Section I
Notices of Development of Proposed Rules and Negotiated Rulemaking

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Division of Standards

RULE TITLE: RULE NO.:
Adoption of Uniform Packaging and Labeling Regulation 5F-3.001

PURPOSE AND EFFECT: The purpose of Rule 5F-3.001, F.A.C., is to amend it to adopt the most recent national standards for packaging and labeling requirements as adopted by the National Conference on Weights and Measures and published in 2005 edition of National Institute of Standards and Technology Handbook 130. Adoption of the current national standards will make Florida's requirements uniform with the national requirements and facilitate interstate commerce and trade.

SUBJECT AREA TO BE ADDRESSED: Requirements for packaging and labeling of commodities sold in package form in Florida.

SPECIFIC AUTHORITY: 531.41(3) FS.

LAW IMPLEMENTED: 531.41(4), 531.47, 531.49 FS.

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

TIME AND DATE: 10:00 a.m., Monday, February 21, 2005

PLACE: Division of Standards' Conference Room, Suite E, Room 135, Doyle Conner Administration Building, 3125 Conner Boulevard, Tallahassee, Florida 32399-1650

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Max Gray, Bureau Chief, Bureau of Weights and Measures, 3125 Conner Blvd., Bldg. #2, Tallahassee, FL 32399-1650, (850)488-9140

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

5F-3.001 Adoption of Uniform Packaging and Labeling Regulation.

The Department of Agriculture and Consumer Services hereby adopts the Uniform Packaging and Labeling Regulation promulgated by the United States Department of Commerce, National Institute of Standards and Technology, NIST Handbook 130, 2005 ~~2004~~ Edition, as the Rule for packaging and labeling of commodities and incorporates said uniform regulation herein by this reference. A copy of NIST Handbook 130, 2005 ~~2004~~ Edition, may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402, Phone: (202)512-1800 or http://ts.nist.gov/ts/htdocs/230/235/pubs.htm ~~http://ts.nist.gov/ts/htdocs/230/235/h130-01.htm~~. Copies of this uniform regulation are available from the Division of Standards, Bureau of Weights and Measures, 3125 Conner Boulevard, Lab #2, Tallahassee, Florida 32399-1650, phone (850)488-9140.

Specific Authority 531.41(3) FS. Law Implemented 531.41(4), 531.47, 531.49 FS. History–New 1-1-73, Formerly 5F-3.01, Amended 6-14-95, 8-27-98, 8-19-99, 7-3-00, 9-3-01, 6-23-02, 6-29-03, 6-21-04, _____.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Division of Standards

RULE TITLE: RULE NO.:
Specifications, Tolerances and Other Technical Requirements for Commercial Weighing and Measuring Devices 5F-5.001

PURPOSE AND EFFECT: The purpose of this rule is to amend Rule 5F-5.001, F.A.C., to adopt the most recent national standards for weighing and measuring devices developed by the National Conference on Weights and Measures and published in the 2005 edition of National Institute of Standards and Technology Handbook 44. Adoption of the standards provides for uniformity of Florida's requirements with the national requirements to facilitate interstate commerce and trade.

SUBJECT AREA TO BE ADDRESSED: The requirements, including tolerances, specifications and other technical requirements for weighing and measuring devices used for commercial transactions and law enforcement use in the state.

SPECIFIC AUTHORITY: 531.40, 531.41(3) FS.

LAW IMPLEMENTED: 531.40 FS.

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

TIME AND DATE: 10:00 a.m., Monday, February 21, 2005

PLACE: Division of Standards' Conference Room, Suite E, Room 135, Doyle Conner Administration Building, 3125 Conner Boulevard, Tallahassee, Florida 32399-1650

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Max Gray, Bureau Chief, Bureau of Weights and Measures, 3125 Conner Blvd., Bldg. #2, Tallahassee, FL 32399-1650, (850)488-9140

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

5F-5.001 Specifications, Tolerances, and Other Technical Requirements for Commercial Weighing and Measuring Devices.

(1) The specifications, tolerances, and other technical requirements for commercial weighing and measuring devices adopted by the National Conference on Weights and Measures and contained in National Institute of Standards and

Technology (NIST) Handbook 44, 2005 ~~2004~~ Edition, are hereby adopted as rules for the requirements for commercial weighing and measuring devices of the Department of Agriculture and Consumer Services. A copy of NIST Handbook 44, 2005 ~~2004~~ Edition, may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402, Phone (202)512-1800 or http://ts.nist.gov/ts/htdocs/230/235/pubs.htm ~~http://ts.nist.gov/ts/htdocs/230/235/h130-01.htm~~.

(2) The violation of any of the provisions of these rules and regulations is subject to the penalties and remedies provided in the Weights, Measures, and Standards Law, Chapter 531, Florida Statutes.

Specific Authority 531.40, 531.41(3) FS. Law Implemented 531.40 FS. History–New 1-1-73, Amended 7-1-74, 4-18-75, 1-25-76, 1-17-77, 3-29-78, 2-15-79, 6-4-80, 4-5-81, 5-2-82, 6-30-83, 7-15-84, 8-11-85, Formerly 5F-5.01, Amended 7-7-86, 4-5-87, 4-27-88, 5-31-89, 8-21-90, 8-5-91, 12-10-92, 6-21-94, 8-16-95, 10-8-96, 8-27-98, 8-19-99, 7-3-00, 9-3-01, 6-23-02, 6-29-03, 6-21-04,_____.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Division of Standards

RULE TITLE: RULE NO.:

Adoption of Uniform Methods of Sale 5F-7.005

PURPOSE AND EFFECT: The purpose of this rule is to adopt the most recent national standards for the methods of sales of commodities developed by the National Conference on Weights and Measures and published in the 2005 edition of National Institute of Standards and Technology Handbook 130. Adoption of the national standards will make Florida's requirements for methods of sale uniform with the national standards and facilitate interstate commerce and trade.

SUBJECT AREA TO BE ADDRESSED: The methods of sale allowable for commodities being sold by weight, measure or count.

SPECIFIC AUTHORITY: 531.41(3) FS.

LAW IMPLEMENTED: 531.41(4), 531.45 FS.

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

TIME AND DATE: 10:00 a.m., Monday, February 21, 2005

PLACE: Division of Standards' Conference Room, Suite E, Room 135, Doyle Conner Administration Building, 3125 Conner Boulevard, Tallahassee, Florida 32399-1650

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Max Gray, Bureau Chief, Bureau of Weights and Measures, 3125 Conner Blvd., Bldg. #2, Tallahassee, FL 32399-1650, (850)488-9140

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

5F-7.005 Adoption of Uniform Methods of Sale.

