

Section II Proposed Rules

DEPARTMENT OF EDUCATION

State Board of Education

RULE NO.: 6A-6.014 RULE TITLE: General Requirements for Adult General Education Program

PURPOSE AND EFFECT: The purpose of this rule amendment is to update the tests for educational functioning levels and to clarify that the tests are to be used for reporting of learning gains, in addition to the placement of a student in an adult general education program. The effect is a rule compliant with federal testing requirements for adult education.

SUMMARY: The proposed amendment requires the use of an updated version of the standards established for test administration and interpretation and clarifies that the test used for placement of a student in adult general education programs is to also be used for documenting learning gains. In addition, the amendment changes, and adds a test, that can be used to measure and report English language acquisition for an adult student enrolled in the English for Speakers of Other Languages program.

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

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

RULEMAKING AUTHORITY: 1001.02(1) FS.

LAW IMPLEMENTED: 1008.405, 1011.80 FS.

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

DATE AND TIME: July 14, 2009, 10:00 a.m.

PLACE: 325 West Gaines Street, Department of Education, Tallahassee, Florida. Conference call #1(888)808-6959, Code 4617163

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Ms. Elsie Rogers, Division of Workforce Education, 325 West Gaines Street, Suite 720, Tallahassee, FL 32399

THE FULL TEXT OF THE PROPOSED RULE IS:

6A-6.014 General Requirements for Adult General Education Program.

In the operation of adult general education programs, the following general requirements shall apply:

- (1) through (3) No change.
- (4) Academic skills tests for adults.

(a) The following tests, English language versions only, are approved to be used for placement and documentation of learning gains of a student enrolled in the adult general education program. The tests and shall be used according to standards established for test administration and interpretation set forth in Standards for Educational and Psychological Testing (APA, AERA, NCME, 1999 +992) and with appropriate accommodations for students with disabilities as specified in Section 1004.02(7), F.S.

1. Tests of Adult Basic Education (TABE), Complete Battery or Survey Form, Forms 9 & 10 (all active assessments as of the date of adoption of this rule);

2. Comprehensive Adult Student Assessment System (CASAS) (all active assessments as of the date of adoption of this rule).

(b) The following tests, English language versions only, are approved to be used for placement of a student enrolled in the adult English for Speakers of Other Languages program and shall be used according to standards established for test administration and interpretation set forth in Standards for Educational and Psychological Testing (APA, AERA, NCME, 1999) and with appropriate accommodations for students with disabilities, as specified in Section 1004.02(7), Florida Statutes ~~When testing students enrolling in Adult ESOL or English Literacy for Career and Technical Education (ELCATE) whose first language is not English, one of the following tests must be used:~~

1. Comprehensive Adult Student Assessment System (CASAS), ~~Reading and Listening~~ (all active assessments as of the date of adoption of this rule);

2. Basic English Skills Test (BEST) Plus (all active assessments as of the date of adoption of this rule); or

3. Basic English Skills Test (BEST) Literacy (all active assessments as of the date of adoption of this rule);

4. Comprehensive Adult Student Assessment System (CASAS) Employability Competency System Reading Skills for English Literacy for Career and Technical Education (ELCATE) students; ~~and-~~

5. Tests for Adult Basic Education Complete Language Assessment System – English (TABE CLAS-E) (all active assessments as of the date of this rule).

(c) through (5)(c) No change.

Rulemaking Specific Authority 1001.02(1) FS. Law Implemented 1008.405, 1011.80 FS. History—Amended 2-20-64, 4-11-70, 11-17-73, 2-18-74, 6-17-74, Repromulgated 12-5-74, Amended 12-6-84, Formerly 6A-6.14, Amended 12-28-86, 10-17-89, 12-29-98, 4-26-06, 9-19-07,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Loretta Costin, Deputy Chancellor, Division of Workforce Education

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Dr. Eric J. Smith, Commissioner of Education

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: June 3, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: January 23, 2009

DEPARTMENT OF EDUCATION

State Board of Education

RULE NO.: 6A-6.0573
RULE TITLE: Industry Certification Process

PURPOSE AND EFFECT: The purpose of this rule amendment is to adopt the 2009-2010 "Comprehensive Industry Certification List" and the 2009-2010 "Industry Certification Funding List."

SUMMARY: The rule is amended to adopt the "Comprehensive Industry Certification List," as compiled by the Agency for Workforce Innovation, as approved and published March 2009 by Workforce Florida, Inc. In addition, the 2009-2010 "Industry Certification Funding List." is presented for approval.

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

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

RULEMAKING AUTHORITY: 1003.492(2) FS.

LAW IMPLEMENTED: 1003.491, 1003.492, 1003.493 FS.

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

DATE AND TIME: July 14, 2009, 10:00 a.m.

PLACE: 325 West Gaines Street, Department of Education, Tallahassee, Florida. Conference call # 1(888)808-6959, Code 4617163

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Ms. Tara Goodman, Division of Workforce Education, 325 West Gaines Street, Suite 744, Tallahassee, FL 32399

THE FULL TEXT OF THE PROPOSED RULE IS:

6A-6.0573 Industry Certification Process.

(1) Pursuant to Section 1003.492(2), Florida Statutes F.S., Workforce Florida, Inc.'s approved list of industry certifications, which has been named the "Comprehensive Industry Certification List, ~~March 2009 April 2008~~" is adopted by the State Board of Education and incorporated by reference in this rule to become effective with the effective date of this rule. The "Comprehensive Industry Certification List" may be obtained from the Department of Education's web site at <http://www.fldoe.org/workforce/fcpea/default.asp>.

(2) No change.

(3) "Industry Certification Funding List." The Department of Education shall review the approved "Comprehensive Industry Certification List" to identify ~~program to certification linkages and to identify~~ certifications deemed sufficiently rigorous academically and, thus, eligible for additional full-time equivalent (FTE) membership bonus FTE funding, pursuant to Section 1011.62(1)(o), Florida Statutes F.S.

(a) This list will be known as the "Industry Certification Funding List," to be published by the Department of Education and which is incorporated by reference in this rule to become effective with the effective date of this rule. The "Industry Certification Funding List" may be obtained from the Department of Education's web site at <http://www.fldoe.org/workforce/fcpea/default.asp>.

(b) To be considered for additional full-time equivalent membership bonus funding and included on the "Industry Certification Funding List" in this paragraph, a certification shall ~~meet the following criteria for academic rigor:~~

1. ~~The certification shall~~ be on the "Comprehensive Industry Certification List.;"
2. ~~The certification shall~~ be achievable by students in a secondary level program.;
3. ~~The certification shall~~ require a minimum of one hundred fifty (150) hours of instruction; and;
4. ~~The certification shall~~ have been offered for at least one year in a school district.

(c) The Commissioner of Education may waive the one-year requirement when failure to do so would inhibit preparation of students for emerging workforce opportunities.

~~(4) The Department of Education shall publish annually a final "Industry Certification Funding List," to be incorporated by reference in this rule.~~

~~(4)(a) No later than March 15 each year,~~ The Department of Education shall produce annually a preliminary "Industry Certification Funding List" no later than March 15 and shall show the industry certifications program to certification linkages for which registered career and professional academy students may be reported for additional full-time equivalent membership bonus funding by school districts under Section 1011.62(1)(o), Florida Statutes F.S.

~~(a)(b) Following the release of a preliminary list,~~ School districts shall be provided a period of time to request additions to the preliminary "Industry Certification Funding List" additional program to certification linkages prior to publication of the final "Industry Certification Funding List" for the following school year.

~~(b)(c) School districts offering career and professional academies under Section 1003.492, Florida Statutes, may submit requests to include an industry certification, not on the preliminary "Industry Certification Funding List," To add a specific program to certification linkage to the final "Industry Certification Funding List" for the following school year,~~

~~school districts offering career and professional academies under Section 1003.493, F.S., may submit requests, along with supporting documentation, to the Department of Education.~~

1. through 3. No change.

4. If the request is denied; for failure to meet the criteria in paragraph (3)(b) of this rule, the a specific reason for denial shall be included in the response to the school district.

(5) The final "Industry Certification Funding List" for the school year shall be published no later than the July 1, preceding the beginning of the school year. With the publication of this list, the Department will recommend linkages to secondary career and technical programs in the Course Code Directory.

(6) Conditions for the additional full-time equivalent membership bonus FTE funding pursuant to Section 1011.62(1)(o), Florida Statutes F.S.

(a) A school district shall be eligible for additional ~~may report a student for bonus~~ FTE membership under the following conditions, for a maximum of one 0.3 full-time equivalent membership funding bonus per student:

1. through 2. No change.

~~3. The course enrollment is reported in a secondary career and technical education program which has been linked to the final "Industry Certification Funding List."~~

~~4. An industry certification may only be reported once for funding per student.~~

~~3.5.~~ Student receives a high school diploma.

(b) through (c) No change.

(7) Registration of Career and Professional Academies. The Department of Education shall maintain a web site for school districts to register career and professional academies that meet the requirements of Section 1003.493, Florida Statutes F.S.

(a) No change.

(b) As part of the registration process, the superintendents shall certify that each academy meets all of the requirements of Section 1003.493, Florida Statutes F.S.

(c) No change.

(d) Academies shall be registered by September 15 of the reporting year for their students to be eligible to generate the additional full-time equivalent membership bonus funding based on the completion of industry certifications.

(8) Performance Criteria.

(a) through (b) No change.

(c) In the annual registration process for the academy, the school district can no longer report an industry certification that fails to meet the performance criteria in the academy and will not be eligible to receive the additional full-time equivalent membership funding bonus FTE for that industry certification under the requirements of Section 1011.62(1)(o), Florida Statutes F.S.

Rulemaking Specific Authority 1003.492(2) FS. Law Implemented 1003.491, 1003.492, 1003.493 FS. History--New 10-20-08, Amended _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Loretta Costin, Deputy Chancellor, Division of Workforce Education

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Dr. Eric J. Smith, Commissioner of Education

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: June 3, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: April 10, 2009

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND

Notices for the Board of Trustees of the Internal Improvement Trust Fund between December 28, 2001 and June 30, 2006, go to <http://www.dep.state.fl.us/> under the link or button titled "Official Notices."

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

RULE NOS.:	RULE TITLES:
40D-1.603	Permit Application Procedures
40D-1.605	Content of Application
40D-1.6051	Timeframe for Providing Requested Information for Permit Applications and Denial of Incomplete Applications
40D-1.659	Forms and Instructions

PURPOSE AND EFFECT: The purpose of this rulemaking is to revise and update District rules governing permit application procedures and permit processing timeframes. The overall effects will be to improve permit processing procedures, make District permit application processing more consistent with other water management districts, and consolidate permit processing rules within Part VI of Chapter 40D-1, F.A.C.

SUMMARY: The purpose of this rulemaking is to revise and update District rules governing permit application procedures and permit processing timeframes. The overall effects will be to improve permit processing procedures, make District permit application processing more consistent with other water management districts, and consolidate permit processing rules within Part VI of Chapter 40D-1, F.A.C.

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

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

RULEMAKING AUTHORITY: 120.54(5), 373.044, 373.113, 373.118, 373.149, 373.171, 373.337, 373.4135, 373.4136, 373.414 FS.

LAW IMPLEMENTED: 120.54(5), 120.60, 120.60(4), 373.0831(3), 373.084, 373.085, 373.106, 373.116, 373.118, 373.119, 373.171, 373.196(1), 373.1961(3), 373.206, 373.207, 373.209, 373.216, 373.219, 373.229, 373.2295, 373.239, 373.246, 373.249, 373.306, 373.308, 373.309, 373.313, 373.323, 373.324, 373.413, 373.4136, 373.414, 373.416, 373.418, 373.419, 373.421, 373.426, 668.50 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Martha A. Moore, Senior Attorney, Office of General Counsel, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, extension 4660

THE FULL TEXT OF THE PROPOSED RULES IS:

40D-1.603 Permit Application Procedures.

(1) A permit application shall be:

(a) Filed with the District on the appropriate form or forms incorporated by reference in the applicable rule, with all application blanks filled in and containing signatures as required for each form; Chapter 40D-1, F.A.C.;

(b) Accompanied by the required number of copies at the time of submittal, as specified in the appropriate rule; and

(c) Accompanied by the appropriate fee as set forth in Rule 40D-1.607, F.A.C.

(d) Any requirement to submit multiple copies of an application shall not apply when the complete application package is received electronically through the District's electronic permitting process.

(2) through (14) No change.

Rulemaking Specific Authority 373.044, 373.113, 373.118 FS. Law Implemented 120.60(4), 373.116, 373.118, 373.229, 373.413 FS. History—New 10-1-84, Amended 5-10-88, 12-22-94, 10-19-95, 3-31-96, 12-16-97, 7-2-98, 7-22-99, 11-8-00, 9-26-02, 12-24-07, 4-7-08, 11-2-08,_____.

40D-1.605 Content of Application.

Rulemaking Specific Authority 373.044, 373.113, 373.149, 373.171 FS. Law Implemented 373.085, 373.106, 373.116, 373.216, 373.229, 373.246, 373.249, 373.413, 373.414, 373.416 FS. History—Readopted 10-5-74, Amended 10-24-76, Formerly 16J-0.10, 16J-0.11, Amended 10-1-84, Formerly 40D-0.101, Amended 12-22-94, Repealed_____.

40D-1.6051 Timeframe for Providing Requested Information for Permit Applications and Denial of Incomplete Applications.

(1) Within 30 days after receipt of an application, the District shall notify the applicant if the application is incomplete and request the additional information required to

make the application complete. The applicant shall have up to 90 days to submit all information requested. If additional information is not supplied within 90 30 days after notice by the District, the application will be denied for lack of completeness as provided in subsection (2). If the application is still incomplete after additional information is provided, the District shall so notify the applicant, who shall have an additional 30 days to render the application complete or be denied for lack of completeness. Upon request by the applicant, an extension of time may be granted by the District staff upon a showing by the applicant that a good faith effort is being made to provide the additional information and the additional time is required. The District may, Wwithin 30 days after receiving all additional information requested from the applicant, the District shall review it and may request only clarifications of the information or request answers to new questions raised or directly related to the information previously furnished. The applicant shall have up to 90 days from issuance of the District's request for clarifying or additional information to submit the information requested. If the requested information is not supplied within 90 days after notice by the District, the application will be denied for lack of completeness as provided in subsection (2). If the applicant believes the request of the District for such clarifying or additional information is not authorized by law or rule, upon receipt of the applicant's written request the District shall proceed to process the permit application.

(a) The applicant shall include with each submittal of information in support of a pending permit application an Applicant Transmittal Form, Form No. LEG-R.046.00 (06/09), which form is incorporated herein by reference and can be obtained from the District's website at www.watmatters.org or from District offices. The applicant shall specify on the Applicant Transmittal Form the application number for which the information or material is being submitted and the contents of the submittal and shall state whether the accompanying submittal completes the applicant's response to the District's request for additional or clarifying information. District staff shall proceed to process the permit application upon receipt of the applicant's information and statement that the submittal completes the applicant's response, upon receipt of the applicant's written request that the District proceed to process the application or, if no statement and additional information is received, upon the conclusion of the 90-day response period.

(b) Upon written request by the applicant, an extension of time may be granted by the District staff upon a showing by the applicant that a good faith effort is being made to provide the additional information and the additional time is required.

(c) Denial of an application for lack of completeness is without prejudice to the applicant's right to file a new application on the same subject matter.

(2) If requested information is not submitted to the District within the time limits set forth in subsection (1) above, or if an application remains incomplete for more than 365 days and no

further extension of time will be granted, District staff shall issue to the applicant a notice of proposed agency action to deny the permit application for lack of completeness. The proposed application denial shall become final 21 days after receipt of written notice, as defined in paragraph 40D-1.1010(2)(b), F.A.C., or 14 days after receipt of written notice for a consolidated application concurrently reviewed pursuant to Section 373.427, F.S., unless prior to that date: the application is amended as provided in subsection 40D-1.603(7), F.A.C.; the application is withdrawn; a petition for administrative hearing is filed; or a written request to refer the application to the Governing Board for agency action is submitted by the applicant.

Rulemaking Specific Authority 120.54(5), 373.044, 373.113, 373.118, 373.4135, 373.4136, 373.414 FS. Law Implemented 120.54(5), 120.60, 373.084, 373.085, 373.116, 373.118, 373.119, 373.171, 373.229, 373.2295, 373.308, 373.309, 373.323, 373.413, 373.4136, 373.414, 373.416, 373.418, 373.426 FS. History—New 7-2-98. Formerly 40D-1.1020, Amended _____.

40D-1.659 Forms and Instructions.

The following forms and instructions have been approved by the Governing Board and are incorporated by reference into this chapter or into a specific District rule as indicated. Copies of these forms may be obtained from the District’s website at www.watermatters.org or from District offices.

- (1) through (2) No change.
- (3) OTHER.
- (a) through (c) No change.

(d) APPLICANT TRANSMITTAL FORM, FORM NO. LEG-R.046.00 (5/09), incorporated by reference in paragraph 40D-1.6051(1)(a), F.A.C.

Rulemaking Specific Authority 373.044, 373.113, 373.149, 373.171, 373.337 FS. Law Implemented 373.0831(3), 373.116, 373.196(1), 373.1961(3), 373.206, 373.207, 373.209, 373.216, 373.219, 373.229, 373.239, 373.306, 373.308, 373.309, 373.313, 373.323, 373.324, 373.413, 373.414, 373.416, 373.419, 373.421, 668.50 FS. History—New 12-31-74, Amended 10-24-76, Formerly 16J-0.40, 40D-1.901, 40D-1.1901, Amended 12-22-94, 5-10-95, 10-19-95, 5-26-96, 7-23-96, 2-16-99, 7-12-99, 7-15-99, 12-2-99, 5-31-00, 9-3-00, 10-26-00, 6-26-01, 11-4-01, 6-12-02, 8-25-02, 2-26-03, 9-14-03, 9-30-04, 2-1-05, 6-5-05, 10-19-05, 2-6-07, 2-26-07, 9-27-07, 11-11-07, 11-25-07, 1-8-08, 4-7-08, 5-12-08, 5-20-08, 8-19-08, 12-30-08, 3-26-09, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Martha A. Moore

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Southwest Florida Water Management District Governing Board

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 20, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: May 29, 2009

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

RULE NO.: 40D-1.659
RULE TITLE: Forms and Instructions

PURPOSE AND EFFECT: The purpose and effect of this rulemaking is to list a newly adopted Water Use Permit Application Form – Mining and Dewatering, Form No. LEG-R.032.01 (5/09), which is incorporated by reference in paragraph 40D-2.101(2)(d), F.A.C.

SUMMARY: The District is revising all of its Water Use Permit application forms in coordination with efforts to enhance electronic permitting capabilities through the District’s Water Management Information System, or WMIS, which has recently been expanded to allow electronic applications for all types of water use permits. New or revised forms are being adopted for all water uses. A new form, Water Use Permit Application – Mining and Dewatering, Form No. LEG-R.032.01 (5/09) has been adopted and is being incorporated by reference into Rule 40D-2.101, F.A.C. The new form is being listed in Rule 40D-1.659, F.A.C., along with all other approved District forms.

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

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

RULEMAKING AUTHORITY: 373.044, 373.113, 373.149, 373.171, 373.337 FS.

LAW IMPLEMENTED: 373.0831(3), 373.116, 373.196(1), 373.1961(3), 373.206, 373.207, 373.209, 373.216, 373.219, 373.229, 373.239, 373.306, 373.308, 373.309, 373.313, 373.323, 373.324, 373.413, 373.414, 373.416, 373.419, 373.421, 668.50 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Barbara Martinez, Sr. Administrative Assistant, Office of General Counsel, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, extension 4660

THE FULL TEXT OF THE PROPOSED RULE IS:

40D-1.659 Forms and Instructions.

The following forms and instructions have been approved by the Governing Board and are incorporated by reference into this chapter or into a specific District rule as indicated. Copies of these forms may be obtained from the District offices or the District’s website at www.watermatters.org.

- (1) GROUND WATER
- (a) through (l) No change.

(m) WATER USE PERMIT APPLICATION SUPPLEMENTAL FORM – MINING AND OR DEWATERING, FORM NO. LEG-R.032.0100 (5/09) (3/09), incorporated by reference in subparagraph 40D-2.101(2)(d)(a)3-, F.A.C.

(n) through (gg) No change.

Rulemaking Specific Authority 373.044, 373.113, 373.149, 373.171, 373.337 FS. Law Implemented 373.0831(3), 373.116, 373.196(1), 373.196(3), 373.206, 373.207, 373.209, 373.216, 373.219, 373.229, 373.239, 373.306, 373.308, 373.309, 373.313, 373.323, 373.324, 373.413, 373.414, 373.416, 373.419, 373.421, 668.50 FS. History–New 12-31-74, Amended 10-24-76, Formerly 16J-0.40, 40D-1.901, 40D-1.1901, Amended 12-22-94, 5-10-95, 10-19-95, 5-26-96, 7-23-96, 2-16-99, 7-12-99, 7-15-99, 12-2-99, 5-31-00, 9-3-00, 10-26-00, 6-26-01, 11-4-01, 6-12-02, 8-25-02, 2-26-03, 9-14-03, 9-30-04, 2-1-05, 6-5-05, 10-19-05(1) and (2), 10-19-05(5), 10-19-05(20), 2-6-07, 9-27-07, 11-11-07, 11-25-07, 1-8-08, 4-7-08, 5-12-08, 5-20-08, 8-19-08, 12-30-08, 3-26-09,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Martha A. Moore

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Southwest Florida Water Management District Governing Board

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 20, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: May 29, 2009

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

RULE NOS.:	RULE TITLES:
40D-2.091	Publications Incorporated by Reference
40D-2.101	Content of Application

PURPOSE AND EFFECT: The purpose of this rulemaking is to adopt and incorporate by reference a new Water Use Permit Application Form – Mining and Dewatering, Form No. LEG-R.032.01 (5/09). The effect will be that applicants will submit only one detailed water use permit application form for mining and dewatering uses instead of submitting an application form for an Individual or General water use permit and a supplemental form for providing more specific information on activities relating to mining and dewatering water uses.

SUMMARY: The District is revising all of its Water Use Permit application forms in coordination with efforts to enhance electronic permitting capabilities through the District’s Water Management Information System, or WMIS, which has recently been expanded to allow electronic applications for all types of water use permits. The District is adopting a new form, Water Use Permit Application – Mining and Dewatering, Form No. LEG-R.032.01 (5/09) which is being incorporated by reference into Rule 40D-2.101, F.A.C. The new form will also be listed in Rule 40D-1.659, F.A.C., which lists all approved District forms. An updated Water Use

Permit Information Manual Part B, “Basis of Review,” is also incorporated by reference in Rule 40D-2.091, F.A.C. The special permit conditions for mining-related permits as set forth in Section 6.2 of the District’s Basis of Review are revised to allow for submittal of ground and surface water levels referenced to North American Vertical Datum (NAVD) 1988 in addition to National Geodetic Vertical Datum (NGVD) 1929, as is allowed on the newly adopted form.

