Section I
Notices of Development of Proposed Rules and Negotiated Rulemaking

DEPARTMENT OF EDUCATION

State Board of Education

RULE TITLE: RULE NO.:
Course Requirements – Grades 6-12 Basic and Adult Secondary Programs 6A-1.09412

PURPOSE AND EFFECT: The purpose of the rule development is to review the current course descriptions to ensure that reading courses are clearly articulated. The effect will be the addition and/or deletion of course descriptions relating to reading.

SUBJECT AREA TO BE ADDRESSED: Course Descriptions.

SPECIFIC AUTHORITY: 1011.62(1)(r) FS.

LAW IMPLEMENTED:1011.62 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. – 12:00 Noon, May 9, 2005

PLACE: Ballroom A, Rosen Center Hotel, 9840 International Drive, Orlando, Florida

Requests for the rule development workshop should be addressed to: Lynn Abbott, Agency Clerk, Department of Education, 325 West Gaines Street, Room 1514, Tallahassee, Florida 32399-0400.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Mary Laura Openshaw, Director, Just Read

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

DEPARTMENT OF TRANSPORTATION

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Bid Guaranty for Construction Contracts 14-21

RULE TITLE: RULE NO.:
Bid Guaranty for Construction Contracts 14-21.001

PURPOSE AND EFFECT: The statute only requires bid guarantee for construction contracts in excess of $150,000.00. The rule is amended to remove any reference to maintenance contracts.

SUBJECT AREA TO BE ADDRESSED: Rule 14-21.001, F.A.C., is being amended to remove reference to maintenance contracts.

SPECIFIC AUTHORITY: 334.044(2), 337.17 FS.

LAW IMPLEMENTED: 337.17 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: James C. Myers, Clerk of Agency Proceedings, Florida Department of Transportation, Office of the General Counsel, 605 Suwannee Street, Mail Station 58, Tallahassee, Florida 32399-0458

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

14-21.001 Bid Guaranty for Construction ~~and Maintenance~~ Contracts.

(1) Scope. This rule defines the security acceptable as bid guaranty for construction ~~and maintenance~~ contracts.

(2) Guaranty Required. The Department shall require a guaranty with each bid for a construction contract in excess of 150,000 in an amount of 5% of the amount of the bid.

Specific Authority 334.044(2), 337.17 FS. Law Implemented 337.17 FS. History–Amended 5-9-70, Formerly 14-7.01, Amended 7-9-75, Formerly 14-21.01, Amended 3-21-90, _____.

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."

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

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

RULE TITLES: RULE NOS.:
Exemptions 40D-4.051
Publications and Agreements Incorporated by Reference 40D-4.091
Additional Conditions for Issuance of Permits 40D-4.302

PURPOSE AND EFFECT: The purpose and effect of this rulemaking is to amend Rules 40D-4.051, 40D-4.091 and 40D-4.302, F.A.C. and section 3.2.2 of the Environmental Resource Permitting Basis of Review to conform to statutory changes and to be consistent with the Florida Department of Environmental Protection's and the other water management districts environmental resource permitting rules.

SUBJECT AREA TO BE ADDRESSED: Environmental Resource Permitting rules. The rules being updated include Rule 40D-4.051, F.A.C., which lists the activities that are exempt from permitting, and Rule 40D-4.302, F.A.C., which

lists additional conditions for issuance of permits. Inconsistencies were also identified in Section 3.2.2 of the Environmental Resource Permitting Information Manual, Part B, Basis of Review.

SPECIFIC AUTHORITY: 373.016, 373.044, 373.046, 373.113, 373.118, 373.171, 373.414 FS.

LAW IMPLEMENTED: 373.016, 373.042, 373.0361, 373.114, 373.171, 373.403, 373.406, 373.409, 373.413, 373.414, 373.414(9), 373.416, 373.426, 373.429, 373.441 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 District does not discriminate on the basis of disability. Anyone requiring reasonable accommodation should contact: Dianne Lee, (352)796-7211, Ext. 4658, TDD only 1(800)231-6103

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

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

AGENCY FOR HEALTH CARE ADMINISTRATION

Division of Managed Care and Health Quality

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Minimum Standards for Nursing Homes	59A-4
RULE TITLES:	RULE NOS.:
Licensure, Administration and Fiscal Management	59A-4.103
Facility Policies	59A-4.106
Physician Services	59A-4.107
Medical Director	59A-4.1075
Nursing Services	59A-4.108
Assistance with Eating	59A-4.1085
Resident Assessment and Care Plan	59A-4.109
Dietary Services	59A-4.110
Pharmacy Services	59A-4.112
Medical Records	59A-4.118
Physical Environment	59A-4.122
Risk Management and Quality Assurance	59A-4.123
Liability Claims	59A-4.1235
Disaster Preparedness	59A-4.126
Evaluation of Nursing Homes and Licensure Status	59A-4.128
Respite Care	59A-4.1285
Exception	59A-4.1288
Additional Standards for Homes That Admit Children 0 Through 20 Years of Age	59A-4.1295
Fire Prevention, Fire Protection, and Life Safety	59A-4.130
Plans Submission and Review and Construction Standards	59A-4.133
Geriatric Outpatient Nurse Clinic	59A-4.150
Nursing Home Guide	59A-4.165
Nursing Home Consumer Satisfaction Survey	59A-4.166
Definitions	59A-4.200
Gold Seal Award	59A-4.201
Quality of Care	59A-4.202
Financial Requirements	59A-4.203
Turnover Ratio	59A-4.204
The State Long Term Care Ombudsmen Council Review	59A-4.205
Termination and Frequency of Review	59A-4.206

PURPOSE AND EFFECT: The Agency proposes to amend Chapter 59A-4, F.A.C., consistent with the provisions of Chapter 400, Part II, Florida Statutes (F.S.). The legislation provides for licensure procedures; establishing criteria for facility policies; establishing criteria of physician services, medical director and nursing services; establishing an assistance with eating program; amending resident assessment and care plan; establishing dietary services; amending pharmacy services; amending medical records; establishing risk management and quality assurance; documentation for liability claims; amending criteria when evaluating nursing homes and licensure status; establishing respite care program; amending exceptions; establishing additional standards for homes that admit children 0 through 20 years of age; amending fire prevention, fire protection and life safety; amending plans submission and review and construction standards; establishing criteria pertaining to geriatric outpatient nurse clinics; amending criteria regarding the nursing home guide; and deleting the nursing home consumer satisfaction survey.

SUBJECT AREAS TO BE ADDRESSED: The proposed changes to Chapter 59A-4, Florida Administrative Code include: methodology for withdrawing licenses issued when licensure fees are returned to the agency due to insufficient funds and criteria for requesting an inactive license for all or part of a facility. (Rule 59A-4.103, F.A.C.); stating criteria of a do not resuscitate order (DNRO) (Rule 59A-4.106, F.A.C.); posting names of direct staff on duty by shift and share programming and staff of Gold Seal facilities and facilities with a standard license that are part of a continuing care facility or a retirement community (Rule 59A-4.108, F.A.C.); establish new rules involving assistance with eating (Rule 59A-4.1085, F.A.C.); stating criteria of the Director of Food Service (Rule 59A-4.110, F.A.C.); adverse incident reporting (Rule 59A-4.123, F.A.C.); establishing methodology regarding liability claims (Rule 59A-4.1235, F.A.C.); deleting reference of deficiencies as measured in terms of scope and severity (Rule 59A-4.128, F.A.C.); establish new rules involving respite

care (Rule 59A-4.1285, F.A.C.); stating criteria in the area of exceptions (Rule 59A-4.1288, F.A.C.); setting criteria when expanding or initiating services to pediatric residents (Rule 59A-4.1295, F.A.C.); amending criteria for pharmacy services; amending criteria relating to fire prevention, life safety, plans submission and construction standards deleting various definitions (Rule 59A-4.150, F.A.C.); setting a time period (Rule 59A-4.165, F.A.C.); and deleting reference to a nursing home consumer satisfaction survey (Rule 59A-4.166, F.A.C.); and makes technical corrections throughout.

SPECIFIC AUTHORITY: 400.23 FS.

LAW IMPLEMENTED: 400.11, 400.022, 400.141, 400.142, 400.23 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., May 12, 2005

PLACE: Agency for Health Care Administration, 2727 Mahan Drive, Building #3, Conference Room A, Tallahassee, FL 32308

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Richard Kelly, Long Term Care Unit, 2727 Mahan Drive, Tallahassee, Florida, (850)488-5861

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT WILL BE MADE AVAILABLE PRIOR TO THE RULE WORKSHOP.

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE TITLE: RULE NO.:

Prescription Drug Coverage Denials 59G-4.255

PURPOSE AND EFFECT: The purpose of this rule amendment is to establish procedures that will expedite the access to fair hearings for eligible Medicaid recipients with cognizable prescription drug claims and to assure full and meaningful compliance with federal and state law. These procedures are also pursuant to a federal court order in Anthony Hernandez v Rhonda Medows, 02-20964 (US District Court, Southern District of FL).

The rule requires Medicaid-participating pharmacies to provide a pamphlet, which is incorporated by reference, to Medicaid recipients whose prescription drug claims are denied by Medicaid. The pharmacy must enter in the pamphlet, the date, the recipient's name, drug name, and reason for the denial or attach a printout of the computer screen stating the reason for the denial. In addition, Medicaid-participating pharmacies must post a sign informing recipients of a toll-free number that can be called if a prescription is denied and the pharmacy failed to provide the denial information and information pamphlet to the recipient.

The rule requires Medicaid recipients who dispute their prescription denials to contact the Medicaid pharmacy Ombudsman for assistance in resolving the dispute before requesting a fair hearing. The rule also requires recipients to request fair hearings for prescription denials in writing.

SUBJECT AREA TO BE ADDRESSED: Prescription Drug Coverage Denials.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.906 FS.

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

TIME AND DATE: 2:00 p.m., Monday, May 9, 2005

PLACE: Agency for Health Care Administration, 2727 Mahan Drive, Bldg. 3, Conference Room B, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Karen Girard, Agency for Health Care Administration, Medicaid Services, 2727 Mahan Drive, Mail Stop 20, Tallahassee, Florida 32308, (850)488-9711

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59G-4.255 Prescription Drug Coverage Denials.