The Florida Department of Agriculture and Consumer Services hereby adopts the Uniform Regulation for the Method of Sale of Commodities, as published by the United States Department of Commerce, National Institute of Standards and Technology, NIST Handbook 130, 2005 ~~2004~~ Edition, as the Rule for the method of sale for commodities, and incorporates said uniform regulation herein by this reference. A copy of NIST Handbook 130, 2005 ~~2004~~ Edition, may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402, Phone: (202)512-1800 or http://ts.nist.gov/ts/htdocs/230/235/pubs.htm ~~http://ts.nist.gov/ts/htdocs/230/235/h130-01.htm~~. Copies of this uniform regulation are available from the Division of Standards, Bureau of Weights and Measures, 3125 Conner Boulevard, Lab #2, Tallahassee, Florida 32399-1650, phone: (850)488-9140.

Specific Authority 531.41(3),(4), 531.45 FS. Law Implemented 531.41(3),(4), 531.45 FS. History–New 1-8-90, Amended 6-14-95, 8-27-98, 8-19-99, 7-3-00, 9-3-01, 6-23-02, 6-29-03, 6-21-04,_____.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Division of Standards

RULE TITLE: RULE NO.:

Test Procedures to Determine Acceptable Pricing Practices 5F-12.001

PURPOSE AND EFFECT: The purpose of Rule 5F-12.001, F.A.C., is to amend it to adopt the current publication in which the referenced standard is now found. It previously was published in *National Conference on Weights and Measures (NCWM) Publication 19, 1995 edition*, but is now published in the United States Department of Commerce, National Institute of Standards and Technology, *NIST Handbook 130, 2005 Edition.* This is the most recent publication for uniform weights and measures requirements. Adoption of this current national standard will make Florida's requirements uniform with the national requirements and facilitate interstate commerce and trade.

SUBJECT AREA TO BE ADDRESSED: Test procedures and compliance standards for determining pricing accuracy.

SPECIFIC AUTHORITY: 531.41(3) FS.

LAW IMPLEMENTED: 531.44 FS.

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

TIME AND DATE: 10:00 a.m., Monday, February 21, 2005

PLACE: Division of Standards' Conference Room, Suite E, Room 135, Doyle Conner Administration Building, 3125 Conner Boulevard, Tallahassee, Florida 32399-1650

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Max Gray, Bureau Chief, Bureau of Weights and Measures, 3125 Conner Blvd., Bldg. #2, Tallahassee, FL 32399-1650, (850)488-9140

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

5F-12.001 Test Procedures to Determine Acceptable Pricing Practices.

The Department of Agriculture and Consumer Services hereby adopts the "Examination Procedure for Price Verification" promulgated by the United States Department of Commerce, National Institute of Standards and Technology, NIST Handbook 130, 2005 Edition, ~~found in "National Conference on Weights and Measures (NCWM) Publication 19, 1995 edition",~~ as the Rule for the sampling procedures and compliance standards in testing the accuracy of pricing practices employed by businesses and other entities in the state and incorporates said regulation herein ~~NCWM Publication 19~~ by this reference. A copy of NIST Handbook 130, 2005 Edition, may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402, Phone: (202)512-1800 or http://ts.nist.gov/ts/htdocs/230/235/pubs.htm. ~~A copy of NCWM Publication 19 may be obtained from the National Conference on Weights and Measures, Post Office Box 4025, Gaithersburg, Maryland 20885, Phone: (301)975-4012.~~

Specific Authority 531.41(3) FS. Law Implemented 531.44 FS. History–New 4-9-98, Amended_____.

DEPARTMENT OF EDUCATION

State Board of Education

RULE TITLES:	RULE NOS.:
Special Programs for Students Who are Physically Impaired	6A-6.03015
Special Programs for Students Who are Autistic	6A-6.03023
Special Programs for Students Who are Emotionally Handicapped	6A-6.03016
Special Programs for Students Who are Deaf or Hard-of-Hearing	6A-6.03013

PURPOSE AND EFFECT: The purpose of the rule developments are to incorporate revisions required for programs for students with disabilities by the amendments to the federal law, the Individuals with Disabilities Education Act (IDEA) 20 U.S.C. Chapter 33, and its implementing regulations and to update rule language to reflect current knowledge in the field. The effect of these revisions will be consistency with the federal requirements and current knowledge in the respective fields.

SUBJECT AREA TO BE ADDRESSED: Federal and state requirements for programs for students with disabilities who are identified as emotionally handicapped, deaf or hard-of-hearing, autistic, and physically impaired. Definition, procedures for referral, procedures for student evaluation, criteria for eligibility, re-evaluation, and instructional program.

SPECIFIC AUTHORITY: 1001.02(1), 1003.57(5) FS.

LAW IMPLEMENTED: 1001.03, 1003.01(3), 1003.57(5), 1011.62(1)(c) FS.

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

TIME AND DATES: 8:00 a.m. – 6:00 p.m.; February 24, 2005; April 21, 2005

PLACE: Holiday Inn Select, 316 W. Tennessee Street, Tallahassee, FL 32301

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Bambi Lockman, Chief, Bureau of Exceptional Education and Student Services, Florida Department of Education, 325 West Gaines Street, Room 601, Tallahassee, Florida 32399-0400, (850)245-0475

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

DEPARTMENT OF EDUCATION

Florida School for the Deaf and the Blind

RULE TITLE:	RULE NO.:
President	6D-4.002

PURPOSE AND EFFECT: This rule establishes qualifications and responsibilities of the President of the Florida School for the Deaf and the Blind as its Chief Executive Officer.

SUBJECT AREA TO BE ADDRESSED: Substantive changes to this rule to create, in one rule, instead of several, organization and responsibilities for administrators and other personnel at the Florida School for the Deaf and the Blind.

SPECIFIC AUTHORITY: 1002.36(4)(c) FS.

LAW IMPLEMENTED: 1002.36(4)(e) FS.

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

TIME AND DATE: 9:00 a.m., February 26, 2005

PLACE: Music Building Auditorium, FSDB Campus, St. Augustine, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Elaine F. Ocuto, Executive Assistant to the President, Florida School for the Deaf and the Blind, 207 N. San Marco Avenue, St. Augustine, FL 32084-2799

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

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."

DEPARTMENT OF CITRUS

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Ownership and Use of "Florida Citrus Growers" Certification Mark 20-109
RULE TITLE: RULE NO.:
Standards for Citrus Fruit and Citrus Products Bearing the Mark 20-109.005

PURPOSE AND EFFECT: Modifying standards for use of the "Florida Citrus Growers'" symbol to allow products exceeding maximum ratio Grade A limitations to qualify.

SUBJECT AREA TO BE ADDRESSED: Modifying standards for use of the mark.

SPECIFIC AUTHORITY: 601.10(1), 601.11, 601.15(10)(a) FS.

LAW IMPLEMENTED: 601.101, 601.15(2), 601.9918 FS.

IF REQUESTED 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 IS: Alice P. Wiggins, License and Regulation Specialist, Legal Department, Florida Department of Citrus, P. O. Box 148, Lakeland, Florida 33802-0148

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

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, modify inpatient data formats, and eliminate data elements. The rule amendments require reporting by Internet transmission starting January 1, 2006. The rule amendments require the reporting of inpatient data by long-term psychiatric hospitals and eliminate the reporting of aggregate data by long-term psychiatric hospitals. The rule amendments modify public record formats consistent with the requirements of the federal Health Insurance Portability and Accountability Act.