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

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

RULEMAKING AUTHORITY: 373.044, 373.113, 373.118, 373.171 FS.

LAW IMPLEMENTED: 373.036, 373.0361, 373.042, 373.0421, 373.0831, 373.116, 373.117, 373.118, 373.149, 373.171, 373.1963, 373.216, 373.219, 373.223, 373.229, 373.239, 373.243 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Martha A. Moore, Senior Attorney, Office of General Counsel, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, ext. 4660

THE FULL TEXT OF THE PROPOSED RULES IS:

40D-2.091 Publications Incorporated by Reference.

The following publications are hereby incorporated by reference into this Chapter, and are available from the District upon request:

- (1) Water Use Permit Information Manual Part B, “Basis of Review (_____) (01-20-09); and
- (2) No change.

**WATER USE PERMIT INFORMATION MANUAL
PART B – BASIS OF REVIEW**

**6.2 SPECIAL PERMIT CONDITIONS
REPORTING**

16. Ground Water Level Monitoring

Condition: The Permittee shall monitor water levels in the _____ (specified) aquifer(s). Reports of the data shall be submitted to the District, in a form acceptable to the District. All data shall be referenced to National Geodetic Vertical Datum (NGVD) 1929 or North American Vertical Datum (NAVD) 1988 as determined by the District. The frequency of water-level recording may be modified by the Director, Resource Regulation Department, as necessary to ensure the protection of the resource. Water levels in the wells shall be recorded for the specified District ID No., aquifer, and recording frequency. District ID No. Aquifer Recording

Frequency Water levels shall be recorded on a continuous hourly basis for those wells with a continuous recording frequency and on the same day of each week for those wells with a weekly recording frequency. The average of the 24-hour values (continuous recording) for each day shall be calculated, and only the average value for each day shall be reported to the District. The time and date that the water level is measured shall be reported with the data.

Discussion: This condition is used in situations such as those addressed in Section 5.4. The location(s) of each monitoring point is linked to the District I.D. No. by latitude-longitude.

6.3 MINING PERMIT CONDITIONS

3. Dewatering Setbacks

Condition: Prior to dewatering within ___ ft of a property boundary, the Permittee shall comply with one of the following alternatives.

a. Secure written consent from all adjacent property users for lowering the water table below their lands. The consent shall be submitted in writing to the Director, Resource Regulation Department, prior to opening mining pits within the specified distance.

b. Implement a procedure to mitigate impacts by maintaining the water table at the property boundary at historic levels. This procedure must be approved by the Director, Resource Regulation Department, and shall include the following:

(6) Data collection shall continue for 6 months following completion of mining and reclamation or until District staff determine that background or steady-state levels are attained. During this time period, water-level data shall be recorded on a weekly basis and reported monthly. Water levels shall be reported in feet relative to the NGVD 29 or NAVD 88 as determined by the District.

Rulemaking Specific Authority 373.044, 373.113, 373.118, 373.171 FS. Law Implemented 373.036, 373.0361, 373.042, 373.0421, 373.0831, 373.116, 373.117, 373.118, 373.149, 373.171, 373.1963, 373.216, 373.219, 373.223, 373.229, 373.239, 373.243 FS. History—New 10-1-89, Amended 11-15-90, 2-10-93, 3-30-93, 7-29-93, 4-11-94, 7-15-98, 7-28-98, 7-22-99, 12-2-99, 8-3-00, 9-3-00, 4-18-01, 4-14-02, 9-26-02, 1-1-03, 2-1-05, 10-19-05, 1-1-07, 8-23-07, 10-1-07, 10-22-07, 11-25-07, 12-24-07, 2-13-08, 2-18-08, 4-7-08, 5-12-08, 7-20-08, 9-10-08, 12-30-08, 1-20-09, 3-26-09,_____.

40D-2.101 Content of Application.

(1) No change.

(2) The following District application forms shall be used to obtain a new Water Use Permit or to renew an existing Water Use Permit. All permit application forms described herein have been approved by the District Governing Board and are incorporated by reference into this Chapter. Forms are available upon request from ~~any District office or from~~ the District’s website at www.watermatters.org or from District offices.

(a) Individual Water Use Permit. Application for a new or renewal of an existing Individual Water Use Permit shall be made using the Individual Water Use Permit Application, Form No. LEG-R.029.00 (3/09). Applicants shall also submit one or more of the following Supplemental Forms as appropriate for each type of water use proposed in the permit application:

1. Water Use Permit Application Supplemental Form – Agriculture, Form No. LEG-R.030.00 (3/09).

2. Water Use Permit Application Supplemental Form – Industrial or Commercial, Form No. LEG-R.031.00 (3/09).

~~3. Water Use Permit Application Supplemental Form – Mining or Dewatering, Form No. LEG-R.032.00 (3/09).~~

~~3.4.~~ Water Use Permit Application Supplemental Form – Public Supply, Form No. LEG-R.033.00 (3/09).

~~4.5.~~ Water Use Permit Application Supplemental Form – Recreation or Aesthetic, Form No. LEG-R.034.00 (3/09).

(b) through (c) No change.

(d) Mining and Dewatering Water Use Permit. Application for a new or renewal of an existing Water Use Permit for mining and dewatering uses shall be made using the Water Use Permit Application – Mining and Dewatering, Form No. LEG-R.032.01 (5/09). The application shall be categorized as an application for an Individual or General Water Use Permit based upon the combined annual average daily water demand as provided in subsection 40D-2.041(2), F.A.C.

(3) through (4) No change.

Rulemaking Specific Authority 373.044, 373.113, 373.171 FS. Law Implemented 373.216, 373.229 FS. History—Readopted 10-5-74, Amended 10-24-76, 1-6-82, 2-14-82, Formerly 16J-2.06, Amended 10-1-89, 10-23-89, 2-10-93, 7-15-99, 1-1-03, 1-1-07, 11-25-07, 9-10-08,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Ken Weber, Water Use Regulation Program Director, Strategic Program Office, Resource Regulation Department, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, ext. 4303
 NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Southwest Florida Water Management District Governing Board

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 20, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: June 5, 2009

WATER MANAGEMENT DISTRICTS

Southwest Florida Water Management District

RULE NOS.:	RULE TITLES:
40D-22.201	Year-Round Water Conservation Measures
40D-22.401	Enforcement

PURPOSE AND EFFECT: To make more consistent the year-round water conservation regulations relating to landscape irrigation among the District, the St Johns River

Water Management District (SJRWMD) and the South Florida Water Management District (SFWMD). Consistency of regulations will promote compliance and more efficient enforcement of the regulations especially in areas where counties or municipalities are located in more than one water management district. In December 2008, the Board approved adoption of the proposed amendments pending adoption by the other Districts of consistent year-round regulations. SJRWMD has adopted its rules. Because there will be a delay in rule adoption for the SFWMD, this District's Board authorized completion of this rulemaking.

SUMMARY: The proposed amendments approved by the Board in December 2008 provide (1) a maximum of twice-per-week watering with specified days for residential properties, (2) a separate twice-per-week watering schedule for nonresidential properties, (3) uniform allowable watering hours for all property types and sources of water, including reclaimed water, (4) modification of the establishment period allowance for new plant material, (5) clarification regarding what constitutes one complete irrigation application, (6) clarification regarding the need to improve the efficiency of reclaimed water, (7) requirements for rain sensors, (8) provisions governing operation of fountains and augmentation of water bodies, and (9) a provision for review of a local government's proposed ordinance that includes different year-round measures prior to approval of the ordinance by the applicable city council or county commission.

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

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

RULEMAKING AUTHORITY: 373.044, 373.113, 373.171, 373.219, 373.223 FS.

LAW IMPLEMENTED: 373.119, 373.171, 373.175, 373.219, 373.223, 373.246, 373.603, 373.609 FS.

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

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 5 days before the workshop/meeting by contacting: Dianne Lee, Office of General Counsel, 2379 Broad Street, Brooksville, FL 34604-6899; (352)796-7211, extension 4657. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Karen Lloyd, Senior Attorney, 2379 Broad Street, Brooksville, FL 34604-6899; (352)796-7211, extension 4651

THE FULL TEXT OF THE PROPOSED RULES IS:

40D-22.201 Year-Round Water Conservation Measures.

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

(b) Irrigation systems may be operated during restricted days and/or times for cleaning and maintenance purposes with an attendant on site in the area being tested. Irrigation systems may routinely be operated for such purposes no more than once per week, ~~and~~ the run time for any one test ~~shall should~~ not exceed 10 minutes, and the total run time shall not exceed ten minutes per hour per zone.

(c) Irrigation for the purpose of chemigation, fertigation or watering-in of applied fertilizers, insecticides, fungicides and herbicides, where such watering-in is required by the manufacturer, or by federal, state or local law, or by applicable best management practices shall not be restricted, with two exceptions when associated with a lawn or landscape. In the absence of specific alternative instructions from the manufacturer, such watering-in shall be limited to one application of one-quarter inches within 24 hours of the application; and, such watering-in shall be accomplished during allowable watering ~~hours~~ times unless a professional applicator has posted a temporary sign containing the date of application and the date(s) of needed watering-in activity and has also provided instructions listing the chemicals used and stating that the watering-in must occur immediately rather than during allowable watering hours.

(d) through (f) No change.

(g) New plant material shall only be irrigated as follows:

1. Any new plant material may be irrigated ~~on any day of the week as needed~~, for the purpose of maintaining plant health and encouraging root grow-in, during a 60-day establishment period. From day 1 through day 30 of this establishment period, irrigation may occur on any day of the week. From day 31 through day 60 of this establishment period, irrigation is limited to one application on each of three specified days, except as otherwise provided herein. The three allowable days shall be as follows: Even Numbered Addresses may provide establishment period irrigation on Tuesday, Thursday and Saturday and Odd Numbered Addresses may provide establishment period irrigation on Wednesday, Friday and Sunday.

2. through 7. No change.

(h) through (j) No change.

(4) Lawn and Landscape Use – The following additional requirements or exceptions to subsections 40D-22.201(1)-(3), F.A.C., shall apply to the irrigation of lawns and landscape.

(a) Except as otherwise specified in this Chapter, residential properties with Even Numbered Addresses may accomplish necessary lawn and landscape irrigation on only Thursday ~~Tuesday~~ and/ or Sunday ~~Saturday~~.

(b) Except as otherwise specified in this Chapter, residential properties with Odd Numbered Addresses or ~~and rights-of-way or other locations~~ without any discernable ~~an~~ Address may accomplish necessary lawn and landscape irrigation on only Wednesday and/ or ~~Saturday~~ Sunday.

(c) Except as otherwise specified in this Chapter, all nonresidential properties, including rights-of-way and common areas not associated with a specific residential property, may accomplish necessary lawn and landscape irrigation on only Tuesday and/or Friday.

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

(e) In addition to following the applicable allowable watering days and times, irrigation is limited to only the amount of water necessary. When Irrigating a lawn, this amount is generally 1/2 to 3/4 inch of water. Since most residential properties can accomplish this amount of lawn irrigation in eight (8) hours or less, the need for a residential property to utilize both the morning and evening allowable watering times is subject to verification. Also, during the cooler winter months or if rain has occurred since the last allowable watering day, lawn irrigation may not be necessary.

(f) Irrigation of a lawn with an automatic sprinkler system shall include the proper installation, maintenance and operation of a rain sensor device or switch that automatically overrides the irrigation system when adequate rainfall has occurred.

(5) through (7) No change.

(8) Other Use – The following additional requirements or exceptions to subsections 40D-22.201(1)-(2), F.A.C., shall apply to other uses as specified:

(a) Operation of water fountains, waterfalls and other artistic or recreational water features is allowed, provided the following conditions are met: the water is recirculated, there is no off-site discharge and the water feature is properly installed, maintained and operated to ensure that a minimal amount of water is used.

(b) Water may be used to create a containment and impoundment facility for aesthetic purposes, provided the facility is not augmented thereafter from any ground or off-site surface water source.

(c) Water body augmentation is allowed, provided the water use is either authorized by a Water Use Permit specific to the augmentation activity or, in the absence of a Water Use Permit, the following conditions are met:

1. The water body is one-half acre in size or less;

2. The water for augmentation is withdrawn from a well with an inside diameter of the largest permanent water bearing casing of no more than 2 inches;

3. Augmentation must not occur if the water body is discharging offsite, except that augmentation may occur flush a pond a maximum of twice per year if the pond is not a natural water body nor part of a stormwater management system; and

4. Augmentation must not occur if the water body's water level is above the average water table condition for the site or minimum management level established for proper operation of the stormwater management system, whichever is lower.

Rulemaking Specific Authority 373.044, 373.113, 373.171 FS. Law Implemented 373.171, ~~373.219~~, 373.223 FS. History–New 3-24-92, Amended 9-15-03,_____.

40D-22.401 Enforcement.

(1) through (2) No change.

(3) Irrigation of lawns and landscapes, as described in this Chapter, may be further restricted by local governments in response to a local water supply system concern. In the event any county or city within the District ~~endeavors to adopt~~ adopts or implements such local measures, the measures contained therein shall be at least as restrictive as those imposed by this Chapter and the county or city shall provide a draft ordinance to the District for review and approval for consistency with the requirements of this section at least 30 days prior to considering adoption of the ordinance. The ordinance must be adopted as approved. Once such an ordinance has been adopted, the county or city shall promptly notify the District of all local measures imposed and the effective implementation date. Irrigation of established lawns and landscaping, as established above, may be further restricted by local governments.

(4) No change.

Rulemaking Specific Authority 373.044, 373.113, 373.171 FS. Law Implemented 373.119, 373.171, 373.175, ~~373.219~~, 373.246, 373.603, 373.609 FS. History–New 3-24-92, Amended 9-15-03,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Karen Lloyd, Senior Attorney, 2379 Broad Street, Brooksville, FL 34604-6899, (352)796-7211, extension 4651

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Governing Board of the Southwest Florida Water Management District

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: December 16, 2008

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 14, 2008

DEPARTMENT OF ELDER AFFAIRS

Community Care for the Elderly

RULE NO.: 58C-1.0031 RULE TITLE: Lead Agency Dispute Resolution

PURPOSE AND EFFECT: The purpose of the proposed rule is to comply with Section 430.203(9)(a), F.S. The statute requires the department to adopt a rule creating a dispute resolution mechanism for substantially affected parties to protest an area agency on aging's intent to award the designation of "lead agency" to a party or parties. The statute requires the rule to include standards for bid protest and procedures for resolution.

SUMMARY: The rule develops standards for bid protest and procedures for resolution. The rule also develops minimum requirements for an impartial decisionmaker.

The text of the proposed rule and DOEA Form CCE-001, incorporated by reference in the rule, are available on the following website under the heading "Community Care for the Elderly, Rule 58C-1.0031, F.A.C., CCE Lead Agency Dispute Resolution": <http://elderaffairs.state.fl.us/english/rulemaking.php>

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: This proposed rule will have an impact on small employers as defined in Section 288.703, F.S. Pursuant to Section 120.54(3)(b)1., F.S., the department's statement of estimated regulatory costs is provided. The cost of the initial hearing conducted by the impartial decisionmaker is estimated to be less than the \$250.00 per hour. The estimated cost is determined to be approximately \$250.00 per hour for review of the decision of the impartial decisionmaker.

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

RULEMAKING AUTHORITY: 430.203(9)(a) FS.

LAW IMPLEMENTED: 430.203(9)(a) FS.

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

DATE AND TIME: July 6, 2009, 9:30 a.m. – 11:00 a.m. EDT.

PLACE: Department of Elder Affairs, 4040 Esplanade Way, Conference Room 225F, Tallahassee, Florida 32399-7000

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 72 hours before the workshop/meeting by contacting: Jim Crochet, Department of Elder Affairs, Office of the General Counsel, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. Telephone number: (850)414-2000. Email address: crochethj@elderaffairs.org. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Jim Crochet, Department of Elder Affairs, Office of the General Counsel, 4040 Esplanade Way, Tallahassee, Florida 32399-7000; telephone number: (850)414-2000. Email address: crochethj@elderaffairs.org

THE FULL TEXT OF THE PROPOSED RULE IS:

58C-1.0031 Lead Agency Dispute Resolution.

(1) AREA AGENCY ON AGING PROCEDURES.

(a) In order to meet the requirement set forth in Section 430.203(9)(a)1., F.S., an area agency on aging must include language in its request for proposal that specifies the manner in which the notice of intent to award will be posted.

(b) An area agency on aging (AAA) must comply with the bid process standards set forth in Section 430.203(9)(a), F.S., and this rule.

(c) The AAA must post the notice of intent to award upon selection of a lead agency or lead agencies. This notice must include information that substantially affected parties will have an opportunity to request a hearing challenging the proposed action and instruction on how to request a hearing.

(d) Upon the effective date of this rule, the AAA must solicit and maintain a registry of at least 3 impartial decisionmakers. The decisionmaker must meet the minimum qualifications below:

1. Have at least 5 years of professional experience with procuring or managing government contracts;

2. Have experience as an issuer of, or responder to, at least 3 requests for proposal (RFPs), invitations to bid (ITBs), invitations to negotiate (ITNs) or other competitive procurements;

3. Have not been directly involved, or have any family member who was directly involved, in the award of the bid under protest; and

4. Not be currently employed by, or have a family member employed by, the AAA awarding the bid, or any lead agency or other agency that has filed a bid for lead agency designation with the AAA awarding the bid.

(e) Individuals interested in designation as an impartial decisionmaker must complete DOEA Form CCE-001, CCE Impartial Decisionmaker Application, August 2009, which is hereby incorporated by reference. The form may be obtained from the following website: <http://elderaffairs.state.fl.us/english/ruleforms/CCE-001.doc>.

(2) STANDARDS FOR BID PROTEST.

(a) In a protest to the notice of award, the following shall apply:

1. No submissions made after the bid or proposal opening that amend or supplement the bid or proposal shall be considered.

2. The burden of proof shall rest with the party protesting the proposed AAA award.

(b) In a protest, the decisionmaker must conduct a de novo proceeding to determine whether the AAA's proposed action is contrary to its governing statutes or rules, or to the solicitation specifications. The standard of proof for the protestor must be whether the AAA's action was clearly erroneous, contrary to competition, arbitrary or capricious.

(c) In any bid protest, the decisionmaker, or any party, may request expedited discovery, which may include mandatory disclosure of any relevant material.

(d) Informal disposition may be made of any proceeding in this rule by stipulation, agreed settlement or consent order.

(3) PROTESTING PARTY PROCEDURES.

(a) Any party who is substantially affected by the AAA's intended decision to award a contract for lead agency must file a written notice of protest with the AAA within 72 hours after the posting of the notice of award, excluding Saturdays, Sundays and state holidays.

1. A formal written protest must be filed within 10 calendar days after the date the notice of protest is filed.

2. The formal written protest must state, with particularity, the facts and law upon which the protest is based.

3. Failure to file a notice of protest or failure to file a formal written protest shall constitute a waiver of proceedings.

4. If any substantially affected party who bid on the RFP, other than the AAA or the protesting party, decides to participate in the protest proceedings, that party must give notice within 3 business days of the posting of the initial notice of protest by the AAA.

(4) PROCEDURES FOR BID PROTEST. Upon receipt of a timely filed formal written protest, the AAA must take the following steps:

(a) Stop the solicitation or contract award process until the subject of the protest is resolved by final action as required by Section 430.03(9)(a)2., F.S.

(b) Immediately post the notice of protest in the same manner as the notice of intended award was posted.

(c) Select an impartial decisionmaker as required by Section 430.203(9)(a), F.S., from the registry referenced in subsection (1) of this rule.

1. The decisionmaker must be randomly selected.

2. The AAA must immediately provide the protesting party with the name of the appointed impartial decisionmaker.

3. If the protesting party has an objection to the selected decisionmaker, the protesting party must raise the objection in writing with the AAA within 48 hours, excluding Saturdays, Sundays and state holidays, or the objection is deemed to be waived.

4. Upon receipt of a timely objection, the AAA must randomly select another decisionmaker.

(d) Provide an opportunity to resolve the protest by mutual agreement between the parties within 7 days, excluding Saturdays, Sundays, and state holidays. If the subject of a protest is not resolved by mutual agreement within the time frame set forth in this paragraph, a proceeding must be conducted as set forth in subsection (5) of this rule.

(5) DISPUTE RESOLUTION.

(a) If the protest is not resolved pursuant to paragraph (4)(d) of this rule, the impartial decisionmaker must commence a hearing within 30 calendar days after the AAA receives the formal written protest. The provisions of this subsection may be waived only upon stipulation by all parties.

(b) In addition to the provisions included in Section 430.203(9)(a)3., F.S., which outline the rights of all substantially affected entities, the following procedures shall apply:

1. All discovery must be concluded at least 48 hours prior to the scheduled hearing date. All discovery requests must be commenced in a manner that allows discovery to be concluded at least 48 hours prior to the scheduled hearing.

2. The decisionmaker shall have the authority to issue subpoenas.

3. Requests for production, requests for admissions and interrogatories must be answered within 5 business days.

4. All depositions must have at least 3 business days notice.

5. If a party fails to comply with the discovery rules provided herein, the decisionmaker must exclude such evidence from the hearing, unless just cause is shown as specified in subparagraph (d)1. of this subsection.

6. Should any party be prejudiced by another party's failure to provide discovery, the decisionmaker may continue the hearing for a period not to exceed 5 business days. The non-complying party must comply with the requested discovery within 48 hours after the decision to continue the hearing.

(c) The decisionmaker must render a written decision to the AAA and each party protesting the award within 30 calendar days after the hearing.

(d) A default must be entered against a party who:

1. Fails to appear at a hearing as directed by the decisionmaker, unless at least one of the following conditions exists:

a. Illness of a party, witness or attorney that would prevent attendance at the hearing;

b. An act of God that would prevent attendance at the hearing.

c. A designated threat to public safety that would prevent attendance at the hearing; or

d. Any other circumstance in the opinion of the decisionmaker that would warrant a continuance of the hearing.

2 Fails to comply with discovery after being granted a continuance as provided in subparagraph (b)6. of this subsection.

(e) An entry of default against a party is deemed the final decision of the decisionmaker and is not subject to the provision of subsection (6) of this rule.

(6) REVIEW OF DECISION.