(1) Medicaid-participating pharmacies shall provide the pamphlet, Important Information About Your Florida Medicaid Prescription Drug Benefits (April 2005), which is incorporated by reference, to Medicaid recipients whose prescription drug claims are denied by Medicaid and the pharmacy cannot resolve the denial during that day's pharmacy visit. The pharmacy must write on the pamphlet, the date, the recipient's name, the drug name, and the reason for the denial or attach a printout of the computer screen stating the reason for the denial. The pamphlets are available from the Agency for Health Care Administration's website at http://ahca.myflorida.com.

(2) Medicaid-participating pharmacies shall post two signs, one in English and one in Spanish, informing recipients of a toll-free number that can be called if the prescription is denied and the pharmacy failed to provide the denial information and the Important Information About Your Florida Medicaid Prescription Drug Benefits pamphlet to the recipient. The signs must be approved by the Agency for Health Care Administration.

(3) Notwithstanding any other provisions of Rule 65-2.045, F.A.C., et seq., the following provisions apply to the fair hearing process for Medicaid recipients who have a denied prescription:

(a) The recipient must contact the Medicaid pharmacy Ombudsman for assistance in resolving the denial before requesting a fair hearing.

(b) The recipient must request the fair hearing in writing. The hearing request can be on the Fair Hearing Request Form contained in the Important Information About Your Florida Medicaid Prescription Drug Benefits pamphlet or by another written request that contains the same information that is on the Fair Hearing Request Form. The recipient or his authorized representative must enter the name of the drug, the reason for denial, the date of the denial, the reason(s) for requesting a hearing, and sign the form or written request.

(c) If the denial was because the drug required prior authorization, the recipient must attach evidence that his doctor tried to get prior authorization.

(d) If a fair hearing form or written request is incomplete, the Department of Children and Families, Office of Appeals Hearings must send a written notice of rejection of the hearing request to the recipient within ten days. The notice must state the reason the hearing request was rejected. An exception shall be granted if the request is related to prior authorization denials for prescriptions identified as clinical protocol drugs by the Agency for Health Care Administration.

(e) Recipients do not have the right to a fair hearing under the following circumstances:

1. The recipient has not made reasonable efforts as defined in the final order issued in Hernandez v Rhonda Medows, 02-20964 (US District Court, Southern District of FL) to resolve rejection of his drug claim;

2. The prescription drug rejection was due to lack of prior authorization, there is no dispute about whether the drug requires prior authorization, and there is not evidence included with the hearing request that the prescriber tried to obtain prior authorization.

3. If the recipient is challenging the legality of a restriction set forth in a federal Medicaid statute or regulation or state Medicaid statute or rule rather than a factual dispute arising from application of the statute;

4. If the rejection is for an early refill and there is no dispute over whether the refill was in fact early;

5. If the prescription is legally invalid pursuant to any state or federal statute that specifies the legal content of a prescription, and only the prescriber (who must be licensed and authorized to do so) can correct the prescription to make it legally valid and refuses to do so; or

6. If the pharmacy is not enrolled as a Medicaid provider; or in the case of an HMO member, the pharmacy is not a participating provider in the HMO.

Specific Authority 409.919 FS. Law Implemented 409.906 FS. History–New _____.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Division of Alcoholic Beverages and Tobacco

RULE CHAPTER TITLE: RULE CHAPTER NO.:
General 61A-2
RULE TITLE: RULE NO.:
Approved Forms 61A-2.019

PURPOSE AND EFFECT: The purpose and effect of the proposed rule is to outline the required forms needed for alcoholic beverages and tobacco related compliance.

SUBJECT AREA TO BE ADDRESSED: The list of forms used by the Department of Business and Professional Regulation, Division of Alcoholic Beverages and Tobacco in its dealing with the public.

SPECIFIC AUTHORITY: 120.53(1)(b) FS.

LAW IMPLEMENTED: 120.53 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: Renee Alsobrook, Chief Attorney, Department of Business and Professional Regulation, Division of Alcoholic Beverages and Tobacco, Office of the General Counsel, 1940 North Monroe Street, Suite 42, Tallahassee, Florida 32399, (850)487-9677

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

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Veterinary Medicine

RULE TITLE: RULE NO.:
Complementary or Alternative
Veterinary Medicine 61G18-19.002

PURPOSE AND EFFECT: The Board proposes a new rule to address the definition of and the requirements for the use of complementary and alternative veterinary practices.

SUBJECT AREA TO BE ADDRESSED: The nature of complementary and alternative therapies based on techniques in practices including acupuncture, homeopathy, osteopathy, chiropractic medicine, nutraceutical and physiotherapy practices; and, the responsibilities of the veterinarian to communicate the use of alternative therapies to the owner of the patient.

SPECIFIC AUTHORITY: 474.206 FS.

LAW IMPLEMENTED: 474.202(13) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Juanita Chastain, Executive Director, Board of Veterinary Medicine, Northwood Centre, 1940 N. Monroe Street, Tallahassee, Florida 32399-0750

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

61G18-19.002 Complementary or Alternative Veterinary Medicine.

(1) Definition – Complementary, alternative and integrative therapies means a heterogenous group of preventive, diagnostic and therapeutic philosophies and practices, which at the time they are performed may differ from current scientific knowledge, or whose theoretical basis and techniques may diverge from veterinary medicine routinely taught in accredited veterinary medical colleges, or both. These therapies include, but are not limited to, veterinary acupuncture, acutherapy and acupressure, veterinary homeopathy, veterinary manual or manipulative therapy (i.e., therapies based on techniques practiced in osteopathy, chiropractic medicine, or physical medicine and therapy); veterinary nutraceutical therapy and veterinary physiotherapy.

(2) Communication of treatment alternatives – A license veterinarian who offers to provide a patient with complementary or alternative health care treatment must inform the owner of the patient of the nature of the treatment and must explain the benefits and risks associated with the treatment to the extent necessary for the owner to make an informed and prudent decision regarding such treatment option. In compliance with this subsection:

(a) The licensed veterinarian must inform the owner of his or her education, experience and credentials in relation to veterinary complementary or alternative health care treatment option.

(b) The licensed veterinarian may, in his or her discretion, communicate the information orally or in written form directly to the owner or to the owner's legal representative.

(c) The licensed veterinarian may, in his or her discretion and without restriction, recommend any mode of treatment that is, in his or her judgment, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of his or her license.

(3) Records – Every licensed veterinarian providing a patient with a complementary or alternative health care treatment must indicate in the patient's record the method by which the requirements of subsection (2) were met.

(4) Effect – This section does not modify or change the scope of practice of any licensed veterinarian, nor does it alter in any way the provisions of Chapter 474, F.S., which require licensees to practice within standards of care, and which prohibit fraud and exploitation of clients.

Specific Authority 474.206 FS. Law Implemented 474.202(13) FS. History–New _____.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Board of Accountancy

RULE TITLE: RULE NO.:
Fees 61H1-31.001

PURPOSE AND EFFECT: The Board proposes to review this Rule to determine if any additions, deletions, fee increases or decreases are necessary.

SUBJECT AREA TO BE ADDRESSED: Fees.

SPECIFIC AUTHORITY: 455.213(2), 455.219(4), 455.271, 473.305, 473.312 FS.

LAW IMPLEMENTED: 119.07, 455.219(4), 455.271, 473.305, 473.312, 473.313 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: John W. Johnson, Executive Director, Board of Accountancy, 240 N. W. 76th Drive, Suite A, Gainesville, Florida 32607

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

61H1-31.001 Fees.

(1) Applicants to sit for the Uniform CPA Examination, as a first time candidate or for candidates transferring partial credits from another state, a fifty dollar ($50.00) application fee will be owed prior to processing the application. Once the applicant has been approved to sit for the exam as a Florida candidate; the following initial examination fee will be charged to take each section of the exam: Auditing $159.25 ~~$134.50~~, Accounting $148.00 ~~$126.00~~, Regulation $125.50 ~~$109.00~~, and Business E & C $114.25 ~~$100.50.~~

(2) through (12) No change.

Specific Authority 455.213(2), 455.219(4), 455.271, 473.305, 473.312 FS. Law Implemented 119.07, 455.219(4), 455.271, 473.305, 473.312, 473.313 FS. History–New 12-4-79, Amended 2-3-81, 3-4-82, 11-6-83, 3-29-84, Formerly 21A-31.01, Amended 6-4-86, 9-16-87, 2-1-88, 8-30-88, 2-6-89, 12-18-89, 12-28-89, 8-16-90, 4-8-92, 12-2-92, Formerly 21A-31.001, Amended 11-04-93, 2-14-95, 11-3-97, 6-22-98, 10-28-98, 7-15-99, 4-4-02, 1-27-04, 1-31-05, _____.

DEPARTMENT OF ENVIRONMENTAL PROTECTION

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

DEPARTMENT OF HEALTH

Board of Medicine

RULE TITLE: RULE NO.:
Medical Records of Physicians Relocating or Terminating Practice; Retention, Disposition, Time Limitations 64B8-10.002

PURPOSE AND EFFECT: The Board has authorized the development of a rule amendment to require medical records to be retained for a period of 7 years.

SUBJECT AREA TO BE ADDRESSED: Retention of medical records.

SPECIFIC AUTHORITY: 456.058, 458.309 FS.

LAW IMPLEMENTED: 456.058 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Larry McPherson, Jr., Executive Director, Board of Medicine/MQA, 4052 Bald Cypress Way, Bin #C03, Tallahassee, Florida 32399-3253

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

64B8-10.002 Medical Records of Physicians Relocating or Terminating Practice; Retention, Disposition, Time Limitations.

(1) through (2) No change.

(3) A licensed physician shall keep adequate written medical records, as required by Section 458.331(1)(m), Florida Statutes, for a period of at least seven ~~five~~ years from the last patient contact.

(4) No change.

Specific Authority 456.058, 458.309 FS. Law Implemented 456.058 FS. History–New 7-3-89, Formerly 21M-26.002, Amended 11-4-93, 1-17-94, Formerly 61F6-26.002, Amended 1-26-97, Formerly 59R-10.002, Amended 3-7-01, _____.

