODE	A/N	L	5	83-87
20. OTHER DIAGNOSIS CODE	A/N	L	5	88-92
21. OTHER DIAGNOSIS CODE	A/N	L	5	93-97
22. OTHER DIAGNOSIS CODE	A/N	L	5	98-102
23. OTHER DIAGNOSIS CODE	A/N	L	5	103-107
24. OTHER DIAGNOSIS CODE	A/N	L	5	108-112
25. OTHER DIAGNOSIS CODE	A/N	L	5	113-117
26. OTHER DIAGNOSIS CODE	A/N	L	5	118-122
27. OTHER DIAGNOSIS CODE	A/N	L	5	123-127
28. PRINCIPAL PROCEDURE CODE	A/N	L	4	128-131
29. PRINCIPAL PROCEDURE DATE	N	R	6	132-137
30. OTHER PROCEDURE	A/N	L	4	138-141
31. OTHER PROCEDURE	A/N	L	4	142-145

32. OTHER PROCEDURE	A/N	L	4	146-149
33. OTHER PROCEDURE	A/N	L	4	150-153
34. OTHER PROCEDURE	A/N	L	4	154-157
35. OTHER PROCEDURE	A/N	L	4	158-161
36. OTHER PROCEDURE	A/N	L	4	162-165
37. OTHER PROCEDURE	A/N	L	4	166-169
38. OTHER PROCEDURE	A/N	L	4	170-173
39. ATTENDING PHYS ID #	A/N	L	11	174-184
40. BLANK FIELD	A/N	L	6	185-190
41. OPERATING PHYS ID #	A/N	L	11	191-201
42. BLANK FIELD	A/N	L	6	202-207
43. ROOM & BOARD CHARGE CODE (11X to 16X)	N	R	8	208-215
44. NURSERY CHARGE CODE (17X)	N	R	8	216-223
45. ICU CHARGE CODE (20X)	N	R	8	224-231
46. CCU CHARGE CODE (21X)	N	R	8	232-239
47. PHARMACY CHARGE CODE (25X)	N	R	8	240-247
48. MED/SURG SUPPLIES CODE (27X)	N	R	8	248-255
49. ONCOLOGY CHARGE CODE (28X)	N	R	8	256-263
50. LABORATORY CHARGE CODE (30X)	N	R	8	264-271
51. PATHOLOGY CHARGE CODE (31X)	N	R	8	272-279
52. DIAGNOSTIC RAD. CHARGE CODE (32X)	N	R	8	280-287
53. THERAPEUTIC RAD. CHARGE CODE (33X)	N	R	8	288-295
54. NUC. MED. CHARGE CODE (34X)	N	R	8	296-303
55. CT SCAN CHARGE CODE (35X)	N	R	8	304-311
56. O.R. SVCS. CHARGE CODE (36X)	N	R	8	312-319
57. ANESTHESIA CHARGE CODE (37X)	N	R	8	320-327
58. RESP. THERAPY CHARGE CODE (41X)	N	R	8	328-335
59. PHYS. THERAPY CHARGE CODE (42X)	N	R	8	336-343
60. OCCUP. THERAPY CHARGE CODE (43X)	N	R	8	344-351
61. E.R. SVC. CHARGE CODE (45X)	N	R	8	352-359
62. CARDIOLOGY CHARGE CODE (48X)	N	R	8	360-367
63. MRI CHARGE CODE (61X)	N	R	8	368-375
64. RECOVERY ROOM CHARGE CODE CHARGES (71X)	N	R	8	376-383
65. LABOR ROOM CHARGE CODE CHARGES (72X)	N	R	3	84-391
66. "OTHER" REVENUE CODE CHARGES	N	R	8	392-399
67. TOTAL GROSS CHARGES	N	R	10	400-409
68. INFANT LINKAGE IDENTIFIER	N	R	9	410-418
69. FILLER	A		62	419-480

~~(c) TRAILER RECORD. Is a required record inserted at the end of the tape/diskette. If field numbers 2 through 5 do not match their counterpart fields in the HEADER RECORD, the file will reject. Contains 480 characters with the following layout of fields:~~

NUMBER DATA ELEMENT	TYPE	JUST	SIZE	FIELD POSITIONS
1. TRANSACTION CODE (T)	A	L	1	1
2. AHCA HOSPITAL NUMBER	A/N	R	10	2-11
3. FLORIDA LICENSE NUMBER	A/N	L	10	12-21
4. PROVIDER MEDICAID NUMBER	A/N	L	10	22-31
5. PROVIDER MEDICARE NUMBER	A/N	L	10	32-41
6. PROVIDER STREET ADDRESS	A/N	L	40	42-81
7. PROVIDER CITY ADDRESS	A/N	L	25	82-106
8. PROVIDER STATE	A	L	2	107-108
9. PROVIDER ZIP CODE	N	R	5	109-113
10. SUBMITTER STREET ADDRESS	A/N	L	40	114-153
11. SUBMITTER CITY ADDRESS	A/N	R	25	154-178
12. SUBMITTER STATE	A	L	2	179-180
13. SUBMITTER ZIP CODE	N	R	5	181-185
14. NUMBER OF RECORDS	N	R	9	186-194
15. FILLER SPACE	N	R	286	195-480

~~"Type" means (A)lpha or (N)umeric or (A/N) alphanumeric field. "Justification" is either (R)ight or (L)eft.~~

~~(3) Reporting Parameters. Hospitals submitting inpatient discharge data pursuant to Rule 59E-7.014, F.A.C., shall report data according to the following parameters:~~

~~(a) HEADER RECORD. Consists of a single record at the beginning of each data submission to validate identification of the hospital and submitter responsible for the inpatient discharge records in subsection 59E-7.014(2), F.A.C. This is a~~

required record with all fields filled to enable the tape/diskette to process. Submit one Header Record per tape/diskette data submission.

1. Record identification is a required five character alpha field which must carry the startup designation "H". If missing or wrong, processing will terminate at this point.

2. Reporting Year is a four digit numeric field in the CCYY format which specifies the year in which the discharges being submitted occurred. This is a mandatory field for submission types "I" (Initial submission) and "R" (Resubmission)(see 5. below).

3. Reporting Quarter is a single digit numeric field which indicates the reporting quarter in which the discharges occurred within 2. above. This is a mandatory field for submission types "I" and "R" (see 5. below).

4. Data Type is a required four character alphanumeric field which identifies the type of data which follows the Header Record. See also subparagraph 59E-7.014(1)(a)4., F.A.C., Header Record for the authorized code.

5. Submission Type is a required single character alpha field which identifies the type of data being submitted: I – Initial submission. This code is used for the first submission of a data set for the specified time period; should also be used when replacing previously rejected files. R – Resubmission. Replaces all accepted or partially accepted records for the specified time period. All Data Set Action Code entries (For "I" or "R") must be "A" in accordance with definitions specified in Rule Section II, subsection 59E-7.014(2), F.A.C. All existing data for the time period will be deleted and replaced with the new data set. M – Maintenance. All submissions in this category are those which do not meet "I" or "R" requirements. All Data Set Action Code entries for "M" will include "A" or "D", or "U" as specified in Rule II, subsection 59E-7.014(2), F.A.C.

6. Process Date is an eight digit required numeric field in which the date that the data file was processed or created by the Provider/Submitter is inserted. Must be in the MMDDCCYY format.

7. AHCA Hospital Number is a required field up to ten alphanumeric characters which designate the hospital identifier. AHCA currently uses and assigns a standard six digit or eight-digit number. Multi-premises hospital systems are required to submit hospital inpatient data separately using a unique AHCA Hospital number to distinguish each individual premises. For hospitals now reporting, this entails no change to the current hospital identifier except for added zeros at the beginning of the field.

8. Florida License Number is an alphanumeric field of up to ten characters which indicates the license number granted to the hospital by the AHCA Division of Health Quality Assurance to legally operate a hospital in the State of Florida.

9. Provider Medicaid Number is an alphanumeric entry of up to ten characters which designates the identification number or account number of the hospital for Medicaid reimbursement.

10. Provider Medicare Number is an alphanumeric entry of up to ten characters which designates the identification number or account number of the hospital granted by HCFA for Medicare reimbursement. The MPN.