(a) Pursuant to Section 430.203(9)(a), F.S., in the event the protesting party or the AAA wishes a review of the decision by the decisionmaker, the protesting party or the AAA must contact one of the entities referenced in subparagraphs 1. and 2. of this paragraph:

1. An arbitrator with the American Arbitration Association. The arbitrator must have experience with government contracts. Contact information for the association is American Arbitration Association, Bank of America Tower at International Place, 100 S. E. 2nd Street, Suite 2300, Miami, FL 33131, telephone number (305)358-7712.

2. A circuit civil mediator certified by the Florida Supreme Court, who has experience with government contracts. Contact information for the Florida Supreme Court Dispute Resolution Center is http://199.242.69.70/pls/drc/drc_main_screen.

(b) This action must be taken within 10 calendar days after the date of the decision from the decisionmaker.

(c) The review shall not be a de novo proceeding, but only a review of the decision based on the record from the hearing.

(d) The written decision of the reviewer must be made within 30 calendar days after the request for review. The decision shall be binding upon both parties.

Rulemaking Authority 430.203(9)(a) FS. Law Implemented 430.203(9)(a) FS. History—New

NAME OF PERSON ORIGINATING PROPOSED RULE:
Jim Crochet

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: E. Douglas Beach, Ph.D., Secretary

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: June 3, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: May 8, 2009

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Facility and Agency Licensing

RULE NO.: 59A-3.2085
RULE TITLE: Department and Services

PURPOSE AND EFFECT: This rule revision will clarify application procedures and forms to be used in licensure of hospital adult cardiovascular services programs.

SUMMARY: The Agency proposes to revise rules governing licensure of hospital adult cardiovascular services programs and incorporate license application forms.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: The proposed rule will affect Florida hospitals that provide adult cardiovascular services. The staffing and resources required to establish a program of adult cardiovascular services dictates that these hospitals will be large organizations with resources and employees beyond the levels that are considered small businesses or small counties. Implementing and enforcing the proposed licensing rules for adult cardiovascular services program will not result in significant increase in the costs to the Agency as the proposed rule provides for applicant hospitals to submit an attestation form confirming compliance with licensure criteria.

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

RULEMAKING AUTHORITY: 408.0361 FS.

LAW IMPLEMENTED: 408.0361 FS.

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

DATE AND TIME: July 7, 2009, 2:00 p.m.

PLACE: Building 3, Conference Room C, 2727 Mahan Drive, Tallahassee, FL 32208

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Bill McCort, 2727 Mahan Drive, MS #28A, Tallahassee, FL 32308, (850)487-0641

THE FULL TEXT OF THE PROPOSED RULE IS:

59A-3.2085 Department and Services.

(1) through (12) No change.

(13) Adult Diagnostic Cardiac Catheterization Program. All licensed hospitals that establish adult diagnostic cardiac catheterization laboratory services under Section 408.0361, F.S., shall operate in compliance with the guidelines of the American College of Cardiology/American Heart Association regarding the operation of diagnostic cardiac catheterization laboratories. Hospitals are considered to be in compliance with American College of Cardiology/American Heart Association guidelines when they adhere to standards regarding staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety. The applicable guideline, herein incorporated by reference, is the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214*. Aspects of the guideline related to pediatric services or outpatient cardiac catheterization in freestanding non-hospital settings are not applicable to this rule. All such licensed hospitals shall have a department, service or other similarly titled unit which shall be organized, directed and staffed, and integrated with other units and departments of the hospitals in a manner designed to assure the provision of quality patient care.

(a) Licensure.

1. A hospital seeking a license for an adult diagnostic cardiac catheterization laboratory services program shall submit an application on a form provided by the Agency, AHCA Form 3130-5003, May 09, License Application Attestation Adult Inpatient Diagnostic Cardiac Catheterization, incorporated herein by reference and available at

[http://ahca.myflorida.com/MCHO/Health Facility Regulation/Hospital Outpatient/hospital.shtml#acs](http://ahca.myflorida.com/MCHO/Health_Facility_Regulation/Hospital_Outpatient/hospital.shtml#acs), signed by the chief executive officer of the hospital, attesting to the hospital's intent and ability to:

a. Comply with the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories.

b. Perform only adult inpatient diagnostic cardiac catheterization services and not provide therapeutic cardiac catheterization or any other cardiology services.

c. Maintain sufficient appropriate equipment and health care personnel to ensure quality and safety.

d. Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

e. Demonstrate a plan to provide services to Medicaid and charity care patients.

2. Hospitals with adult diagnostic cardiac catheterization services programs must renew their licenses at the time of the hospital licensure renewal, providing the information in a. through e. above. Failure to renew the hospital's license or failure to update the information in a. through e. above shall cause the license to expire.

(b)(a) Definitions. The following definitions shall apply specifically to all adult diagnostic cardiac catheterization programs, as described in this subsection 59A-3.2085(13), F.A.C.:

1. "Diagnostic Cardiac Catheterization" means a procedure requiring the passage of a catheter into one or more cardiac chambers of the left and right heart, with or without coronary arteriograms, for the purpose of diagnosing congenital or acquired cardiovascular diseases, or for determining measurement of blood pressure flow; and also includes the selective catheterization of the coronary ostia with injection of contrast medium into the coronary arteries.

2. "Adult" means a person fifteen years of age or older.

3. Therapeutic Procedures. An adult diagnostic cardiac catheterization program established pursuant to Section 408.0361, F.S., shall not provide therapeutic services, such as percutaneous coronary intervention or stent insertion, intended to treat an identified condition or the administering of intra-coronary drugs, such as thrombolytic agents.

4. Diagnostic Procedures. Procedures performed in the adult diagnostic cardiac catheterization laboratory shall include, for example, the following:

- a. Left heart catheterization with coronary angiography and left ventriculography
- b. Right heart catheterization
- c. Hemodynamic monitoring line insertion
- d. Aortogram
- e. Emergency temporary pacemaker insertion
- f. Myocardial biopsy

g. Diagnostic trans-septal procedures

h. Intra-coronary ultrasound (CVIS)

i. Fluoroscopy

j. Hemodynamic stress testing

(c)(b) Support Equipment. A crash cart containing the necessary medication and equipment for ventilatory support shall be located in each cardiac catheterization procedure room. A listing of all crash cart contents shall be readily available. At the beginning of each shift, the crash cart shall be checked for intact lock; the defibrillator and corresponding equipment shall be checked for function and operational capacity. A log shall be maintained indicating review.

(d)(e) Radiographic Cardiac Imaging Systems. A quality improvement program for radiographic imaging systems shall include measures of image quality, dynamic range and modulation transfer function. Documentation indicating the manner in which this requirement will be met shall be available for the Agency's review.

(e)(d) Physical Plant Requirements. Section 419.2.1.2, Florida Building Code, contains the physical plant requirements for the adult diagnostic adult cardiac catheterization program.

(f)(e) Personnel Requirements. There shall be an adequate number of trained personnel available. At a minimum, a team involved in cardiac catheterization shall consist of a physician, one registered nurse, and one technician.

(g)(f) Quality Improvement Program. A quality improvement program for the adult diagnostic cardiac catheterization program laboratory shall include an assessment of proficiency in diagnostic coronary procedures, as described in the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214 guidelines*. Essential data elements for the quality improvement program include the individual physician procedural volume and major complication rate; the institutional procedural complication rate; relevant clinical and demographic information about patients; verification of data accuracy; and procedures for patient, physician and staff confidentiality. Documentation indicating the manner in which this requirement will be met shall be available for the Agency's review.

(h)(g) Emergency Services.

1. All providers of adult diagnostic cardiac catheterization program services in a hospital not licensed as a Level II adult cardiovascular services provider shall have written transfer agreements developed specifically for diagnostic cardiac catheterization patients with one or more hospitals that operate a Level II adult cardiovascular services program. Written agreements must be in place to ensure safe and efficient emergency transfer of a patient within 60 minutes. Transfer

time is defined as the number of minutes between the recognition of an emergency as noted in the hospital's internal log and the patient's arrival at the receiving hospital. Transfer and transport agreements must be reviewed and tested at least every 3 months, with appropriate documentation maintained, including the hospital's internal log or emergency medical services data.

2. Patients at high risk for diagnostic catheterization complications shall be referred for diagnostic catheterization services to hospitals licensed as a Level II adult cardiovascular services provider. Hospitals not licensed as a Level II adult cardiovascular services provider must have documented patient selection and exclusion criteria and provision for identification of emergency situations requiring transfer to a hospital with a Level II adult cardiovascular services program. Documentation indicating the manner in which this requirement will be met shall be available for the Agency's review.

~~(i)(4)~~ Policy and Procedure Manual for Medicaid and Charity Care.

1. Each provider of adult diagnostic cardiac catheterization services shall maintain a policy and procedure manual, available for review by the Agency, which documents a plan to provide services to Medicaid and charity care patients.

2. At a minimum, the policy and procedure manual shall document specific outreach programs directed at Medicaid and charity care patients for adult diagnostic cardiac catheterization services.

~~(j)(4)~~ Enforcement. Enforcement of these rules shall follow procedures established in Rule 59A-3.253, F.A.C.

~~(k)(4)~~ In case of conflict between the provisions of this rule and the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214* guidelines, the provisions of this part shall prevail.

(14) through (15) No change.

(16) Level I Adult Cardiovascular Services.

(a) Licensure.

1. A hospital seeking a license for a Level I adult cardiovascular services program shall submit an application on a form provided by the Agency, AHCA Form 3130-8010, Feb-09, License Application Attestation Level I Adult Cardiovascular Services, incorporated herein by reference and available at <http://ahca.myflorida.com/MCHQ/Health Facility Regulation/Hospital Outpatient/hospital.shtml#acs>, to the Agency, (See Form 1: Level I Adult Cardiovascular Services License Application Attestation; AHCA Form, Section 18(a) of this rule), signed by the chief executive officer of the hospital, attesting that for the most recent 12-month period, the hospital

has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or, for the most recent 12-month period, has discharged or transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease (defined by ICD-9-CM codes 410.0 through 414.9).

a. Reportable cardiac catheterization procedures are defined as single sessions with a patient in the hospital's cardiac catheterization procedure room(s), irrespective of the number of specific procedures performed during the session.

b. Reportable cardiac catheterization procedures shall be limited to those provided and billed for by the Level I licensure applicant and shall not include procedures performed at the hospital by physicians who have entered into block leases or joint venture agreements with the applicant.

2. The request shall attest to the hospital's intent and ability to comply with the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214*; and the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)*; including guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety.

3. The request shall attest to the hospital's intent and ability to comply with physical plant requirements regarding cardiac catheterization laboratories and operating rooms found in Section 419.2.1.2, Florida Building Code.

4. The request shall also include copies of one or more written transfer agreements with hospitals that operate a Level II adult cardiovascular services program, including written transport protocols to ensure safe and efficient transfer of an emergency patient within 60 minutes. Transfer time is defined as the number of minutes between the recognition of an emergency as noted in the hospital's internal log and the patient's arrival at the receiving hospital.

5. All providers of Level I adult cardiovascular services programs shall operate in compliance with subsection 59A-3.2085(13), F.A.C., the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214* and the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of*

the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention) guidelines regarding the operation of adult diagnostic cardiac catheterization laboratories and the provision of percutaneous coronary intervention.

6. The applicable guidelines, herein incorporated by reference, are the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214*; and the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)*. Aspects of the guideline related to pediatric services or outpatient cardiac catheterization in freestanding non-hospital settings are not applicable to this rule. Aspects of the guideline related to the provision of elective percutaneous coronary intervention only in hospitals authorized to provide open heart surgery are not applicable to this rule.

7. Hospitals are considered to be in compliance with the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214* and the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention) guidelines* when they adhere to standards regarding staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety. Hospitals must also document an ongoing quality improvement plan to ensure that the cardiac catheterization program and the percutaneous coronary intervention program meet or exceed national quality and outcome benchmarks reported by the American College of Cardiology-National Cardiovascular Data Registry.

8. Level I adult cardiovascular service providers shall report to the American College of Cardiology-National Cardiovascular Data Registry in accordance with the timetables and procedures established by the Registry. All data shall be reported using the specific data elements, definitions and transmission format as set forth by the American College of Cardiology-National Cardiovascular Data Registry.

a. Each hospital licensed to provide Level I adult cardiovascular services shall execute the required agreements with the American College of Cardiology-National Cardiovascular Data Registry to participate in the data registry.

b. Each hospital licensed to provide Level I adult cardiovascular services shall stay current with the payment of all fees necessary to continue participation in the American College of Cardiology-National Cardiovascular Data Registry.

c. Each hospital licensed to provide Level I adult cardiovascular services shall release the data reported by the American College of Cardiology-National Cardiovascular Data Registry to the Agency for Health Care Administration.

d. Each hospital licensed to provide Level I adult cardiovascular services shall use the American College of Cardiology-National Cardiovascular Data Registry data sets and use software approved by the American College of Cardiology for data reporting.

e. Each hospital licensed to provide Level I adult cardiovascular services shall ensure that software formats are established and maintained in a manner that meets American College of Cardiology-National Cardiovascular Data Registry transmission specifications and encryption requirements. If necessary, each hospital shall contract with a vendor approved by the American College of Cardiology-National Cardiovascular Data Registry for software and hardware required for data collection and reporting.

f. To the extent required by the American College of Cardiology-National Cardiovascular Data Registry, each hospital licensed to provide Level I adult cardiovascular services shall implement procedures to transmit data via a secure website or other means necessary to protect patient privacy.

g. Each hospital licensed to provide Level I adult cardiovascular services shall ensure that all appropriate data is submitted on every patient that receives medical care and is eligible for inclusion in the American College of Cardiology-National Cardiovascular Data Registry.

h. Each hospital licensed to provide Level I adult cardiovascular services shall maintain an updated and current institutional profile with the American College of Cardiology-National Cardiovascular Data Registry.

i. Each hospital licensed to provide Level I adult cardiovascular services shall ensure that data collection and reporting will only be performed by trained, competent staff and that such staff shall adhere to the American College of Cardiology-National Cardiovascular Data Registry standards.

j. Each hospital licensed to provide Level I adult cardiovascular services shall submit corrections to any data submitted to the American College of Cardiology-National Cardiovascular Data Registry as discovered by the hospital or by the American College of Cardiology-National Cardiovascular Data Registry. Such corrections shall be submitted within thirty days of discovery of the need for a

correction or within such other time frame as set forth by the American College of Cardiology-National Cardiovascular Data Registry. Data submitted must be at a level that the American College of Cardiology-National Cardiovascular Data Registry will include the data in national benchmark reporting.

k. Each hospital licensed to provide Level I adult cardiovascular services shall designate an American College of Cardiology-National Cardiovascular Data Registry site manager that will serve as a primary contact between the hospital, the American College of Cardiology-National Cardiovascular Data Registry and the Agency with regard to data reporting. The identity of each site manager shall be provided to the Hospital and Outpatient Services Unit at the Agency for Health Care Administration in Tallahassee.

l. By submitting data to the American College of Cardiology-National Cardiovascular Data Registry in the manner set forth herein, each hospital shall be deemed to have certified that the data submitted for each time period is accurate, complete and verifiable.

9. Notwithstanding guidelines to the contrary in the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214* and the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)*, all providers of Level I adult cardiovascular services programs may provide emergency and elective percutaneous coronary intervention procedures. Aspects of the guidelines related to pediatric services or outpatient cardiac catheterization in freestanding non-hospital settings are not applicable to this rule.

10. Hospitals with Level I adult cardiovascular services programs are prohibited from providing the following procedures:

a. Any therapeutic procedure requiring transseptal puncture, or

b. Any lead extraction for a pacemaker, biventricular pacer or implanted cardioverter defibrillator.

11. Hospitals with Level I adult cardiovascular services programs must renew their licenses at the time of the hospital licensure renewal, providing the information in two through five above. Failure to renew the hospital's license or failure to update the information in two through five above shall cause the license to expire.

(b) Staffing.

1. Each cardiologist shall be an experienced physician who has performed a minimum of 75 interventional cardiology procedures, exclusive of fellowship training and within the previous 12 months from the date of the Level I adult cardiovascular licensure application or renewal application.

2. Physicians with less than 12 months experience shall fulfill applicable training requirements in the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)* prior to being allowed to perform emergency percutaneous coronary interventions in a hospital that is not licensed for a Level II adult cardiovascular services program.

3. The nursing and technical catheterization laboratory staff shall be experienced in handling acutely ill patients requiring intervention or balloon pump. Each member of the nursing and technical catheterization laboratory staff shall have at least 500 hours of previous experience in dedicated cardiac interventional laboratories at a hospital with a Level II adult cardiovascular services program. They shall be skilled in all aspects of interventional cardiology equipment, and must participate in a 24-hour-per-day, 365 day-per-year call schedule.

4. The hospital shall ensure that a member of the cardiac care nursing staff who is adept in hemodynamic monitoring and Intra-aortic Balloon Pump (IABP) management shall be in the hospital at all times.

(c) Emergency Services.

A hospital provider of Level I adult cardiovascular services program must ensure it has systems in place for the emergent transfer of patients with intra-aortic balloon pump support to one or more hospitals licensed to operate a Level II adult cardiovascular services program. Formalized written transfer agreements developed specifically for emergency Percutaneous Coronary Intervention (PCI) patients must be developed with a hospital that operates a Level II adult cardiovascular services program. Written transport protocols must be in place to ensure safe and efficient transfer of a patient within 60 minutes. Transfer time is defined as the number of minutes between the recognition of an emergency as noted in the hospital's internal log and the patient's arrival at the receiving hospital. Transfer and transport agreements must be reviewed and tested at least every 3 months, with appropriate documentation maintained.

(d) Policy and Procedure Manual for Medicaid and Charity Care.

1. Each provider of Level I adult cardiovascular services shall maintain a policy and procedure manual, available for review by the Agency, which documents a plan to provide services to Medicaid and charity care patients.

2. At a minimum, the policy and procedure manual shall document specific outreach programs directed at Medicaid and charity care patients for Level I adult cardiovascular services.

(e) Physical Plant Requirements.

Section 419.2.1.2, Florida Building Code, contains the physical plant requirements for adult cardiac catheterization laboratories operated by a licensed hospital.

(f) Enforcement.

1. Enforcement of these rules shall follow procedures established in Rule 59A-3.253, F.A.C.

2. Unless in the view of the Agency there is a threat to the health, safety or welfare of patients, Level I adult cardiovascular services programs that fail to meet provisions of this rule shall be given 15 days to develop a plan of correction that must be accepted by the Agency.

3. Failure of the hospital with a Level I adult cardiovascular services program to make improvements specified in the plan of correction shall result in the revocation of the program license. The hospital may offer evidence of mitigation and such evidence could result in a lesser sanction.

(g) In case of conflict between the provisions of this rule and the guidelines in the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214* and the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)*, the provisions of this part shall prevail.

(17) Level II Adult Cardiovascular Services.

(a) Licensure.

1. A hospital seeking a license for a Level II adult cardiovascular services program shall submit an application on a form provided by the Agency, AHCA Form 3130-8011, Feb-09, License Application Attestation Level II Adult Cardiovascular Services, incorporated herein by reference and available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/hospital.shtml#acs. (See Form 2: Level II Adult Cardiovascular Services License Application Attestation; AHCA Form, Section 18(b) of this rule) to the Agency, signed by the chief executive officer of the hospital, attesting that for the most recent 12-month period, the hospital has provided a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic cardiac catheterizations, or, for the most recent 12-month period, has discharged at least 800 patients with the principal diagnosis of ischemic heart disease (defined by ICD-9-CM codes 410.0 through 414.9).

a. Reportable cardiac catheterization procedures shall be limited to those provided and billed for by the Level II licensure applicant and shall not include procedures performed at the hospital by physicians who have entered into block leases or joint venture agreements with the applicant.

2. The request shall attest to the hospital's intent and ability to comply with applicable guidelines in the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-2*; in the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)*; and in the *ACC/AHA 2004 Guideline Update for Coronary Artery Bypass Graft Surgery: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1999 Guidelines for Coronary Artery Bypass Graft Surgery) Developed in Collaboration With the American Association for Thoracic Surgery and the Society of Thoracic Surgeons*, including guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety.

3. The request shall attest to the hospital's intent and ability to comply with physical plant requirements regarding cardiac catheterization laboratories and operating rooms found in Section 419.2.1.2, Florida Building Code.

4. All providers of Level II adult cardiovascular services programs shall operate in compliance with subsections 59A-3.2085(13) and 59A-3.2085(16), F.A.C. and the applicable guidelines of the American College of Cardiology/American Heart Association regarding the operation of diagnostic cardiac catheterization laboratories, the provision of percutaneous coronary intervention and the provision of coronary artery bypass graft surgery.

a. The applicable guidelines, herein incorporated by reference, are the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214*; and

b. *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention)*; and

c. ACC/AHA 2004 Guideline Update for Coronary Artery Bypass Graft Surgery: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1999 Guidelines for Coronary Artery Bypass Graft Surgery) Developed in Collaboration With the American Association for Thoracic Surgery and the Society of Thoracic Surgeons.

d. Aspects of the guidelines related to pediatric services or outpatient cardiac catheterization in freestanding non-hospital settings are not applicable to this rule.

5. Hospitals are considered to be in compliance with the guidelines in the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214*; in the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention*; and in the *ACC/AHA 2004 Guideline Update for Coronary Artery Bypass Graft Surgery: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1999 Guidelines for Coronary Artery Bypass Graft Surgery) Developed in Collaboration With the American Association for Thoracic Surgery and the Society of Thoracic Surgeons* when they adhere to standards regarding staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety. Hospitals must also document an ongoing quality improvement plan to ensure that the cardiac catheterization program, the percutaneous coronary intervention program and the cardiac surgical program meet or exceed national quality and outcome benchmarks reported by the American College of Cardiology-National Cardiovascular Data Registry and the Society of Thoracic Surgeons.