SUBJECT AREA TO BE ADDRESSED: 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.

SPECIFIC AUTHORITY: 408.15(8) FS.

LAW IMPLEMENTED: 408.061, 408.15(11) FS.

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

TIME AND DATE: 10:00 a.m., February 23, 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 RULE DEVELOPMENT IS: Beth C. Dye, Bureau Chief, State Center for Health Statistics, Agency for Health Care Administration, Building 3, 2727 Mahan Drive, Tallahassee, Florida 32308

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

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(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.

~~(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:~~

~~a. IBM label or nonlabel tapes~~

~~b. Density 1600 or 6250 BPI~~

~~c. 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:~~

~~a. Format – MS-DOS text file (ASCII)~~

~~b. 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:~~

~~a. "HOSPITAL INPATIENT DISCHARGE DATA"~~

~~b. 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~~

~~f. Tape Density: 1600 or 6250 BPI~~

~~g. 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 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. 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)(j), 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 ~~Other~~ – The means by which the patient was admitted to this hospital is not known.

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 primary source of expected reimbursement for services rendered. A required entry. Must be a ~~A~~ one (1) character alpha field using upper case as follows:

1. A – Medicare

2. B – Medicare HMO

3. C – Medicaid

4. D – Medicaid HMO

5. E – Commercial Insurance

6. F – Commercial HMO

7. G – Commercial PPO

8. H – Workers' Compensation

9. I – CHAMPUS

10. J – VA

11. K – Other State/Local Government

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. 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, another 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 physician 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 care 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. ~~A required field up to eight digits containing an aggregate dollar amount charged to the inpatient account.~~ Include charges that 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 twenty four (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	8	384-391
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(c) 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.

~~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 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 Section 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, _____.

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.

SUBJECT AREA TO BE ADDRESSED: Rule renewal dates.

SPECIFIC AUTHORITY: 455.203(5) FS.

LAW IMPLEMENTED: 455.203(1) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Michael Martinez, Special Counsel to the Secretary, Office of the General Counsel, Northwood Centre, 1940 North Monroe Street, Tallahassee, FL 32399

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT 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 Assistants~~	~~February 28~~	
~~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:~~	~~July 31~~	
~~Registered and Advanced Registered Nurse Practitioners~~		
~~Group III:~~		~~April 30~~
~~Registered and Advanced Registered Nurse Practitioners~~		
~~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, _____.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Architecture and Interior Design

RULE TITLE: RULE NO.:

Florida Laws and Rules Examination for Architects 61G1-13.004

PURPOSE AND EFFECT: To establish an examination on Florida Laws and Rules to ensure applicant is appropriately knowledgeable in Florida Laws and Rules.

SUBJECT AREA TO BE ADDRESSED: An examination of Florida Laws and Rules will be added to the criteria for licensure as an architect.

SPECIFIC AUTHORITY: 455 FS.

LAW IMPLEMENTED: 455.217(7) FS.

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

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

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

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Architecture and Interior Design

RULE TITLE:	RULE NO.:
Florida Laws and Rules Examination for Interior Designers	61G1-22.004

PURPOSE AND EFFECT: To establish an examination on Florida Laws and Rules to ensure applicant is appropriately knowledgeable in Florida Laws and Rules.

SUBJECT AREA TO BE ADDRESSED: An examination of Florida Laws and Rules will be added to the criteria for licensure as an interior designer.

SPECIFIC AUTHORITY: 455 FS.

LAW IMPLEMENTED: 455.217(7) FS.

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

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

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

DEPARTMENT OF ENVIRONMENTAL PROTECTION

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 Speech-Language Pathology and Audiology

RULE TITLES:	RULE NOS.:
Continuing Education as a Condition for Renewal or Reactivation	64B20-6.001
Standards for Approval of Continuing Education Activities and Providers	64B20-6.002
Continuing Education Requirements for Activation or Reactivation of an Inactive Status License or Certificate	64B20-6.003

PURPOSE AND EFFECT: The Board proposes to review these sections to decide if amendments are necessary.

SUBJECT AREA TO BE ADDRESSED: Continuing Education as a Condition for Renewal or Reactivation; Standards for Approval of Continuing Education Activities and Providers; Continuing Education Requirements for Activation or Reactivation of an Inactive Status License or Certificate.

SPECIFIC AUTHORITY: 456.013(7), 456.036, 468.1135(4)(a), 468.1195(1),(3), 468.1205(1) FS.

LAW IMPLEMENTED: 456.013(7), 456.036, 468.1195(1),(3), 468.1205(1) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Pamela E. King, Executive Director, Board of Speech-Language Pathology and Audiology, 4052 Bald Cypress Way, Bin #C06, Tallahassee, Florida 32399

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

DEPARTMENT OF HEALTH

Board of Speech-Language Pathology and Audiology

RULE TITLE:	RULE NO.:
Place of Practice	64B20-9.003

PURPOSE AND EFFECT: The Board intends to review this section to decide if amendments are necessary.

SUBJECT AREA TO BE ADDRESSED: Place of Practice.

SPECIFIC AUTHORITY: 468.1135(4) FS.

LAW IMPLEMENTED: 456.035 FS.

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

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

E. King, Executive Director, Board of Speech-Language Pathology and Audiology, 4052 Bald Cypress Way, Bin #C06, Tallahassee, Florida 32399

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

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Family Safety and Preservation Program

RULE CHAPTER TITLE: RULE CHAPTER NO.:
In-Home Protective Services 65C-11

PURPOSE AND EFFECT: This rule outlines the procedures the Department and contracted agencies will use in providing in-home protective supervision to dependent children.

SUBJECT AREA TO BE ADDRESSED: In-Home Protective Services.

SPECIFIC AUTHORITY: 39.0121 FS.

LAW IMPLEMENTED: 39.01, 39.401, 39.521, 39.601, 39.701 FS.

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

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 21, 2005

PLACE: Hilton Tampa, 2225 North Lois Avenue, Tampa, FL 33607

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 28, 2005

PLACE: Hilton Fort Lauderdale/Sunrise, 3003 North University Drive, Sunrise, Florida 33322

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Ed Cox, Department of Children and Family Services, 1317 Winewood Blvd., Bldg. 6, Room 159, Tallahassee, FL 32399-0700, (850)922-2298

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

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Family Safety and Preservation Program

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Licensed Out-of-Home Care 65C-13

PURPOSE AND EFFECT: This rule outlines the procedures the Department and contracted agencies will use in the creation of licensed foster homes.

SUBJECT AREA TO BE ADDRESSED: Licensed Out-of-Home Care.

SPECIFIC AUTHORITY: 39.0121, 409.175 FS.

LAW IMPLEMENTED: 39.4085, 409.175 FS.

F REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIMES, DATES AND PLACES SHOWN BELOW:

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 21, 2005

PLACE: Hilton Tampa, 2225 North Lois Avenue, Tampa, FL 33607

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 28, 2005

PLACE: Hilton Fort Lauderdale/Sunrise, 3003 North University Drive, Sunrise, Florida 33322

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Ed Cox, Department of Children and Family Services, 1317 Winewood Blvd., Bldg. 6, Room 159, Tallahassee, FL 32399-0700, (850)922-2298

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

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Family Safety and Preservation Program

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Child-Placing Agencies 65C-15

PURPOSE AND EFFECT: This rule specifies the requirements for the creation of licensed child-placing agencies.

SUBJECT AREA TO BE ADDRESSED: The requirements for the creation of child-placing agencies.

SPECIFIC AUTHORITY: 409.175 FS.

LAW IMPLEMENTED: 409.175 FS.

F REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIMES, DATES AND PLACES SHOWN BELOW:

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 21, 2005

PLACE: Hilton Tampa, 2225 North Lois Avenue, Tampa, FL 33607

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 28, 2005

PLACE: Hilton Fort Lauderdale/Sunrise, 3003 North University Drive, Sunrise, Florida 33322

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Ed Cox, Department of Children and Family Services, 1317 Winewood Blvd., Bldg. 6, Room 159, Tallahassee, FL 32399-0700, (850)922-2298

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

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Family Safety and Preservation Program

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Out-of-Home Care 65C-28

PURPOSE AND EFFECT: This rule outlines the procedures the Department and contracted agencies will use in providing protective supervision to dependent children in licensed out-of-home care.

SUBJECT AREA TO BE ADDRESSED: Out-of-Home Care.

SPECIFIC AUTHORITY: 39.0121, 409.175 FS.

LAW IMPLEMENTED: 39.01, 39.4085, 39.521, 39.601, 39.701, 409.175 FS.

F REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIMES, DATES AND PLACES SHOWN BELOW:

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 21, 2005

PLACE: Hilton Tampa, 2225 North Lois Avenue, Tampa, FL 33607

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 28, 2005

PLACE: Hilton Fort Lauderdale/Sunrise, 3003 North University Drive, Sunrise, Florida 33322

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Ed Cox, Department of Children and Family Services, 1317 Winewood Blvd., Bldg. 6, Room 159, Tallahassee, FL 32399-0700, (850)922-2298

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

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Family Safety and Preservation Program

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Protective Investigations 65C-29

PURPOSE AND EFFECT: This rule outlines the procedures the Department and contracted agencies will use in carrying out protective investigations.

SUBJECT AREA TO BE ADDRESSED: Protective Investigations.

SPECIFIC AUTHORITY: 39.0121 FS.

LAW IMPLEMENTED: 39.301, 39.302, 39.304, 39.308, 39.402 FS.

F REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIMES, DATES AND PLACES SHOWN BELOW:

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 21, 2005

PLACE: Hilton Tampa, 2225 North Lois Avenue, Tampa, FL 33607

TIME AND DATE: 9:00 a.m. – 5:00 p.m., February 28, 2005

PLACE: Hilton Fort Lauderdale/Sunrise, 3003 North University Drive, Sunrise, Florida 33322

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Ed Cox, Department of Children and Family Services, 1317 Winewood Blvd., Bldg. 6, Room 159, Tallahassee, FL 32399-0700, (850)922-2298

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

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Mental Health Program

RULE TITLES:	RULE NOS.:
Applicability	65E-16.001
Requirements to Participate for Providers	65E-16.002
Pharmacy Requirements	65E-16.003
Eligibility Criteria for Individuals	65E-16.004
Continuity of Care with State Hospitals	65E-16.005
Formulary	65E-16.006
Sanctions	65E-16.007

PURPOSE AND EFFECT: Chapter 65E-16, F.A.C., entitled Rules for the Indigent Drug Program, is being developed to establish administrative requirements for the purchase of psychiatric medications for eligible clients not residing in a state mental health treatment facility or an inpatient unit.

SUBJECT AREA TO BE ADDRESSED: Chapter 65E-16, F.A.C., is being developed to: establish financial and clinical eligibility criteria for clients receiving services under the indigent drug program; establish requirements that community-based providers must meet to participate in the program; and establish the sanctions to be applied for failure to meet the requirements of this rule.

SPECIFIC AUTHORITY: 394.676 FS.

LAW IMPLEMENTED: 394.676 FS.

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

TIME AND DATE: 10:00 a.m., Thursday, March 3, 2005

PLACE: The Department of Children and Family Services, 1317 Winewood Boulevard, Building 6, Conference Room A, Tallahassee, Florida 32399-0700

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Amy Johnson, Department of Children and Family Services, Mental Health Program Office, 1317 Winewood Boulevard, Building 6, Room 260, Tallahassee, Florida 32399-0700

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

65E-16.001 Applicability.

As used in this chapter the following words and phrases have the following definitions:

(1) Provider – Means agencies that contract with the district Substance Abuse and Mental Health Program Office of the Department of Children and Families to provide and be reimbursed for mental health and/or substance abuse services rendered in accordance with their contract.

(2) Formulary – Means a listing of medications available through the IDP Warehouse to agencies participating in the Indigent Drug Program.

(3) IDP – Means Indigent Drug Program which provides psychotropic medications for individuals served by the Department who have a mental illness, reside in the community and do not have other means of purchasing psychotropic medications.

(4) IDP Dispensing Unit – Means a pharmacy holding a current permit from the Florida Board of Pharmacy that dispenses medication for the Indigent Drug Program.

(5) IDP Warehouse – Means a physical space located on the campus of Florida State Hospital in Chattahoochee, Florida, reserved for receiving, storage and shipping of IDP medications.

(6) Eligible Recipient – Means individuals identified as members of one or more of the Substance Abuse or Mental Health target populations.

(7) Side effects and adverse effects – Any effect other than the primary intended effect resulting from medication treatment. Side effects may be negative, neutral, or positive for the patient. Adverse effects are undesired or toxic reactions to medications that must be reported to healthcare providers.

Specific Authority 394.676 FS. Law Implemented 394.676 FS. History–New _____.

65E-16.002 Requirements to Participate for Providers.

(1) Substance Abuse and Mental Health district offices and managing entities are responsible for the fiscal and programmatic coordination of the IDP in their district.

(2) No provider shall enroll individuals receiving pharmaceuticals under the IDP, or recruit applicants as subjects, in any type of human-subjects research, including surveys, without prior review and written approval by the Florida Department of Health's Review Council for Human Subjects.

(3) All prescriptions dispensed through the IDP must be:

(a) Prescribed by a clinician licensed under Chapter 458 or 459, F.S., or by a clinician licensed under Chapter 464, F.S., who has a protocol with a collaborative clinician licensed under Chapter 458 or 459, F.S., and

(b) Reviewed, not less than once every 90 calendar days, through personal contact with the recipient, by a Florida licensed practitioner(s), per Chapter 458, 459, or 464, F.S.