11. Provider Organization Name is the name of the hospital submitting the inpatient discharge data. Enter up to forty alphanumeric characters.

12. Provider Contact Person is the person who actually prepares the inpatient discharge data and/or is the individual most knowledgeable about the data and its preparation, to whom all queries concerning hospital data are to be directed. Use up to twenty-five alphanumeric characters.

13. Provider Contact Phone is the telephone number at which the contact person in field 12 above can normally be contacted by the AHCA staff. Use a ten digit number which includes the area code. Do Not include hyphens, parenthesis, braces, or any other alpha character.

14. Provider Phone Extension is an optional field up to four numeric digits in which the contact person's telephone extension is entered, if one exists. Zero fill if no extension is provided.

15. Submitter Organization Name consists of the name of the hospital, corporate headquarters, or other data preparation service which is actually submitting the data to AHCA. Must be provided even if it is the hospital. Use up to forty alphanumeric characters.

16. Submitter Contact Person is the individual designated by the submitting organization or agency to be the point of contact person for the hospital's data being submitted.

17. Submitter Contact Phone is the telephone at which the contact person in field 16 above can normally be contacted by AHCA staff. Use a ten digit number which includes the area code. Do Not include hyphens, parenthesis, braces, or any other alpha character.

18. Submitter Phone Extension is an optional field up to four numeric digits in which the contact person's telephone extension is entered, if one exists. Zero fill if no extension is provided.

19. Filler is provided by making allowance for two hundred sixty three spaces.

(b) INPATIENT DATA ELEMENTS FORMAT AND EDIT CRITERIA. This section specifies the format requirements for inpatient discharge data requirements which are required to be submitted to the AHCA in accordance with the provisions of this rule. Unless otherwise specified in the instructions as being optional or discretionary fields, each field is a required input. An omission can cause fatal rejection or be an error flagged for correction/validation.

~~1. Data Type is a required four character alphanumeric designator for the type of data being submitted; i.e., Hospital Inpatient Discharge Data. The approved code to be used is PD10. Must match the data submitted in subparagraph 59E-7.014(1)(a)4., F.A.C., Header Record.~~

~~2. Action Code is a single character alpha designator for the specific processing action required by the record being submitted. Authorized codes which must be used are: A – Add a new record; D – Delete an existing record; U – Update (correct) an existing record. Failure to provide will result in an error flagged record.~~

~~3. Reporting Quarter is a single digit numeric field designating the calendar quarter in which the discharge occurred for each record. Designation is made as follows: 1 – January 1 through March 31; 2 – April 1 through June 30; 3 – July 1 through September 30; 4 – October 1 through December 31. The quarter code must match the code in the Header Record in this rule.~~

~~4. Reporting Year Code is a required two digit numeric identifier submitted by hospitals to identify the time of the year in which the discharges occurred.~~

~~5. The AHCA Hospital Number is a ten alphanumeric character field in which is placed the current six digit or eight-digit hospital number on file with AHCA or as furnished by the AHCA. A required field within each inpatient record. Will lead to a fatal error (i.e., data will cease processing) if not provided.~~

~~6. The Hospital Record Identifier must be provided – the field cannot be all spaces. Must be a unique identifier for each inpatient, no more than seventeen alphanumeric characters (Standard characters: Letters and/or Numbers). Failure to provide an identifier or duplication of an identifier will result in a fatal error and REJECTION of the entire file without further processing.~~

~~7. The Social Security Number (SSN) is a nine (9) digit required field for all patients having social security numbers. SSNs should be submitted for all inpatients two (2) years of age or older. Patients not having SSNs should be in one of the following groups: newborns and infants less than 2 years of age, very old inpatients never issued a SSN, foreign visitors (including aliens), and migrant workers (i.e., non-citizens). An entry of 000000000 is acceptable for patients less than two (2) years of age who do not have an SSN. For patients not from the U.S., 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 two (2) years or older and a resident of the U.S., use 777777777. DO NOT share SSNs in this field; one SSN — one inpatient.~~

~~8. Inpatient Race is a single digit entry showing: 1 — American Indian/Eskimo/Aleut, 2 — Asian or Pacific Islander, 3 — Black, 4 — White, 5 — Hispanic-White, 6 — Hispanic-Black, 7 — Other (Use if patient is not described by above categories), 8 — No Response (Use if patient refuses to disclose). For use by AHCA as demographic and epidemiological information, and health planning. Not an optional field.~~

~~9. Inpatient Date of Birth is required; must be eight digits in the MMDDCCYY format. Month must be entered as 01 through 12 (as appropriate for the month in which born); Day must be entered as 01 through 31; Year must be in four digits (e.g., 1932).~~

~~10. Inpatient Sex is a required field. Entry must be a single digit; 1 – Male, 2 – Female, or 3 – unknown.~~

~~11. A valid Zip Code is required; must be five digits. Use 00009 for patients of foreign origin. Use 00007 for homeless patients. Use 00000 for unknown zip codes. Spaces are not acceptable.~~

~~12. Type of Admission entry is a required single digit numeric field. Must be 1-5 (See subparagraph 59E-7.014(1)(b)12., F.A.C.), Type of Admission 4, Newborn reporting, includes all infants born in the hospital. If an infant is born in a hospital, the hospital in which the birth occurred will report the event as a Type of Admission 4, regardless of the outcome of the birth; i.e., normal birth with infant discharged home, premature birth transferred within hours, stillborn, infant death following delivery, delivery with problems requiring transfer, etc.~~

~~13. A Source of Admission entry is required; a two digit field. Must be 01-14 (See subparagraph 59E-7.014(1)(b)13., F.A.C.), Additional codes have been included to provide the hospital with more specificity selections for infant admissions. If the Type of Admission is 4 (Newborn) (12. above), the Source of Admission "Codes Required For Newborn 10-14 MUST be used.~~

~~14. An Admission Date is required; a six digit field using the MMDDYY format. Month must be entered as 01 through 12; Day must be entered as 01 through 31; Year must be in two digits (e.g., 94). Admission date must be equal to or precede the Discharge Data (Field 15).~~

~~15. A Discharge Date is required; a six digit field using the MMDDYY format. Month must be entered as 01 through 12 (as appropriate for the discharge month); Day must be entered as 01 through 31; Year must be in two digits (e.g., 92). The Discharge Date must equal or follow the Admission Date (Field 14), Discharge Date must occur within a specified reporting quarter as shown on the external label or the tape/diskette: e.g., 01/01-03/31, 04/01-06/30, 07/01-09/30, 10/01-12/31.~~

~~16. Inpatient Discharge Status is a required field; must be two digits using the codes 01-08, 20, or 50-51 (subparagraph 59E-7.014(1)(b)16., F.A.C.).~~

~~17. Principal Payer Code is a required field; must be a single alpha character (UPPERCASE), A-O. Describes the primary source of expected reimbursement to the hospital for services.~~

~~18. A Principal Diagnosis Code is required for every inpatient, and must be a valid ICD-9-CM code as defined by the Health Care Finance Administration (HCFA) Medicare Code Editor. Diagnosis codes vary from three character codes to three characters plus one or two decimal digits, but are submitted WITHOUT the decimal. Applicable V-Codes are acceptable. The principal diagnosis cannot be an E-Code or a manifestation code. The Principal Diagnosis code cannot be repeated in any of the Other Diagnosis codes. The Principal Diagnosis cannot conflict with an inpatient's age/sex as defined by the HCFA code editor. The accepted definition of Principal Diagnosis is "Principal diagnosis is the condition established, after study, to be chiefly responsible for occasioning the admission of the inpatient to the hospital." A space filled field IS NOT acceptable.~~

~~19. through 27. Other Diagnosis fields are optional fields of valid three to five digit ICD-9-CM codes in a five digit field which describe additional health factors affecting the inpatient's treatment and length of stay in the hospital. Space fill if no other diagnosis is present in the inpatient's medical record. If not space filled, codes used must be valid ICD-9-CM codes as defined by the HCFA Code Editor. Codes cannot duplicate the Principal Diagnosis code or any Other Diagnosis Codes. Other Diagnosis codes cannot conflict with inpatient age/sex as defined by the HCFA code editor. E-codes are included in Other Diagnosis fields as valid codes. Applicable V-Codes are acceptable. Blank spaces between two consecutive Other Diagnosis fields will cause an error flag.~~