6. In addition to the requirements set forth in subparagraph (16)(a)7. of this rule, each hospital licensed to provide Level II adult cardiovascular services programs shall participate in the Society of Thoracic Surgeons National Database.

a. Each hospital licensed to provide Level II adult cardiovascular services shall report to the Society of Thoracic Surgeons National Database in accordance with the timetables and procedures established by the Database. All data shall be reported using the specific data elements, definitions and transmission format as set forth by the Society of Thoracic Surgeons.

b. Each hospital licensed to provide Level II adult cardiovascular services shall stay current with the payment of all fees necessary to continue participation in the Society of Thoracic Surgeons National Database data registry.

c. Each hospital licensed to provide Level II adult cardiovascular services shall release the data reported by the Society of Thoracic Surgeons National Database to the Agency.

d. Each hospital licensed to provide Level II adult cardiovascular services shall use the most current version of the Society of Thoracic Surgeons National Database and use software approved by the Society of Thoracic Surgeons for data reporting.

e. Each hospital licensed to provide Level II adult cardiovascular services shall ensure that software formats are established and maintained in a manner that meets Society of Thoracic Surgeons transmission specifications and encryption requirements. If necessary, each hospital shall contract with a vendor approved by the Society of Thoracic Surgeons National Database for software and hardware required for data collection and reporting.

f. To the extent required by the Society of Thoracic Surgeons National Database, each hospital licensed to provide Level II adult cardiovascular services shall implement procedures to transmit data via a secure website or other means necessary to protect patient privacy.

g. Each hospital licensed to provide Level II adult cardiovascular services shall ensure that all appropriate data is submitted on every patient who receives medical care and is eligible for inclusion in the Society of Thoracic Surgeons National Database.

h. Each hospital licensed to provide Level II adult cardiovascular services shall maintain an updated and current institutional profile with the Society of Thoracic Surgeons National Database.

i. Each hospital licensed to provide Level II adult cardiovascular services shall ensure that data collection and reporting will only be performed by trained, competent staff and that such staff shall adhere to Society of Thoracic Surgeons National Database standards.

j. Each hospital licensed to provide Level II adult cardiovascular services shall submit corrections to any data submitted to the Society of Thoracic Surgeons National Database as discovered by the hospital or by the Society of Thoracic Surgeons National Database. Such corrections shall be submitted within thirty days of discovery of the need for a correction or within such other time frame as set forth by the Society of Thoracic Surgeons National Database. Data submitted must be at a level that the Society of Thoracic Surgeons National Database will include the data in national benchmark reporting.

k. Each hospital licensed to provide Level II adult cardiovascular services shall designate a Society of Thoracic Surgeons National Database site manager that will serve as a primary contact between the hospital, the Society of Thoracic Surgeons National Database and the Agency with regard to data reporting. The identity of each site manager shall be provided to the Hospital and Outpatient Services Unit at the Agency for Health Care Administration in Tallahassee.

1. By submitting data to the Society of Thoracic Surgeons National Database and the American College of Cardiology-National Cardiovascular Data Registry in the manner set forth herein, each hospital shall be deemed to have certified that the data submitted for each time period is accurate, complete and verifiable.

7. Hospitals with Level II adult cardiovascular services programs must renew their licenses at the time of the hospital licensure renewal, providing the information in two through four above. Failure to renew the hospital's license or failure to update the information in two through four above shall cause the license to expire.

(b) Staffing.

1. Each cardiac surgeon shall be Board certified.

a. New surgeons shall be Board certified within 4 years after completion of their fellowship.

b. Experienced surgeons with greater than 10 years experience shall document that their training and experience preceded the availability of Board certification.

2. Each cardiologist shall be an experienced physician who has performed a minimum of 75 interventional cardiology procedures, exclusive of fellowship training and within the previous 12 months from the date of the Level II adult cardiovascular licensure application or renewal application.

3. The nursing and technical catheterization laboratory staff shall be experienced in handling acutely ill patients requiring intervention or balloon pump. Each member of the nursing and technical catheterization laboratory staff shall have at least 500 hours of previous experience in dedicated cardiac interventional laboratories at a hospital with a Level II adult cardiovascular services program. They shall be skilled in all aspects of interventional cardiology equipment, and must participate in a 24-hour-per-day, 365 day-per-year call schedule.

4. The hospital shall ensure that a member of the cardiac care nursing staff who is adept in hemodynamic monitoring and Intra-aortic Balloon Pump (IABP) management shall be in the hospital at all times.

(c) Policy and Procedure Manual for Medicaid and Charity Care.

1. Each provider of adult Level II adult cardiovascular services shall maintain a policy and procedure manual, available for review by the Agency, which documents a plan to provide services to Medicaid and charity care patients.

2. At a minimum, the policy and procedure manual shall document specific outreach programs directed at Medicaid and charity care patients for Level II adult cardiovascular services.

(d) Physical Plant Requirements.

Section 419.2.1.2, Florida Building Code, contains the physical plant requirements for adult cardiac catheterization laboratories and operating rooms for cardiac surgery operated by a licensed hospital.

(e) Enforcement.

1. Enforcement of these rules shall follow procedures established in Rule 59A-3.253, F.A.C.

2. Unless in the view of the Agency there is a threat to the health, safety or welfare of patients, Level II adult cardiovascular services programs that fail to meet provisions of this rule shall be given 15 days to develop a plan of correction that must be accepted by the Agency.

3. Failure of the hospital with a Level II adult cardiovascular services program to make improvements specified in the plan of correction shall result in the revocation of the program license. The hospital may offer evidence of mitigation and such evidence could result in a lesser sanction.

(f) In case of conflict between the provisions of this rule and the guidelines in the *American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214*; the *ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention*; and the *ACC/AHA 2004 Guideline Update for Coronary Artery Bypass Graft Surgery: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1999 Guidelines for Coronary Artery Bypass Graft Surgery) Developed in Collaboration With the American Association for Thoracic Surgery and the Society of Thoracic Surgeons*, the provisions of this part shall prevail.

~~(18) Forms:~~

~~(a) Form 1: Level I Adult Cardiovascular Services License Application. AHCA Form 3130-8010.~~

~~Attestation~~

~~AHCA Facility Number:~~

~~Facility Name:~~

~~Facility/Premise Address:~~

~~12-month Reporting Period:~~

~~Volume:~~

Total number of adult cardiac catheterization patients/sessions:

Inpatient Sessions:

Outpatient Sessions:

Or

Total number of inpatient discharges or transfers with principal diagnosis of ischemic heart disease (ICD 9 CM codes 410.0 through 414.9)

Inpatient Discharges:

Inpatient Transfers:

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital volume are true, accurate, and complete.

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital will fully comply, where applicable, with the guidelines in the American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-214, and the ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention) for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure quality patient care and safety, except where they are in conflict with Florida law.

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital will fully comply with the physical plant requirements regarding cardiac catheterization laboratories and operating rooms found in Section 419.2.1.2, Florida Building Code as applicable.

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital has a formalized, written transfer agreement with a hospital that has a Level II adult cardiovascular program, including a written transport agreement(s) to ensure safe and efficient transfer of a patient within 60 minutes.

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital will participate in the American College of Cardiology National Cardiovascular Data Registry.

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital has a formalized plan to provide services to Medicaid and charity care patients in need of Level I adult cardiovascular services.

I, _____, hereby swear or affirm that the statements in this attestation are true and correct.

Signature of Chief Executive Officer Date

STATE OF FLORIDA

COUNTY OF _____

Sworn to and subscribed before me this _____, _____ by _____.

This individual is personally known to me or produced the following identification: _____

Notary Public

NOTARY SEAL:

(b) Form 2: Level II Adult Cardiovascular Services License Application. AHCA Form 3130-8011.

Attestation

AHCA Facility Number:

Facility Name:

Facility/Premise Address:

12 month Reporting Period:

Volume:

Total number of adult cardiac catheterization patients/sessions:

Inpatient Sessions:

Outpatient Sessions:

Or

Total number of inpatient discharges or transfers with principal diagnosis of ischemic heart disease (ICD 9 CM codes 410.0 through 414.9)

Inpatient Discharges:

Inpatient Transfers:

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital volume are true, accurate, and complete.

I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital will fully comply with the physical plant requirements regarding cardiac catheterization laboratories and operating rooms found in Section 419.2.1.2, Florida Building Code as applicable. I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above named hospital will fully comply with the guidelines in the American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards: Bashore et al, ACC/SCA&I Clinical Expert Consensus Document on Catheterization Laboratory Standards, JACC Vol. 37, No. 8, June 2001: 2170-21; in the ACC/AHA/SCAI 2005 Guideline Update for Percutaneous Coronary Intervention A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (ACC/AHA/SCAI Writing Committee to Update the 2001 Guidelines for Percutaneous Coronary Intervention); and in the ACC/AHA 2004 Guideline Update for Coronary Artery Bypass Graft Surgery: A Report of the American College of

~~Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1999 Guidelines for Coronary Artery Bypass Graft Surgery) Developed in Collaboration With the American Association for Thoracic Surgery and the Society of Thoracic Surgeons for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety.~~

~~I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above name hospital will participate in the American College of Cardiology National Cardiovascular Data Registry and the Society of Thoracic Surgeons National Database.~~

~~I, the undersigned, upon oath and affirmation of belief and personal knowledge, attest that the above name hospital/facility has a formalized plan to provide services to Medicaid and charity care patients in need of Level II adult cardiovascular services.~~

~~I, _____, hereby swear or affirm that the statements in this attestation are true and correct.~~

Signature of Chief Executive Officer _____
Date

STATE OF FLORIDA
COUNTY OF _____

~~Sworn to and subscribed before me this _____,
_____ by _____.~~

~~This individual is personally known to me or produced the following identification: _____~~

~~Notary Public~~

~~NOTARY SEAL:~~

~~Rulemaking Specific Authority 395.1055, 395.3038, 395.401, 408.036, 408.036(1) FS. Law Implemented 395.001, 395.1055, 395.1065, 395.3038, 395.401, 408.036, 408.0361, 957.05 FS. History--New 4-17-97, Amended 3-29-98, 8-23-99, 3-23-06, 1-8-09, _____.~~

NAME OF PERSON ORIGINATING PROPOSED RULE:
Jeffrey Gregg

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Holly Benson

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 29, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: February 6, 2009

DEPARTMENT OF MANAGEMENT SERVICES

Agency for Workforce Innovation

RULE NO.: 60BB-8.205 RULE TITLE: Advance Payment and Reconciliation for the Voluntary Prekindergarten Education Program

PURPOSE AND EFFECT: To implement the authority of the Agency for Workforce Innovation to adopt a rule related to advance payment of early learning coalitions and Voluntary Prekindergarten Education (VPK) providers in conformance with recently revised legislation.

SUMMARY: The rule provides for advance payment of coalitions which will, in turn, provide advance payments to VPK providers. Payment to providers is based on enrollment and reconciliation is based on attendance.

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

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

RULEMAKING AUTHORITY: 1002.75(2)(h), 1002.75(4), 1002.79(2) FS.

LAW IMPLEMENTED: 1002.71(5)(b), 1002.75(2)(h), 1002.75(4) FS.

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

DATE AND TIME: July 7, 2009, 1:30 p.m – 2:30 p.m. or until business is concluded

PLACE: Agency for Workforce Innovation, 107 East Madison Street, Tallahassee, Florida 32399-4128 and by phone at (888)808-6959 conference code 921-3193

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Kristin R. Harden, 107 East Madison St., MSC #110, Tallahassee, FL 32399-4128, (850)245-7150

THE FULL TEXT OF THE PROPOSED RULE IS:

60BB-8.205 Advance Payment and Reconciliation for the Voluntary Prekindergarten Education Program.

(1) Coalition Advance Payment.

(a) During the first month of each fiscal year, contingent upon funding availability, the Agency for Workforce Innovation (the Agency) shall provide a Coalition Advance Payment to each early learning coalition so that the early learning coalition may issue provider advance payments in accordance with this rule. Each coalition’s Coalition Advance Payment shall not exceed the school-year base student allocation (BSA) divided by twelve (12) multiplied by two (2) multiplied by the highest monthly Voluntary Prekindergarten Education (VPK) program enrollment, as defined in Rule 60BB-8.100, F.A.C., at the coalition during the previous fiscal year.

(b) A coalition shall also utilize the Coalition Advance Payment to make payments for allowable expenditures incurred in the administration of the VPK program on a monthly basis.

(c) If the early learning coalition estimates that it will have insufficient funds to make payments for actual VPK expenditures which are due in a calendar month, the coalition may submit a request in writing to the Agency's Office of Early Learning, Financial Administration and Budget Services Section, at 107 E. Madison St., MSC 140, Tallahassee, Florida 32399 for enough additional funds to make payments for its actual VPK expenditures at least ten (10) business days prior to the date the payment for actual VPK expenditures is due. The coalition shall support its request for additional funds with documentation indicating the amount due in the month and the total amount of VPK funding available to the coalition. The Agency shall determine the total amount of funding necessary for the coalition to make payments for actual VPK expenditures for the month and may provide additional funding to the coalition as the Agency deems necessary.

(2) Provider Advance Payment.

(a) A provider is eligible to receive a one time advance payment for each VPK class offered by the provider.

(b) An early learning coalition shall make a provider advance payment to each Voluntary Prekindergarten Education provider operating in the coalition's service area which does not decline the advance payment under subsection (3) of this rule. A coalition shall calculate the provider advance payment for each VPK provider by multiplying the total enrollment in each of the provider's VPK classes by five (5) percent of the county's allocation per child as calculated in accordance with Section 1002.71(3), F.S.

(c) In order to determine the number of children enrolled in each VPK class, each early learning coalition shall establish one day each month by which a VPK provider must submit to the coalition the individual enrollment materials of each student for each VPK class scheduled to begin in the following month. At the discretion of the coalition, the VPK provider may instead submit a class roster for each VPK class. Each coalition shall notify all VPK providers operating within its service area of the date selected in each month upon which enrollment calculations will be based. Enrollment materials or class rosters submitted after the date established by the coalition under this paragraph shall not be included in the calculation of a provider advance payment.

1. "Enrollment materials" means a child's certificate of eligibility and notice of the child's assigned VPK class submitted to the coalition in accordance with paragraph 60BB-8.202(2)(a), F.A.C.

2. "Class roster" means a list of students for which a provider has received a certificate of eligibility who are assigned to a VPK class. A class roster shall be created in a format approved by the coalition and shall include, at a minimum, the name of each student and the primary instructor for the class.

(3) Refusal of Provider Advance Payment. A VPK provider may choose not to accept a provider advance payment made under subsection (2) of this rule. A VPK provider which chooses not to receive an advance payment shall notify the coalition in writing of its choice no later than seven (7) calendar days prior to the date established under paragraph (2)(c) by the coalition as the date upon which enrollment calculations will be based.

(4) Reconciliation. A coalition shall provide payment for each VPK student in accordance with Rule 60BB-8.204, F.A.C. Each coalition shall reconcile advance payments for each VPK class two times. The first reconciliation shall be conducted for the month in which 150 hours for the summer program or 270 hours for the school-year program have been offered in a VPK class. The second reconciliation shall be conducted during the last full calendar month of services. Each coalition shall reconcile advance payments by determining the total amount due as payment under Rule 60BB-8.204, F.A.C., to a VPK provider during the months in which reconciliation is to occur and subtracting half of the amount paid to the provider under subsection (2) of this rule.

(5) Reconciliation for classes fewer than 90 calendar days. Notwithstanding any other provision of this rule, the coalition shall conduct one reconciliation for VPK classes which are scheduled to last fewer than 90 calendar days. Each coalition shall reconcile the advance payment by determining the total amount due as payment in the last full calendar month of services to a VPK provider under Rule 60BB-8.204, F.A.C., and subtracting amount paid to the provider under subsection (2) of this rule.

(6) Overpayment.

(a) If the coalition determines during reconciliation under subsection (4) or (5) of this rule that a provider received a provider advance payment in an amount greater than what is owed to the provider, resulting in a negative balance, the coalition shall make reasonable efforts to collect the overpayment from the provider. Reasonable efforts include but are not limited to informing the provider of the full amount owed, making written requests for repayment, offering to negotiate a repayment schedule, and offsetting the overpayment against future payments.

(b) If the coalition is unable to collect the overpayment within ninety (90) calendar days after making a reasonable effort, as determined by the Agency for Workforce Innovation, the coalition shall request in writing that the Agency for Workforce Innovation report the overpayment for collection by the Department of Financial Services, in accordance with Rule 69I-21.003, F.A.C. The coalition shall provide all information necessary for the Agency for Workforce Innovation to report the overpayment for collection by the Department of Financial Services.

(c) A VPK provider that fails to reimburse a coalition when it has received an overpayment as the result of a provider advance payment shall be ineligible to receive additional payment for offering the VPK program until the provider has reimbursed the coalition.

Rulemaking Authority 1002.75(2)(h), 1002.75(4), 1002.79(2) FS. Law Implemented 1002.71(5)(b), 1002.75(2)(h), 1002.75(4) FS. History—New _____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Kristin R. Harden

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Cynthia R. Lorenzo

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 20, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: April 24, 2009

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Construction Industry Licensing Board

RULE NO.: 61G4-12.006
RULE TITLE: Approved Form; Incorporation
PURPOSE AND EFFECT: The Board proposes the rule amendment to update the forms and reincorporate them by reference.

SUMMARY: The rule amendment will update the forms and reincorporate them by reference.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: No Statement of Estimated Regulatory Cost was prepared. The Board determined that small businesses would not be affected by this rule.

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

RULEMAKING AUTHORITY: 489.108 FS.
LAW IMPLEMENTED: 120.52(15), (16), 489.108, 489.143 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: G. W. Harrell, Executive Director, Construction Industry Licensing, P. O. Box 5257, Tallahassee, Florida 32399-5257

THE FULL TEXT OF THE PROPOSED RULE IS:

61G4-12.006 Approved Form; Incorporation.
The following form used by the Board in its dealings with the public is hereby adopted and incorporated by reference, and can be obtained from the Board at the following address:

Florida Construction Industry Licensing Board
1940 North Monroe Street
Tallahassee, Florida 32399-1039

Florida Homeowners' Construction Recovery Fund Claim Form, DBPR/CILB/022-(Rev. ~~October 2008~~ ~~January 2005~~).

Rulemaking Specific Authority 489.108 FS. Law Implemented 120.52(15), 489.108, 489.143 FS. History—New 1-6-80, Formerly 21E-12.06, Amended 1-1-89, Formerly 21E-12.006, Amended 1-4-94, 2-24-94, 11-23-95, 2-6-96, 7-22-96, 11-25-97, 8-2-98, 2-24-00, 3-26-01, 2-14-05, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Construction Industry Licensing Board

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Construction Industry Licensing Board

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: February 12, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: February 6, 2009

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Construction Industry Licensing Board

RULE NO.: 61G4-22.001
RULE TITLE: Mediation
PURPOSE AND EFFECT: The Board proposes the rule amendment to correct references to Section 489.129(1), Florida Statutes and to add new reference and language.

SUMMARY: The rule amendment will correct references to Section 489.129(1), Florida Statutes and to add new reference and language to Section 489.129(1)(q), Florida Statutes.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: No Statement of Estimated Regulatory Cost was prepared. The Board determined that small businesses would not be affected by this rule.

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

RULEMAKING AUTHORITY: 489.108, 455.2235 FS.
LAW IMPLEMENTED: 455.2235 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: G. W. Harrell, Executive Director, Construction Industry Licensing Board, P. O. Box 5257, Tallahassee, Florida 32399-5257

THE FULL TEXT OF THE PROPOSED RULE IS:

THE FULL TEXT OF THE PROPOSED RULE IS:

61G4-22.001 Mediation.

The following alleged violations may be resolved by mediation using the procedure adopted by the department pursuant to Section 455.2235, F.S.:

- (1) Section 489.129(1)(g)(h), F.S., Committing misconduct or mismanagement in the practice of contracting that causes financial harm to a customer.
- (2) Sections 489.129(1)(i)(j); 489.1195, F.S., Failing in any material respect to comply with the provisions of Chapter 489, Part I, F.S., by failing to properly supervise the activities of a construction business qualified by the contractor.
- (3) Section 489.129(1)(i)(k), F.S., Abandoning a construction project.
- (4) Section 489.129(1)(l)(m), F.S., Committing fraud or deceit in the practice of contracting.
- (5) Section 489.129(1)(m)(n), F.S., Committing incompetency or misconduct in the practice of contracting.
- (6) Section 489.129(1)(n), F.S., Committing gross negligence, repeated negligence, or negligence resulting in a significant danger to life or property in the practice of contracting.
- (7) Section 489.129(1)(q), F.S., Failing to satisfy within a reasonable time the terms of a civil judgment.

Rulemaking Authority 489.108, 455.2235 FS. Law Implemented 455.2235 FS. History--New 6-27-95, Amended.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Construction Industry Licensing Board
NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Construction Industry Licensing Board
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 13, 2009
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: April 3, 2009

DEPARTMENT OF ENVIRONMENTAL PROTECTION
Notices for the Department of Environmental Protection between December 28, 2001 and June 30, 2006, go to <http://www.dep.state.fl.us/> under the link or button titled "Official Notices."

DEPARTMENT OF HEALTH
Board of Medicine
RULE NO.: 64B8-30.014
RULE TITLE: Citation Authority
PURPOSE AND EFFECT: The proposed rule amendment is intended to add to the penalty language with regard to CME violations.

SUMMARY: The proposed rule amendment subjects licensees who have failed to document CME to a CME audit for the next two biennia.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: No Statement of Estimated Regulatory Cost has been prepared. The Board has determined that the proposed rule amendments will not have an impact on small business.

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

RULEMAKING AUTHORITY: 456.077, 458.309, 458.347(7)(g), (12) FS.

LAW IMPLEMENTED: 456.077, 458.331, 458.347(7)(g), (12) FS.

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

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

THE FULL TEXT OF THE PROPOSED RULE IS:

64B8-30.014 Citation Authority.

In lieu of the disciplinary procedures contained in Section 456.073, F.S., the offenses enumerated in this rule may be disciplined by the issuance of a citation. The citation shall include a requirement that the licensee correct the offense, if possible, within a specified period of time, impose whatever obligations will correct the offense, and impose the prescribed penalty.

(1) through (2) No change.

(3) The following violations with accompanying penalty may be disposed of by citation with the specified penalty:

VIOLATIONS	PENALTY
(a) CME violations. (Section 458.347(7)(c), F.S.) (Section 458.331(1)(g), (x), F.S.) (Section 456.072(1)(e), (s), F.S.)	Within twelve months of the date the citation is issued, Respondent must submit certified documentation of completion of all CME requirements for the period for which the citation was issued; prior to renewing the license for the next biennium, Respondent must document compliance with the CME requirements for the relevant period; AND pay a \$250 fine. <u>In addition, the Respondent will be subject to a CME audit for the next two biennial renewal periods.</u>

- 1. through 5. No change.
- (b) through (i) No change.
- (4) through (5) No change.

Rulemaking Specific Authority 456.077, 458.309, 458.347(7)(g), (12) FS. Law Implemented 456.077, 458.331, 458.347(7)(g), (12) FS. History--New 3-3-02, Amended 5-19-03, 11-17-03, 5-4-04, 12-12-05, 8-2-06,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Council on Physician Assistants
NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Board of Medicine
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: April 3, 2009
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: October 17, 2008

DEPARTMENT OF HEALTH

Board of Osteopathic Medicine

RULE NO.: 64B15-6.01051
RULE TITLE: Citation Authority

PURPOSE AND EFFECT: The proposed rule amendment is intended to add to the penalty language with regard to CME violations.