DEPARTMENT OF HEALTH

Board of Pharmacy

RULE TITLES: RULE NOS.:
Definitions – Nuclear Pharmacy 64B16-28.900
Nuclear Pharmacy – Minimum Requriements 64B16-28.902

PURPOSE AND EFFECT: The purpose of the amendment to Rule 64B16-28.900, F.A.C., is to remove the reference to Rule 64B16-28.903, F.A.C., as it has been repealed and is now referenced to Rule 64B16-26.303, F.A.C. The purpose to the amendment to Rule 64B16-28.902, F.A.C., is to add the effective dates for clarification of Chapters and Regulations for use within the rules.

SUBJECT AREA TO BE ADDRESSED: The amendment to Rule 64B16-28.900, F.A.C., removes the reference to Repealed Rule 64B16-28.903, F.A.C., and replaces with the reference to Rule 64B16-26.303, F.A.C. Amendment to Rule 64B16-28.902, F.A.C., adds effective dates for clarification of Chapters and Regulations for use within the rules.

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

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

SPECIFIC AUTHORITY: 465.005, 465.022 FS.

LAW IMPLEMENTED: 465.003(14), 465.0193, 465.002(1), 465.022(1)(e) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Danna Droz, Executive Director, Board of Pharmacy/MQA, 4052 Bald Cypress Way, Bin #C04, Tallahassee, Florida 32399

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

64B16-28.900 Definitions – Nuclear Pharmacy.

(1) No change.

(2) A "nuclear pharmacist" is an actively licensed pharmacist who has met the training qualifications as described in Rule 64B16-26.303 ~~64B16-28.903~~, F.A.C., and has been certified by the Board of Pharmacy.

(3) through (6) No change.

Specific Authority 465.005 FS. Law Implemented 465.003(14), 465.022(1)(e) FS. History–New 1-7-76, Formerly 21S-3.01, Amended 4-4-88, Formerly 21S-3.001, Amended 7-31-91, 4-15-92, 10-1-92, Formerly 21S-28.900, 61F10-28.900, 59X-28.900, Amended _____.

64B16-28.902 Nuclear Pharmacy – Minimum Requirements.

In order to insure compliance with the general safety requirements as previously set forth above, the following minimum requirements shall be met by a nuclear pharmacy. These requirements are in addition to the general requirements for space and equipment for other types of pharmacies, the requirements of the Department of Health for the control of

radiation hazards, and the applicable requirements of the Federal Food and Drug Administration. Such minimum permit requirements are set forth as follows:

(1) through (3)(f) No change.

(4) Current references:

(a) through (c) No change.

(d) Chapters 64B16-26 and 64B16-28, F.A.C., Rules of the Florida Board of Pharmacy in effect as of April 1, 2005;

(e) Chapter 64E-5, F.A.C., Rules of the Department of Health in effect as of April 1, 2005;

(f) Title 10 C.F.R., Code of Federal Regulations, FDA Regulations in effect as of April 1, 2005;

(g) Title 21 C.F.R., Code of Federal Regulations, FDA Regulations in effect as of April 1, 2005;

(h) Title 49 C.F.R., Code of Federal Regulations, Department of Transportation Regulations in effect as of April 1, 2005;

(i) through (j) No change.

Specific Authority 465.005, 465.022 FS. Law Implemented 465.0193, 465.022(1) FS. History–New 1-7-76, Formerly 21S-3.04, Amended 12-11-86, 4-4-88, Formerly 21S-3.004, Amended 7-31-91, Formerly 21S-28.902, 61F10-28.902, Amended 2-26-95, Formerly 59X-28.902, Amended 4-26-01, _____.

DEPARTMENT OF HEALTH

Optical Establishments

RULE TITLE: RULE NO.:
Optical Establishment Inspection 64B29-1.002

PURPOSE AND EFFECT: The Department of Health proposes to amend the rule addressing matters pertaining to optical establishment inspections.

SUBJECT AREA TO BE ADDRESSED: Optical establishment inspections.

SPECIFIC AUTHORITY: 484.007, 484.014, 484.015 FS.

LAW IMPLEMENTED: 484.007, 484.014, 484.015 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Sue Foster, Executive Director, Department of Health, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

64B29-1.002 Optical Establishment Inspection.

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

1. Whether prescriptions written by an optometrist, allopathic or osteopathic ~~a~~ physician ~~or optometrist,~~ for any lenses, spectacles, eyeglasses, contact lenses, or other optical devices are kept on file for a period of 2 years; and

2. No change.

(d) through (f) No change.

Specific Authority 484.007, 484.014, 484.015 FS. Law Implemented 484.007, 484.014, 484.015 FS. History–New 5-27-03, Amended _____.

DEPARTMENT OF FINANCIAL SERVICES

Division of Workers' Compensation

RULE TITLE: RULE NO.:
Conditional Release of Stop Work Order and Periodic Payment Agreement 69L-6.025

PURPOSE AND EFFECT: The purpose and effect is to amend existing Rule 69L-6.025, F.A.C., which sets forth procedures for the Division of Workers' Compensation to conditionally release an employer from a stop-work order upon a finding that the employer has complied with the coverage requirements of Chapter 440, Florida Statutes, and has agreed to remit periodic payments of the penalty pursuant to a payment agreement schedule. The proposed amendment will allow employers that have been assessed a penalty greater than $1000 up to sixty months to pay the remaining penalty regardless of the amount of the remaining penalty.

SUBJECT AREA TO BE ADDRESSED: Stop-work orders and periodic payment of penalties under Section 440.107, F.S.

SPECIFIC AUTHORITY: 440.107(9), 440.591 FS.

LAW IMPLEMENTED: 440.107(7)(a) FS.

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

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

PLACE: 104J Hartman Building, 2012 Capital Circle, Southeast, Tallahassee, Florida

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Andrew Sabolic, Bureau Chief, Bureau of Compliance, Division of Workers' Compensation, Department of Financial Services, 200 East Gaines Street, Tallahassee, Florida 32399-4228, (850)413-1600

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

69L-6.025 Conditional Release of Stop Work Order and Periodic Payment Agreement.

(1) The requirements for issuance of an Order of Conditional Release From Stop Work Order as provided for in Section 440.107, F.S. are:

(a) The employer has come into compliance with the coverage requirements of Chapter 440, F.S. Compliance with the coverage requirements of Chapter 440, F.S. includes demonstration by the employer that it is no longer failing to secure the payment of compensation within the meaning of Section 440.107, F.S.

(b) The employer and the Department have executed a Payment Agreement Schedule for Periodic Payment of Penalty, Form Number DFS-F4-1600 (rev. 7/04).

(c) The employer agrees to file probationary periodic reports with the Department for a time period that does not exceed 2 years that demonstrate the employer's continued compliance with Chapter 440, F.S. The probationary periodic reports shall be filed as a section of each monthly payment installment invoice pursuant to the Payment Agreement Schedule for Periodic Payment of Penalty.

(2) The terms and conditions of a Payment Agreement Schedule for Periodic Payment of Penalty shall be:

(a) The employer shall make a down payment on the total assessed penalty amount to the Department that is the greater of $1000.00 or at least 10% of the total assessed penalty amount. The amount constituting the total assessed penalty amount, less the down payment, shall be referred to as the "remaining penalty".

(b) Each monthly payment installment is due on the first day of the month in which it is due, and the employer is in violation of the Payment Agreement Schedule for Periodic Payment of Penalty if the full monthly payment installment is not received by the Department by the last day of the month in which the payment installment is due;

1. The ~~An~~ employer ~~whose remaining penalty is less than $13,500,~~ shall pay the remaining penalty in up to sixty ~~twelve~~ consecutive monthly installments.

~~2. An employer whose remaining penalty is $13,500 or greater shall pay the remaining penalty in twenty-four consecutive monthly installments.~~

2.~~3.~~ The employer may at any time pre-pay the installments of the remaining penalty, which have not become due.

3.~~4.~~ The first monthly payment installment shall be due on the first day of the second month following the month of issuance of the Conditional Release From Stop Work Order, Form Number DFS-F4-1602 (rev. 6/04), and each subsequent payment installment shall be due on the first day of each consecutive month.

(c) Monthly payment installments shall only be remitted to the Department's address designated in the Payment Agreement Schedule for Periodic Payment of Penalty.

(d) Monthly payment installments shall be in the form of a cashier's check or money order only, made payable to the DFS-Workers' Compensation Administration Trust Fund.

(e) If the employer is a corporation, only an officer of the corporation may execute the Payment Agreement Schedule For Periodic Payment of Penalty on behalf of the employer.

(f) If the employer is a business entity other than a corporation, any principal of the business entity may execute the Payment Agreement Schedule For Periodic Payment of Penalty on behalf of the employer.

(g) Failure by the employer to meet or violation of any term or condition of the Payment Agreement Schedule For Periodic Payment of Penalty shall constitute a default by the employer.

(3) The Payment Agreement Schedule For Periodic Payment of Penalty becomes effective when it is executed on behalf of the employer and by the Department. Upon execution of the Payment Agreement Schedule For Periodic Payment of Penalty, the Department will provide the employer with a Monthly Payment Installment Invoice, Form Number DFS-F4-1601 (rev. 8/04), which shall be submitted with each monthly payment installment. Each Monthly Payment Installment Invoice contains a probationary reporting section that shall be completed by the employer.

(4) If an employer defaults under any of its obligations under the Payment Agreement Schedule For Periodic Payment of Penalty, the Stop Work Order to which the penalty applies shall be immediately reinstated and the entire unpaid balance of the remaining penalty shall immediately become due and payable.

(5) The Department hereby adopts and incorporates the following forms by reference. Copies of the forms can be obtained from the Division of Workers' Compensation's Bureau of Compliance, 200 East Gaines Street, Tallahassee, Florida 32399-4228, or from any field office identified in Rule 69L-6.009, F.A.C.

(a)	DFS-F4-1600	Payment Agreement Schedule For Periodic Payment of Penalty	rev. 7/04
(b)	DFS-F4-1601	Monthly Payment Installment Invoice	rev. 8/04
(c)	DFS-F4-1602	Order of Conditional Release From Stop-Work Order	rev. 6/04

Specific Authority 440.107(9), 440.591 FS. Law Implemented 440.107(7)(a) FS. History–New 4-6-05, Amended _____.