(4) All direct care and professional staff having contact with individuals participating in the IDP will be given competency-based training by the provider on how to recognize, report, and document medication side effects, adverse effects, and possible allergic reactions. This competency-based training will occur within the first six months of employment and annually thereafter and be documented in the employee's personnel record or in the provider's staff development files.

(5) Participation in services by individuals receiving IDP medications, other than those services directly related to medication monitoring, shall not be required as a condition of participation in the IDP.

(6) Providers participating in IDP shall not require an individual to have previously failed on a less expensive or traditional medication as a prerequisite to prescribing a newer, more costly medication.

(7) During the initial medication appointment, the provider shall determine each individual's eligibility. If the individual is eligible for the IDP, and is not currently enrolled with Medicaid, the provider shall simultaneously offer assistance to the individual in attaining Medicaid eligibility and enrollment.

(8) Many pharmaceutical companies offer free psychotropic medications, for individuals who are indigent. These are known as Patient Assistance Programs (PAP). Participation in the IDP requires active provider participation in PAP programs. The provider shall:

(a) Determine which PAP(s), if any, an individual is eligible for;

(b) Assist eligible individuals in applying for the PAP(s); and

(c) If an individual is eligible for free psychotropic medications, they shall receive medications from the IDP until their PAP medications become available.

(9) For each IDP participant, the provider's clinical record shall include:

(a) A psychiatric evaluation with a current DSM or ICD diagnosis, made or reviewed within less than 366 days or more frequently, as warranted by the individual's condition. The psychiatric evaluation shall meet the requirement as outlined in subsection 65E-5.180(3), F.A.C.;

(b) An active treatment/service plan that addresses the symptoms for which medications are being prescribed.

(10) Education about the medication side effects, benefits and interactions with other medications and foods, shall be offered to each individual in care, based upon their current situation, diagnoses and needs with respect to the psychotropic medication they are prescribed.

(a) Education shall be provided in private sessions if requested, so confidential questions may be asked and answered.

(b) Participation in group education and discussions shall be voluntary.

(c) Education and training regarding psychotropic medication shall be sufficient to meet the Section 394.459(3), F.S., definition and intent encompassing "express and informed consent."

(11) The clinician will obtain written express and informed consent for prescribed psychotropic medications from the recipient or if the individual is incompetent to consent to treatment, the duly authorized substitute decision maker consistent with Rule 65E-5.170, F.A.C. and Section 394.459(3), F.S.

(12) Providers shall not impose additional requirements for IDP eligibility beyond those in this rule and through contractual agreements.

(13) Providers shall make every reasonable effort to use the most cost efficient means of procuring medications.

Specific Authority 394.676 FS. Law Implemented 394.676 FS. History–New _____.

65E-16.003 Pharmacy Requirements.

(1) All IDP providers shall either be authorized by law to administer or dispense prescription drugs consistent with Section 499.012(1)(d), F.S. or shall contract with private licensed pharmacies as defined by Section 465.003(11)(a), F.S.

(a) A current copy of the applicable license shall be provided annually to the Florida State Hospital, IDP Program.

(2) Pharmacies may charge a dispensing fee. Other than the dispensing fee, no co-pays, fees, assessment or initiation charges to individuals shall be permitted except as expressly permitted in Rule 65E-14.018, F.A.C. The amount of the dispensing fee shall not exceed the amount of the dispensing fee charged for an individual enrolled in the Florida Medicaid program. These fees can be charged to the recipient or the provider may reimburse the pharmacies on a monthly or quarterly basis. The dispensing fee may be paid with IDP funds for individuals who are not able to pay.

(3) IDP medications will be dispensed by a licensed pharmacist or prescriber duly licensed to dispense medications in Florida. All applicable state and federal laws and rules related to the dispensing and labeling of medications shall be followed, including but not limited to Chapters 465, 893, F.S., and Chapter 64B1-6, F.A.C.

Specific Authority 394.676 FS. Law Implemented 394.676 FS. History–New _____.

65E-16.004 Eligibility Criteria for Individuals.

(1) To be determined eligible for the IDP program each individual must meet both clinical and financial criteria.

(1) Clinical Eligibility for Individuals.

(a) Eligible individuals shall be enrolled pursuant to the guidelines established in Rule 65E-14.022, F.A.C. Individuals currently residing in a state mental health treatment facility or inpatient unit are not eligible for IDP medications. Having a co-occurring developmental disability or having a substance abuse disorder shall not disqualify an individual from eligibility for the IDP.

(2) Financial Eligibility for Individuals.

(a) Annual income is at or below 150% of the Federal Poverty Income Guidelines, as published annually in the Federal Register.

(b) No other third-party insurance or other source of psychotropic medications available (such as private insurance, Medicaid, Medicare, nor is the individual in a program where psychotropic medications are provided).

(c) The individual is not receiving all prescribed psychotropic medications through one or more Patient Assistance Programs.

(d) If the individual has third party insurance for psychotropic medications but has temporarily been denied benefits for these medications, they may receive IDP medications until such time as eligibility has been reestablished.

Specific Authority 394.676 FS. Law Implemented 394.676 FS. History–New _____.

65E-16.005 Continuity of Care with State Hospitals.

The following special consideration shall be given to individuals who are discharged from state mental health treatment facilities to providers in order to ensure appropriate continuity of care with respect to psychotropic medications:

(1) The provider shall not change the psychotropic medications in use at the time of discharge for a period of at least 90 days, post discharge, unless there is a written clinical rationale by the prescribing practitioner for the change.

(2) The provider shall follow the guidelines established in paragraph 65E-5.1303(2)(d),(e), F.A.C, and Rule 65E-5.1305, F.A.C., in scheduling appointments.

Specific Authority 394.676 FS. Law Implemented 394.676 FS. History–New _____.

65E-16.006 Formulary.

Participating providers must offer the full IDP formulary, effective December 10, 2004, which is hereby incorporated by reference.

Specific Authority 394.676 FS. Law Implemented 394.676 FS. History–New _____.

65E-16.007 Sanctions.

(1) Providers shall be bound to this Rule through their contract with the District Substance Abuse and Mental Health Program Office and, therefore, may be subject to a compliance audit.

(2) Any provider found to be out of compliance with this rule may be required to submit a performance improvement plan addressing the issues of non-compliance to their District Substance Abuse and Mental Health Program Office.

(3) Failure to provide a performance improvement plan or failure to implement this plan may result in the provider having their allocation withheld until compliance is attained. If they have already received their fourth quarter allocation, their next year's first quarter allocation may be withheld until they have achieved compliance.

The following document is hereby incorporated by reference, copies of which may be obtained from the Florida State Hospital, Attention: Pharmacy Department, Indigent Drug Program, Post Office Box 1000 Chattahoochee, Florida 32324: IDP Formulary, December 10, 2004.

Specific Authority 394.676 FS. Law Implemented 394.676 FS. History–New _____.