SUMMARY: The proposed rule amendment subjects licensees who have failed to document CME to a CME audit for the next two biennia.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: No Statement of Estimated Regulatory Cost has been prepared. The Board has determined that the proposed rule amendments will not have an impact on small business.

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

RULEMAKING AUTHORITY: 456.077, 459.005, 459.022(7)(f), (12) FS.

LAW IMPLEMENTED: 456.077, 459.015, 459.022(7)(d), (f), (12) FS.

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

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

THE FULL TEXT OF THE PROPOSED RULE IS:

64B15-6.01051 Citation Authority.

In lieu of the disciplinary procedures contained in Section 456.073, F.S., the offenses enumerated in this rule may be disciplined by the issuance of a citation. The citation shall include a requirement that the licensee correct the offense, if possible, within a specified period of time, impose whatever obligations will correct the offense, and impose the prescribed penalty.

- (1) through (2) No change.
- (3) The following violations with accompanying penalty may be disposed of by citation with the specified penalty:

VIOLATIONS	PENALTY
(a) CME violations. (Sections 459.022(7)(b), 459.015(1)(g), (bb), 456.072(1)(e), (s), F.S.)	Within twelve months of the date the citation is issued, Respondent must submit certified documentation of completion of all CME requirements for the period for which the citation was issued; prior to renewing the license for the next biennium, Respondent must document compliance with the CME requirement for the relevant period; AND pay a \$250 fine. <u>In addition, the Respondent will be subject to a CME audit for the next two biennial renewal periods.</u>

- 1. through 5. No change.
- (b) through (i) No change.
- (4) through (5) No change.

Rulemaking Specific Authority 456.077, 459.005, 459.022(7)(f), (12) FS. Law Implemented 456.077, 459.015, 459.022(7)(d), (f), (12) FS. History--New 3-10-02, Amended 1-12-04, 5-4-04, 12-12-05, 8-2-06,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Council on Physician Assistants
NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Board of Osteopathic Medicine
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 15, 2009
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: October 17, 2008

DEPARTMENT OF HEALTH

Board of Physical Therapy Practice

RULE NOS.: 64B17-3.001
RULE TITLES: Licensure as a Physical Therapist by Examination

64B17-3.003
Licensure by Endorsement

PURPOSE AND EFFECT: The Board proposes the rule amendments for incorporation of revised forms.

SUMMARY: The revised forms will be incorporated into the rules.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: A Statement of Estimated Regulatory Cost has been prepared and is available by contacting Allen Hall, Executive Director, at the address listed below.

The following is a summary of the SERC:

- Over a five year period, an estimated 6,510 applications could be received.
- The only costs to be incurred are rulemaking costs. No effect on state or local revenue is expected.
- No transactional costs are expected to be incurred by applicants or other entities by the proposed changes to the rule.
- The proposed change is not expected to impact small business, small counties or small cities.

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

RULEMAKING AUTHORITY: 486.025, 486.031(3), 486.081 FS.

LAW IMPLEMENTED: 456.017, 486.031, 486.051, 486.081 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Allen Hall, Executive Director, Board of Physical Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3253

THE FULL TEXT OF THE PROPOSED RULE IS:

64B17-3.001 Licensure as a Physical Therapist by Examination.

Every physical therapist who applies for licensure by examination shall file DOH Form #DH-MQA 1142 Application for Licensure, Revised 02/09 ~~12/08~~, incorporated by reference, which is available through www.doh.state.fl.us/mqa, and demonstrate to the Board that the applicant:

- (1) through (4) No change.

Rulemaking Authority 486.025(1), 486.031(3) FS. Law Implemented 456.017, 486.031, 486.051 FS. History—New 8-6-84, Amended 6-2-85, Formerly 21M-7.20, Amended 5-18-86, Formerly 21M-7.020, 21MM-3.001, Amended 3-1-94, Formerly 61F11-3.001, Amended 12-22-94, 4-10-96, Formerly 59Y-3.001, Amended 12-30-98, 1-23-03, 4-9-06, 9-19-06, 3-13-07, 5-11-08, 5-21-09, _____.

64B17-3.003 Licensure by Endorsement.

An applicant filing DOH Form #DH-MQA 1142 Application for Licensure, Revised 02/09 ~~12/08~~, which is available through www.doh.state.fl.us/mqa, and demonstrating that he or she meets the requirements of Rule 64B17-3.001, F.A.C., may be licensed to practice physical therapy by endorsement by

presenting evidence satisfactory to the Board that the applicant has active licensure in another jurisdiction and has passed an examination before a similar, lawful, authorized examining board in physical therapy in such other jurisdiction if their standards for licensure are as high as those maintained in Florida. The standard for determining whether the standards of another jurisdiction are as high as the standards in Florida shall be whether the written examination taken for licensure in such other jurisdiction by applicants meeting Florida's minimum educational qualifications was through the national physical therapy examination provider certified by the Department. An applicant who has failed to pass the National Physical Therapy Examination for Physical Therapists by or on the fifth attempt, regardless of the jurisdiction through which the examination was taken, is precluded from licensure.

Rulemaking Authority 486.025, 486.081 FS. Law Implemented 486.081 FS. History—New 8-6-84, Formerly 21M-7.26, Amended 5-18-86, Formerly 21M-7.026, 21MM-3.004, 61F11-3.004, 59Y-3.004, Amended 4-21-02, 11-11-02, 11-1-04, 4-9-06, 5-21-09, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Physical Therapy Practice

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Board of Physical Therapy Practice

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: February 12, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 27, 2009

DEPARTMENT OF HEALTH

Board of Physical Therapy Practice

RULE NO.:	RULE TITLE:
64B17-3.002	Licensure Examination Subjects and Passing Score; Additional Requirements After Third Failure; Florida Jurisprudence Examination

PURPOSE AND EFFECT: The Board proposes the rule amendment for incorporation of revised form.

SUMMARY: The revised form will be incorporated into the rule.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: A Statement of Estimated Regulatory Cost has been prepared and is available by contacting Allen Hall, Executive Director, at the address listed below.

The following is a summary of the SERC:

- Over a five year period, an estimated 2,935 re-exam applications could be received.
- The only costs to be incurred are rulemaking costs. No effect on state or local revenue is expected.

- No transactional costs are expected to be incurred by applicants or other entities by the proposed changes to the rule.
- The proposed change is not expected to impact small business, small counties or small cities.

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

RULEMAKING AUTHORITY: 456.017, 486.025, 486.051 FS.

LAW IMPLEMENTED: 456.017, 486.051 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Allen Hall, Executive Director, Board of Physical Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3253

THE FULL TEXT OF THE PROPOSED RULE IS:

64B17-3.002 Licensure Examination Subjects and Passing Score; Additional Requirements After Third Failure; Florida Jurisprudence Examination.

(1) through (2) No change.

(3) An applicant must reapply, using DOH Form #DH-MQA 1143, Re-Exam Application, Revised 02/09 ~~12/08~~, incorporated by reference, which is available through www.doh.state.fl.us/mqa, in order to retake the examination. If an applicant wishes to take the examination for the fourth time, the applicant must submit to the Board for approval satisfactory evidence of having successfully completed the following since the last taking of the examination: successful completion of a course of study or internship designed to prepare the applicant for the physical therapy examination. An applicant who has completed these additional requirements may take the examination on two more occasions.

(4) All applicants for licensure including those licensed by endorsement under Rule 64B17-3.003, F.A.C., are required to take and pass the Florida Jurisprudence Examination developed by the Federation of State Boards of Physical Therapy.

(a) The Florida Jurisprudence Examination has 40 scored questions and the content and approximate weights are:

1. Legislative Intent and Definitions 25%;
2. Board Powers and Duties 5%;
3. Licensure and Examination 7.5%;
4. Patient Care 35%;
5. Disciplinary Action and Unlawful Practice 15%; and

6. Consumer Advocacy 12.5%. In order to achieve a passing score on the examination, an applicant must obtain a score equal to or greater than the scaled score based upon a passing score study conducted by the Federation of State Boards of Physical Therapy.

(b) Applicants must reapply to retake the Florida Jurisprudence Examination, using DOH Form #DH-MQA 1143, Re-Exam Application, Revised 02/09 ~~12/08~~, which is available through www.doh.state.fl.us/mqa.

Rulemaking Authority 456.017, 486.025, 486.051 FS. Law Implemented 456.017, 486.051 FS. History—New 8-6-84, Formerly 21M-7.22, Amended 3-16-88, 6-20-89, Formerly 21M-7.022, Amended 6-6-90, 6-3-92, 3-24-93, Formerly 21MM-3.002, 61F11-3.002, Amended 12-22-94, Formerly 59Y-3.002, Amended 2-14-02, 4-23-02, 12-5-04, 4-9-06, 1-7-07, 6-27-07, 5-21-09,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Physical Therapy Practice

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Board of Physical Therapy Practice

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: February 12, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 27, 2009

DEPARTMENT OF HEALTH

Board of Physical Therapy Practice

RULE NOS.:

RULE TITLES:

64B17-4.001

Licensure as a Physical Therapist Assistant by Examination

64B17-4.003

Licensure by Endorsement

PURPOSE AND EFFECT: The Board proposes the rule amendments for incorporation of revised forms.

SUMMARY: Revised forms will be incorporated into the rules.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: A Statement of Estimated Regulatory Cost has been prepared and is available by contacting Allen Hall, Executive Director, at the address listed below.

The following is a summary of the SERC:

- Over a five year period, an estimated 6,510 applications could be received.
- The only costs to be incurred are rulemaking costs. No effect on state or local revenue is expected.
- No transactional costs are expected to be incurred by applicants or other entities by the proposed changes to the rule.
- The proposed change is not expected to impact small business, small counties or small cities.

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

RULEMAKING AUTHORITY: 486.025, 486.102, 486.107(1) FS.

LAW IMPLEMENTED: 456.017, 486.102(3), 486.104, 486.107(1) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Allen Hall, Executive Director, Board of Physical Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3253

THE FULL TEXT OF THE PROPOSED RULES IS:

64B17-4.001 Licensure as a Physical Therapist Assistant by Examination.

Every physical therapist assistant who applies for licensure by examination shall file DOH Form #DH-MQA 1142 Application for Licensure, Revised ~~2/09~~ 12/08, ~~incorporated by reference~~, which is available through www.doh.state.fl.us/mqa, and demonstrate to the Board that the applicant:

- (1) through (3) No change.

Rulemaking Authority 486.025, 486.102 FS. Law Implemented 456.017, 486.102(3), 486.104 FS. History—New 8-6-84, Amended 6-2-85, Formerly 21M-10.20, Amended 5-18-86, Formerly 21M-10.020, 21MM-4.001, Amended 3-1-94, Formerly 61F11-4.001, Amended 12-22-94, 4-10-96, Formerly 59Y-4.001, Amended 1-23-03, 4-9-06, 9-19-06, 5-21-09,_____.

64B17-4.003 Licensure by Endorsement.

An applicant, filing DOH Form #DH-MQA 1142 Application for Licensure, Revised ~~0209~~ 12/08, which is available through www.doh.state.fl.us/mqa, and demonstrating that he or she is licensed in another state may be licensed to practice as a physical therapist assistant by endorsement by presenting evidence of active licensure in another jurisdiction, under oath, and evidence satisfactory to the Board that the applicant from such other jurisdiction has been licensed under standards for licensure as high as those maintained in Florida. The standard for determining whether those requirements are as high as those in Florida shall be whether the applicant was required to meet educational standards equivalent to those set forth in subsection 64B17-4.001(3), F.A.C., and whether the written examination taken for licensure in such other jurisdiction was through the designated national physical therapist assistants examination provider certified by the Department. An applicant who has failed to pass the National Physical Therapy Examination for Physical Therapist Assistants by or on the fifth attempt, regardless of the jurisdiction through which the examination was taken, is precluded from licensure.

Rulemaking Authority 486.025, 486.107(1) FS. Law Implemented 486.107(1) FS. History—New 8-6-84, Formerly 21M-10.26, Amended 5-18-86, Formerly 21M-10.026, 21MM-4.004, 61F11-4.004, 59Y-4.004, Amended 7-11-02, 11-11-02, 12-5-04, 4-9-06, 5-21-09,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Physical Therapy Practice

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Board of Physical Therapy Practice

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: February 12, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 27, 2009

DEPARTMENT OF HEALTH

Board of Physical Therapy Practice

RULE NO.:	RULE TITLE:
64B17-4.002	Licensure Examination Subjects and Passing Score; Additional Requirements After Third Failure; Florida Jurisprudence Examination

PURPOSE AND EFFECT: The Board proposes the rule amendment for a revised form.

SUMMARY: The revised form will be added into the rule.
 SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: A Statement of Estimated Regulatory Cost has been prepared and is available by contacting Allen Hall, Executive Director, at the address listed below.

The following is a summary of the SERC:

- Over a five year period, an estimated 2,935 re-exam applications could be received.
- The only costs to be incurred are rulemaking costs. No effect on state or local revenue is expected.
- No transactional costs are expected to be incurred by applicants or other entities by the proposed changes to the rule.
- The proposed change is not expected to impact small business, small counties or small cities.

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

RULEMAKING AUTHORITY: 456.017(1)(b), 486.025, 486.104 FS.

LAW IMPLEMENTED: 456.017, 486.104 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Allen Hall, Executive Director, Board of Physical Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3253

THE FULL TEXT OF THE PROPOSED RULE IS:

64B17-4.002 Licensure Examination Subjects and Passing Score; Additional Requirements After Third Failure; Florida Jurisprudence Examination.

(1) through (2) No change.

(3) An applicant must reapply, using DOH Form #DH-MQA 1143, Re-Exam Application, Revised 02/09 ~~12/08~~, which is available through www.doh.state.fl.us/mqa, in order to retake the examination. If an applicant wishes to take the examination for the fourth time, the applicant must submit to the Board for approval satisfactory evidence of having successfully completed the following since the last taking of the examination: successful completion of a course of study or internship designed to prepare the applicant for the physical therapy assistant examination. An applicant who has completed these additional requirements may take the examination on two more occasions.

(4) All applicants for licensure including those licensed by endorsement under Rule 64B17-4.003, F.A.C., are required to take and pass the Florida Jurisprudence Examination developed by the Federation of State Boards of Physical Therapy.

(a) The Florida Jurisprudence Examination has 40 scored questions and the content and approximate weights are:

1. Legislative Intent and Definitions 25%;
2. Board Powers and Duties 5%;
3. Licensure and Examination 7.5%;
4. Patient Care 35%;
5. Disciplinary Action and Unlawful Practice 15%; and
6. Consumer Advocacy 12.5%. In order to achieve a passing score on the examination, an applicant must obtain a score equal to or greater than the scaled score based upon a passing score study conducted by the Federation of State Boards of Physical Therapy.

(b) Applicants must reapply to retake the Florida Jurisprudence Examination, using DOH Form #DH-MQA 1143, Re-Exam Application, Revised 02/09 ~~12/08~~, which is available through www.doh.state.fl.us/mqa.

Rulemaking Authority 456.017(1)(b), 486.025, 486.104 FS. Law Implemented 456.017, 486.104 FS. History—New 8-6-84, Formerly 21M-10.22, Amended 4-12-87, 3-16-88, 6-20-89, Formerly 21M-10.022, Amended 6-3-92, 3-24-93, Formerly 21MM-4.002, 61F11-4.002, Amended 12-22-94, Formerly 59Y-4.002, Amended 2-14-02, 4-23-02, 12-5-04, 4-9-06, 6-27-07, 5-21-09, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Board of Physical Therapy Practice

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Board of Physical Therapy Practice

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: February 12, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 27, 2009

DEPARTMENT OF HEALTH

Board of Physical Therapy Practice

RULE NO.: 64B17-7.0027
 RULE TITLE: Procedure for Compliance with Board Ordered Laws and Rules Exam

PURPOSE AND EFFECT: The Board proposes the rule amendment for incorporation of revised form.

SUMMARY: The revised form will be incorporated into the rule.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: A Statement of Estimated Regulatory Cost has been prepared and is available by contacting Allen Hall, Executive Director, at the address listed below.

The following is a summary of the SERC:

- Over a five year period, approximately eighty licensees would be required to pass the laws and rules examination due to discipline.
- The only costs to be incurred are rulemaking costs. No effect on state or local revenue is expected.
- No transactional costs are expected to be incurred by applicants or other entities by the proposed changes to the rule.
- The proposed change is not expected to impact small business, small counties or small cities.

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

RULEMAKING AUTHORITY: 456.036, 456.072, 456.079, 486.025 FS.

LAW IMPLEMENTED: 456.072, 456.073, 456.079, 486.125 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Allen Hall, Executive Director, Board of Physical Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3253

THE FULL TEXT OF THE PROPOSED RULE IS:

64B17-7.0027 Procedure for Compliance with Board Ordered Laws and Rules Exam.

Licensees ordered to take and pass the examination as a result of a disciplinary proceeding or reinstatement, must file DOH Form #DH-MQA 1144, PT Florida Laws and Rules Examination Application, Revised 02/09 ~~12/08~~, which is available through www.doh.state.fl.us/mqa.

Rulemaking Authority 456.036, 456.072, 456.079, 486.025 FS. Law Implemented 456.072, 456.073, 456.079, 486.125 FS. History—New 5-21-09, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Board of Physical Therapy Practice
NAME OF AGENCY HEAD WHO APPROVED THE
PROPOSED RULE: Board of Physical Therapy Practice
DATE PROPOSED RULE APPROVED BY AGENCY
HEAD: February 12, 2009
DATE NOTICE OF PROPOSED RULE DEVELOPMENT
PUBLISHED IN FAW: March 27, 2009

DEPARTMENT OF HEALTH

Board of Physical Therapy Practice

RULE NO.: RULE TITLE:
64B17-9.001 Continuing Education

PURPOSE AND EFFECT: The Board proposes the rule amendment for incorporation of a revised form.

SUMMARY: A revised form will be incorporated into the rule.
SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: A Statement of Estimated Regulatory Cost has been prepared and is available by contacting Allen Hall, Executive Director, at the address listed below.

The following is a summary of the SERC:

- The number of laws and rules applications for continuing education credit received each year from licensees will vary, so the precise number impacted in future years is not available.
- The only costs to be incurred are rulemaking costs. No effect on state or local revenue is expected.
- No transactional costs are expected to be incurred by applicants or other entities by the proposed changes to the rule.
- The proposed change is not expected to impact small business, small counties or small cities.

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

RULEMAKING AUTHORITY: 486.025 FS.

LAW IMPLEMENTED: 456.013(6), 486.109(2) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Allen Hall, Executive Director, Board of Physical Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3253

THE FULL TEXT OF THE PROPOSED RULE IS:

- 64B17-9.001 Continuing Education.
- (1) through (5) No change.
- (6) The Board approves for continuing education credit:
- (a) through (e) No change.

(f) Licensees who file DOH form #DH-MQA 1144, PT Florida Laws and Rules Examination Application, Revised ~~02/09~~ ~~42/08~~, incorporated by reference, which is available through www.doh.state.fl.us/mqa, and take and pass the Florida laws and rules examination shall receive two (2) hours of continuing education per biennium. The continuing education credit shall be awarded only for the biennium in which the examination was taken and passed. Continuing education credit shall not be awarded to licensees that take and pass the examination as a result of a disciplinary proceeding or as a board ordered condition of initial licensure, re-activation or reinstatement.

(7) through (8) No change.

Rulemaking Authority 486.025 FS. Law Implemented 456.013(6), 486.109(2) FS. History—New 4-6-92, Formerly 21MM-9.001, Amended 3-7-94, Formerly 61F11-9.001, Amended 12-5-95, Formerly 59Y-9.001, Amended 2-14-02, 4-21-02, 1-2-03, 6-28-04, 4-9-06, 5-28-06, 2-17-08, 5-21-09,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Board of Physical Therapy Practice
NAME OF AGENCY HEAD WHO APPROVED THE
PROPOSED RULE: Board of Physical Therapy Practice
DATE PROPOSED RULE APPROVED BY AGENCY
HEAD: February 12, 2009
DATE NOTICE OF PROPOSED RULE DEVELOPMENT
PUBLISHED IN FAW: March 27, 2009

DEPARTMENT OF HEALTH

Division of Emergency Medical Operations

RULE NOS.:	RULE TITLES:
64J-1.002	Basic Life Support Service License – Ground
64J-1.003	Advanced Life Support Service License – Ground
64J-1.005	Air Ambulances
64J-1.007	Vehicle Permits

PURPOSE AND EFFECT: The purpose is to update DH Forms 631, Ground Ambulance Service Provider License Application, 1575, Air Ambulance Service License Application, and 1576, Application for Air Ambulance Permit to require the provider’s identification number and air worthiness certificate of each air transport vehicle to be licensed. The amendments to the rules are to reflect the new effective dates in the form titles. The effect will be ensuring air transport vehicles are air worthy and to help aid in the efficiency of administration of applications.

SUMMARY: The purpose of the rule amendments is to update the forms to require an air worthiness certificate for each air transport vehicle the emergency medical services provider wants to license and to ask for the provider’s identification number. Rules 64J-1.002, 64J-1.003, 64J-1.005 and 64J-1.007, F.A.C., are being amended to reflect the new effective dates within the DH Form titles. The changes to the forms will help

increase the quality of care by further ensuring the air transport vehicles are certified as air worthy and help the efficiency of the administration process by requiring the provider's identification number on the application.

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

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

RULEMAKING AUTHORITY: 401.251, 401.26, 401.35 FS.

LAW IMPLEMENTED: 401.251 FS.

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

DATE AND TIME: July 7, 2009, 2:00 p.m. – 3:00 p.m. Eastern Standard Time

PLACE: Florida Department of Health, 4025 Esplanade Way, 3rd Floor, Room 301, Tallahassee, FL 32311

A copy of the forms with the noted changes can be found on the Bureau of EMS website, Legislation and Rules page at: <http://www.fl-ems.com>

A conference line will be available for those unable to attend in person. We request that parties from the same agency utilize one line if possible to allow other participants to dial in.

Toll free conference number: 1(888)808-6959

Conference code: 1454440

REQUEST FOR HEARING MUST BE RECEIVED IN WRITING TO: Lisa Walker, Government Analyst II at the address below.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 24 hours before the workshop/meeting by contacting: Alexander Macy, Administrative Assistant I, Bureau of EMS, (850)245-4440, extension *2735, or by email at Alexander_Macy@doh.state.fl.us If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Lisa Walker, Government Analyst II, Bureau of EMS, 4052 Bald Cypress Way, Bin C-18, Tallahassee, FL 32399, phone: (850)245-4440, ext. 2733; or email Lisa_Walker2@doh.state.fl.us. **NOTE:** If you have written comments that you wish to be added to the record please send them to Lisa Walker before the hearing so your comments may be read into the record.