~~28. Principal Procedure Code is an optional field; use four alphanumeric characters. Space fill if not used. If a procedure has been performed, then Principal Procedure Code is a mandatory entry. Must be a valid ICD-9-CM code as defined by the HCFA Code Editor. If used, both a Principal Procedure Date (field 30) and Operating Physician Identification (field #42) must be supplied. A Principal Procedure code cannot conflict with an inpatient's sex or age as defined by the HCFA Code Editor.~~

~~29. A Principal Procedure Date is required if the Principal Procedure field 28 contains an entry; must be a six digit numeric field using the MMDDYY format. Month must be entered as 01 through 12; Day must be entered as 01 through 31 (as appropriate for the month of occurrence); Year must be in two digits (e.g., 94). The Principal Procedure date may occur no sooner than three days prior to the admission date and not later than the discharge date. If not required, zero fill.~~

~~30. through 38. Other Procedure Codes are optional, four digit alphanumeric fields. Space fill if not used. Must be preceded by a Principal Procedure. If an Other Procedure has been performed on the inpatient, a valid ICD-9-CM procedure code as defined by the HCFA Code Editor must be entered. Codes cannot conflict with the inpatient's sex or age as defined by the HCFA Code Editor. Space filled fields between two successive coded procedure fields will create an error.~~

~~39. The Attending Physician ID is a mandatory entry showing the identification number of the physician having primary responsibility for the inpatient's care program and treatment, or the physician who certified medical necessity for the inpatient's admission to the hospital. Use up to eleven alphanumeric characters. Insert the State of Florida physician license number as issued and recorded by the AHCA Division of Medical Quality Assurance, preceded by the suffix "FL". No other entries will be accepted, and the file will be error flagged.~~

~~40. Blank Field is a blank fill entry.~~

~~41. The Operating Physician ID is a required entry only if the Principal Procedure code field 28 is filled. Fill with the identification number of the physician having primary responsibility for the inpatient's surgery and/or who scheduled the surgery. May also be the attending physician (Field 40). An eleven character alphanumeric field using the State of Florida physician license number as issued and recorded by the AHCA Division of Medical Quality Assurance, preceded by the suffix FL. No other entries will be accepted.~~

~~42. Blank Field is a blank fill entry.~~

~~43. through 65. Charges by Revenue Code are required fields if charges are debited to the inpatient account for services rendered in these fields, as reported in the UB-92. Charges are rounded to the nearest dollar. All charges are to be reported under the major code of a group, (e.g., 115 in the 11X to 16X group, 282 in the 28X group, 427 in the 42X group, etc.). An eight digit field; right justified.~~

~~66. "Other" Charges by Revenue Code is required for all charges to the inpatient account which do not fall in one of the individual groups (Fields 44-65). A sum of all "other" charges by revenue account fields. An eight digit field; right justified. DO NOT include charges for revenue codes 96X, 97X, 98X, or 99X. Negative charges are not accepted. This field will be edited to ensure that all charges by revenue code are not being placed into it.~~

~~67. Total Gross Charges is a required field; a ten digit field rounded to the nearest dollar. Zero filled or space filled total gross charges are not accepted unless the Type of Admission is 4, (Field 12) and Discharge Status is 02, 05, or 20 (Field 18). MUST equal the sum of all of the charges by revenue code in fields 43 through 66. The AHCA will make an allowance for rounding only.~~

~~68. Infant Linkage Identifier is a required field of nine numeric digits for patients less than two (2) years of age. Enter the birth mother's Social Security Number or if the birth mother's Social Security Number is not available, enter the father's Social Security Number in the Infant Linkage Identifier field. For patients not from the U.S., use 555555555, if a SSN is not assigned. For patients in the custody of the State or adoptions, use 333333333 if the birth mother's or father's~~

~~SSN is not available. Use 999999999 in the Infant Linkage Identifier field for unknown mother's and father's SSN. If the patient is two (2) years of age or older, the field is zero filled.~~

~~69. The Filler Space field is a required field which is completed by inserting the correct number of spaces noted in paragraph 59E-7.014(2)(b).~~

~~1. Transaction Code is a on(e) TRAILER RECORD. This record must be included at the end of the inpatient discharge records file for the data processing to complete the run. Failure to provide it will cause the hospital's file to cease processing and to be rejected. Is entered into the file only once. Elements 2 through 5 must match the data in their counterpart fields in the HEADER RECORD, else the file will discontinue processing at the field with the difference, and will reject. All fields are required.e character alpha field which requires the entry of the letter "T". This establishes the end of the inpatient discharge data file and diverts the program into a close-out validation run.~~

~~2. AHCA Hospital Number is up to a ten digit field in which the standard six digit or eight-digit number currently being used or those issued to hospitals coming on line by the AHCA is used.~~

~~3. Florida License Number is an alphanumeric field up to ten characters which indicate the license number granted to the hospital by the AHCA Division of Health Quality Assurance to legally operate a hospital in the State of Florida.~~

~~4. Provider Medicaid Number is up to a ten character alphanumeric entry which designates the identification number or account number of the hospital for Medicaid reimbursement.~~

~~5. Provider Medicare Provider Number is up to a ten character alphanumeric entry which designates the identification number or account number of the hospital for Medicare reimbursement.~~

~~6. Provider Street Address consists of the hospital address as carried in official document(s). Do Not use P. O. Box numbers for AHCA files since mail sent registered to the hospital through the U.S. Postal Service cannot be delivered to a P. O. Box location. Use up to forty alphanumeric characters.~~

~~7. Provider City Address is the city in which the hospital is located. Use up to twenty-five alphanumeric characters.~~

~~8. Provider State is the State of Florida using the approved U.S. Postal Service two character abbreviation.~~

~~9. Provider Zip Code includes only the five digit numeric data as issued by the U.S. Postal Service. Do not submit zip code extensions.~~

~~10. Submitter Street Address is the address where the data is prepared and shipped from. DO NO USE P. O. Boxes. Enter up to forty alphanumeric characters. A required entry even if the provider and submitter are the same.~~

~~11. Submitter City Address is the city in which the organization submitting the data is located. Use up to twenty five alphanumeric characters. A required entry even if the provider and submitter are the same.~~

~~12. Submitter State is a two character alpha field using the U.S. Postal Service authorized two letter abbreviation of the state where the submitter is located. A required entry even if the provider and submitter are the same.~~

~~13. Submitter Zip Code includes only the five digit numeric data as issued by the U.S. Postal Service. Do not send zip code extensions. A required entry even if the provider and submitter are the same.~~

~~14. Number of Records is the actual count of records (minus the Header Record and the Trailer Record) included on the tape/diskette submission. A matching count with the number of records physically processed is important if the hospital data is to complete processing. If the number in this field does not match the number of records counted by the AHCA program, the hospital file will be rejected. Use up to nine numeric digits.~~

~~15. Filler consists of all spaces as designated in Section III of the AHCA Data Set and Format.~~

~~(4) The effective date of all data reporting changes in Rule 59E-7.014, F.A.C., as amended, shall be for discharges occurring on or after January 1, 2002 unless a later date is indicated in Rule 59E-7.014, F.A.C.~~

Specific Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061 FS. History–New 12-15-96, Amended 7-11-01, ________.

59E-7.015 Public Records.

(1) No change.

(2) Patient-specific records collected by the Agency pursuant to Rules 59E-7.011-7.016, F.A.C., are exempt from disclosure pursuant to Section 408.061(8), F.S., and shall not be released unless modified to protect patient confidentiality as described in paragraph (2)(a) below and released in the manner described in paragraphs (2)(c) and (2)(d).

(a) The patient-specific record shall be modified to protect patient confidentiality as follows:

1. Patient's Record ID Number as Assigned by the Facility. ~~Will be deleted or a~~ Substitute Sequential Number ~~used~~.

2. Patient Social Security Number. ~~Substitution with a Record Linkage Number.~~ Deleted. Indicators of readmission at any Florida reporting hospital within 30 days of discharge will be substituted when available. Readmission data will not be released for any quarter until each subsequent quarter is 100 percent certified.