FLORIDA HOUSING FINANCE CORPORATION

RULE TITLES:	RULE NOS.:
Purpose and Intent	67-50.001
Definitions	67-50.005
Fees	67-50.010
Notice of Funding Availability (NOFA)	67-50.020
General Program Eligible Activities	67-50.030
General Program Restrictions	67-50.040
HAP Program Restrictions	67-50.050
HOME Program Restrictions	67-50.060
Application and Selection Procedures	67-50.070
Credit Underwriting Procedures	67-50.080
Disbursement of Funds, Draw Requests, and Loan Servicing	67-50.090
Reallocation for Disaster Areas	67-50.105

PURPOSE AND EFFECT: The purpose of this Rule Chapter is to establish the procedures by which the Corporation shall:

(1) Administer the Application process, determine loan amounts, and service loans to Developers for the construction of affordable housing under the Florida Homeownership Assistance Program (HAP)/Construction Loan Program and provide purchase assistance to Eligible Homebuyers under the HAP Permanent Loan Program; and

(2) Administer the Application process, determine loan amounts, and service loans to Developers for the construction of affordable housing and provide purchase assistance to Eligible Homebuyers under the HOME Investment Partnerships (HOME) Homeownership Program. The adoption of these revisions will increase the efficiency and effectiveness of the Program.

SUBJECT AREA TO BE ADDRESSED: The Rule Development Workshop will be held to receive comments and suggestions from interested persons relative to program requirements as specified in Rule Chapter 67-50, Florida Administrative Code.

SPECIFIC AUTHORITY: 420.507, 420.5088, 420.5089 FS.

LAW IMPLEMENTED: 420.507(23), 420.5088, 420.5089(2) FS.

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

TIME AND DATE: 2:00 p.m. – 4:00 p.m., Tuesday, February 22, 2005

PLACE: Florida Housing Finance Corporation, Seltzer Conference Room, 227 North Bronough Street, Tallahassee, FL 32301, (850)488-4197

Any person requiring special accommodation at this hearing because of a disability or physical impairment should contact Elizabeth Loggins at the address below. If you are hearing or speech impaired, please use the Florida Dual Party Relay system, 1(800)955-8770 (Voice) or 1(800)955-9771 (TDD).

The preliminary text of the proposed rule development shall be posted on Florida Housing Finance Corporation's web site: www.floridahousing.org, when available.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Elizabeth Loggins, Homeownership Loan Program Administrator, Florida Housing Finance Corporation, 227 North Bronough Street, Tallahassee, Florida 32301, (850)488-4197

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

DEPARTMENT OF FINANCIAL SERVICES

Division of Consumer Services

RULE TITLE:	RULE NO.:
Alternative Procedures for Resolution of Disputed Personal Lines Insurance Claims Arising From Hurricane and Tropical Storm Damage	69J-2.001

PURPOSE AND EFFECT: This rule establishes a special mediation program for personal lines residential insurance claims resulting from Hurricanes Charley, Frances, Ivan and Jeanne and Tropical Storm Bonnie. The rule creates procedures for notice of the right to mediation, request for mediation, assignment of mediators, payment for mediation, conduct of mediation, and guidelines for the quality repair of residential property damage.

SUBJECT AREA TO BE ADDRESSED: A mediation program for the resolution of disputed residential insurance claims and guidelines for the quality repair of residential property damaged by Hurricanes Charley, Frances, Ivan and Jeanne and Tropical Storm Bonnie.

SPECIFIC AUTHORITY: 624.308, 626.9611, 627.7015(4) FS.
LAW IMPLEMENTED: 624.307(1),(2),(4),(5), 624.316, 624.3161, 624.317, 624.318, 624.320, 624.324, 624.418(2)(a), 624.4211, 626.859, 626.874, 626.877, 626.9541(1)(a),(e),(i),(u), 626.9561, 626.9641(1)(g), 627.7015 FS.
IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:
TIME AND DATE: 10:00 a.m., February 22, 2005
PLACE: Room 116, Larson Building, 200 E. Gaines Street, Tallahassee, Florida
THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Tom Terfinko, Assistant Director, Division of Consumer Services, Department of Financial Services, 200 East Gaines Street, Tallahassee, FL 32399-0320, (850)413-5802

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

69J-2.001 Alternative Procedures for Resolution of Disputed Personal Lines Insurance Claims Arising From Hurricane and Tropical Storm Damage.

(1) Purpose and Scope. This rule implements Section 627.7015, Florida Statutes, by setting forth a non-adversarial alternative dispute resolution procedure for a facilitated claim resolution conference prompted by the critical need for effective, fair, and timely handling of personal lines insurance claims arising out of damages to residential property caused by hurricanes and tropical storms during the 2004 hurricane season (June 1, 2004 through November 30, 2004). This rule also addresses guidelines for the quality repair of residential property damaged by Hurricanes Charley, Frances, Ivan and Jeanne and Tropical Storm Bonnie at reasonable and fair prices. Before resorting to these procedures, insureds and insurers are encouraged to resolve claims as quickly and fairly as possible. The procedure established by this rule is available to all first party claimants who have personal lines claims resulting from damage to residential property occurring in the State of Florida. This rule does not apply to commercial insurance, private passenger motor vehicle insurance or to liability coverage contained in property insurance policies.

(2) Definitions. The following definitions apply to the terms of this rule as used herein.

(a) "Administrator" means the Department or its designee, and the term is used interchangeably with regard to the Department's duties under this rule.

(b) "Claim" means any matter on which there is a dispute or for which the insurer has denied payment. Unless the parties agree to mediate a claim involving a lesser amount, a "claim" involves the insured requesting $500 or more to settle the dispute, or the difference between the positions of the parties is $500 or more, in either case, notwithstanding any applicable deductible. "Claim" does not include a dispute with respect to which the insurer has reported allegations of fraud, based on an investigation by the insurer's special investigative unit, to the Department's Division of Insurance Fraud.

(c) "Department" means the Department of Financial Services or its designee. Reporting to the Department shall be directed to: Department of Financial Services, Mediation Section, Bureau of Insurance Consumer Assistance, Tallahassee, Florida 32399-0322; or by facsimile to (850)488-2349.

(d) "Mediator" means an individual selected by the Department to mediate disputes pursuant to this rule. The mediators will be selected from a panel of Circuit Court – Civil mediators approved by the Florida Supreme Court pursuant to the Florida Rules of Certified and Court Appointed Mediators or from the list of approved mediators pursuant to Rule 69B-166.031, Florida Administrative Code.

(e) "Party" or "Parties" means the insured and his or her insurer, including Citizens Property Insurance Corporation, when applicable.