DEPARTMENT OF FINANCIAL SERVICES

Division of Workers' Compensation

RULE TITLE: RULE NO.:

Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule 69L-7.602

PURPOSE AND EFFECT: The amendments clarify rule language and data reporting requirements, amend an administrative penalty dollar amount to a decreased value for untimely medical bill reporting to the division, amend the form DFS-F5-DWC-25, and its completion instructions, update form completion instructions for forms DFS-F5-DWC-09, DFS-F5-DWC-10, DFS-F5-DWC-11, and to incorporate the recommendations of Florida's Worker's Compensation Three-Member Panel that affect medical health care provider billing procedures for implant devices, prosthetics, and orthotics.

SUBJECT AREA TO BE ADDRESSED: Reimbursement of healthcare providers that provide medical services for workers' compensation claimants.

SPECIFIC AUTHORITY: 440.13(4), 440.15(3)(b),(d), 440.185(5), 440.525(2), 440.591, 440.593(5) FS.

LAW IMPLEMENTED: 440.09, 440.13(2)(a),(3),(4),(6),(11),(12),(14),(16), 440.15(3)(b),(d), 440.20(6), 440.185(5),(9), 440.593 FS.

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

TIME AND DATE: 9:00 a.m., May 13, 2005

PLACE: Room 104J, Hartman Building, 2012 Capital Circle, Southeast, Tallahassee, Florida

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Don Davis, Division of Workers' Compensation, Office of Data Quality and Collection, Department of Financial Services, 200 East Gaines Street, Tallahassee, Florida 32399-4226, (850)413-1711

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

69L-7.602 Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule.

(1) Definitions. As used in this rule:

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

(b) "Agency" means the Agency for Health Care Administration as defined in Section 440.02(3), F.S.

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

(d)~~(c)~~ "Billing" means the process by which a health care provider submits a claim to an insurer, service company/third party administrator (TPA) or any entity acting on behalf of the insurer, to receive reimbursement for medical services provided to an injured employee.

(e)~~(d)~~ "Catastrophic Event" means the occurrence of an event outside the control of an insurer, ~~or~~ submitter, service company/third party administrator (TPA) or any entity acting on behalf of the insurer, such as a natural disaster, an act of terrorism (including but not limited to cyber terrorism) or a telecommunications failure, in which recovery time will prevent an insurer, ~~or~~ submitter, service company/third party administrator (TPA) or any entity acting on behalf of the insurer from meeting the filing and reporting requirements of Chapter 440, F.S., and this rule.

(f)~~(e)~~ "Charges" means the dollar amount billed.

(g)~~(f)~~ "Charge Master" means a comprehensive coded list developed by a hospital or an ambulatory surgical center representing the ~~its~~ usual charges for specific services and/or supplies.

(h)~~(g)~~ "Claims-Handling Entity File Number" means the number assigned to the claim file by the insurer or~~,~~ service company/ ~~or~~ third party administrator (TPA) for purposes of internal tracking.

(i)~~(h)~~ "Current Dental Terminology (CDT-4)" (CDT) means the American Dental Association's reference document containing descriptive terms to identify codes for billing and reporting dental procedures.

(j)~~(i)~~ "Date Insurer Paid" means the date the insurer, service company/~~,~~ third party administrator (TPA), ~~or~~ submitter or any entity acting on behalf of the insurer mails, transfers or electronically transmits payment to the health care provider.

(k)~~(j)~~ "Date Insurer Received" means the date that a Form DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-90 or the electronic form equivalent is delivered to, and manually or electronically date stamped by~~,~~ the insurer, service company/~~,~~ third party administrator (TPA), ~~or~~ submitter or any entity acting on behalf of the insurer ~~from a provider~~.

(l)~~(k)~~ "Deny" means to determine that no payment is to be made for a specific procedure code or other service reported by a health care provider to an insurer, service company/TPA or any entity acting on behalf of the insurer on a bill.

(m)~~(l)~~ "Division" means the Division of Workers' Compensation (DWC) as defined in Section 440.02(14), F.S.

(n)~~(m)~~ "Disallow" means to determine that no payment is to be made for a specific procedure code or other service reported by a health care provider to an insurer, service company/TPA or any entity acting on behalf of the insurer for reimbursement, based on identification of a billing error, inappropriate utilization or over utilization, use of an incorrect billing form, only one line-item billed and the bill has an invalid code, or required information is missing or illegible.

(o)~~(n)~~ "Electronic Filing" means the computer exchange of medical data from a submitter to the division in the standardized format defined in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 20054.

(p)~~(o)~~ "Electronic Form Equivalent" means the format, provided in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 20054, to be used when a submitter electronically transmits required data to the division. Electronic form equivalents do not include transmission by facsimile, data file(s) attached to electronic mail, or computer-generated paper-forms.

(q)~~(p)~~ "Electronically Filed with the Division" means the date an electronic filing has been received by the division and has successfully passed structural and data-quality edits.

(r) "Entity" means any party, involved in the provision of or the payment for medical services, care or treatment rendered to the injured employee, excluding the insurer, service company/third party administrator (TPA) or health care provider as identified in this section.

(s)~~(q)~~ "Explanation of Bill Review" (EOBR) means the codes and written explanation of an insurer's reimbursement decision sent to the health care provider as payment, notice of denial, disallowance or adjustment.

(t)~~(r)~~ "Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 20054" is the Florida Division of Workers' Compensation's reference document containing the specific electronic formats and data elements required for insurer reporting of medical data to the division.

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

(v)~~(t)~~ "Health Care Provider" is defined in Section 440.13(1)(h), F.S.

(w)~~(u)~~ "Hospital" is defined in Section ~~means any health care institution licensed under Chapter~~ 395.002(13), F.S.

(x)~~(v)~~ "ICD-9-CM International Classification of Diseases" (ICD-9) is the U.S. Department of Health and Human Services' reference document listing the official diagnosis and inpatient-procedure code sets.

(y)~~(w)~~ "Insurer" is defined in Section 440.02(38), F.S.

(z)~~(x)~~ "Insurer Code Number" means the number the division assigns to each individual insurer, self-insured employer or self-insured fund.

(aa)~~(y)~~ "Itemized Statement" means a detailed listing of ~~hospital provided~~ services and supplies provided to an injured employee, including the quantity and charges for each service or supply.

(bb) "Itemized Invoice" means a document substantiating the actual cost, including applicable manufacturer's shipping and handling, paid by the provider for medically necessary devices, items, or products.

~~(z) "Medical Summary Report" means an Excel spreadsheet format that denotes an insurer, service company or third party administrator payment, adjustment and payment, disallowance or denial information.~~

(cc)~~(aa)~~ "Medically Necessary" or "Medical Necessity" is defined in Section 440.13(1)(l), F.S.

(dd)~~(bb)~~ "NDC number" means the National Drug Code (NDC) number, assigned under Section 510 of the Federal Food, Drug, and Cosmetic Act, that identifies the drug product labeler/vendor, product, and trade package size.

~~(cc) "Paper-Form Filed with the Division" means the date a paper document is accurately completed, postmarked and mailed pre-paid to the Department of Financial Services as a required filing under this rule.~~

(ee)~~(dd)~~ "Physician" is defined in Section 440.13(1)(q), F.S.

(ff)~~(ee)~~ "Physician's Current Procedural Terminology (CPT®)" (CPT) means the American Medical Association's reference document (HCPCS Level I) containing descriptive terms to identify codes for billing and reporting medical procedures and services.

(gg)~~(ff)~~ "Principal Physician" means the treating physician responsible for the oversight of medical care, treatment and attendance rendered to an injured employee, to include recommendation for appropriate consultations or referrals.

(hh)~~(gg)~~ "Report" means any form related to medical services rendered, in relation to a workers' compensation injury, that is required to be filed with the division under this rule.

(ii)~~(hh)~~ "Service Company/Third Party Administrator (TPA)" means a~~n~~ party that ~~entity which~~ has contracted with an insurer for the purpose of providing all services necessary to adjust workers' compensation claims on the insurer's behalf.

(jj)~~(ii)~~ "Service Company/Third Party Administrator (TPA) Code Number" means the number the division assigns to each third party administrator, claims administrator or servicing company.

(kk)~~(jj)~~ "Submitter" means an insurer, service company/~~, or third party administrator (~~TPA~~)~~, entity or any other party ~~entity~~ acting as an agent or vendor on behalf of an insurer, service company/~~ or (~~TPA~~) third party administrator~~, or entity to fulfill any insurer responsibility to electronically transmit required medical data to the division.

(mm)~~(kk)~~ "UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee, March ~~May~~ 2005~~4~~" (UB-92 manual) is the reference document providing billing and reporting completion instructions for the Form DFS-F5-DWC-90 (UB-92 HCFA-1450, Uniform Bill, Rev.1992~~/UB-92~~).

(2) Forms for Medical Billing, Filing and Reporting.

(a) Form DFS-F5-DWC-9 (CMS -1500 Health Insurance Claim Form, Rev. 12/90), Form DFS-F5-DWC-9 – A, Rev. January 19, 2005, Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form, Rev. 03/21/2005~~4~~), Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2002), Form DFS-F5-DWC-11– A, Rev. January 19, 2005, Form DFS-F5-DWC-25 (Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form, Rev. 1/19/2005 ~~03/2004~~), Form DFS-F5-DWC-25 completion instructions, Rev. January 19, 2005, and Form DFS-F5-DWC-90 (UB-92 HCFA-1450, ~~Hospital~~ Uniform Bill, Rev.~~/UB-92, Effective~~ 1992) ~~and completion instructions for these forms~~ are hereby incorporated by reference into this rule.

1. A copy of the Form DFS-F5-DWC-9 can be obtained from the CMS web site: http://www.cms.hhs.gov/forms/. Completion instructions can be obtained from the DFS/DWC web site: http://www.fldfs.com/WC/forms.html#7.

2. A copy of the Form DFS-F5-DWC-10 and completion instructions can be obtained from the DFS/DWC web site: http://www.fldfs.com/WC/forms.html#7.