3. Patient Birth Date. Substitute Age in Years and an indicator of Age < 29 Days.

~~4. Patient ZIP Code. If less than 500 population for the ZIP Code per the most recent U.S. Census, a masked code representing a combination set of ZIP Codes will be substituted; if out of state, the state ID, territory designation, or country ID will be substituted.~~

4.~~5.~~ Admission Date. Deleted.

5.~~6.~~ Discharge Date. Length of Stay (LOS) is substituted.

6.7. Principal Procedure Date. Days from Admission to Principal Procedure will be substituted.

7. Other Procedure Date. Days from Admission to Other Procedure will be substituted.

8. Infant First Year Linkage ID. Deleted.

(b) A record linkage number shall be assigned which does not identify an individual patient and cannot reasonably be used to identify an individual patient through use of data available through the Agency for Health Care Administration, but which can be used for non-confidential data output for bona fide research purposes.

(c) No change.

(d) The modified data described in paragraph (2)(a) shall be released in accordance with the Limited Data Set requirements of the federal Health Insurance Portability and Accountability Act public information and shall be made available to the public on or after quarterly data has been certified as accurate by the 95% of reporting hospitals as required by paragraph 408.061(1)(a), Florida Statutes. Local Health Council (LHC) and Community Health Purchasing Alliance (CHPA) data will be released when 100% of the hospitals within that LHC or CHPA have certified data.

(3) Aggregate reports derived from patient-specific hospital records collected pursuant to Rules 59E-7.011-7.016, F.A.C., are public records and shall be released as described in this Rule, provided that the aggregate reports do not include the patient's record ID number as assigned by the facility, patient social security number, record linkage number, patient birth date, admission date, discharge date, principal procedure date, other procedure date, patient ZIP Code, or infant newborn linkage identifier; and provided the aggregate reports contain the combination of five or more records for any data disclosed.

(4) No change.

Specific Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 119.07(1)(a),(2)(a), 408.061(8) FS. History–New 12-15-96, Amended ________.

59E-7.016 General Provisions.

(1) through (2) No change.

(3) Hospital data processing/MIS personnel must assure that the tape or disk data conforms to specifications in format from subsections 59E-7.014(1), (2) and (3), F.A.C., without any breaks or blocking or other failure in the data processing cycle.

Specific Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061 FS. History–New 12-15-96, Amended 7-11-01, ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Lisa Rawlins, Bureau Chief, State Center for Health Statistics

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Alan Levine, Secretary, Agency for Health Care Administration

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: April 5, 2005

DATES NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: October 22, 2004 and February 4, 2005

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

RULE TITLES:	RULE NOS.:
Department Personnel Disciplinary Policies and Procedures/Distribution	61-2.0010
Sick Leave Pool	61-2.0011
Sexual Harassment Policy	61-2.014
Affirmative Action Policy	61-2.026

PURPOSE AND EFFECT: Repeals above rules, per Section 110.1055, F.S.

SUMMARY: This is a housekeeping rule deleting rules addressing the distribution of Disciplinary Policies and Procedures manual, administration of the Sick Leave Pool program, incorporation and distribution of the Sexual Harassment Policy and Procedure information, and incorporation of the Affirmative Action Policy. The substance of the repealed rules is now contained within the Uniform Personnel Rules, and the above rules were repealed by operation of Section 110.1055, F.S., on January 1, 2002.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: No statement of estimated regulatory costs was prepared.

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

SPECIFIC AUTHORITY: 110.201(2), 110.227 FS.

LAW IMPLEMENTED: 110.1055 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW. (IF NOT REQUESTED, A HEARING WILL NOT BE HELD):

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Gail Scott Hill, Assistant General Counsel, Northwood Centre, 1940 North Monroe Street, Tallahassee, FL 32399-2202

THE FULL TEXT OF THE PROPOSED RULES IS:

61-2.0010 Department of Personnel Disciplinary Policies and Procedures/Distribution.

Specific Authority 20.05(1)(b),(5), 110.201(2) FS. Law Implemented 110.201(2), 110.227 FS. History–New 5-29-96, Repealed ________.

61-2.0011 Sick Leave Pool.

Specific Authority 110.121 FS. Law Implemented 760.10, 110.121 FS. History–New 11-17-96, Repealed ________.

61-2.014 Sexual Harassment Policy.

Specific Authority 20.05, 110.105, 110.201 FS. Law Implemented 760.10, 110.105, 110.227, 110.233 FS. History–New 7-2-84, Formerly 7-2.003, 7-2.0003, Amended 11-17-96, Repealed ________.

61-2.026 Affirmative Action Policy.

Specific Authority 110.112(2) FS. Law Implemented 110.112(2) FS. History–New 8-26-80, Formerly 7-5.01, 7-5.001, Repealed ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Gail Scott Hill, Assistant General Counsel, Office of the General Counsel, Florida Department of Business and Professional Regulation, 1940 North Monroe Street, Tallahassee, Florida 32399

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Diane Carr, Secretary, Florida Department of Business and Professional Regulation

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: March 31, 2005

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

RULE TITLE: RULE NO.:
Biennial Licensing 61-6.001

PURPOSE AND EFFECT: Update the rule language to omit practice acts no longer regulated by the Department, add renewal dates for continuing education providers, and extend the renewal date for real estate appraisers.

SUMMARY: Deletes rule renewal dates for professions no longer regulated and updates renewal dates for regulated professions.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

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

SPECIFIC AUTHORITY: 455.203(5) FS.

LAW IMPLEMENTED: 455.203(1) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Gail Scott-Hill, Assistant General Counsel, Office of the General Counsel, Florida Department of Business and Professional Regulation, 1940 North Monroe Street, Tallahassee, Florida 32399

THE FULL TEXT OF THE PROPOSED RULE IS:

61-6.001 Biennial Licensing.

(1) Pursuant to Section 455.203(1), Florida Statutes 2004 ~~(1979)~~, the Department hereby implements a plan for staggered biennial renewal of licenses issued by the Central Intake Unit, The Division of Service Operations and Licensure, ~~Bureau of Licensure of the Division of Technology, Licensure, and Testing of the~~ Department on behalf of the boards within the Department and the Department.

(2) The staggered biennial renewal issuance plan does not apply to the renewal of licenses which have a statutory period of one year or less and which do not mature into permanent licenses which would be subject to regular annual renewal.

(3) Biennial period shall mean a period of time consisting of two 12 month years. The first biennial period for the purposes of each board shall commence and continue on the dates specified in the department plan as set forth for each respective profession.

(4) The schedule for biennial license renewal for each respective profession shall be as follows:

	EVEN YEARS	ODD YEARS
Accountancy Firms		December 31
Accountants Group 3 ~~(CE Codes in 30 series)~~	December 31	
Accountants Group 2 ~~(CE codes in 20 series)~~		December 31
~~Acupuncturists~~	~~February 28~~	
Athlete Agents	May 31	
Architects/Architect Businesses		February 28
Asbestos Consultants/ Contractors	November 30	
Asbestos Business		November 30
Auctioneers, Businesses & Apprentices		November 30
Barber Shops	November 30	
Barbers	July 31	
Barbers CE Provider	May 31	
Building Code Administrators & Inspectors		November 30
Building Code CE Provider		May 31
Community Association Managers	September 30	
Community Association Managers CE Provider		May 31
Community Association Managers Pre-Licensure CE Provider	May 31	
Centralized Embalming Facilities	November 30	
~~Certified Master Social Workers~~		~~January 31~~
~~Chiropractors and~~	~~February 28~~	