THE FULL TEXT OF THE PROPOSED RULES IS:

64J-1.002 Basic Life Support Service License – Ground.

(1) To obtain a license or renewal each applicant shall submit an application to the department on DH Form 631, ~~04/09 December 2008~~, Ground Ambulance Service Provider License Application. This form is incorporated by reference and is available from the department, as defined by subsection 64J-1.001(9), F.A.C., or at <http://www.fl-ems.com>.

(2) The department shall issue a license to any applicant who:

(a) Furnished evidence of insurance coverage for claims arising out of injury or death of persons and damage to the property of others resulting from any cause for which the owner of said business or service would be liable. Each motor vehicle shall be insured for the sum of at least \$100,000 for injuries to or death of any one person arising out of any one accident; the sum of at least \$300,000 for injuries to or death of more than one person in any one accident; and, for the sum of at least \$50,000 for damage to property arising from any one accident. Government operated service vehicles shall be insured for the sum of at least \$100,000 for any claim or judgment and the sum of \$200,000 total for all claims or judgments arising out of the same occurrence. Every insurance policy or contract for such insurance shall provide for the payment and satisfaction of any financial judgment entered against the operator and present insured, or any person driving the insured vehicle. All such insurance policies shall provide for 30-day cancellation notice to the department.

(b) Obtained a Certificate of Public Convenience and Necessity (COPCN).

(3) Each BLS provider shall ensure and document in its employee records that each of its EMTs and paramedics hold a current certification from the department.

(4) Every provider, except those exempted in paragraph 64J-1.006(1)(a), F.A.C., shall ensure that each EMS vehicle permitted by the department, when available for call, shall be equipped and maintained as approved by the medical director of the service in the vehicle minimum equipment list. The vehicle minimum equipment list shall include, at a minimum, one each of the items listed in Table I and shall be provided to the department upon request.

TABLE I

GROUND VEHICLE

BLS MEDICAL EQUIPMENT AND SUPPLIES

ITEM	QTY.
1. Bandaging, dressing, and taping supplies:	
a. Adhesive, silk, or plastic tape – assorted sizes.	
b. Sterile 4 × 4 inch gauze pads.	
c. Triangular bandages.	
d. Roller gauze.	
e. ABD (minimum 5 × 9 inch) pads.	
2. Bandage shears.	

3. Patient restraints, wrist and ankle.
 4. Blood pressure cuffs: infant, pediatric, and adult.
 5. Stethoscopes: pediatric and adult.
 6. Blankets.
 7. Sheets (not required for non-transport vehicle.)
 8. Pillows with waterproof covers and pillow cases or disposable single use pillows (not required for non-transport vehicle).
 9. Disposable blanket or patient rain cover.
 10. Long spine board and three straps or equivalent.
 11. Short spine board and two straps or equivalent.
 12. Adult and Pediatric cervical immobilization devices (CID), approved by the medical director of the service.
 13. Padding for lateral lower spine immobilization of pediatric patients or equivalent.
 14. Portable oxygen tanks, "D" or "E" cylinders, with one regulator and gauge.
Each tank must have a minimum pressure of 1000 psi, and liter flow at 15 liters per minute.
 15. Transparent oxygen masks; adult, child and infant sizes, with tubing.
 16. Sets of pediatric and adult nasal cannulae with tubing.
 17. Hand operated bag-valve mask resuscitators, adult and pediatric accumulator, including adult, child and infant transparent masks capable of use with supplemental oxygen.
 18. Portable suction, electric or gas powered, with wide bore tubing and tips which meet the minimum standards as published by the GSA in KKK-A 1822E specifications.
 19. Extremity immobilization devices. Pediatric and Adult.
 20. Lower extremity traction splint. Pediatric and Adult.
 21. Sterile obstetrical kit to include, at minimum, bulb syringe, sterile scissors or scalpel, and cord clamps or cord-ties.
 22. Burn sheets.
 23. Flashlight with batteries.
 24. Occlusive dressings.
 25. Oropharyngeal airways. Pediatric and Adult.
 26. Installed oxygen with regulator gauge and wrench, minimum "M" size cylinder (minimum 500 PSI) with oxygen flowmeter to include a 15lpm setting, not required for non-transport (vehicles.) (Other installed oxygen delivery systems, such as liquid oxygen, as allowed by medical director.)
 27. Gloves – suitable to provide barrier protection for biohazards. Sufficient quantity, sizes, and material for all crew members.
 28. Face Masks – both surgical and respiratory protective. Sufficient quantity, sizes and material for all crew members.
 29. Rigid cervical collars as approved in writing by the medical director and available for review by the department.
 30. Nasopharyngeal airways, pediatric and adult.
 31. Approved biohazardous waste plastic bag or impervious container per Chapter 64E-16, F.A.C.
 32. Safety goggles or equivalent meeting A.N.S.I. Z87.1 standard. One per crew member.
 33. Bulb syringe separate from obstetrical kit.
 34. Thermal absorbent reflective blanket.
 35. Multitrauma dressings.
 36. Pediatric length based measurement device for equipment selection and drug dosage.
- Rulemaking Specific Authority 381.0011, 395.405, 401.121, 401.25, 401.35 FS. Law Implemented 381.0011, 395.401, 395.4015, 395.402, 395.4025, 395.403, 395.404, 395.4045, 401.23, 401.24, 401.25, 401.252, 401.26, 401.27, 401.281, 401.30, 401.31, 401.321, 401.34, 401.35, 401.41, 401.411, 401.414, 401.421 FS. History–New 11-29-82, Amended 4-26-84, 3-11-85, Formerly 10D-66.49, Amended 4-12-88, 8-3-88, 12-10-92, 10-2-94, 1-26-97, Formerly 10D-66.049, Amended 8-4-98, 1-3-99, 11-19-01, 12-18-06, Formerly 64E-2.002, Amended _____.
- 64J-1.003 Advanced Life Support Service License – Ground.
- (1) To obtain a license or renewal each applicant for an ALS license shall submit to the department DH Form 631, 04/09 ~~December 2008~~, Ground Ambulance Service Provider

License Application, which is incorporated by reference and available from the department, as defined by subsection 64J-1.001(9), F.A.C., or at <http://www.fl-ems.com>.

(2) Each ALS provider shall ensure and document in its employee records that each of its EMTs or paramedics hold a current certification from the department.

(3) Each ALS provider shall ensure that a current copy of all standing orders authorized by the medical director shall be available in each of the provider's vehicles; for review by the department; to each of the provider's paramedics; and supplied to each physician designated by the medical director to receive a copy.

(4) Each ALS permitted vehicle when available for call, shall be equipped and maintained as approved by the medical director of the service in the vehicle minimum equipment list. The vehicle minimum equipment list shall include, at a minimum, one each of the items listed in Tables I and II, and shall be provided to the department upon request, except those exempted in paragraph 64J-1.006(1)(a), F.A.C. Substitutions are allowed with signed approval from the medical director and written notification to the department.

(5) The medical director may authorize an EMT instead of the paramedic or licensed physician to attend a BLS patient on an ALS permitted ambulance under the following conditions:

(a) The medical director determines what type of BLS patient may be attended by an EMT and develops standing orders for use by the EMT when attending the type of BLS patients identified. The onscene paramedic shall conduct the primary patient assessment to determine if the patient's condition meets the criteria in the standing orders for BLS care. This survey shall be documented on the patient care record and shall identify the paramedic who conducted the survey.

(b) The patient care record for any patient care or transport shall clearly state whenever an EMT attends the patient.

(c) The provider shall maintain and have accessible for review by the department documentation of compliance with the above requirements.

(6) ALS Nontransport:

(a) Unless otherwise specifically exempted, each advanced life support nontransport vehicle, when personnel are providing advanced life support treatment or care, must be staffed with a certified paramedic or licensed physician.

(b) A permitted advanced life support nontransport vehicle may operate as a basic life support emergency vehicle when the vehicle is not staffed by a certified paramedic or licensed physician and only in lieu of placing the unit completely out of service. When such advanced life support nontransport vehicle is operating under this section, the vehicle must be staffed with at least one person who must be an emergency medical technician, and shall carry portable oxygen, airway adjuncts, supplies and equipment as determined by the medical director of the licensed service.

1. Each service provider having permitted vehicles operating pursuant to this section shall log changes in vehicle status.

2. Vehicles operating pursuant to this section shall not display markings indicating advanced life support (other than permit sticker) when responding as basic life support emergency vehicle.

(c) Unless otherwise specifically exempted, the following advanced life support non-transport vehicles when personnel are providing emergency treatment or care, must be staffed, at a minimum, with a certified paramedic or licensed physician:

1. Advanced life support vehicles that respond to requests to provide emergency treatment or care during special events or activities or in locations where access by permitted transport vehicles is restricted or limited.

2. Advanced life support vehicles that respond to requests to provide emergency treatment or care in vehicles that cannot accommodate two persons, due to design and construction of the vehicle.

3. Advanced life support vehicles under 13,000 pounds gross vehicle weight that respond to requests to provide emergency treatment or care and are met at the scene by other concurrently responding permitted vehicles. Examples include vehicles that respond to requests to provide emergency treatment or care within a gated or restricted community that is established pursuant to Chapter 190, F.S.; vehicles that respond to requests to provide emergency treatment or care which are owned or operated by counties or municipalities established pursuant to Chapter 125 or 166, F.S.; or vehicles that respond to requests to provide emergency treatment and care which are owned or operated by advanced life support services licensees. Vehicles staffed pursuant to this section shall operate in accordance with a certificate of public convenience and necessity.

4. Advanced life support non-transport vehicle over 13,000 pounds gross vehicle weight that respond to requests to provide emergency treatment or care. Vehicles staffed pursuant to this section shall operate in accordance with a certificate of public convenience and necessity.

(d) Vehicles staffed pursuant to paragraph 64J-1.003(6)(c), F.A.C., may respond to requests for medical assistance in accordance with Section 252.40, F.S.

(e) Nothing herein shall prohibit an on duty certified EMT or paramedic who arrives on scene from initiating emergency care and treatment at the level of their certification prior to the arrival of other responding vehicles.

(7) Advanced life support non-transport vehicles, staffed pursuant to paragraph 64J-1.003(6)(c), F.A.C., are not required to carry the equipment and supplies identified in Table I or II. Such vehicles when personnel are providing advanced life support treatment or care, or when responding to calls in an ALS capacity shall at a minimum carry portable oxygen,

defibrillation equipment, airway management supplies and equipment, and medications and fluids authorized by the medical director of the licensed service.

TABLE II
GROUND VEHICLE

ALS EQUIPMENT AND MEDICATIONS
MEDICATION WT/VOL

1. Atropine Sulfate.	
2. Dextrose, 50 percent.	
3. Epinephrine HCL.	1:1,000
4. Epinephrine HCL.	1:10,000
5. Ventricular dysrhythmic.	
6. Benzodiazepine sedative/anticonvulsant.	
7. Naloxone (Narcan).	
8. Nitroglycerin.	0.4 mg.

9. Inhalant beta adrenergic agent with nebulizer apparatus, as approved by the medical director.

I.V. SOLUTIONS

1. Lactated Ringers or Normal Saline.

EQUIPMENT

- (a) Laryngoscope handle with batteries.
- (b) Laryngoscope blades; adult, child and infant sizes.
- (c) Pediatric I.V. arm board or splint appropriate for I.V. stabilization.
- (d) Disposable endotracheal tubes; adult, child and infant sizes. Those below 5.5 shall be uncuffed. 2.5 mm – 5.0 mm uncuffed; 5.5 mm – 7.0 mm; 7.5 mm – 9.0 mm).
- (e) Endotracheal tube stylets pediatric and adult.
- (f) Magill forceps, pediatric and adult sizes.
- (g) Device for intratracheal meconium suctioning in newborns.
- (h) Tourniquets.
- (i) I.V. cannulae 14 thru 24 gauge.
- (j) Micro drip sets.
- (k) Macro drip sets.
- (l) I.V. pressure infuser.
- (m) Needles 18 thru 25 gauge.
- (n) Intraosseous needles and three way stop cocks.
- (o) Syringes, from 1 ml. to 20 ml.
- (p) D.C. battery powered portable monitor with defibrillation and pacing capabilities, ECG printout and spare battery. The unit shall be capable of delivering pediatric defibrillation (energy below 25 watts/sec and appropriate equipment).
- (q) Monitoring electrodes for adults and pediatrics.
- (r) Pacing electrodes. Pediatric and Adult.

- (s) Glucometer.
- (t) Approved sharps container per Chapter 64E-16, F.A.C.
- (u) Flexible suction catheters.
- (v) Electronic waveform capnography capable of real-time monitoring and printing record of the intubated patient (effective 01/01/2008).

Rulemaking Specific Authority 381.0011, 395.405, 401.121, 401.265, 401.35 FS. Law Implemented 381.0011, 381.025, 395.401, 395.4015, 395.402, 395.4025, 395.403, 395.404, 395.4045, 395.405, 401.23, 401.24, 401.25, 401.26, 401.265, 401.27, 401.281, 401.30, 401.31, 401.321, 401.34, 401.35, 401.41, 401.411, 401.414, 401.421 FS. History—New 11-29-82, Amended 4-26-84, 3-11-85, Formerly 10D-66.50, Amended 4-12-88, 8-3-88, 8-7-89, 12-10-92, 11-30-93, 1-26-97, Formerly 10D-66.050, Amended 8-4-98, 1-3-99, 7-14-99, 2-20-00, 9-3-00, 4-15-01, 11-19-01, 6-3-02, 12-18-06, Formerly 64E-2.003, Amended _____.

64J-1.005 Air Ambulances.

(1) Each applicant for an air ambulance license shall pay the required fee as specified in Section 401.34(1)(j), F.S., and submit an application to the department on DH Form 1575, 04/09 December 2008, Air Ambulance Service License Application which is incorporated by reference and available from the department, as defined by subsection 64J-1.001(9), F.A.C., or at <http://www.fl-ems.com>. The air ambulance license shall automatically expire 2 years from the date of issuance.

(2) Each air ambulance applicant or provider, pursuant to subsection 64J-1.014(1), F.A.C., shall maintain on site and make available to the department at license application, license application renewal, change of insurance carrier or policy renewal, and documentation of the following minimum insurance coverage:

(a) Each aircraft shall be insured for the sum of at least \$100,000 for injuries to or death of any one person arising out of any one accident and the sum of at least \$300,000 for injuries to or death of more than one person in any one accident. Any such policy on a leased aircraft must identify both the owner and the lessee of the aircraft.

(b) In lieu of the insurance required in paragraph (2)(a), the provider or applicant may furnish a certificate of self-insurance establishing that the provider or applicant has a self-insurance plan to provide coverage identical to what is required in paragraph (2)(a) and that the plan has been approved by the Department of Insurance.

(3) Each licensed air ambulance shall have emergency protocols which address at least, emergency procedures when the aircraft is overdue, when radio communications cannot be established, or when aircraft location cannot be verified. Each licensed rotary wing air ambulance shall document at least every 15 minutes of flight while en route to and from the patient's location.

(4) Each provider shall maintain in each paramedic’s employment file documentation of successful completion of an initial air crew member (ACM) education program that was conducted in accordance with the 1988 United States (U.S.) Department of Transportation (DOT) Air Medical Crew-Advanced National Standard Curriculum (NSC), which is incorporated by reference and is available for purchase from AAMS; 526 King Street, Suite 415, Alexandria, VA 22314; (703)836-8732. Each provider shall ensure and shall document in its employee records that each EMT and paramedic which it employs holds a current certification from the department.

(5) Each air ambulance provider shall establish a safety committee. The committee shall:

(a) Consist of a membership to include: one pilot, one flight medical crew member, the provider’s medical director, one hospital administrator if the provider is a hospital based program, and a representative of a quality assurance division if one exists;

(b) Develop safety procedures for the provider;

(c) Meet at least quarterly to review safety policies, procedures, unusual occurrences, safety issues, and audit compliance with safety policies and procedures:

(d) Communicate the results of the safety audit to all program personnel; and

(e) Record minutes of the meeting and retain them on file for 2 years.

(6) Each prehospital air ambulance provider shall staff the aircraft with a minimum of one person who shall be a paramedic who meets the criteria in subsection 64J-1.005(4), F.A.C.

(7) Every air ambulance maintained by an air ambulance provider shall meet the structural, equipment and supply requirements listed in Table III.

(8) Each prehospital rotary wing air ambulance when available for call shall meet the structural requirements listed in Table III, and shall be equipped as approved by the medical director of the service in the aircraft minimum equipment list. The aircraft minimum equipment list shall include, at a minimum, one each of the items listed in Table IV and shall be provided to the department upon request.

TABLE III
AIR AMBULANCE

Structural, Equipment and Supply Requirements

ITEM

Aircraft Requirements

1. Entrance large enough to allow loading of a patient.
2. Interior large enough for two medical crew members.
3. Cabin illumination of 40 foot-candles at patient level.
4. FAA approved stretcher system with 2 straps.

5. Isolated aircraft cockpit to protect pilot from in-flight interference.

6. Each aircraft shall be equipped with FAA approved communication equipment that operates on frequencies which allow the flight allow the flight and medical crew to communicate with ground and landing zone medical support exclusive of the air traffic control system.

7. No smoking sign.

8. External search light with a minimum of 400,000 candle power illumination at 200 feet separate from the aircraft landing lights, movable 90 degrees longitudinally, 180 degrees laterally and capable of being controlled from inside the aircraft (Helicopter only).

Medical Equipment Requirements

1. Oxygen sufficient for duration of flight.

2. Oxygen administration equipment.

3. Oropharyngeal airways. Pediatric and adult.

4. Hand operated bag-valve mask resuscitators, adult and pediatric accumulator, including adult, child and infant transparent masks capable of use with supplemental oxygen.

5. Equipment suitable to determine blood pressure of the adult and pediatric patient during flight.

6. Approved sharps container per Chapter 64E-16, F.A.C.

7. Approved biohazardous waste plastic bag or impervious container per Chapter 64E-16, F.A.C.

8. Portable suction unit with wide bore tubing and tips, electric or gas powered, which meets the minimum standards as published by the General Services Administration (GSA) in KKK-A-1822C specifications.

9. Equipment suitable to determine blood pressure of the adult and pediatric patient during the flight.

TABLE IV

Prehospital Rotary Wing Air Ambulances

ITEM

Equipment

1. Laryngoscope handle with batteries.
2. Laryngoscope blades; adult, child and infant size.
3. Pediatric I.V. arm board or splint appropriate for I.V. stabilization.
4. Disposable endotracheal tubes; adult, child and infant sizes. Those below 5.5 mm shall be uncuffed.

- 2.5 mm-5.0 mm uncuffed;
- 5.5 mm-7.0 mm;
- 7.5 mm-9.0 mm
- 5. Endotracheal tube stylets pediatric and adult.
- 6. Magill forceps, pediatric and adult sizes.
- 7. Device for intratracheal meconium suctioning in newborns.
- 8. Tourniquets.
- 9. I.V. cannulae between 14 and 24 gauge.
- 10. Macro drip sets.
- 11. Micro drip sets.
- 12. I.V. pressure infuser.
- 13. Needles between 18 and 25 gauge.
- 14. Intraosseous needles and three way stop cocks.
- 15. Assorted syringes.
- 16. D.C. battery powered portable monitor with defibrillation and pacing capabilities, ECG printout and spare battery. The unit shall be capable of delivering pediatric defibrillation (energy below 25 watts/sec and appropriate equipment).
- 17. Monitoring electrodes for adults and pediatrics.
- 18. Glucometer.
- 19. Pediatric length based measurement device for equipment selection and drug dosage.
- 20. Flexible suction catheters assorted sizes.
- 21. Multitrauma dressings.
- 22. ABD pads.
- 23. Sterile gauze pads.
- 24. Adhesive tape assorted sizes.
- 25. Patient restraints, wrist and ankle.
- 26. Soft roller bandages.
- 27. Bandage shears.
- 28. Sterile obstetrical kit to include, at minimum, bulb syringe, sterile scissors or scalpel, and cord clamps or cord ties.
- 29. Burn sheets.
- 30. Flashlight with batteries.
- 31. Vaseline gauze.
- 32. Gloves – latex or other suitable material. For all crew members.
- 33. Face masks for all crew members.
- 34. Naso and oropharyngeal airways assorted sizes.
- 35. Safety goggles or equivalent meeting A.N.S.I. Z87.1 standard.

- 36. Bulb syringe separate from obstetrical kit.
- 37. Thermal, absorbent, reflective blanket.
- 38. Standing orders.
- 39. Electronic waveform capnography capable of real-time monitoring and printing record of the intubated patient (effective 01/01/2008).

MEDICATION

WT./VOL.

- 1. Atropine sulfate.
- 2. Dextrose 50 percent.
- 3. Epinephrine HCL. 1:1,000
- 4. Epinephrine HCL. 1:10,000
- 5. Ventricular dysrhythmic.
- 6. Sodium Bicarbonate. 50 mEq. or 44.6. mEq.
- 7. Naloxone (Narcan). 1 mg./ml. 2 mg. amp.
- 8. Nitroglycerin. 0.4 mg.
- 9. Benzodiazepine sedative/anticonvulsant.
- 10. Inhalant beta adrenergic agent of choice with nebulizer apparatus, as approved by the medical director.

I.V. Solutions

- 1. Lactated Ringers or Normal Saline.

Rulemaking Specific Authority 381.0011, 401.25, 401.251, 401.265, 401.35 FS. Law Implemented 381.0011, 395.405, 401.23, 401.24, 401.25, 401.251, 401.252, 401.26, 401.27, 401.30, 401.31, 401.321, 401.34, 401.35, 401.41, 401.411, 401.414, 401.421 FS. History—New 11-29-82, Amended 4-26-84, 3-11-85, Formerly 10D-66.51, Amended 4-12-88, 8-3-88, 8-7-89, 12-10-92, 11-30-93, 10-2-94, 1-26-97, Formerly 10D-66.051, Amended 1-3-99, 9-3-00, 5-15-01, 12-18-06, Formerly 64E-2.005, Amended _____.

64J-1.007 Vehicle Permits.

(1) Each application for a ground vehicle permit shall be on DH Form 1510, December 2008, Application for Vehicle Permit(s). Each application for an aircraft permit shall be on DH Form 1576, 04/09 December 2008, Application for Air Ambulance Permit. These forms are incorporated by reference and available from the department, as defined by subsection

64J-1.001(9), F.A.C., or at <http://www.fl-ems.com>. All applications shall be accompanied by the required fee as specified in Section 401.34(1)(c), (k), F.S.