3. A copy of the Form DFS-F5-DWC-11 can be obtained by contacting the American Dental Association. Completion instructions can be obtained from the DFS/DWC web site: http://www.fldfs.com/WC/forms/html#7.

4. A copy of the Form DFS-F5-DWC-25 and completion instructions can be obtained from the DFS/DWC web site: http://www.fldfs.com/WC/forms.html#7.

5. A copy of the Form DFS-F5-DWC-90 can be obtained from the CMS web site: http://www.cms.hhs.gov/forms/. Completion instructions can be obtained from the UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee (Rev. March 2005) and subparagraph (4)(d)5. of this rule ~~DFS/DWC web site: http://www.fldfs.com/WC/forms.html#7.~~

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

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

2. The form provides all information required on the Form DFS-F5-DWC-10. Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be submitted as an alternate form.

(3) Materials Adopted for Reference. The following publications are incorporated by reference herein:

(a) UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee (Rev. March ~~May~~ 2005~~4~~). A copy of this manual can be obtained from the Florida Hospital Association.

(b) The Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2005~~4~~. Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2005~~4~~ can be obtained from the DFS/DWC web site: http://www.fldfs.com/WC/edi_med.html.

(c) The American Medical Association "Healthcare Common Procedure Coding System, Medicare's National Level II Codes (HCPCS), as adopted in Rule 69L-7.020, F.A.C. ~~Centers for Medicare and Medicaid Services, Copyright 2003, American Medical Association.~~

(d) The Physicians' Current Procedural Terminology (CPT®), as adopted in Rule 69L-7.020, F.A.C. ~~Copyright 2003, American Medical Association.~~

(e) The Current Dental Terminology (CDT-4), as adopted in Rule 69L-7.020, F.A.C., ~~Fourth Edition Copyright 2003, American Dental Association.~~

(f) The ICD-9-CM International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2003, American Medical Association.

(g) The American Medical Association's Guide to the Evaluation of Permanent Impairment~~, 3rd Edition, (AMA Guide) (Copyright 1988 by the American Medical Association)~~, as adopted ~~incorporated~~ in Rule 69L-7.604, F.A.C.

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

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

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

(4) Health Care Provider Responsibilities.

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

(b)~~(a)~~ Insurers and providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of the injured employee's medical treatment/status. Any other reporting forms may not be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

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

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

(c)~~(b)~~ Special Billing Requirements.

1. When anesthesia services are billed on a Form DFS-F5-DWC-9, completion of the form must include the CPT code and the "P" code (physical status modifier), which correspond with the procedure performed, in Field 24D. Anesthesia health care providers shall enter the date of service and the 5-digit qualifying circumstance code, which correspond with the procedure performed, in Field 24D on the next line, if applicable.

2. When an Advanced Registered Nurse Practitioner (ARNP) provides services as a Certified Registered Nurse Anesthetist, he/she shall bill on a Form DFS-F5-DWC-9 for the services rendered and enter his/her Florida Department of Health license number in Field 33, regardless of the employment arrangement under which the services were rendered, or the party submitting the bill.

3. When a licensed physician or licensed non-physician health care provider, including physician assistant or ARNP (not providing an anesthesia-related service) renders direct billable services for which reimbursement is sought from an insurer, he/she shall enter his/her Florida Department of Health license number in Field 33 on the Form DFS-F5-DWC-9, regardless of the employment arrangement under which the services were rendered or the party submitting the bill.

4. For hospital billing, the following special requirements apply:

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

I. Attach an itemized statement with charges based on the facility's Charge Master, and~~,~~

II. Attach an itemized invoice that documents the hospital's actual cost of the implant, prosthetic or orthotic devices or items, including applicable manufacturer's shipping and handling, when applicable, and

III. Use appropriate revenue codes, pursuant to Rule 69L-7.501, F.A.C. when billing implant, prosthetic or orthotic devices or items.

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

I. ~~Hospitals shall~~ enter the CPT, HCPCS, or unique workers' compensation code (provided in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005~~4~~ Edition), in Locator 44 on the Form DFS-F5-DWC-90, to bill outpatient radiology, clinical laboratory and/or physical, occupational or speech therapy charges ~~treatments~~.

II. Enter a surgical CPT code in Locator 44 when billing outpatient surgery or surgical services.

III.~~II. Hospitals shall~~ enter the date of service on Form DFS-F5-DWC-90, in Locator 45, for outpatient billing.

IV.~~III. Hospitals shall bill supplies by filing a Form DFS-F5-DWC-90 and~~ attach~~ing~~ an itemized statement with charges based on the ~~a~~ facility's Charge Master if there is no line item detail shown on the Form DFS-F5-DWC-90.

V. Attach an itemized invoice that documents the hospital's actual cost of implant, prosthetic or orthotic devices or items, including applicable manufacturer's shipping and handling, and

VI. Use appropriate revenue codes, pursuant to Rule 69L-7.501, F.A.C. when billing implant, prosthetic or orthotic devices or items.

5. Licensed physician assistants and certified ~~first~~ nurse first assistants who provide surgical assistance on procedures with codes permitting an assistant surgeon-physician shall bill on a Form DFS-F5-DWC-9 entering the CPT code(s) plus modifier(s), which represent the service(s) rendered, in Field 24D, and must enter their Florida Department of Health license number in Field 33.

6. Ambulatory Surgical Centers (ASCs) shall in addition to filing ~~bill on~~ a Form DFS-F5-DWC-9:~~.~~

a. Attach an itemized statement with charges based on the facility's Charge Master.

b. Attach an itemized invoice that documents the ASC's actual cost of implant, prosthetic or orthotic devices or items, including applicable manufacturer's shipping and handling.

7. Federal Facilities shall bill on their usual form.

8. Dental Services.

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

b. Oral surgeons shall bill for oral and maxillofacial surgical services on a Form DFS-F5-DWC-9. Non-surgical dental services shall be billed on a Form DFS-F5-DWC-11.

c. Dentists and oral surgeons shall submit, to the insurer, service company/TPA or any entity acting on behalf of the insurer, a copy of an itemized invoice documenting the actual cost of implant devices or items, including applicable manufacturer's shipping and handling.

9. Pharmaceutical and Medical Supplies.

a. Pharmacists and medical suppliers shall bill on a Form DFS-F5-DWC-10 or on an insurer pre-approved alternate form. Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be submitted as an alternate form.

b. Pharmacists shall complete Field 9, on a Form DFS-F5-DWC-10, by entering the unique workers' compensation code 96371 ~~word "COMPOUND"~~ when medicinal drugs are compounded and the formulation prescribed is not commercially available.

c. Dispensing physicians, physician assistants or ARNPs shall bill on a Form DFS-F5-DWC-9, when supplying commercially available medicinal drugs (commonly known as legend or prescription drugs) and shall enter the NDC number in Field 24D.

Optionally, the unique workers' compensation code 96370 may be entered in addition to the NDC code, in Field 24D.

d. When administering or supplying injectable drugs, the physician, physician assistant or ARNP shall bill on a Form DFS-F5-DWC-9 and enter the appropriate HCPCS "J" code in Field 24D.

e.~~d.~~ Dispensing physicians, physician assistants or ARNPs shall complete Field 24D, on a Form DFS-F5-DWC-9, by entering the unique workers' compensation code 96371 when medicinal drugs are compounded and the formulation prescribed is not commercially available.

f.~~e.~~ Dispensing physicians, physician assistants or ARNPs shall bill by entering code 99070 in Field 24D, on a Form DFS-F5-DWC-9, when supplying over-the-counter drugs and shall submit an itemized invoice indicating the name, dosage, package size and cost of the drug(s).

g.~~f.~~ Physicians and other licensed health care providers providing medical supplies shall bill on a Form DFS-F5-DWC-9 and attach an itemized invoice documenting ~~indicating~~ the actual cost of the supply, including applicable manufacturer's shipping and handling ~~and taxes, when applicable~~.

10. Physicians billing for a failed appointment for a scheduled independent medical examination (when the injured employee does not report to the physician office as scheduled) shall bill on their invoice or letterhead.

11.~~10.~~ Health care providers and other insurer authorized providers rendering health care services reimbursable ~~reimburseable~~ under workers' compensation, whose billing requirements are not otherwise specified in this rule, shall bill on their invoice or business letterhead.

(d)~~(c)~~ Bill Completion.

1. Bills shall be legibly and accurately completed by all health care providers, regardless of location or reimbursement methodology, as set forth in this paragraph.

2. Billing elements required by the division to be completed by a health care provider are identified in specific DFS-F5-DWC-9 completion instructions – A, available at the following websites ~~as follows~~:

a. http://www.fldfs.com/wc/pdf/DWC-9instrHCP.pdf when submitted by Licensed Health Care Providers;

b. http://www.fldfs.com/wc/pdf/DWC-9instrASC.pdf when submitted by Ambulatory Surgical Centers;

c. http://www.fldfs.com/wc/pdf/DWC-9instrWHPM.pdf when submitted by Work Hardening and Pain Management Programs.