~~Assistants~~		
~~Clinical Social Workers~~		~~January 31~~
Construction Industry Licensing Board (Certified)	August 31	
Construction Industry Licensing Board (Registered)		August 31
Construction Industry Licensing Board CE Provider		May 31
Construction Industry Licensing Board Specialty Structure	August 31	
Cosmetologists & Specialties		
Group I		October 31
Group II	October 31	
Cosmetology Salons	November 30	
Cosmetology CE Provider		May 31
Registered Cinerators	November 30	
~~Crematories~~		
~~Dental Hygienists~~	~~February 28~~	
~~Dental Laboratories (These licenses renew annually.)~~	~~February 28~~	
~~Dentists~~	~~February 28~~	
~~Dietitians/Nutritionists~~		~~February 28~~
Direct Disposers & Establishments		August 31
~~Dispensing Opticians~~	~~July 31~~	
Electrical Contractors	August 31	
Electrical Contractors CE Provider		May 31
~~Electrologists~~		~~October 31~~
~~Electrologist Facilities~~	~~April 30~~	
Employee Leasing Companies	April 31	
Funeral Home Establishments	November 30	
Funeral Directors & Embalmers		August 31
Geologists/Geology Businesses	July 31	
~~Hearing Aid Specialists~~		~~February 28~~
Interior Designers/ Interior Design Businesses		February 28
Landscape Architects/Landscape Architecture Businesses		November 30
Landscape Architecture CE Provider		May 31
Architecture Business		
~~Marriage & Family Therapists~~		~~January 31~~
~~Massage Therapists/Massage Establishments~~		~~January 31~~
~~Mental Health Counselors~~		~~January 31~~
~~Midwives~~		~~December 31~~
~~Naturopaths~~	~~May 1~~	
~~Nuclear Pharmacists~~	~~February 28~~	
~~Nurses~~	~~April 30~~	
~~Group I: Registered and Advanced Registered Nurse Practitioners~~		
~~Group II: Registered and Advanced Registered Nurse Practitioners~~	~~July 31~~	
~~Group III: Registered and Advanced Registered Nurse Practitioners~~		~~April 30~~
~~Licensed Practical Nurses~~		~~July 31~~
~~Nursing Home Administrators~~	~~July 31~~	
~~Occupational Therapists & Assistants~~		~~January 31~~
~~Optometrists/Optometry Branch Offices~~		~~February 28~~
~~Osteopathic Physicians~~	~~January 31~~	
~~Osteopathic Physician Assistants~~		~~July 31~~
~~Pharmacies~~		~~February 28~~
~~Pharmacist Consultants~~	~~December 31~~	
~~Pharmacists~~		~~July 31~~
~~Physical Therapists & Assistants~~		
~~Physicians & Physician Assistants~~	~~January 31~~	
Pilots		January 31
~~Podiatrists~~	~~February 28~~	
~~Professional Engineers/Engineer Business~~		~~February 28~~

~~Psychologists~~	~~February 28~~	
Real Estate Appraisers	November 30	
Real Estate Appraiser Instructors		September 30
Real Estate		
Real Estate – Group I	September 30	
Real Estate – Group II		March 31
Real Estate – Group III		September 30
Real Estate – Group IV	March 31	
Real Estate Schools		September 30
Refrigeration Facilities	November 30	
Removal Services	November 30	
~~Respiratory Care Practitioners~~		~~January 31~~
~~Respiratory Therapists~~		~~January 31~~
~~School Psychologists~~		~~January 31~~
~~Speech Language Pathologists/ Audiologists & Assistants~~		~~December 31~~
Surveyors & Mappers		February 28
Surveying & Mapping Businesses		February 28
Surveying and Mapping CE Provider		May 31
Talent Agencies	May 31	
Veterinarians	May 31	
~~Water/Waste Water Treatment Operators~~		~~February 28~~

EXTENSION OF BIENNIAL LICENSURE PERIODS – When a current biennial licensure period for a profession is extended for a period longer than two years to conform to the above schedule of biennial periods, the biennial licensure fee for the profession shall be increased pro-rata to cover the additional extended period. The increased licensure fee shall be based on the biennial licensure fee established by the board. The amended licensure period and the pro-rated renewal fee shall be implemented for the purpose of restructuring the Department's renewal schedule.

(5) The biennial license renewal fees shall be established by rule by each board, or by the Department, whichever is appropriate.

(6) The renewal date for real estate appraisers will be extended from November 30, 2004 to April 15, 2005. Thereafter, renewals shall be due on November 30 of each even-numbered year.

Specific Authority 455.203(5) FS. Law Implemented 455.203(1) FS. History–New 9-17-78, Amended 9-21-78, 8-20-80, 2-3-81, 4-8-81, 12-7-81, 6-14-82, 11-23-83, 12-2-83, 1-26-84, 7-9-84, Formerly 21-6.08, Amended 4-27-86, 4-21-87, 2-16-88, 11-28-90, 7-18-91, Formerly 21-6.008, Amended 4-3-95, ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Gail Scott-Hill, Assistant General Counsel, Office of the General Counsel, Department of Business and Professional Regulation, 1940 North Monroe Street, Tallahassee, Florida 32399

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Diane Carr, Secretary, Department of Business and Professional Regulation

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: March 31, 2005

DATES NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: December 3, 2004 and February 4, 2005

DEPARTMENT OF ENVIRONMENTAL PROTECTION

Pursuant to Chapter 2003-145, Laws of Florida, all notices for the Department of Environmental Protection are published on the Internet at the Department of Environmental Protection's home page at http://www.dep.state.fl.us/ under the link or button titled "Official Notices."

DEPARTMENT OF HEALTH

Board of Medicine

RULE TITLE:	RULE NO.:
Examinations	64B8-5.001

PURPOSE AND EFFECT: The proposed rule amendments are intended to clarify examination requirements and delete the 7 year requirement based upon written comments submitted by the staff of the Joint Administrative Procedures Committee.

SUMMARY: The proposed rule amendments delete the 7-year time frame for completion of the USMLE.

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 regulatory cost alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 456.017(1), 458.309, 458.311(1)(h), 458.313(4) FS.

LAW IMPLEMENTED: 456.017(1),(2), 458.311, 458.313 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Larry McPherson, Executive Director, Board of Medicine/MQA, 4052 Bald Cypress Way, Bin #C03, Tallahassee, Florida 32399-3253

THE FULL TEXT OF THE PROPOSED RULE IS:

64B8-5.001 Examinations.

(1) No change.

(2) Any applicant who attempts to qualify for licensure by successfully completing the USMLE first used in 1994 shall meet the following requirements~~:~~

~~(a) A candidate may take any step or steps at any sitting and may take Step 3 only after completion of Steps 1 and 2. However, all steps must be successfully completed within a seven-year period. Applicants may exceed the seven-year requirement under the following conditions:~~

~~1. The applicant has successfully passed all three steps of the USMLE in no more than two attempts on each step; or~~

~~2. The applicant was enrolled in an M.D./Ph.D. program at the time the USMLE was taken.~~

~~(b)~~ An applicant must achieve a weighted score of no less than 75 on each step in order to be eligible for licensure in Florida.

~~(3) For purposes of determining the time period of seven years within which all steps of the examination must be passed the last day of the month during which the applicant sat for the examination shall be the date from which (and to which) the time calculations shall be made.~~

(3)~~(4)~~ Any applicant for licensure who began taking an examination for licensure prior to 1994 may utilize any of the examinations set forth in subsection (3) above or a combination thereof as follows up to the year 2000:

(a) through (c) No change.

~~(d) The limitation of seven years begins with passage of the first applicable Step, Part or Component and ends seven years from that date, the limitation of five attempts is applicable to each Step, Part or Component up to the year 2000; thereafter five (5) attempts on each Step. Pursuant to subsection 458.311(2), F.S., an applicant who fails to meet the five attempt requirement may petition the Board to retake the examination. Prior to retaking the examination the applicant must complete remedial education consisting of one (1) complete year of ACGME approved post-graduate training.~~

(4)~~(5)~~ No change.