(2) When it is necessary for a permitted vehicle to be out of service for routine maintenance or repairs, a substitute vehicle meeting the same transport capabilities and equipment specifications as the out-of-service vehicle may be used for a period of time not to exceed 30 days. If the substitute vehicle needs to be in service for longer than 30 days, the agency must seek written approval from the department. An unpermitted vehicle cannot be placed into service, nor can a BLS vehicle be used at the ALS level, unless it is replacing a vehicle that has been temporarily taken out of service for maintenance. When such a substitution is made, the following information shall be maintained by the provider and shall be accessible to the department:

- (a) Identification of permitted vehicle taken out of service.
- (b) Identification of substitute vehicle.
- (c) The date on which the substitute vehicle was placed into service and the date on which it was removed from service and the date on which the permitted vehicle was returned to service.

(3) All transport vehicles permitted to licensed services must meet the vehicle design specifications, except for color schemes and insignias, as listed in United States General Services Administration (GSA)-KKK-1822, Federal Specifications for Ambulances as mandated by Section 401.35(1)(d), F.S., applicable to the year of the manufacture of the vehicle.

(4) All licensed providers applying for an initial air ambulance aircraft permit after January 1, 2005, shall submit to the department a valid airworthiness certificate (unrestricted), issued by the Federal Aviation Administration, for each permitted aircraft, prior to issuance of the initial permit. Aircraft replacements are subject to the initial application process.

(5) For purposes of Section 401.26(1), F.S.:

(a) Water vehicles with a total capacity of two persons or less are neither transport vehicles nor advanced life support transport vehicles.

(b) Water vehicles with a total capacity of three or more persons are neither transport vehicles nor advanced life support transport vehicles, if:

1. Staffed and equipped per the Licensee Medical Director's protocols consistent with the certification requirements of Chapter 401, F.S.; and

2. Reported to the department with sufficient information to identify the water vehicle and to document compliance with subparagraph 1., above. Such report shall be updated with each license renewal.

(c) A transport vehicle or advanced life support transport vehicle that has explicit staffing, equipment and permitting requirements under Chapter 401, F.S., and other rules of the department cannot fall under paragraph (a) or (b), above.

Rulemaking Specific Authority 381.0011, 401.23, 401.26, 401.35 FS. Law Implemented 381.001, 381.0205, 401.23, 401.24, 401.25, 401.251, 401.26, 401.27, 401.30, 401.31, 401.34, 401.35, 401.41, 401.411, 401.414 FS. History—New 11-29-82, Amended 4-26-84, 3-11-85, Formerly 10D-66.53, Amended 4-12-88, 12-10-92, 11-30-93, 1-26-97, Formerly 10D-66.053, Amended 1-3-99, 12-18-06, 10-16-07, Formerly 64E-2.007, Amended _____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
John C. Bixler, Paramedic, RN, BSN, Chief, Bureau of EMS, Florida Department of Health, 4052 Bald Cypress Way, Tallahassee, FL 32399

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: State Surgeon General Ana Viamonte Ros, Florida Department of Health, 4052 Bald Cypress Way, Tallahassee, FL 32399

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 27, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: April 17, 2009, Vol. 35, No. 15

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Agency for Persons with Disabilities

RULE NOS.:	RULE TITLES:
65G-4.0021	Tier Waivers
65G-4.0022	Tier One Waiver
65G-4.0024	Tier Three Waiver
65G-4.0025	Tier Four Waiver

PURPOSE AND EFFECT: The purpose of the proposed rulemaking is to clarify existing language and includes incorporation of information collected in the "Operational Detail."

SUMMARY: The purpose of the proposed rulemaking is to clarify certain provisions regarding the description of services provided under Rule 65G-4.0021, 65G-4.0022, 65G-4.0024 and 65G-4.0025.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: The Agency for Persons with Disabilities provides a summary of the Statement of Estimated Regulatory Costs (SERC). Rule 65G-4.022, F.A.C., is being amended for clarification of the description of services provided under Tier One pursuant to Section 120.541, Florida Statutes. There is no economic impact to the clients being served by the Developmental Disability Home and Community-based Waiver or its service providers due to the amendment to Rule 65G-4.0022, F.A.C.

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

RULEMAKING AUTHORITY: 393.0661(3) FS.

LAW IMPLEMENTED: 393.0661(3) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Mike Dunn, Deputy Director of Legislative Affairs, Office of the Chief of Staff, (850)414-5853

THE FULL TEXT OF THE PROPOSED RULES IS:

65G-4.0021 Tier Waivers.

(1) The Agency for Persons with Disabilities will assign clients of home and community-based waiver services for persons with developmental disabilities to one of the four Tier Waivers created by Section 393.0661, F.S. (2007~~8~~). The Agency will determine the Tier Waiver for which the client is eligible and assign the client to that waiver based on the developmental disabilities waiver criteria and limitations contained in the following provisions: Sections 409.906(13) and 393.0661, F.S.; and Rule 59G-13.080~~3~~, F.A.C.:

(a) The client's level of need in functional, medical, and behavioral areas, as reflected in the client's approved cost plan, determined through Agency evaluation of client characteristics, the Agency approved assessment process, and support planning information;

(b) The client's cost plan is developed through Agency evaluation of client characteristics, the Agency approved assessment process, support planning information, and the Agency's prior service authorization process as determined through the Agency's prior service authorization process to be medically necessary;

(c) The client needs considered in tier assignments are only those services approved through the prior service authorization process;

~~(d)(e)~~ The client's age and the current living setting; and

~~(e)(d)~~ The availability of supports and services from other sources, including natural and community supports.

(2) The services described by the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, July 2007 (hereinafter referred to as the "DD Handbook"), adopted by Rule 59G-13.080~~3~~, F.A.C. and incorporated herein by reference, are available to clients of the Developmental Disabilities Waiver (hereinafter called "the Tier One Waiver"), the Developmental Disabilities Tier Two Waiver (hereinafter called "the Tier Two Waiver"), and Developmental Disabilities Tier Three Waiver (hereinafter called "the Tier Three Waiver"). The following services described in the DD Handbook are available to clients assigned to the Tier Four Waiver (presently known as The Family and Supported Living Waiver):

- (a) Adult Day Training;
- (b) Behavior Analysis;
- (c) Behavior Assistance;
- (d) Consumable Medical Supplies;

- (e) Durable Medical Equipment;
- (f) Environmental Accessibility Adaptations;
- (g) In-Home Support Service;
- (h) Personal Emergency Response System;
- (i) Respite Care;
- (j) Support Coordination;
- (k) Supported Employment;
- (l) Supported Living Coaching; and
- (m) Transportation.

(3) For all Tiers the client must utilize all available State Plan Medicaid services including, but not limited to, personal care assistance, therapies, ~~and~~ medical services, and nursing services, that duplicate the waiver services proposed for the client. A client shall not be provided waiver services that duplicate available State Plan Medicaid Services including, but not limited to, personal care assistance, therapies, and medical services.

(4) The Agency will review a client's tier eligibility when a client has a significant change in circumstance or condition that impacts on the client's health, and safety, ~~or welfare~~ or when a change in the client's plan of care is required to avoid institutionalization. The information identifying and documenting a significant change in circumstance or condition that necessitates additional or different services must be submitted by the client's Waiver Support Coordinator to the appropriate Agency Area office for determination.

(5) Only the following services, if approved through the Agency's prior authorization process, will be used as the basis for making a tier assignment or determining whether a tier change is required:

- (a) Personal Care Assistance;
- (b) Behavior Analysis;
- (c) Behavior Assistance;
- (d) Supported Living Coaching;
- (e) In-home Supports;
- (f) Skilled, Residential or Private Duty Nursing Services;
- (g) Intensive Behavioral Residential Habilitation Services;
- (h) Behavior Focus Residential Habilitation Services at the moderate or above level of support;
- (i) Standard Residential Habilitation at the extensive 1, or higher, level of support;
- (j) Special Medical Home Care;
- (k) Occupational Therapy;
- (l) Physical Therapy;
- (m) Speech Therapy;
- (n) Respiratory Therapy; or
- (o) Specialized Mental Health Services.

(6) The following services will not be used as the basis for making a tier assignment or determining whether a tier change is required:

(a) Meaningful Day Activities (Supported Employment, Adult Day Training, Companion);

(b) Respite;

(c) Support Coordination;

(d) Transportation;

(e) Durable Medical Equipment;

(f) Consumable Medical Supplies;

(g) Dental Services;

(h) Dietician;

(i) Environmental Accessibility;

(j) Medication Review;

(k) Personal Emergency Response;

Rulemaking Specific Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History--New 10-20-08, Amended _____.

65G-4.0022 Tier One Waiver.

(1) The Tier One Waiver is limited to clients that the Agency has determined meet at least one of the following criteria:

(a) The client's needs for medical or adaptive services are intense and cannot be met in Tiers Two, Three, and Four and are essential for avoiding institutionalization, or

(b) The client possesses behavioral problems that are exceptional in intensity, duration, or frequency with resulting service needs that cannot be met in Tiers Two, Three, and Four, and the client presents a substantial risk of harm to themselves or others.

(2) Clients receiving any of the following services shall be deemed to have intense medical or adaptive needs and shall be assigned to the Tier One Waiver if their need for these services cannot be met in any other Tier:

(a) 180 hours or more of intensive Personal Care Assistance, if age 21 or older;

(b) Supported Living Coaching and In-home Supports, in combination with any of the following additional services: Physical Therapy, Occupational Therapy, Respiratory Therapy or Behavior Analysis, if age 18 or older;

(c) Behavior analysis and Behavior Assistance services of sixty or more hours per month, if age 22 or older and living in the family home; or

(d) More than four or more hours of continuous Nursing Services, if age 21 or older.

~~(3)(2)~~ Clients living in a licensed residential facility receiving any of the following services shall be assigned to the Tier One Waiver:

(a) Intensive behavioral residential habilitation Services;

(b) Behavior focus residential habilitation Services at the moderate or above level of support; or

(c) Standard residential habilitation at the extensive 1, or higher, level of support; or

(d) Special medical home care.

~~(4)(3)~~ Nursing service needs that can be met through the Tier Two, Tier Three, or Tier Four Waivers are not "services" or "service needs" that support assignment to the Tier One Waiver.

Rulemaking Specific Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History--New 10-20-08, Amended _____.

65G-4.0024 Tier Three Waiver.

The total budget in a cost plan year for each Tier Three Waiver client shall not exceed \$35,000. A client must meet at least one of the following criteria for assignment to the Tier Three Waiver:

(1) The client resides in a licensed residential facility and is not eligible for the Tier One Waiver or the Tier Two Waiver; or

(2) The client is 21 or older, resides in their own home and receives In-Home Support Services, and is not eligible for the Tier One Waiver or the Tier Two Waiver or the client's needs cannot be met in Tier Four; or

(3) The client is 21 or older and is authorized to receive Personal Care Assistance services at the standard or moderate level of support as defined in the DD Handbook.

(4) The client is 21 or older and is authorized to receive Skilled or Private Duty Nursing Services and is not eligible for the Tier One Waiver or the Tier Two Waiver; or

(5) The client is 22 or older and is authorized to receive services of a behavior analyst and/or a behavior assistant.

(6) The client is under the age of 22 and authorized to receive the combined services of a behavior analyst and/or a behavior assistant for more than 60 hours per month and is not eligible for the Tier One Waiver or the Tier Two Waiver.

(7) The client is 21 or older and is authorized to receive at least one of the following services:

(a) Occupational Therapy;

(b) Physical Therapy;

(c) Speech Therapy;

(d) Respiratory Therapy;

(e) Specialized Mental Health Services.

Rulemaking Specific Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History--New 10-20-08, Amended _____.

65G-4.0025 Tier Four Waiver.

(1) The total budget in a cost plan year for each Tier Four Waiver client shall not exceed \$14,792 per year.

(2) Clients who are not eligible for assignment to the Tier One Waiver, the Tier Two Waiver, or the Tier Three Waiver, and who meet the following criteria, shall be assigned to the Tier Four Waiver:

(a) Clients who are currently assigned to receive services through the Family and Supported Living Waiver unless there is a significant change in condition or circumstance as described in subsection 65G-4.0021(4), F.A.C.; or

(b) Clients who are under the age of 22 and residing in their own home or the family home, or

(c) Clients who are dependent children who reside in residential facilities licensed by the Department of Children and Families under Section 409.175, F.S.;

Rulemaking Specific Authority 393.0661(3) FS. Law Implemented 393.0661(3) FS. History--New 10-20-08, Repromulgated.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Lorena Fulcher, Program Administrator, Home and Community Based Services, (850)488-5998

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Jim DeBeaugrine, Director (850)488-4257

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: June 2, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: June 5, 2009

DEPARTMENT OF FINANCIAL SERVICES

Division of Worker's Compensation

RULE NO.: 69L-7.602
RULE TITLE: Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule

PURPOSE AND EFFECT: To amend the rule to adopt revised reference manuals for medical billing, filing, and reporting, including the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2009; the 2009 ICD-9-CM Professional for Hospitals, Volumes 1, 2 and 3, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2008, Ingenix, Inc. (American Medical Association); the Physician ICD-9-CM 2009, Volumes 1 & 2, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2008, Ingenix, Inc. (American Medical Association); the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2009, version 3.00, July 2008; and the Current Procedural Terminology (CPT®), 2009 Professional Edition, Copyright 2008, American Medical Association. The proposed amendment also transfers ambulatory surgical centers billing from Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form) to Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill), effective 03/22/2010, incorporates by reference a revised hospital billing instruction form, Form DFS-F5-DWC-90-B (Completion Instructions for Form DFS-F5-DWC-90 for use by hospitals) and a new ambulatory surgical center billing instruction form, Form DFS-F5-DWC-90-C (Completion Instructions for Form DFS-F5-DWC-90, for use by ambulatory surgical centers), both of which supply guidance regarding the completion of Form DFS-F5-DWC-90. The proposed amendment also adds statutory definitions for "Home Health Agency" and "Nursing

Homes", and provides new billing forms and completion instructions for each respective application. Form DFS-F5-DWC-90-D (for Home Health Agencies) and Form DFS-F5-DWC-90-E (for Nursing Homes), including their respective completion instructions, Form DFS-F5-DWC-90-D (Completion Instructions for Home Health Agencies), and Form DFS-F5-DWC-90-E (Completion Instructions for Nursing Homes), have been incorporated by reference. The proposed amendment further clarifies the meaning of "Recognized Practitioner" and changes "Principal Physician" to "Primary Physician" when referring to the treating physician responsible for oversight of medical care, treatment and referrals for injured employees. A definition for "Explanation of Bill Review Code" has also been added. The electronic record layout for form DFS-F5-DWC-90 in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2009, which details the Revision E layout requirements, also provides new fields for the submission of a facility's Florida Agency for Health Care Administration ambulatory surgical center number and National Provider Identifier (NPI) number, as well as the submission of data regarding procedures, service and supply codes, and code modifiers, as paid by the insurer. These changes, in conjunction with the introduction of refined edits, provide enhanced medical data submission and facilitate the Department's ability to monitor and promote compliance by insurers and submitters with the requirements associated with electronic submission, filing, and reporting of data to the Division of Workers' Compensation. The proposed amendment also provides new language which specifies that a health care provider shall bill multiple services, rendered on the same date of service, on a contiguous bill and also clarifies billing instructions for dentists and oral surgeons who dispense medications, and for those entities that are neither physicians nor recognized health care providers. Such entities are required to bill on their invoice or letterhead rather than using Department forms. New language provides that insurers, or entities acting on behalf of insurers, are responsible for correcting and resubmitting previously accepted data which is later deemed inadequate by the Division. The proposed amendment also clarifies the reciprocal responsibilities between health care providers and insurers regarding requests for the submission of any supporting documentation which is outside the requirements of this rule and applicable manual. Finally, the proposed amendment deletes obsolete references and language, rennumbers the rule, and makes ministerial changes where necessary.

SUMMARY: Rule amendment reflecting changes and updates to forms, reference materials, EDI requirements, and billing instructions for providers and insurers associated with the Florida Workers' Compensation Medical Services Billing, Filing, and Reporting Rule.

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

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

RULEMAKING 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), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS.

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

DATE AND TIME: Tuesday, July 7, 2009, 10:00 a.m. – 12:00 Noon

PLACE: 104J Hartman Bldg., 2012 Capital Circle S.E., Tallahassee, Florida

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 5 days before the workshop/meeting by contacting: Samuel Willis @ (850)413-1898. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Sam Willis, Office of Medical Services, Division of Workers' Compensation, Department of Financial Services, 200 East Gaines Street, Tallahassee, Florida 32399-4225, (850)413-1898

THE FULL TEXT OF THE PROPOSED RULE 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) "Adjust" or "Adjusted" means payment is made with modification to the information provided on the bill.

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

~~(c)(4) "Ambulatory Surgical Center" is defined in Section 395.002(3), F.S.~~

(d)(e) "Billing" means the process by which a health care provider submits a medical claim form or medical bill to an insurer, service company/third party administrator or any entity

acting on behalf of the insurer, to receive reimbursement for medical services, goods or supplies provided to an injured employee.

~~(e)(f)~~ "Catastrophic Event" means the occurrence of an event outside the control of an insurer, submitter, service company/third party administrator or any entity acting on behalf of the insurer, such as an electronic data transmission failure due to a natural disaster or an act of terrorism (including but not limited to cyber terrorism), in which recovery time will prevent an insurer, submitter, service company/third party administrator or any entity acting on behalf of the insurer from meeting the filing and reporting requirements of Chapter 440, F.S., and this rule. Programming errors, system malfunctions or electronic data interchange transmission failures that are not a direct result of a catastrophic event are not considered to be a catastrophic event as defined in this rule. See paragraph (6)(d) for requirements to request approval of an alternative method and timeline for medical report filing with the Division due to a catastrophic event.

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

~~(g)(h)~~ "Charge Master" means for hospitals a comprehensive listing of all the goods and services for which the facility maintains a separate charge, with the facility's charge for each of the goods and services, regardless of payer type and means for ASCs a listing of the gross charge for each CPT[®] procedure for which an ASC maintains a separate charge, with the ASC's charge for each CPT[®] procedure, regardless of payer type.

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

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

~~(j)(k)~~ "Current Procedural Terminology" (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.

~~(k)(l)~~ "Date Insurer Paid" or "Date Insurer Paid, Adjusted, Disallowed or Denied" means the date the insurer, service company/third party administrator or any entity acting on behalf of the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. If payment is disallowed or denied, "Date Insurer Paid" or "Date Insurer Paid, Adjusted, Disallowed or Denied" means the date the insurer, service company/third party administrator or any entity acting on behalf of the insurer mails, transfers or electronically transmits the appropriate

notice of disallowance or denial to the health care provider or the health care provider representative. See paragraph (5)(l) for the requirement to accurately report the “date insurer paid”.

~~(l)(m)~~ “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 in the possession of the insurer, service company/third party administrator or any entity acting on behalf of the insurer. See paragraph (5)(l) for the requirement to accurately report the “date insurer received”. If a medical bill meets any of the criteria in paragraph (5)(j) of this rule and possession of the form is relinquished by the insurer, service company/TPA or any entity acting on behalf of the insurer by returning the medical bill to the provider with a written explanation for the insurer’s reason for return, then “date insurer received” shall not apply to the medical bill as submitted.

~~(m)(n)~~ “Deny” or “Denied” means payment is not made because the service rendered is treatment for a non-compensable injury or illness.

~~(n)(o)~~ “Department” means Department of Financial Services (DFS) as defined in Section 440.02(12), F.S.

~~(o)(p)~~ “Disallow” or “Disallowed” means payment is not made because the service rendered has not been substantiated for reasons of medical necessity, insufficient documentation, lack of authorization or billing error.

~~(p)(q)~~ “Division” means the Division of Workers’ Compensation (DWC) as defined in Section 440.02(14), F.S.

~~(q)(r)~~ “Electronic Filing” means the computer exchange of medical data from a submitter to the Division in the standardized format defined in the Florida Medical EDI Implementation Guide (MEIG).

~~(r)(s)~~ “Electronic Form Equivalent” means the format, provided in the Florida Medical EDI Implementation Guide (MEIG) 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.

~~(s)(t)~~ “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.

~~(t)(u)~~ “Entity” means any party involved in the processing, adjudication or payment of medical bills on behalf of the insurer, provision of or the payment for medical services, care or treatment rendered to the injured employee, excluding the insurer, service company/third party administrator or health care provider as identified in this section.

~~(u)(v)~~ “Explanation of Bill Review” (EOBR) means the notice of payment or notice of adjustment, disallowance or denial sent by an insurer, service company/third party administrator or any entity acting on behalf of an insurer to a health care provider containing code(s) and code descriptor(s), in conformance with subsection paragraph (5)(e) of this rule.

~~(v)~~ “Explanation of Bill Review Code” (EOBR Code) means a code listed in subparagraph (5)(o)2. of this rule that describes the basis for the reimbursement decision of an insurer, service company/TPA or any entity acting on behalf of the insurer.

~~(w)~~ “Florida Medical EDI Implementation Guide (MEIG)” 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.

~~(x)~~ “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.

~~(y)~~ “Health Care Provider” is defined in Section 440.13(1)(h), F.S.

~~(z)~~ “Home Health Agency” is defined in Section 400.462(12), F.S. “Hospital” is defined in Section 395.002(13), F.S.

~~(aa)~~ “Home Medical Equipment Provider” (sometimes referred to as durable medical equipment (DME) provider) is defined in Section 400.925(7), F.S. “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.

~~(bb)~~ “Hospital” is defined in Section 395.002(12), F.S. “Insurer” is defined in Section 440.02(38), F.S.

~~(cc)~~ “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. “Insurer Code Number” means the number the Division assigns to each individual insurer, self-insured employer or self-insured fund.

~~(dd)~~ “Insurer” is defined in Section 440.02(38), F.S. “Itemized Statement” means a detailed listing of goods, services and supplies provided to an injured employee, including the quantity and charges for each good, service or supply.

~~(ee)~~ “Insurer Code Number” means the number the Division assigns to each individual insurer, self-insured employer or self-insured fund. “Medical Bill” means the document or electronic equivalent submitted by a health care provider to an insurer, service company/TPA or any entity acting on behalf of the insurer for reimbursement for services or supplies (e.g. DFS F5-DWC-9, DFS F5-DWC-10, DFS F5-DWC-11, DFS F5-DWC-90 or the provider’s usual invoice or business letterhead) as appropriate pursuant to paragraph (4)(b) of this rule.

(ff) “Itemized Statement” means a detailed listing of goods, services and supplies provided to an injured employee, including the quantity and charges for each good, service or supply “Medically Necessary” or “Medical Necessity” is defined in Section 440.13(1)(l), F.S.