~~Physician and Non-Physician/Certified Provider Billing – Form DFS-F5-DWC-9.~~

~~(I) Field 1a Injured employee's Social Security Number or division-assigned number (obtained from the Insurer).~~

~~(II) Field 2 Injured employee's name: Last, First, Middle initial, if applicable.~~

~~(III) Field 14 Date of current accident, illness or injury.~~

~~(IV) Field 16 Dates injured employee is unable to work, as applicable.~~

~~(V) Field 21(1) Diagnosis of primary injury or illness (Include decimal in ICD-9 code, as applicable).~~

~~(VI) Field 21 (2-4) Additional diagnoses (Include decimal in ICD-9 code, as applicable).~~

~~(VII) Field 24A Date(s) of service: 'From' and 'To' date. Multiple dates of service are billable on a single line only if the dates are consecutive. If there is a single date of service, enter the same date in both 'From' and 'To' fields.~~

~~(VIII) Field 24B Place of service (as listed in the CPT manual).~~

~~(IX) Field 24D Procedure, service or supply code (CPT, CDT-4, HCPCS, NDC or unique workers' compensation code plus modifier, as required for reimbursement).~~

~~(X) Field 24E Diagnosis code reference numbers: '1', '2', '3', '4' refer to corresponding diagnoses listed in Field 21 (1, 2, 3, 4).~~

~~(XI) Field 24F Total dollar charges for units billed per line.~~

~~(XII) Field 24G Number of days, hours, units, or quantity of drug or supply must be entered in whole numbers. Total length of anesthesia service time must be entered in minutes.~~

~~(XIII) Field 25 Federal tax identification number.~~

~~(XIV) Field 32 Zip code where services were rendered.~~

~~(XV) Field 33 (PIN#) License number of the health care provider rendering direct billable service(s): Providers shall enter their Florida Department of Health provider license, out of state license, or other facility number as assigned by the professional regulatory board, licensing authority or state regulatory agency.~~

~~(A) Work Hardening/Pain Programs enter "WC" for required alpha characters (i.e. WC########).~~

~~(B) Ambulatory Surgical Centers enter "ASC" for required alpha characters (i.e. ASC### or ASC####).~~

~~(C) Independent Laboratories enter "IL" for required alpha characters (i.e. IL8000#####, IL80000#### or IL800000###).~~

~~(D) Advanced Registered Nurse Practitioners enter "ARNP" for required alpha characters (i.e. ARNP##### or ARNP###### or ARNP########).~~

(E) Radiology or Other Facilities (providing only the technical component) enter "XX" for required alpha characters and 99999999999 for required numeric characters (i.e. XX99999999999).

3. Billing elements required by the division to be completed for Pharmaceutical or Medical Supplier Billing are identified in specific DFS-F5-DWC-10 completion instructions available at website: http://www.fldfs.com/wc/pdf/DWC-10.pdf.

b. Pharmaceutical/Medical Supplier Billing – Form DFS-F5-DWC-10.

(I) Form DFS-F5-DWC-10 Section 1 – Fields required to be completed by Pharmacy and Medical Supply providers:

(A) Field 1 Injured employee's name: Last, First, Middle Initial, if applicable.

(B) Field 2 Injured employee's Social Security Number or division-assigned number (obtained from the insurer).

(C) Field 3 Date of current accident, injury or illness in MM/DD/CCYY format.

(II) Form DFS-F5-DWC-10 Section 2 – Fields required to be completed by pharmacy providers only:

(A) Field 6 Medication/drug name and strength.

(B) Field 7 Number of tablets, capsules, suppositories, milliliters of liquid, grams of ointment or units of injectable medication.

(C) Field 8 Estimated number of days that medication will last according to prescription dosage and administration instructions.

(D) Field 9 National Drug Code number: manufacturer number, item number, package number; enter "COMPOUND" if a compounded drug is dispensed.

(E) Field 10 Pharmacy's internal number assigned to the prescription.

(F) Field 15 Pharmacy's usual charges for the drug. When field 13 is coded, enter the usual charges for the generic equivalent.

(III) Form DFS-F5-DWC-10 Section 3 – Fields required to be completed by Medical Supplier or Pharmacy providing medical supplies:

(A) Field 16 Description or name of item supplied: quantity and size, when applicable.

(B) Field 17 Prescriber's Florida Department of Health license number. If the prescriber is not licensed by the Florida Department of Health, enter the license number assigned by the appropriate jurisdictional professional regulatory board or licensing authority.

(C) Field 18 Purchase date in MM/DD/CCYY format.

(D) Field 19 Medical supplier's usual charge for item(s) supplied.

(IV) Form DFS-F5-DWC-10 Section 4 – Fields required to be completed by Pharmacy and Medical Supply providers:

(A) Field 20 Total dollar charges appearing on this statement.

(B) Field 22 Date pharmacy or medical supplier submits statement to insurer for payment in MM/DD/CCYY format.

(C) Field 23 Pharmacist's license number assigned by professional regulatory board or licensing authority.

(D) Field 24 Pharmacy's or medical supplier's federal employer identification number.

4. Billing elements required by the division to be completed for Dental Billing are identified in specific DFS-F5-DWC-11 completion instructions – A, available at website: http://www.fldfs.com/WC/forms.html#7.

c. Dental Billing – Form DFS-F5-DWC-11.

(I) Field 20 Injured employee's name: Last, First, Middle initial, if applicable.

(II) Field 8 Injured employee's Social Security Number or Division-assigned number (obtained from the insurer).

(III) Field 51 Federal tax identification number.

(IV) Field 55 Dentist's Florida Department of Health license number (i.e. DN#### or DN######).

(V) Field 38 Place of treatment (check appropriate box):

(A) Office.

(B) Hospital.

(C) Extended Care Facility.

(D) Other.

(VI) Field 56 Address where services were rendered, including zip code.

(VII) Field 46 Date of current accident, injury or illness.

(VIII) Field 24 Date treatment/service performed.

(IX) Field 29 'Procedure Code' Procedure, service or supply code (CPT, CDT-4 or HCPCS 'D' code).

(X) Field 31 Total dollar charges per line item.

5. Billing elements required by the division to be completed for Hospital Billing are identified in the UB-92 Manual and as follows:

a. Locators 39-41 ZIP Code of the physical location where services were rendered.

(I) Locator 1 Hospital's location zip code.

(II) Locator 4 Type of bill.

(III) Locator 5 Federal tax identification number.

(IV) Locator 6 Date statement covers period from/through.

(V) Locator 12 Injured employee's name: Last, First, Middle initial, if applicable.

(VI) Locator 17 Admission date.

(VII) Locator 18 Admission hour.

(VIII) Locator 19 Type of Admission/Visit.

(IX) Locator 21 Discharge hour, if applicable.

(X) Locator 32 Date of accident, injury or illness.

(XI) Insurer name, address and location zip code.

(XII) Locator 42 Revenue code.

~~(XIII) Locator 44 CPT, HCPCS, or unique workers' compensation code and modifier(s), as required for reimbursement.~~

~~(XIV) Locator 45 Date of Service, required for outpatient billing.~~

~~(XV) Locator 46 Number of service units.~~

~~(XVI) Locator 47 Total dollar charges billed by revenue code.~~

~~(XVII) Locator 60A Injured employee's Social Security Number or Division assigned number (obtained from the insurer).~~

~~(XVIII) Locator 67 Principal diagnosis code (ICD-9 code).~~

~~(XIX) Locators 68-75 Other diagnosis codes (ICD-9 codes), as applicable.~~

~~(XX) Locator 80 Principal procedure code, as applicable.~~

~~(XXI) Locator 81 (A, B, C, D, E) Other procedure codes, as applicable.~~

~~(XXII) Locator 82 Attending physician's Florida Department of Health license number.~~

6.~~3.~~ An insurer can require a health care provider to complete additional data elements that are not required by the division on Forms DFS-F5-DWC-9 or DFS-F5-DWC-11.

(e)~~(d)~~ Provider Bill Submission/Filing and Reporting Requirements.

1. All medical claim form(s) or bill(s) related to services rendered for a compensable injury shall be submitted by a health care provider to the insurer, service company/TPA or any entity acting on behalf of the insurer, as a requirement for billing.

2. Medical claim form(s) or bill(s) may be electronically filed by a health care provider to the insurer, service company/TPA or any entity acting on behalf of the insurer, provided the insurer agrees.

3. Medical claim form(s) or bill(s) shall be filed with an insurer, service company/TPA or any entity acting on behalf of the insurer, according to the following requirements:

a. Health Care Providers (excluding hospitals):
Within 30 calendar days of initial or additional service or treatment and accompanied by required documentation that supports medical necessity. This requirement includes Pharmacies, Medical Suppliers, and Ambulatory Surgical Centers.

b. Hospitals:

(I) Within 30 calendar days following emergency room or initial outpatient treatment.

(II) Within 30 calendar days of an injured employee's discharge from an in-patient hospital stay or follow-up outpatient treatment.

(5) Insurer Responsibilities.

(a) An insurer is responsible for meeting its obligations under this rule regardless of any business arrangements with any service company/TPA, submitter or any entity acting on behalf of an insurer under which claims are adjusted, processed or submitted to the division.

(b) At the time of authorization for medical service(s), an insurer shall notify a health care provider of additional form completion requirements or supporting documentation from the medical record that are necessary for reimbursement in excess of the requirements set forth in this rule. Copies of hospital medical records shall be subject to charges allowed pursuant to Section 395.3025, F.S.

(c) At the time of authorization for medical service(s), an insurer shall inform an out-of-state health care provider of the specific reporting, billing and submission requirements of this rule.

(d) Insurers and providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of an injured employee's medical treatment /status. ~~and~~ A~~a~~ny other reporting forms may not be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

(e) Required data elements on Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, and DFS-F5-DWC-90, for both medical only and lost-time cases, shall be filed with the division within 45 calendar days of insurer, service company/TPA or any entity acting on behalf of the insurer, payment, adjustment and payment, disallowance or denial. This 45 calendar day requirement includes initial submission and correction and re-submission of all errors identified in the "Medical Claim Processing Report", as defined in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2005~~4~~.

(f) An insurer shall be responsible for accurately completing required data filed with the division, as of the effective date of this rule, pursuant to the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2005~~4~~ and subparagraph~~s~~ (4)(d)~~(e)~~2.-5. of this rule.

(g) When an injured employee does not have a Social Security Number or division-assigned number, the insurer must contact the division via information provided on the following website: http://www.fldfs.com/WC/organization/odqc.html (under Records Management) to obtain a division-assigned number prior to submitting the report to the division.

~~(h) An insurer shall attach an accurately completed cover sheet, as required in subparagraph (6)(f)4. of this rule, to each paper form batch submitted to the division.~~

(h)~~(i)~~ An insurer or service company/TPA must report to the division the procedure, diagnosis or modifier code(s) or amount(s) charged, as billed by the health care provider.

(i)~~(j)~~ An insurer, service company/TPA or any entity acting on behalf of the insurer shall manually or electronically date stamp Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or

insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-90 or a submitter shall date stamp the electronic form equivalent with the date insurer received.

(j)~~(k)~~ An insurer, service company/TPA or any entity acting on behalf of the insurer shall return any bills to the provider, with a written explanation, when: services are billed on an incorrect billing form; an invalid code is used and is the only line-item billed; or required information is illegible or not provided.