Specific Authority 456.017(1), 458.309, 458.311(1)(h), 458.313(4) FS. Law Implemented 456.017(1),(2), 458.311, 458.313 FS. History–New 12-5-79, Amended 11-10-82, 11-28-84, 3-13-85, 8-11-85, 12-4-85, Formerly 21M-21.01, Amended 2-16-86, 12-16-86, 5-10-89, Formerly 21M-21.001, Amended 5-9-94, Formerly 61F6-21.001, Amended 10-18-94, 1-2-95, Formerly 59R-5.001, Amended 8-18-98, 2-3-00, 8-20-02, ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Credentials Committee, Board of Medicine

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

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: April 1, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: February 18, 2005

DEPARTMENT OF HEALTH

Division of Disease Control

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Eligibility Requirements For HIV/AIDS Patient Care Programs	64D-4
RULE TITLES:	RULE NOS.:
Purpose	64D-4.001
Definitions	64D-4.002
Eligibility and Documentation Requirements	64D-4.003
Determined Eligible or Ineligible	64D-4.004
Re-Determination and Continued Eligibility	64D-4.005
Rights and Responsibilities	64D-4.006

PURPOSE AND EFFECT: The purpose and effect of this new rule is to standardize the eligibility requirements and procedures for the HIV/AIDS Patient Care Programs to better serve low-income persons living with HIV disease. The HIV/AIDS Patient Care Programs include the Ryan White Title II Consortia Program, the AIDS Insurance Continuation Program (AICP), the AIDS Drug Assistance Program (ADAP), the State Housing Opportunities for Persons with AIDS (HOPWA) Program and the HIV/AIDS patient care programs as administered by the Department of Health, Bureau of HIV/AIDS.

The program qualifications for the AIDS Insurance Continuation Program (AICP), AIDS Drug Assistance Program (ADAP) and the State Housing Opportunities for Persons with AIDS (HOPWA) Program remain unchanged.

SUMMARY: This new rule provides eligibility requirements and procedures for low-income persons to receive services from the HIV/AIDS Patient Care Programs.

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: 381.0011(13) FS.

LAW IMPLEMENTED: 381.001(1), 381.003(1)(c), 381.0011(5) FS.

A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 1:00 p.m. – 4:00 p.m., Tuesday, May 24, 2005

PLACE: John F. Germany Public Library (Auditorium), 900 North Ashley Street, Tampa, Florida 33602

Any person requiring a special accommodation at the hearings because of a disability or physical impairment should contact the Bureau of HIV/AIDS, HIV/AIDS Patient Care Section, Program Administrator, at least five calendar days prior to the

hearing. If you are hearing or speech impaired, please contact the Bureau of HIV/AIDS using the Florida Dual Party Relay System, 1(800)955-8770 (Voice) and 1(800)955-8771 (TDD).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Pamela McWilliams, Bureau of HIV/AIDS, 4052 Bald Cypress Way, Bin #A09, Tallahassee, Florida 32399-1715, (850)245-4335 (The proposed rule text is on-line at: www.Myflorida.com)

THE FULL TEXT OF THE PROPOSED RULES IS:

64D-4.001 Purpose.

(1) The Department of Health, Bureau of HIV/AIDS, HIV/AIDS Patient Care Programs are intended to provide primary health care and support services to low-income persons living with HIV disease, based on availability, accessibility and funding of the program.

(2) It is the Department of Health's responsibility to establish eligibility requirements to ensure services are provided to the individuals intended.

Specific Authority 381.0011(13) FS. Law Implemented 381.001(1), 381.003(1)(c), 381.0011(5) FS. History–New ________.

64D-4.002 Definitions.

For the purpose of this rule chapter, the words and phrases listed below are defined in the following manner:

(1) "Allowable services" mean the HIV/AIDS patient care services listed in the current federal Glossary of Services as referenced by the Health Resources and Services Administration; the eligible activities as governed by 24 CFR Part 574.300 (b)(1) and (6) by the U. S. Department of Federal Housing and Urban Development (HUD), and the HIV/AIDS patient care services administered by the Department of Health, Bureau of HIV/AIDS, all of which are incorporated by reference and available upon request. Allowable Services are based on availability, accessibility and funding of the service.

(2) "Application" means the Bureau's Application for Eligibility Determination to Receive Allowable Services and the Brochure which are incorporated by reference. Effective Date: ________.

(3) "Applicant" means an individual who has submitted or is in process of preparing and submitting the Application.

(4) "Bureau" means the Department of Health, Bureau of HIV/AIDS.

(5) "Cash Assets" mean items of value such as second cars and homes, boats, real estate and financial investments. Not included as cash assets are items such as the applicant's primary residence, personal transportation, individual retirement accounts and deferred compensation, which are not accessed.

(6) "Client" means an applicant who has been determined eligible.

(7) "Department" means the Florida Department of Health.

(8) "Economic Needs" mean essential items such as food, housing, clothing, transportation, personal needs and other like needs.

(9) "Eligible" means approved by the Department to receive allowable services.

(10) "Eligibility Staff" means personnel authorized by the Department to determine eligibility.

(11) "Federal Poverty Level" (FPL) means the poverty income levels published and updated annually by the Federal Office of Management and Budget (OMB), which is incorporated by reference.

(12) "Household Income" means income received by the applicant, the applicant's spouse (if married) and other adults who contribute to the economic needs of the applicant. For purposes of household income, other adults include adult siblings, parents, significant others, partners or other relatives, if they contribute to the economic needs of the applicant as defined in subsection 64D-4.002(8), F.A.C., of this rule.

(13) "HIV/AIDS Patient Care Programs" means the:

(a) Ryan White Title II Consortia Program;

(b) Ryan White Title II AIDS Drug Assistance Program;

(c) Ryan White Title II AIDS Insurance Continuation Program;

(d) State Housing Opportunities for Persons with AIDS Program; and

(e) HIV/AIDS Patient Care Programs provided by the Patient Care Networks and County Health Departments as administered by the Department of Health, Bureau of HIV/AIDS.

(14) "Low Income" means a gross income less than or equal to 300% of the FPL as published and updated annually by the Federal Office of Management and Budget (OMB) and cash assets not to exceed $12,000. The FPL is incorporated by reference.

(15) "Program Qualifications" are program specific requirements to qualify for enrollment in the following specialty programs, after eligibility has been approved:

(a) Ryan White Title II AIDS Drug Assistance Program;

(b) Ryan White Title II AIDS Insurance Continuation Program; and

(c) State Housing Opportunities for Persons with AIDS.

(16) "Verification" means to confirm the accuracy of information through sources other than a self-declaratory statement of the individual originally supplying the information.

Specific Authority 381.0011(13) FS. Law Implemented 381.001(1), 381.003(1)(c), 381.0011(5) FS. History–New ________.

64D-4.003 Eligibility and Documentation Requirements.

The applicant eligibility and documentation requirements to receive allowable services from the HIV/AIDS Patient Care Programs include the following:

(1) Must have documentation of a medical diagnosis of HIV disease with a laboratory test documenting confirmed HIV infection from one of the following:

(a) A confirmed positive HIV antibody test result (e.g. Elisa (EIA) & Western Blot) by blood or Orasure;

(b) A positive HIV direct viral test such as PCR or P24 antigen;

(c) A positive viral culture result; or

(d) A detectable HIV-viral load & viral resistance test.

(2) Must be currently living in the state of Florida with the intent to remain in the state for employment, school, migrant work, family or other like situations.

(3) Cannot be receiving services or be eligible to participate in local, state or federal programs where the same type service is provided or available. This requirement does not preclude an individual from receiving allowable services not provided or available by other local, state or federal programs, or pending a determination of eligibility from other local, state or federal programs.

(4) Must have low-income and cash assets not to exceed $12,000.

(5) Must be willing to cooperate with Eligibility Staff during the eligibility process and sign and comply with the Rights and Responsibilities established in the Application.

(6) Must submit a completed Application in accordance with the application instructions.

(7) Must include all requested information and documentation with the Application or provided to Eligibility Staff during the eligibility process. Failure to provide the requested information may delay or prevent a determination of eligibility.

Specific Authority 381.0011(13) FS. Law Implemented 381.001(1), 381.003(1)(c), 381.0011(5) FS. History–New ________.

64D-4.004 Determined Eligible or Ineligible.

(1) Eligibility Staff are required to complete verification and make a determination of eligibility of an applicant's status within 30 days from the receipt of the Application and requested information. The time-limit can be extended for unusual circumstances with supervisory approval.

(2) If determined eligible, the applicant is provided a written confirmation of the eligibility determination and referrals are made to the appropriate programs for allowable services.

(3) If determined ineligible, the applicant is provided a written explanation as to why he/she is ineligible and is provided information on the right to appeal the decision.