(3) Notification of Right to Mediate. The insurer shall mail a notice of the right to mediate disputed claims to the insured within 5 days of the time the policyholder or the Department notifies an insurer of a dispute regarding the policyholder's claim. If the insurer has not been notified of a disputed claim prior to the time an insurer notifies the insured that a claim has been denied in whole or in part, the insurer shall mail a notice of the right to mediate disputed claims to the insured in the same mailing as a notice of denial. However, the insurer is not required to send a notice of the right to mediate disputed claims if a claim is denied because the amount of the claim is less than the policyholder's deductible. For disputed claims identified prior to October 11, 2004, Rule 69BER04-18 required insurers to send the notice to insureds no later than October 25, 2004. This requirement is not negated by this rule and therefore any insurer that failed to do so is subject to administrative penalty for violation of a Department rule. The mailing that contains the notice of the right to mediate may include the Department's consumer brochure on mediation but no other materials, forms or documents may be included. Notification shall be in writing and shall be legible, conspicuous, and printed in at least 12-point type. The first paragraph of the notice shall contain the following statement: "Tom Gallagher, Chief Financial Officer for the State of Florida, has adopted an emergency rule to facilitate fair and timely handling of residential property insurance claims arising out of the hurricanes that have recently devastated so many homes in Florida. The emergency rule gives you the right to attend a mediation conference with your insurer in order to settle any dispute you have with your insurer about your claim. You can start the mediation process 21 days after the date of this notice by calling the Department of Financial

Services at 1(800)227-8676 (1(800)22-Storm). An independent mediator, who has no connection with your insurer, will be in charge of the mediation conference." The notice shall also:

(a) Include detailed instructions on how the insured is to request mediation, including name, address, and phone and fax numbers for requesting mediation through the Department;

(b) State that the parties have 21 days from the date of the notice within which to settle the claim before the insured may request mediation;

(c) Include the insurer's address and phone number for requesting additional information; and

(d) State that the Department or the Administrator will select the mediator.

(4) Request for Mediation. After 21 days from the date of the notice of the right to mediation, an insured may request mediation by contacting the insurer or by writing to the Department of Financial Services, Mediation Section, Bureau of Insurance Consumer Assistance, Tallahassee, Florida 32399-0322; by calling the Department at 1(800)22-Storm (1(800)227-8676); or by faxing a request to the Department at (850)488-2349. If an insured requests mediation prior to receipt of the notice of the right to mediation or if the date of the notice cannot be established, the insurer shall be notified by the Department of the existence of the dispute 21 days prior to the Administrator processing the insured's request for mediation. If an insurer receives a request for mediation, the insurer shall fax the request to the Mediation Section within 48 hours of receipt of the request. The Department will forward requests to the Administrator within 24 hours of receipt of the requests. The Administrator shall notify the insurer within 48 hours of receipt of requests filed with the Department. The insured should provide the following information if known:

(a) Name, address, and daytime telephone number of the insured and location of the property if different from the address given;

(b) The claim and policy number for the insured;

(c) A brief description of the nature of the dispute; and

(d) The name of the insurer and the name, address and phone number of the contact person for scheduling mediation.

(e) Information with respect to any other policies of insurance that may provide coverage of the insured property for named perils such as flood or windstorm.

(5) Mediation Costs. Within 5 days of receipt of the request for mediation from the insured or receipt of notice of the request from the Department or immediately after receipt of notice from the Administrator pursuant to subsection (4) that mediation has been requested, whichever occurs first, the insurer shall pay a non-refundable administrative fee, not to exceed $100, as determined by the Department, to the Administrator to defer the expenses of the Administrator and the Department. The insurer shall pay $250 to the Administrator for the mediator's fee not later than 5 days prior to the date scheduled for the mediation conference. However, if the mediation is cancelled for any reason more than 120 hours prior to the scheduled mediation time and date, the insurer shall pay $50 to the Administrator for the mediator's fee instead of $250. No part of the fee for the mediator shall be refunded to the insurer if the conference is cancelled within 120 hours of the scheduled time.

(6) Scheduling of Mediation. The Administrator will select a mediator and schedule the mediation conference. The Administrator will attempt to facilitate reduced travel and expense to the parties and the mediator when selecting a mediator and scheduling the mediation conference. The Administrator shall confer with the mediator and all parties prior to scheduling a mediation conference. The Administrator shall notify each party in writing of the date, time and place of the mediation conference at least 10 days prior to the date of the conference and concurrently send a copy of the notice to the Department. The insurer shall notify the Administrator as soon as possible after settlement of any claim that is scheduled for mediation pursuant to this rule.

(7) Conduct of the Mediation Conference.

(a) Section 627.7015, Florida Statutes, provides that mediation is a non-adversarial process held in an informal, non-threatening forum intended to bring the parties together for a settlement conference without the trappings or drawbacks of an adversarial process. As such, it is not necessary to involve a private attorney and participation by private attorneys is discouraged by the Department. If the insured elects to have an attorney participate in the conference, the insured shall provide the name of the attorney to the Administrator at least six days before the date of the conference. Parties and their representatives must conduct themselves in the cooperative spirit of the intent of the law and this rule. Parties and their representatives must refrain from turning the conference into an adversarial process. Both parties must negotiate in good faith. A party will be determined to have not negotiated in good faith if the party, or a person participating on the party's behalf, continuously disrupts, becomes unduly argumentative or adversarial, or otherwise inhibits the negotiations as determined by the mediator. The mediator shall terminate the conference if the mediator determines that either party is not negotiating in good faith or if the mediator determines that the conference should be terminated under the provisions of Rule 10.420(b) of the Florida Rules for Certified and Court-Appointed Mediators. The party responsible for causing termination shall be responsible for paying the mediator's fee and the administrative fee for any rescheduled mediation.

(b) Upon request of the insured or the mediator, a representative of the Department will be available to help insureds prepare for the mediation conferences. A representative of the Department will be present at and participate in the conference if requested at least 5 days prior to the scheduled mediation by a party or the mediator to offer

guidance and assistance to the parties. The Department will attempt to have a representative at the conference if the request is received less than 5 days prior to the scheduled mediation. Representatives of the Department that participate in the conference shall not assume an advocacy role but shall be available to provide legal and technical insurance information.

(c) The representative of the insurer attending the conference must bring a copy of the policy and the entire claims file to the conference. The representative of the insurer attending the conference must know the facts and circumstances of the claim and be knowledgeable of the provisions of the policy. An insurer will be deemed to have failed to appear if the insurer's representative lacks authority to settle the full amount of the claim or lacks the ability to disburse the settlement amount at the conclusion of the conference.

(d) The mediator will be in charge of the conference and will establish and describe the procedures to be followed. Mediators shall conduct the conference in accordance with the standards of professional conduct for mediation under the Florida Rules of Certified and Court-Appointed Mediators. Each party will be given an opportunity to present their side of the controversy. In so doing, parties may utilize any relevant documents and may bring any individuals with knowledge of the issues, such as adjustors, appraisers, or contractors, to address the mediator. The mediator may meet with the parties separately, encourage meaningful communications and negotiations, and otherwise assist the parties to arrive at a settlement. For purposes of this claims settlement process, mediators shall be deemed agents of the Department and shall have the immunity from suit provided to mediators in Section 44.107, Florida Statutes. All statements made and documents produced at a settlement conference shall be deemed settlement negotiations in anticipation of litigation.