(k)~~(l)~~ An insurer shall pay, adjust and pay, disallow or deny billed charges within 45 calendar days from the date insurer received, pursuant to Section 440.20(2)(b), F.S.

(l)~~(m)~~ An insurer, service company/TPA or any entity acting on behalf of the insurer, when reporting paid medical claims data to the division, shall report the ~~actual~~ dollar amount paid by the insurer for the healthcare service(s) or supply(ies) ~~to the health care provider~~ or directly reimbursed to the employee for medically necessary service(s) or supply(ies). When reporting ~~On~~ disallowed or denied charges, the dollar amount paid shall ~~should~~ be reported as $0.00.

(m) An insurer shall not report as medical payment data, those payments made for failed appointments for scheduled independent medical examinations.

(n) A~~n~~ submitter ~~insurer~~, filing electronically, shall submit to the division the Explanation of Bill Review (EOBR) code(s), relating to the adjudication of each line item billed and:

1. Maintain the EOBR in a format that can be legibly reproduced, and

2. Use the EOBR codes and descriptors as follows:

a. 01 Services not authorized, as required.

b. 02 Services denied as not related to the compensable work injury.

c. 03 Services related to a denied work injury: Form DFS-F2-DWC-12 on file with the division.

d. 04 Services billed are listed as not covered or non-covered ("NC") in the applicable reimbursement manual.

e. 05 Documentation does not support the level, intensity or duration of service(s) billed. (Insurer must specify to the provider.)

f. 06 Location of service(s) is not consistent with the level of service(s) billed.

g. 07 Reimbursement equals the amount billed.

h. 08 Reimbursement is based on the applicable reimbursement schedule.

i. 09 Reimbursement is based on the contracted amount.

j. 10 Reimbursement is based on charges exceeding the stop-loss point.

k. 11 Reimbursement is based on insurer re-coding. (Insurer must specify to the provider.)

l. 12 Charge(s) are included in the per diem reimbursement.

m. 13 Reimbursement is included in the allowance of another service. (Insurer must specify procedure to the provider.)

n. 14 ~~Hospital I~~itemized statement or itemized invoice not submitted with billing form. (Insurer must specify 'statement' or 'invoice' to the provider.)

o. 15 Invalid procedure code. (Use when other valid procedure codes are present.)

p. 16 Documentation does not support that services rendered were medically necessary.

q. 17 Required supplemental documentation not filed with the bill. (Insurer must specify required documentation to the provider.)

r. 18 Duplicate Billing: Service previously paid, adjusted and paid, disallowed or denied on prior claim form or multiple billing of service(s) billed on same date of service.

s. 19 Required DFS-F5-DWC-25 form not submitted within three business days of the first treatment pursuant to Section 440.13(4)(a), F.S.

t. 20 Other: Unique EOBR code description. Use of EOBR code "20" is restricted to circumstances when a listed EOBR code does not explain the reason for adjustment, disallowance or denial of payment. When using EOBR code "20", an insurer must include the specific explanation of the code and maintain a standardized EOBR code description list.

(o) An insurer, service company/TPA, submitter or any entity acting on behalf of the insurer shall make available to the division and to the Agency, upon request and without charge, a legibly reproduced copy of Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-25, DFS-F5-DWC-90, supplemental documentation, proof of payment, EOBR and/or standardized EOBR code "20" description list.

(p) An insurer, service company/TPA or any entity acting on behalf of the insurer shall submit to the health care provider an Explanation of Bill Review, utilizing the EOBR codes listed above, including the insurer name and specific insurer contact information.

(6) Insurer Electronic Medical Report ~~(Electronic Format, Paper format, or Excel Spreadsheet format)~~ Filing t~~T~~o t~~T~~he Division.

(a) Effective March 16, 2005, all required medical reports shall be electronically filed with the division by all insurers. ~~In meeting this requirement an insurer shall comply with the following implementation schedule, as applicable:~~

1. An insurer shall be responsible for accurately completing the electronic record layout programming requirements for the reporting of the Form DFS-F5-DWC-09 Claim Detail Record Layout – Revision "C" and the Form DFS-F5-DWC-10 Claim Detail Record Layout – Revision "C" in accordance with the Florida Workers' Compensation Medical Implementation Guide (MEIG), 2005, to the division on or before December 1, 2005. The electronic record layout

for Form DFS-F5-DWC-9 adds the new field 18B for submission of the National Drug Code (NDC) number. The electronic record layout for Form DFS-F5-DWC-10 in the 2005 MEIG adds a claim detail record layout which includes form fields 6, 7, 8, 9, 10, 11, 12,13, 14 and 15 for Section 2 – Prescription Drugs, and form fields 16, 17, 18 and 19 for Section 3 – Medical Supplies . The conversion implementation schedule is as follows:

a. Insurers who have been approved for reporting production data with the new Medical Data System between August 2, 2004 and November 9, 2004 shall begin testing on September 1, 2005 and shall be in production with the new record layouts no later than September 30, 2005.

b. Insurers who have been approved for reporting production data with the new Medical Data System between November 18, 2004 and February 28, 2005 shall begin testing on October 1, 2005 and shall be in production with the new record layouts no later than October 31, 2005.

c. Insurers who have been approved for reporting production data with the new Medical Data System between March 4, 2005 and April 30, 2005 shall begin testing on November 1, 2005 and shall be in production with the new record layouts no later than November 30, 2005.

~~1. Submitters who are electronically filing any medical reports with the division, as of the effective date of this rule, must complete a test transmission and be approved by the division for production transmission that meets the requirements set forth in the Florida Workers' Compensation Medical EDI Implementation Guide, 2004 according to the following schedule:~~

~~a. August 2 through September 15, 2004, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with the letters A through E and that are submitting for multiple insurers, service companies or third party administrators.~~

~~b. September 16 through October 29, 2004, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with the letters F through Z and that are submitting for multiple insurers, service companies or third party administrators.~~

~~2. Submitters who are not electronically filing any medical reports with the division, as of November 1, 2004, must complete a test transmission and be approved by the division for production transmission that meets the requirements set forth in the Florida Workers' Compensation Medical EDI Implementation Guide, 2004 according to the following schedule:~~

~~a. November 1 through December 15, 2004, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with A through H and that are submitting for multiple insurers, service companies or third party administrators.~~

~~b. December 16, 2004 through January 31, 2005, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with I through Q and that are submitting for multiple insurers, service companies or third party administrators.~~

~~c. February 1 through March 15, 2005, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with R through Z and that are submitting for multiple insurers, service companies or third party administrators.~~

~~(b) Special Conversion to Electronic Reporting.~~

~~1. Submitters who have implemented electronic filing of any medical reports with the division within 120 calendar days prior to the effective date of this rule, shall be scheduled for the test transmission to production transmission processes, for all electronic form equivalents, to comply with requirements set forth in the Florida Workers' Compensation Medical EDI Implementation Guide, 2004, beginning February 1 through March 15, 2005.~~

2. The Division will, resources permitting, allow submitters that volunteer to complete the test transmission to production transmission processes earlier than the schedule denoted above. Each voluntary submitter shall have four ~~six~~ weeks to complete test transmission to production transmission processes, for all electronic form equivalents, that comply with requirements set forth in Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2005**4**.

(b) Any insurer, or any other entity acting on behalf of the insurer, who enters into new EDI programming arrangements on or after March 16, 2005, shall not be relieved of the responsibility to comply with the EDI filing mandate pursuant to subparagraph (6)(a) of this rule. Any insurer's non-compliance with the EDI filing mandate shall be subject to administrative penalties and administrative fines pursuant to paragraph (7) of this rule or Section 440.525, F.S.

(c) Required data elements shall be submitted in compliance with the instructions and formats as set forth in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2005**4**.

(d) The division will notify the insurer on the "Medical Claim Processing Report" of the corrections necessary for rejected medical reports to be electronically re-filed with the division. An insurer shall correct and re-file all rejected medical claim reports to meet the filing requirements of paragraph (5)(e) of this rule.

(e) Submitters who experience a catastrophic event resulting in the insurer's failure to meet the reporting requirements in paragraph (5)(e) of this rule, shall submit a

written request within 3 business days of the catastrophic failure to the division for approval to submit in an alternative reporting method and an alternative filing timeline ~~paper forms in order to meet division reporting requirements. The submission of paper forms due to a catastrophic failure shall not exceed 30 calendar days~~. Approval must be obtained from the Division's Office of Data Quality and Collection, 200 E. Gaines Street, Tallahassee, Florida 32399-4226. Approval to submit in an alternative reporting method and an alternative filing timeline ~~paper forms~~ shall be granted if a catastrophic event beyond the control of the submitter prevents electronic submission.