(4) An exception to the eligibility requirements must be approved by the Department or designated staff. The request for an exception must be initiated by the Eligibility Staff on the Request for Exception form, which is incorporated by reference and approved by the supervisor. The following criteria applies for all exception requests:

(a) The reason for the request for exception must include one of the following:

1. To prevent the loss of health insurance benefits, or

2. To prevent hospitalization, or

3. To ensure continued access to medications and treatment.

(b) The request for an exception can be granted only for:

1. An Emergency Situation; and

2. A Short-Term Circumstance (less than 180 days).

Specific Authority 381.0011(13) FS. Law Implemented 381.001(1), 381.003(1)(c), 381.0011(5) FS. History–New ________.

64D-4.005 Re-Determination and Continued Eligibility.

(1) Eligibility of an existing client is re-determined every six months or at shorter intervals if the client's income and other eligibility factors change before the 6-month period. The written confirmation requirements established in Rules 64D-4.003 and 64D-4.004, F.A.C., of this rule will apply.

(2) The client must report any change in his/her situation, which will impact his/her eligibility status to the Eligibility Staff no later than 10 days after it is known.

(3) A client can be determined ineligible to receive services for the following reasons:

(a) A client is no longer living in the state of Florida with the intent to remain in the state.

(b) A client is eligible to receive services or participating in local, state or federal programs where the same type service is provided or available.

(c) A client is no longer considered low-income.

(d) A client has not complied with the Rights and Responsibilities in the Application.

(4) The request for exception requirements established in subsection 64D-4.004(4), F.A.C., of this rule will apply during the Re-Determination of a client's eligibility.

Specific Authority 381.0011(13) FS. Law Implemented 381.001(1), 381.003(1)(c), 381.0011(5) FS. History–New ________.

64D-4.006 Rights and Responsibilities.

(1) The applicant or client must comply with the rights and responsibilities established in the Application throughout the eligibility process and during participation in the HIV/AIDS Patient Care Programs.

(2) Failure to comply with the Rights and Requirements established in the Application at any time during the initial eligibility and re-determination process or while receiving services from the HIV/AIDS Patient Care Programs can result in time-limited suspension or final termination from the HIV/AIDS Programs indefinitely.

Specific Authority 381.0011(13) FS. Law Implemented 381.001(1), 381.003(1)(c), 381.0011(5) FS. History–New ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Pamela McWilliams, Patient Care Program, Bureau of HIV/AIDS, Department of Health

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Tom Liberti, Chief, Bureau of HIV/AIDS, Department of Health
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: March 29, 2005
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: June 18, 2004

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Economic Self Sufficiency Program

RULE TITLE:	RULE NO.:
Overpayment and Benefit Recovery	65A-1.900

PURPOSE AND EFFECT: The proposed amendment provides criteria for when the department will consider a compromise of a food stamp program claim or any portion of a food stamp claim.
SUMMARY: This rule amendment provides that the department reserves the right to approve or not approve a compromise of a food stamp program claim or any portion of a food stamp claim. It also provides that a compromise will be considered only to resolve (1) pending litigation; (2) bankruptcy proceedings.
SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: An estimate of the regulatory cost was not prepared for this rule.
Any person who wishes to provide information regarding the statement of estimated 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: 414.41, 414.45 FS.
LAW IMPLEMENTED: 24.115(4), 414.31, 414.41 FS.
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: 10:30 a.m., May 11, 2005
PLACE: Building 3, Room 439, 1317 Winewood Boulevard, Tallahassee, FL 32399-0700
THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: John Bowman, Program Administrator, 1317 Winewood Boulevard, Building 3, Room 417, Tallahassee, FL 32399-0700, (850)921-5549

THE FULL TEXT OF THE PROPOSED RULE IS:

65A-1.900 Overpayment and Benefit Recovery.
The purpose of this section is to define the administrative policies applicable to the establishment and recovery of overpayment in the public assistance programs.

(1) through (5) No change.

(6) Compromising Food Stamp Claims. Effective August 1, 2001, a food stamp claim or any portion of a food stamp claim may be compromised if the department can determine that a household's economic circumstances dictate that the claim will not be paid in three years. The department reserves the right to approve or not approve the compromise. Default of a compromise or repayment agreement by the client occurs when one scheduled payment is missed. Compromise will be considered only to resolve:

(a) Pending litigation;

(b) Bankruptcy proceedings.

(7) No change.

(8) Notification of Overpayment. The persons responsible for repayment of overpayment must be notified in writing that overpayment exists and that they are required, by law, to repay the entire amount pursuant to Section 414.41, F.S., or that they may seek compromise of a food stamp overpayment pursuant to 7 CFR 273.18(e)(3),(7) (incorporated by reference).

(9) through (11) No change.

(12) The following notices, hereby incorporated by reference in Rule 65A-1.400, F.A.C., are used by the department in the process of establishing and recovering overpayment:
CF-ES Form 3057, ~~Aug 2001,~~ Information Concerning Administrative Disqualification Hearings; CF-ES Form 3400, ~~Aug 83,~~ Request for Additional Information; CF-ES Form 3410, ~~Aug. 2001,~~ Waiver of Administrative Disqualification Hearing; CF-ES Form 3410A, ~~Aug. 2001,~~ Waiver of Administrative Disqualification Hearing; and, CF-ES Form 3414, ~~Aug. 99,~~ Disqualification Consent Agreement. Each of these forms listed as incorporated by reference may be obtained without cost from any Benefit Recovery office or by written request to the Economic Self-Sufficiency Program Office, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700.

Specific Authority 414.41, 414.45 FS. Law Implemented 24.115(4), 414.31, 414.41 FS. History–New 7-21-92, Amended 1-5-93, 9-5-93, Formerly 10C-1.900, Amended 7-9-98, 4-22-00, 2-26-02, 3-18-03,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: John Bowman, Program Administrator, Technologies and Systems Development Bureau, Special Programs Unit
NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Kim Shaver, Director, Economic Self-Sufficiency
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: March 29, 2005
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: February 11, 2005

DEPARTMENT OF FINANCIAL SERVICES

OIR Insurance Regulation

RULE TITLE: RULE NO.:
Reports of Information by Health Insurers Required 69O-137.004

PURPOSE, EFFECT AND SUMMARY: The purpose of the rule is to update forms required to be filed by Health Carriers annually concerning annual premiums and enrollment based on recent legislation changes to Section 627.9175, F.S.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated 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: 624.308(1), 627.9175 FS.

LAW IMPLEMENTED: 624.307(1), 627.9175 FS.

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: 9:30 a.m., May 13, 2005

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

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Frank Dino, Life and Health Product Review, Office of Insurance Regulation, e-mail: frank.dino@fldfs.com

THE FULL TEXT OF THE PROPOSED RULE IS:

69O-137.004 Reports of Information by Health Insurers Required.

(1) Any insurer authorized to write a policy or certificate of health insurance in the state shall, on or before April 1 for the preceding year ending December 31, report the information required by Form OIR-B2-1094, "Report of Gross Annual Premiums and Enrollment Data for Health Benefit Plans Issued to Florida Residents", providing information on health benefit plans written in this state. ~~Section 627.9175, Florida Statutes, or required by rule, by annually completing and submitting to the Office of Insurance Regulation the forms below in accordance with the instructions provided therein.~~

~~(a) OIR-B2-331 "Consumer Guide Information Form."~~

~~(b) OIR-B2-333 "Health Insurance Cost Containment Information Form."~~

(2) The following forms are hereby adopted and incorporated by reference: ~~Reports for the preceding calendar year are due on or before the following dates:~~

(a) OIR-B2-1094, Rev. 8/03, "Report of Gross Annual Premiums and Enrollment Data for Health Benefit Plans Issued to Florida Residents". ~~OIR-B2-331 – March 15.~~

(b) Copies of forms are available and may be printed from the Office's website: http://www.fldfs.com/. ~~OIR-B2-333 – March 30.~~

(c) All filings shall be submitted electronically through https://iportal.fldfs.com.