(e) A party may move to disqualify a mediator for good cause at any time. The request shall be directed to the Department if the grounds are known prior to the mediation conference. Good cause consists of conflict of interest between a party and the mediator, inability of the mediator to handle the conference competently, or other reasons that would reasonably be expected to impair the conference.

(f) If the insured fails to appear, without good cause as determined by the Department, the insured may have the conference rescheduled only upon the insured's payment of the mediation fees for the rescheduled conference. If the insurer fails to appear at the conference, without good cause as determined by the Department, the insurer shall pay the insured's actual expenses incurred in attending the conference and shall pay the mediator's fee whether or not good cause exists. Failure of a party to arrive at the mediation conference within 30 minutes of the conference's starting time shall be considered a failure to appear. Good cause shall consist of severe illness, injury, or other emergency which could not be controlled by the insured or the insurer and, with respect to an insurer, could not reasonably be remedied prior to the conference by providing a replacement representative or otherwise. If an insurer fails to appear at conferences with such frequency as to evidence a general business practice of failure to appear, the insurer shall be subject to penalty, including suspension, revocation, or fine for violating Section 626.9541(1)(i), Florida Statutes.

(8) Guidelines for the Quality Repair Of Residential Property at a Reasonable and Fair Price.

(a) The provisions of insurance policies and applicable statutes require claims payments made by insurers to be sufficient to effectuate required repairs. Further, misrepresentation by any person regarding the cost of repairs is also prohibited. The Department of Financial Services has developed construction pricing guidelines based upon information provided by the construction industry, the insurance industry and nationally recognized vendors that compile and sell construction pricing guidelines. Insurers and policyholders participating in mediations conducted pursuant to this rule shall use Form DFS-I1-1610 Guidelines for Quality Repair of Residential Property At A Reasonable and Fair Price, rev. 12/04, hereby incorporated and adopted by reference, as guidelines for repairs to residential property arising in any county of this state in which a state of emergency was declared as a result of a hurricane or tropical storm in 2004. These guidelines are not intended to be used in the context of civil litigation. The guidelines reflect data from both the construction and insurance industries and the ranges take into consideration price differentials between geographic areas of the state.

(b) The guidelines adopted herein do not apply to any portion of repairs necessary to fulfill the insurer's contractual obligation to restore the insured residence to pre-hurricane condition where, as of the effective date of this rule, there is an executed repair contract to effectuate such repairs for an agreed price and the insurer has tendered full payment for the repair contract amount for those repairs.

(9) Post Mediation. Within 5 days of the conclusion of the conference, the mediator shall file with the Department and the Administrator a mediator's status report on Form DFS-HO-1159, which is entitled Disposition of Property Insurance Mediation Conference, indicating whether or not the parties reached a settlement. Form DFS-HO-1159 is available from the Department and is hereby incorporated in this rule by reference. If the parties reached a settlement, the mediator shall include a copy of the settlement agreement with the status report. Mediation is non-binding. However, if a settlement is reached, the insured shall have 3 business days within which he or she may rescind any settlement agreement provided that the insured has not cashed or deposited any check or draft disbursed to him or her for the disputed matters as a result of the conference. If a settlement agreement is reached and is not

rescinded, it shall act as a release of all specific claims that were presented in the conference. Any additional claims under the policy shall be presented as separate claims. However, the release shall not constitute a final waiver of rights of the insured with respect to claims for damages or expenses if circumstances that are reasonably unforeseen arise resulting in additional costs that would have been covered under the policy but for the release.

(10) If the insured decides not to participate in this claim resolution process or if the parties are unsuccessful at resolving the claim, the insured may choose to proceed under the appraisal process set forth in the insured's insurance policy, by litigation, or by any other dispute resolution procedure available under Florida law.

(11) If as a result of mediation it is determined that the only coverage applicable is provided under the National Flood Insurance Program, the administrative fee and mediator's fee paid by the insurer for the mediation shall be refunded to the insurer or credited to the insurer's account with the Administrator.

(12) The Department is authorized to designate an entity or person as its Administrator to carry out any of the Department's duties under this rule.

(13) If a court holds any subsection or portion of a subsection of this rule or the applicability thereof to any person or circumstance invalid, the remainder of the rule shall not be affected thereby.

(14) The applicable provisions of Rule 69B-166.031, Florida Administrative Code, shall govern issues relating to mediation that are not addressed in this rule. The provisions of this rule shall govern in the event of any conflict with the provisions of Rule 69B-166.031, Florida Administrative Code.

(15) This mediation program will expire on December 31, 2005.

Specific Authority 624.308, 626.9611, 627.7015(4) FS. Law Implemented 624.307(1)(2)(4)(5), 624.316, 624.3161, 624.317, 624.318, 624.320, 624.324, 624.418(2)(a), 624.4211, 626.859, 626.874, 626.877, 626.9541(1)(a),(e),(i),(u), 626.9561, 626.9641(1)(g), 627.7015 FS. History–New _____.

Section II
Proposed Rules

DEPARTMENT OF COMMUNITY AFFAIRS

Division of Community Planning

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Rules of Procedure and Practice Pertaining to Developments of Regional Impact	9J-2
RULE TITLE:	RULE NO.:
Development of Regional Impact Review Fee Rule	9J-2.0252

PURPOSE, EFFECT AND SUMMARY: To adopt uniform criteria for the assessment and collection of fees to fund the regional planning agencies' direct and indirect costs of conducting the DRI review process.

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

SPECIFIC AUTHORITY: 380.032(2)(a), 380.06(23)(a),(d) FS.

LAW IMPLEMENTED: 380.06(23)(d) 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: 1:30 p.m., March 2, 2005

PLACE: Randall Kelly Training Center, Sadowski Building, Room 305, Department of Community Affairs, 2555 Shumard Oak Boulevard, Tallahassee, Florida 32399-2100

Any person requiring special accommodation at the hearing because of a disability or physical impairment should contact Beth Barineau, Administrative Secretary, 2555 Shumard Oak Boulevard, Tallahassee, Florida 32399-2100, (850)922-1757, Suncom 292-1757, at least seven days before the date of the hearing. If you are hearing or speech impaired, please contact the Department of Community Affairs using the Florida Dual Party Relay System, 1(800)955-8770 (Voice) or 1(800)955-9771 (TDD).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: James Stansbury, Principal Planner, Division of Community Planning, 2555 Shumard Oak Boulevard, Tallahassee, Florida 32399-2100, (850)922-1818, Suncom 292-1818

THE FULL TEXT OF THE PROPOSED RULE IS:

9J-2.0252 Development of Regional Impact Review Fee Rule.

(1) through (2) No change.

(3) ALLOWABLE CHARGES.

(a) The applicant shall be liable to the regional planning agency for 100% of the actual costs, both direct and indirect, of coordinating or reviewing an application for development approval, an application for development approval of a substantial deviation, an application for development designation, or an application for development designation of a substantial change.

Each regional planning agency shall develop a cost allocation plan which addresses direct and indirect costs in compliance with the Office of Management and Budget Circular A-87, for use in its operations, including management of the DRI review