~~(f) Until March 16, 2005 required medical reports may be paper form filed with the division by an insurer, service company or third party administrator as follows:~~

~~1. The insurer code number and service company/third party administrator code number (if applicable) accurately and legibly entered in the upper-right corner on the form.~~

~~2. The date insurer paid legibly stamped on the front of the form. Payments of $0.00 are valid amounts on disallowed or denied charges.~~

~~3. The required data elements as set forth in record layout sections of the Florida Workers' Compensation Medical EDI Implementation Guide, 2004. An insurer shall submit to the division the listed information, legibly entered on the paper form, as follows:~~

~~a. Form DFS-F5-DWC-9.~~

~~I. "Procedure, Service or Supply Code" (as paid by the insurer, if different from billed code) – entered in Field 24D1 without obscuring the billed code;~~

~~II. "Procedure, Service or Supply Code Modifier" (as paid by the insurer, if different from billed modifier) – entered in Field 24D2 without obscuring the billed modifier;~~

~~III. "Insurer Payment per Line" entered in Field 24K.~~

~~IV. Additional data elements required pursuant to the Florida Workers' Compensation Medical EDI Implementation Guide, 2004 may be entered on the form, location to be determined by the insurer.~~

~~b. Form DFS-F5-DWC-10.~~

~~I. "Insurer Payment per Line" – written above the 'Usual Charge' in Field 15 or 19, respectively;~~

~~II. Additional data elements required pursuant to the Florida Workers' Compensation Medical EDI Implementation Guide, 2004 may be entered on the form, location to be determined by the insurer.~~

~~c. Form DFS-F5-DWC-11.~~

~~I. "Insurer Payment per Line" – entered in Field 30 following description;~~

~~II. Additional data elements required pursuant to the Florida Workers' Compensation Medical EDI Implementation Guide, 2004 may be entered on the form, location to be determined by the insurer.~~

~~d. Form DFS-F5-DWC-90.~~

~~I. "HCPCS/RATES" code (as paid by the insurer, if different from billed code). Enter the reimbursed code above the billed code;~~

~~II. "HCPCS/RATES" code modifier (as paid by the insurer if different from billed modifier). Enter the reimbursed modifier above the billed modifier;~~

~~III. "Insurer Payment per Line" entered in Locator 49;~~

~~IV. Additional data elements required pursuant to the Florida Workers' Compensation Medical EDI Implementation Guide, 2004 may be entered on the form, location to be determined by the insurer.~~

~~4. In order to facilitate the division's responsibility to determine the timeliness of health care provider reimbursement and submission of medical reports to the division, reports submitted in paper-form must be submitted in batches and each batch must be accompanied with a cover sheet and the following requirements:~~

~~a. Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11 or DFS-F5-DWC-90 forms shall be separated by form type into 100-count batches prior to submitting to the division. Insurers, processing less than 100 forms in 30 calendar days shall separate by form type category and submit batches of less than 100.~~

~~b. Within each submitted paper form batch, the insurer shall separate and band into groups, medical reports as being untimely paid to a provider or untimely reported to the division pursuant to Section 440.20(6)(b), F.S., and paragraph (5)(e) of this rule, respectively.~~

~~c. Every submitted paper-form batch shall be accompanied by a cover sheet providing the following information:~~

~~I. The title shall read "Medical Paper-Form Submission Cover Sheet".~~

~~II. The date the batch was submitted to the division shall be specified.~~

~~III. The insurer name, address including zip code of the medical claim office submitting the batch, insurer code number and service company third party administrator code number shall be specified.~~

~~IV. The insurer contact name, telephone number and email address shall be specified.~~

~~V. The form type (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90) shall be specified.~~

~~VI. The total number of medical reports in each batch submitted to the division shall be specified.~~

~~VII. The total number of medical reports filed with the division more than 45 calendar days after insurer payment, adjustment and payment, disallowance or denial shall be specified.~~

~~VIII. The total number of medical reports reflecting medical bills that were paid to the provider more than 45 calendar days from the date insurer received.~~

~~a. Every paper batch which is not accompanied by an accurately completed cover sheet or is not in compliance with sub-subparagraph (6)(f)4.a. of this rule, will be returned to the insurer, service company or third party administrator, and considered not in compliance with paragraph (5)(e) of this rule, until re-filed with an accurately completed cover sheet or correctly batched.~~

~~5. All required medical reports (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90) shall be submitted to the division at:~~

~~Department of Financial Services~~

~~Division of Workers' Compensation~~

~~Office of Data Quality and Collection, Medical Data Management Section~~

~~200 East Gaines Street~~

~~Tallahassee, FL 32399-4226.~~

~~(g) As an alternative to submitting paper-form batches, as described in paragraph (6)(f) of this rule, medical data that would otherwise be provided on paper, between the effective date of this rule and each submitter's deadline for electronic submission according to the schedule in paragraph (6)(a) of this rule, may be filed in electronic format to the division in a Medical Summary Report to meet the requirements of this rule. A request to submit medical data in this format shall be sent to ssmedrequest@dfs.state.fl.us. Upon receiving written approval from the division via e-mail, each electronic Medical Summary Report shall be filed by a submitter as follows:~~

~~1. No later than 15 calendar days following the end of each calendar month, an insurer, service company or third party administrator shall submit four division-approved electronic Excel spreadsheets; one Excel spreadsheet for each of the four medical form-types (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 and DFS-F5-DWC-90).~~

~~2. Each Excel spreadsheet must contain the following data elements:~~

~~a. Form Type (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90).~~

~~b. Calendar Month/Year of medical data processed by the insurer submitted to the division, (i.e. 01/01/2004 through 01/31/2004).~~

~~c. Name of Insurer, Service Company, or Third Party Administrator submitting the monthly division-approved electronic Excel spreadsheet.~~

~~d. Insurer code number, Service Company/Third Party Administrator code number submitting the monthly division-approved electronic Excel spreadsheet.~~

~~e. Contact Name, address, including zip code, telephone number and e-mail address of the Insurer, Service Company or Third Party Administrator.~~

~~f. Total number of bills that were paid, adjusted and paid, disallowed or denied for the calendar month reported.~~

~~g. Total number of bills reported in sub-subparagraph f. above, that were paid, adjusted and paid, disallowed or denied more than 45 calendar days after the date insurer received the bill from the provider.~~

~~h. For each of the bills that were paid, adjusted and paid, disallowed or denied more than 45 calendar days after the date insurer received the bill from provider, the following additional data elements shall be provided on the division-approved electronic Excel spreadsheet:~~

~~(I) Injured Employee Last Name;~~

~~(II) Injured Employee First Name;~~

~~(III) Injured Employee SSN;~~

~~(IV) Claims Handling Entity File Number;~~

~~(V) Date of Accident;~~

~~(VI) Date Insurer Received Bill from Provider;~~

~~(VII) Date Insurer Paid, Adjusted and Paid, Disallowed, or Denied the Bill;~~

~~(VIII) Total Dollar Amount Paid by Insurer. If disallowed or denied, $0.00 is to be reported; and~~

~~(IX) Provider License, Pharmacist or Other Facility number as assigned by the professional regulatory board, licensing authority or state regulatory agency, whichever is applicable depending on form-type that is submitted.~~

~~(i) Each Insurer, Service Company, or Third Party Administrator approved to submit the electronic Medical Summary Report, shall submit the division-approved electronic Excel spreadsheets within the required time frame under subparagraph (6)(g)1. of this rule to ssmedformat@dfs.state.fl.us.~~

(7) Insurer Administrative Penalties and Administrative Fines.

(a) Insurer administrative penalties for untimely provider-payment or disposition of medical bills. The department shall impose insurer administrative penalties for failure to comply with the payment, adjustment and payment, disallowance or denial requirements pursuant to Section 440.20(6)(b), F.S. Timely performance standards for timely payments, adjustments and payments, disallowances or denials, reported on Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 and DFS-F5-DWC-90, shall be calculated and applied on a monthly basis for each separate f~~F~~orm category that was received within a specific calendar month.

(b) Insurer administrative fines for failure to submit, untimely submission, filing and reporting of medical data requirements. Pursuant to Section 440.185(9), F.S., the department shall impose insurer administrative fines for failure to comply with the submission, filing or reporting requirements of this rule. Insurer administrative fines shall be:

1. Calculated on a monthly basis for each separate Form category (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, DFS-F5-DWC-90) received and accepted by the division within a specific calendar month; and

2. Imposed for each failure to file, untimely filed ~~un-filed~~, rejected and not re-submitted, or rejected and re-submitted untimely medical data report according to the following schedule:

a. 1-15 calendar days late $10.00;

b. 16-30 calendar days late $20.00;

c. 31-45 calendar days late $30.00;

d. 46-60 calendar days late $40.00;

e. 61-75 calendar days late $50.00;

f. 76-90 calendar days late $100.00; and

g. 91 calendar days or greater $2~~5~~00.00.

~~(c) An Insurer that fails to submit, or who untimely submits, any division-approved Medical Summary Report electronic Excel spreadsheet required in subparagraph (6)(g)1. of this rule, shall be assessed a penalty for improper filing of $25.00 per day, not to exceed a total penalty of $1,000.00 per improperly filed Excel spreadsheet, in addition to any administrative penalty pursuant to Section 440.20(6)(b), F.S.~~

Specific Authority 440.13(4), 440.15(3)(b),(d), 440.185(5), 440.525(2), 440.591, 440.593(5) FS. Law Implemented 440.09, 440.13(2)(a),(3),(4),(6),(11),(12),(14),(16), 440.15(3)(b),(d), 440.20(6), 440.185(5),(9), 440.593 FS. History–New 1-23-95, Formerly 38F-7.602, 4L-7.602, Amended 7-4-04, _____.

DEPARTMENT OF FINANCIAL SERVICES

OIR Insurance Regulation

RULE TITLE: RULE NO.:
Annual Audited Financial Reports 69O-137.002

PURPOSE AND EFFECT: This rule deals with the annual audit by an independent CPA filed pursuant to Section 624.424(8), F.S. This revision removes the surplus language dealing with remedies; such remedies already being part of the rules of the Secretary of State. The rule also changes the number of the form to be used to file for this exemption, changes the names of the entities from which the form may be procured, and states it is available from the DFS web page.

SUBJECT AREA TO BE ADDRESSED: Annual Audited Financial Reports.

SPECIFIC AUTHORITY: 624.308(1), 624.424(8)(e) FS.

LAW IMPLEMENTED: 624.307(1), 624.324, 624.424(8) FS.

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

TIME AND DATE: 9:30 a.m., May 19, 2005

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

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Paul Johns, Life and Health Financial Oversight, Office of Insurance Regulation, e-mail: paul.johns@fldfs.com

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

DEPARTMENT OF FINANCIAL SERVICES

OIR Insurance Regulation

RULE TITLES: RULE NOS.:
Disclosure 69O-144.003
Credit for Reinsurance 69O-144.005

PURPOSE AND EFFECT: Requires domestic insurance companies to disclose any of their finite reinsurance agreements and requires compliance with the disclosure requirement for credit for reinsurance. Changes form number OIR-D0-1 to OIR-D0-1464.

SUBJECT AREA TO BE ADDRESSED: The subject area of the rule development is reinsurance, specifically the disclosure of any existing finite reinsurance agreements and compliance for credit for reinsurance and change in form number.

SPECIFIC AUTHORITY: 624.308, 624.610(14) FS.

LAW IMPLEMENTED: 624.307(1), 624.610 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., May 10, 2005

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

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Claude Mueller, Property and Casualty Financial Oversight, Office of Insurance Regulation, e-mail: claude.mueller@fldfs.com

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