~~(3) Forms OIR-B2-331 and OIR-B2-333 are hereby incorporated by reference and shall take effect on March 21, 1985. These forms are available from the Office of Insurance Regulation, Bureau of Rates, Larson Building, Tallahassee, Florida 32399-0300.~~

Specific Authority 624.308(1), 627.9175~~(1),(3),(4)(b)~~ FS. Law Implemented 624.307(1), 627.9175~~(1),(3),(4)(a)~~ FS. History–New 3-21-85, Amended 2-9-86, Formerly 4-59.081, Amended 2-25-87, 2-22-89, Formerly 4-59.0081, Formerly 4-137.004, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Frank Dino, Actuary, Life and Health Product Review, Office of Insurance Regulation

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Rich Robleto, Deputy Commissioner, Office of Insurance Regulation

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: January 22, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 4, 2005

DEPARTMENT OF FINANCIAL SERVICES

OIR Insurance Regulation

RULE TITLES: RULE NOS.:
Employee Health Care Access Act Statement Reporting Requirement 69O-149.038
Forms 69O-149.044

PURPOSE, EFFECT AND SUMMARY: The rules are being updated to comply with Section 627.9175, F.S., regarding small group carrier reports and to clarify the annual actuarial certification.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated 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: 624.308(1), 626.9641, 627.6699(5)(i)4.,(16), 627.9175 FS.

LAW IMPLEMENTED: 624.424(6), 626.9541, 627.401, 627.410, 627.411, 627.6699, 627.9175 FS.

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: 9:30 a.m., May 13, 2005

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

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Frank Dino, Life and Health Product Review, Office of Insurance Regulation, e-mail: frank.dino@fldfs.com

THE FULL TEXT OF THE PROPOSED RULES IS:

69O-149.038 Employee Health Care Access Act ~~Annual and Quarterly~~ Statement Reporting Requirement.

(1)~~(a) Pursuant to Section 627.6699, F.S., each carrier that provides health benefit plans in this state shall file, pursuant to paragraph 69O-149.044(2)(b), F.A.C., on or before March 1 for the preceding year ending December 31, Form OIR-B2-1094, Report of Gross Annual Premiums and Enrollment Data for Health Benefit Plans Issued to Florida Residents, adopted in Rule 69O-149.044, F.A.C., providing information on health benefit plans written in this state.~~

~~(b)~~ Pursuant to Section 627.6699, F.S., each carrier that provides health benefit plans in this state shall file, ~~The company shall file~~ an actuarial certification, pursuant to paragraph 69O-149.044(2)(b), F.A.C., on or before March 15 of each year that the carrier is in compliance with the provisions of Section 627.6699(6), F.S., as required by Section 627.6699(8)(b), F.S., for the prior calendar year and that the current rating methods of the carrier are actuarially sound. The actuary shall provide a detailed explanation if this certification cannot be made.

(2) through (3) No change.

Specific Authority 627.6699(5)(i)~~3.a.,~~4.~~a.~~,(16), 627.9175 FS. Law Implemented 624.424(6), 627.6699(5)(i)~~3.a.,~~4.~~a.~~, 627.6699(6)(b)5., 627.6699(8)(b), 627.9175 FS. History–New 3-1-93, Amended 11-7-93, 8-4-02, 6-19-03, Formerly 4-149.038, Amended 5-18-04,________.

69O-149.044 Forms.

(1) The following forms are hereby adopted and incorporated by reference:

~~(a) OIR-B2-1094, rev. 11/01, Report of Gross Annual Premiums and Enrollment Data for Health Benefit Plans Issued to Florida Residents.~~

(a)~~(b)~~ OIR-B2-1117, R~~r~~ev. 1/05 ~~5/02~~, Florida Employee Health Care Access Act Enrollment Report.

(c) through (e) renumbered (b) through (d) No change.

(2) No change.

Specific Authority 624.308(1), 626.9641, 627.6699(16) FS. Law Implemented 626.9541, 627.401, 627.410, 627.411, 627.6699 FS. History–New 8-4-02, Formerly 4-149.044, Amended 5-18-04,________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Frank Dino, Actuary, Life and Health Product Review, Office of Insurance Regulation

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Rich Robleto, Deputy Commissioner, Office of Insurance Regulation

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: January 22, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 4, 2005

DEPARTMENT OF FINANCIAL SERVICES

OIR Insurance Regulation

RULE TITLE:	RULE NO.:
Guaranteed Availability of Individual Health Coverage to Eligible Individuals	69O-154.112

PURPOSE, EFFECT AND SUMMARY: To change the reporting date in the rule from March to April.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated 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: 624.308, 624.424(1)(c), 627.6487(4)(b) FS.

LAW IMPLEMENTED: 624.307(1), 627.6487 FS.

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: 9:30 a.m., May 13, 2005

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

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Frank Dino, Life and Health Product Review, Office of Insurance Regulation, e-mail: frank.dino@fldfs.com

THE FULL TEXT OF THE PROPOSED RULE IS:

69O-154.112 Guaranteed Availability of Individual Health Coverage to Eligible Individuals.

(1) through (2) No change.

(3) To enable the Office to monitor this coverage, the issuer shall file, no later than April ~~March~~ 1 of each year, Form OIR-B2-1386, (R~~r~~ev. 8/03 ~~05/03~~), Individual Health Coverage Policy Forms Issued/Renewed in Florida, which is hereby adopted and incorporated by reference. All filings shall be submitted electronically to https://iportal.fldfs.com. Copies of the form may ~~be obtained from the Bureau of Life and Health Forms and Rates, Office of Insurance Regulation, Tallahassee, FL 32399-0328, or may~~ be printed from the Office's website: ~~<~~http://www.fldfs.com/companies/pdf/OIR-B2-1386.PDF~~>~~.

(4) through (8) No change.

Specific Authority 624.308, 624.424(1)(c), 627.6487(4)(b) FS. Law Implemented 624.307(1), 627.6487 FS. History–New 9-19-00, Amended 9-30-01, 2-13-03, 9-22-03, Formerly 4-154.112, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Frank Dino, Actuary, Life and Health Product Review, Office of Insurance Regulation

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Rich Robleto, Deputy Commissioner, Office of Insurance Regulation

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: January 22, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 4, 2005

DEPARTMENT OF FINANCIAL SERVICES

OIR Insurance Regulation

RULE TITLE:	RULE NO.:
Escrow Agreements and Amendments	69O-193.023

PURPOSE, EFFECT AND SUMMARY: This rule is being amended to delete the Office as a "party in interest" and a required signatory to escrow agreements. There is no statutory authority to support the rule, as it currently exists.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated 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: 651.015(3) FS.

LAW IMPLEMENTED: 651.022, 651.023, 651.033 FS.

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: 9:30 a.m., May 11, 2005

PLACE: Room 142, Larson Building, 200 East Gaines Street, Tallahassee, Florida

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Gary Mills, Specialty Product Administration, Office of Insurance Regulation, e-mail: gary.mills@fldfs.com

THE FULL TEXT OF THE PROPOSED RULE IS:

69O-193.023 Escrow Agreements and Amendments.

(1) No change.

(2) Each escrow agreement or amendment must be signed by:

(a) through (b) No change.

~~(c) The Office, as a party-in-interest.~~

(3) No change.

Specific Authority 651.015(3) FS. Law Implemented 651.022, 651.023, 651.033 FS. History–New 7-16-92, Formerly 4-193.023, Amended ________.

NAME OF PERSON ORIGINATING PROPOSED RULE: Gary Mills, Specialty Product Administration, Office of Insurance Regulation

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Richard Robleto, Deputy Commissioner, Office of Insurance Regulation

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: March 22, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 4, 2005

Section III
Notices of Changes, Corrections and Withdrawals

DEPARTMENT OF TRANSPORTATION

RULE CHAPTER NO.:	RULE CHAPTER TITLE:
14-43	Regulation of Encroachments Over State Rights of Way
RULE NO.:	RULE TITLE:
14-43.001	Regulation of Overhanging Encroachments

NOTICE OF CHANGE

SUMMARY OF CHANGE: The notice of rulemaking was published in Florida Administrative Weekly, Vol. 30, No. 50, December 10, 2004. Requests for a public hearing were received and a notice of hearing was published in Florida Administrative Weekly, Vol. 30, No. 52, scheduling the public hearing for January 13, 2005. In addition, the Joint Administrative Procedures Committee provided comments