(gg) “Medical Bill” means the document or electronic equivalent submitted by a health care provider to an insurer, service company/TPA or any entity acting on behalf of the insurer for reimbursement for services or supplies (e.g. DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, DFS-F5-DWC-90 or the provider’s usual invoice or business letterhead) as appropriate pursuant to paragraph (4)(b) of this rule. “NDC Number” means the National Drug Code (NDC) number, assigned under Section 510 of the Federal Food, Drug, and Cosmetic Act, which identifies the drug product labeler/vendor, product, and trade package size. The NDC number is an eleven digit number that is expressed in the universal 5-4-2 format and included on all applicable reports with each of the three segments separated by a dash (-).

(hh) “Medically Necessary” or “Medical Necessity” is defined in Section 440.13(1)(l), F.S. “Pay” or “Paid” means payment is made applying the applicable reimbursement formula to the medical bill as submitted.

(ii) “NDC Number” means the National Drug Code (NDC) number, assigned under Section 510 of the Federal Food, Drug, and Cosmetic Act, which identifies the drug product labeler/vendor, product, and trade package size. The NDC number is an eleven-digit number that is expressed in the universal 5-4-2 format and included on all applicable reports with each of the three segments separated by a dash (-). “Physician” is defined in Section 440.13(1)(q), F.S.

(jj) “Nursing Home Facility” is defined in Section 400.021(12), F.S. “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.

(kk) “Pay” or “Paid” means payment is made applying the applicable reimbursement formula to the medical bill as submitted. “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.

(ll) “Physician” is defined in Section 440.13(1)(q), F.S. “Service Company/Third Party Administrator (TPA)” means a party that has contracted with an insurer for the purpose of providing services necessary to adjust workers’ compensation claims on the insurer’s behalf.

(mm) “Primary 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. “Service Company/Third Party Administrator (TPA) Code

Number” means the number the Division assigns to a service company, adjusting company, managing general agent or third party administrator.

(nn) “Recognized Practitioner” means a non-physician health care provider licensed by the Department of Health who works under the protocol of a physician or who, upon referral from a physician, can render direct billable services that are within the scope of their license, independent of the supervision of a physician). “Submitter” means an insurer, service company/TPA, entity or any other party acting as an agent on behalf of an insurer, service company/TPA or any entity to fulfill any insurer responsibility to electronically transmit required medical data to the Division.

(oo) “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. “UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee, November 2006” (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).

(pp) “Service Company/Third Party Administrator (TPA)” means a party that has contracted with an insurer for the purpose of providing services necessary to adjust workers’ compensation claims on the insurer’s behalf. “UB-04 Manual” means the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2007, which is the reference document providing billing and reporting completion instructions for the Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2007).

(qq) “Service Company/Third Party Administrator (TPA) Code Number” means the number the Division assigns to a service company, adjusting company, managing general agent or third party administrator.

(rr) “Submitter” means an insurer, service company/TPA, entity or any other party acting as an agent on behalf of an insurer, service company/TPA or any entity to fulfill any insurer responsibility to electronically transmit required medical data to the Division.

(ss) “UB-04 Manual” means the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2009, which is the reference document providing billing and reporting completion instructions for the Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2006).

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

(a)1. ~~Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form, Rev. 12/90); Form DFS-F5-DWC-9-A (Completion Instructions for Form DFS-F5-DWC-9; comprised of three sets of completion instructions for use by health care providers, ambulatory surgical centers, and work~~

hardening and pain management programs), Rev. 5/26/05. Effective to bill for dates of service up to and including 03/31/07.

(a)2. Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form, Rev. 08/05); Form DFS-F5-DWC-9-B (Completion Instructions for Form DFS-F5-DWC-9: comprised of three sets of completion instructions; one for use by health care providers, Rev. 3/1/2009; one each for ambulatory surgical centers, and work hardening and pain management programs), Rev. 1/1/07. ~~May be used to bill for dates of service up to and including 3/31/07 and shall be used to bill for dates of service on and after 4/1/07.~~

(b)1. ~~Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form), Rev. 2/14/06. Effective to bill for dates of service up to and including 3/31/07.~~

(b)2. Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form), Rev. 3/1/09 4/1/07. ~~May be used to bill for dates of service up to and including 3/31/07 and shall be used to bill for dates of service on and after 4/1/07.~~

(c)1. ~~Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2002); Form DFS-F5-DWC-11-A (Completion Instructions for Form DFS-F5-DWC-11), Rev. 5/26/05. Effective to bill for dates of service up to and including 3/31/07.~~

(c)2. Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2006); Form DFS-F5-DWC-11-B (Completion Instructions for Form DFS-F5-DWC-11), Rev. 1/1/07. ~~May be used to bill for dates of service up to and including 3/31/07 and shall be used to bill for dates of service on and after 4/1/07.~~

(d) Form DFS-F5-DWC-25 (Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form), Rev. 1/31/08 2/14/06.

(e)1. ~~Form DFS-F5-DWC-90 (UB-92 HCFA 1450, Uniform Bill, Rev. 1992). Effective for submissions up to and including 5/22/07.~~

(e)2. Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2006); Form DFS-F5-DWC-90-B (Completion Instructions for Form DFS-F5-DWC-90 for use by hospitals), Rev. 1/1/09; 4/1/07. Form DFS-F5-DWC-90-C (Completion Instructions for Form DFS-F5-DWC-90 for use by Ambulatory Surgical Centers), Form DFS-F5-DWC-90-D (Completion Instructions for Form DFS-F5-DWC-90 for use by Home Health Agencies), Form DFS-F5-DWC-90-E (Completion Instructions for Form DFS-F5-DWC-90 for use by Nursing Homes Facilities), New 1/1/09. May be used to bill for submissions between 3/1/07 and 5/22/07 and shall be used to bill for submissions on and after 5/23/07.

(f) Obtaining Copies of Forms and Instructions.

1. A copy of ~~either revision~~ of the Form DFS-F5-DWC-9 can be obtained from the AMA CMS web site: <https://catalog.ama-assn.org/Catalog> ~~http://www.ems.hhs.gov/forms/~~. Completion instructions for ~~either revision~~ of the form can be obtained from the Department of Financial

Services/Division of Workers' Compensation (DFS/DWC) web site: <http://www.myfloridacfo.com/WC/forms.html> ~~http://www.fldfs.com/WC/forms.html#7~~.

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

3. A copy of ~~either revision~~ of the Form DFS-F5-DWC-11 can be obtained from the American Dental Association web site: <http://www.ada.org/>. Completion instructions for ~~either revision~~ of the form can be obtained from the DFS/DWC web site: <http://www.myfloridacfo.com/WC/forms.html> ~~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.myfloridacfo.com/WC/forms.html> ~~http://www.fldfs.com/WC/forms.html#7~~.

5. A copy of ~~either revision~~ of the Form DFS-F5-DWC-90 can be obtained from the CMS web site: <http://www.ems.hhs.gov/forms/>. Completion instructions for Form DFS-F5-DWC-90 (Rev. 1992) can be obtained from the UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee (Rev. September 2006) and subparagraph (4)(b)4. of this rule. A copy of the Completion instructions for completion of Form DFS-F5-DWC-90 (Rev. 2006), Form DFS-F5-DWC-90-B (for hospitals) (Rev. 1/1/09 4/1/07), Form DFS-F5-DWC-90-C (for ASCs) (4/1/09), Form DFS-F5-DWC-90-D (for Home Health Agencies), Form DFS-F5-DWC-90-E (for Nursing Home Facilities), New 1/1/09, can be obtained from the DFS/DWC web site: <http://www.myfloridacfo.com/WC/forms.html> ~~http://www.fldfs.com/WC/forms.html#7~~.

(g) 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 to be submitted to the Division, pursuant to the date-appropriate applicable Florida Medical EDI Implementation Guide (MEIG), on the Form DFS-F5-DWC-10, Form DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be submitted as an alternate form.

(3) Materials Adopted by 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. September 2006). A copy of this manual can be obtained from the Florida Hospital Association by calling (407)841-6230.~~

~~(b)~~ The Florida Medical EDI Implementation Guide (MEIG), 2006, applicable for data submission until 7/1/07. The Florida Medical EDI Implementation Guide (MEIG), 2006 can be obtained from the DFS/DWC web site: http://www.fldfs.com/WC/edi_med.html.

~~(a)(e)~~ 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.

~~(b)(d)~~ The Current Procedural Terminology (CPT[®]), as adopted in Rule 69L-7.020, F.A.C.

~~(c)(e)~~ The Current Dental Terminology (CDT-2005), as adopted in Rule 69L-7.020, F.A.C.

~~(d)(f)~~ The 2009~~7~~ ICD-9-CM Professional for Hospitals, Volumes 1, 2 and 3, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2008~~6~~, Ingenix, Inc. (American Medical Association).

~~(e)(g)~~ The Physician ICD-9-CM 2009~~7~~, Volumes 1 & 2, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2008~~6~~, Ingenix, Inc. (American Medical Association).

~~(f)(h)~~ The American Medical Association's Guide to the Evaluation of Permanent Impairment, as adopted in Rule 69L-7.604, F.A.C.

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

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

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

~~(j)(l)~~ National Uniform Billing Committee Official UB-04 Data Specifications Manual 2009~~7~~, version 3+00, July 2008 ~~September 2006~~, as adopted by the National Uniform Billing Committee. A copy of this manual can be obtained from the National Uniform Billing Committee web site: <http://www.nubc.org/become.html> ~~<http://www.nubc.org/UB-04%20SUBSCRIPTION%20ORDER%20FORM.doc>~~.

~~(k)(m)~~ The Florida Medical EDI Implementation Guide (MEIG), 2009~~7~~, applicable for data submission on or after 4/2/07 and required for all data submission on or after 8/9/07. The Florida Medical EDI Implementation Guide (MEIG), 2009~~7~~ can be obtained from the DFS/DWC web site: http://www.myfloridacfo.com/WC/edi_med.html ~~http://www.fldfs.com/WC/edi_med.html~~.

~~(n)~~ Current Procedural Terminology (CPT[®]), 2009~~7~~ Professional Edition, Copyright 2006, American Medical Association.

(4) Health Care Provider Responsibilities.

(a) Bill Submission/Filing and Reporting Requirements.

1. All health care 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.

2. Each health care provider is responsible for submitting any ~~additional~~ form completion information and supporting documentation requested by the insurer that is in addition to the requirements of this rule and the applicable reimbursement manual, when it is requested, in writing, by the insurer at the time of authorization or upon receipt of notification of emergency care ~~or at the time a reimbursement request is received~~.

3. Each health care provider shall resubmit a medical claim form or medical bill with insurer requested documentation when the EOB provides an explanation for the disallowed service disallowance based on the provider's failure to submit requested ~~lack of~~ documentation ~~submitted~~ with the medical bill.

4. Insurers and health care providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of the injured employee's medical treatment/status. ~~No~~ ~~Any~~ other reporting forms may ~~not~~ be used in lieu of or supplemental to the Form DFS-F5-DWC-25. Provider failure to accurately complete and submit the DFS-F5-DWC-25, in accordance with the Form DFS-F5-DWC-25 Completion/Submission Instructions adopted in this rule, may result in the Department Agency imposing sanctions or penalties pursuant to subsection 440.13(8), F.S. or subsection 440.13(11), F.S.

a. The Form DFS-F5-DWC-25 does not replace physician notes, medical records or Division-required medical reports.

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

5. All medical claim form(s) or medical bill(s) related to authorized services rendered for a compensable injury shall be coded by the health care provider at the highest level of specificity and 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.

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

7. When requested by the insurer, service company/TPA or any entity acting on behalf of the insurer, a health care provider shall send documentation that supports the medical necessity of the specific services rendered and any other required documentation pursuant to paragraph (4)(b) of this rule and the applicable reimbursement manual.

8. Each health care provider is responsible for correcting and resubmitting any billing forms returned by an insurer, service company/TPA or any entity acting on behalf of the insurer pursuant to paragraph (5)(j) of this rule.

9. Each hospital and ambulatory surgical center shall maintain its charge master and shall produce relevant portions when requested for the purpose of verifying its usual charges pursuant to Section 440.13(12)(d), F.S.

10. A health care provider shall bill multiple services, rendered on the same date of service, on a contiguous bill.

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

3. ~~Recognized practitioners, except physician assistants, advanced registered nurse practitioners, certified registered nurse anesthetists and anesthesia assistants, who are salaried employees of an authorized treating physician and~~ Regardless of the employment arrangement under which the services are rendered or the party submitting the bill, the following health care providers, who render direct billable services for which reimbursement is sought from an insurer, service company/TPA or any entity acting on behalf of the insurer, service company/TPA, shall report and bill for such services on a Form DFS-F5-DWC-9 by entering the employing physician's and enter his/her Florida Department of Health license number in Field 33b on the Form DFS-F5-DWC-9.:

a. ~~Any licensed physician; or~~

b. ~~Any non-physician health care provider, including a physician assistant or an ARNP (not providing an anesthesia related service); or~~

e. ~~Any licensed non-physician health care provider who is seeking reimbursement under his or her license number issued by the Florida Department of Health~~

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. Submit all specifically requested and additional applicable documentation requested at the time of authorization or certification required pursuant to Rule 69L-7.501, F.A.C.; and

III. Bill professional services provided by a physician, physician assistant, advanced registered nurse practitioner, or registered nurse first assistant on the Form DFS-F5-DWC-9, regardless of employment arrangement;

IV. Make written entry “implant(s)” followed by the reimbursement amount calculated pursuant to Rule 69L-7.501, F.A.C., in Form Locator 80 of Form revision 2006 – ‘Remarks’ on the DFS-F5-DWC-90, or certification required pursuant to Rule 69L-7.501, F.A.C. ~~When entering the CPT[®], HCPCS or unique workers’ compensation codes in Form Locator 44 on the Form DFS-F5-DWC-90, the hospital shall utilize CPT[®], HCPCS or unique workers’ compensation codes provided in the Florida Workers’ Compensation Health Care Provider Reimbursement Manual adopted in Rule 69L-7.501, F.A.C.~~

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

I. Enter the CPT[®], HCPCS or ~~unique~~ workers’ compensation unique code and the applicable CPT[®] or HCPCS modifier code ~~(provided in the Florida Workers’ Compensation Health Care Provider Reimbursement Manual as incorporated for reference in Rule 69L-7.501, F.A.C.)~~ in Form Locator 44 on the Form DFS-F5-DWC-90, when required pursuant to the UB-04 Manual where applicable to bill outpatient radiology, clinical laboratory and physical, occupational or speech therapy charges; and

II. Make written entry “scheduled” or “non-scheduled” in ~~Form Locator 84 of Form revision 1992 and in Form Locator 80 of Form revision 2006 – ‘Remarks’ on the DFS-F5-DWC-90,~~ when billing outpatient surgery or outpatient surgical services; and

~~III. Make written entry “implant(s)” followed by the reimbursement calculation made pursuant to Rule 69L-7.501, F.A.C., in Form Locator 84 of Form revision 1992 and in Form Locator 80 of Form revision 2006 – ‘Remarks’ on the DFS-F5-DWC-90, directly after entry of “scheduled” or “non-scheduled”, when present;~~

~~III/IV. Attach an itemized statement with charges based on the facility's Charge Master if there is no line item detail shown on the Form DFS-F5-DWC-90; and~~

~~V/V. Submit all applicable documentation or certification required pursuant to Rule 69L-7.501, F.A.C.;~~

~~V/VI. Bill professional services provided by a physician or recognized practitioner, physician assistant, advanced registered nurse practitioner, or registered nurse first assistant on the Form DFS-F5-DWC-9, regardless of employment arrangement;~~

5. A certified, licensed physician assistant, ~~anesthesia assistant~~ and registered nurse first assistant who provides services as a surgical assistant, in lieu of a second 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 his/her Florida Department of Health license number in Field 33b.

6. Ambulatory Surgical Centers (ASCs) shall bill as follows:

a. For dates of service up to and including 03/21/10, ASCs shall bill on a Form DFS-F5-DWC-9 using the American Medical Association's CPT[®] procedure codes, or using the unique workers' compensation unique procedure code 99070 with required modifiers and shall bill charges based on the ASC's Charge Master except when billing for procedure code 99070.

b. For dates of service on or after 03/22/10, Ambulatory Surgical Centers shall bill on Form DFS-F5-DWC-90 and shall enter the CPT[®], HCPCS or workers' compensation unique code and the applicable CPT[®] or HCPCS modifier code in Form Locator 44 for each service rendered. ASCs shall use Revenue Center Code 0278 when billing for implant devices, associated disposable instrumentation, pursuant to Rule 69L-7.100, F.A.C., ASC medical bills shall be accompanied by all applicable documentation or certification required pursuant to Rule 69L-7.100, F.A.C.

7. Home Health Agencies (HHAs) shall bill on Form DFS-F5-DWC-90. Federal Facilities shall bill on their usual form.

a. For dates of service up to and including 03/21/10, HHAs shall bill on letterhead or invoice.

b. For dates of service on or after 03/22/10, HHAs shall bill on Form DFS-F5-DWC-90 and shall enter the CPT[®], HCPCS or workers' compensation unique codes and the applicable CPT[®] or HCPCS modifier code in Form Locator 44 for each service rendered.

8. Nursing Home Facilities shall bill on Form DFS-F5-DWC-90. Out-of-State health care providers shall bill on the applicable medical bill form pursuant to paragraph (4)(c) of this rule.

a. For dates of service up to and including 03/21/10, Nursing Home Facilities shall bill on letterhead or invoice.

b. For dates of service on or after 03/22/10, Nursing Home Facilities shall bill on Form DFS-F5-DWC-90 and shall enter the CPT[®], HCPCS or workers' compensation unique codes and the applicable CPT[®] or HCPCS modifier code in Form Locator 44 for each service rendered.

9. Federal Facilities shall bill on their usual form 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.

10. Out-of-State health care providers shall bill on the applicable medical bill form pursuant to paragraph (4)(c) of this rule. Pharmaceutical(s), Durable Medical Equipment and Medical Supplies.

a. When dispensing commercially available medicinal drugs commonly known as legend or prescription drugs:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format, in Field 9, with each segment separated by a dash (-).

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9 and shall enter the NDC number, in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). Optionally, the unique workers' compensation code 96370 may be entered in addition to the NDC number in Field 24D.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes:

b. When dispensing medicinal drugs which are compounded and the prescribed formulation is not commercially available:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the unique workers' compensation code 96371 in Field 9.

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9 and shall enter the unique workers' compensation code 96371 in form Field 24D.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes:

e. When dispensing over the counter drug products:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format in form Field 9, with each segment separated by a dash (-).

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the NDC number in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). The requirement to enter the NDC number in Field 24D supersedes the instruction to enter 99070 in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes:

d. When administering or dispensing injectable drugs:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format, in form Field 9, with each segment separated by a dash (-).

II. Physicians, physician assistants or ARNPs shall bill on a Form DFS-F5-DWC-9 and enter the appropriate HCPCS "J" code in form Field 24D. When an appropriate HCPCS "J" code is not available for the injectable drug, enter the NDC number, in the universal 5-4-2 format in form Field 24D with each segment separated by a dash (-).

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes:

e. When dispensing durable medical equipment (DME):

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on form revision 2/14/06 and in Field 21 on form revision 1/1/07.

H. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply, including applicable manufacturer's shipping and handling.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the applicable revenue codes.

IV. Ambulatory Surgical Centers shall bill for these products on Form DFS-F5-DWC-9 using applicable HCPCS codes.

V. Medical Suppliers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in form Field 21 on form revision 2/14/06 and in Field 21 on form revision 1/1/07. The requirement to enter the HCPCS code when billing for medical equipment or supplies supersedes the instruction that "the medical supplier is not required to submit codes" in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.

f. When dispensing medical supplies which are not incidental to a service or procedure:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 16 on form revision 2/14/06 and in Field 21 on form revision 1/1/07.

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply, including applicable manufacturer's shipping and handling. The requirement to enter the HCPCS code when billing for medical equipment or supplies supersedes the instruction "under the specific HCPCS code or 99070" in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.

III. Hospitals shall bill on Form DFS-F5-DWC-90 under the applicable revenue codes.

IV. Ambulatory Surgical Centers shall bill separately for these products on Form DFS-F5-DWC-9 and shall enter the applicable CPT[®] code or HCPCS in Field 24D.

V. Medical Suppliers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 16 on form revision 2/14/06 and in Field 19 on form revision 1/1/07. The requirement to enter the HCPCS code when billing for medical equipment or supplies supersedes the instruction that "the medical supplier is not required to submit codes" in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.

g. Pharmacists who provide Medication Therapy Management Services shall bill for these services on a Form DFS-F5-DWC-9 by entering the appropriate CPT[®] code(s) 0115T, 0116T or 0117T that represent the service(s) rendered in form Field 24D, shall enter their Florida Department of Health license number in Field 33b and shall submit a copy of the physician's written prescription with the medical bill.

h. Pharmacists and medical suppliers may only bill on an alternate to Form DFS-F5-DWC-10 when an insurer has pre-approved use of the alternate form. Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be approved for use as the alternate form.

11. Dental Services. 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. The invoice shall not be a Form DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, or DFS-F5-DWC-90.

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

c. When dispensing medications, dentists and oral surgeons shall submit charges on the forms specified in paragraph 11.a. and 11.b. above.

12. Pharmaceutical(s), Durable Medical Equipment and Home Medical Equipment or Supplies. Health care providers receiving reimbursement under any payment plan (pre-payment, prospective pay, capitation, etc.) must accurately complete the Form DFS-F5-DWC-9 and submit the form to the insurer.

a. When dispensing commercially available medicinal drugs commonly known as legend or prescription drugs:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format, in Field 9, with each segment separated by a dash (-).

II. Physicians, physician assistants, or ARNPs shall bill on Form DFS-F5-DWC-9 and shall enter the NDC number, in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). Optionally, the workers' compensation unique code DSPNS may be entered in addition to the NDC number in Field 24D. DME and medical supplies dispensed by a physician or recognized practitioner during an office visit must be billed on the DWC-9.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

b. When dispensing medicinal drugs which are compounded and the prescribed formulation is not commercially available:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the workers' compensation unique code COMPD in Field 9.

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9 and shall enter the workers' compensation unique code COMPD in form Field 24D.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

c. When dispensing over-the-counter drug products:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format in form Field 9, with each segment separated by a dash (-).

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the NDC number in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). Medication dispensed by a physician or recognized practitioner during an office visit must be billed on the DWC-9.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

d. When administering or dispensing injectable drugs:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the NDC number, in the universal 5-4-2 format, in form Field 9, with each segment separated by a dash (-).

II. Physicians, physician assistants or ARNPs shall bill on a Form DFS-F5-DWC-9 and enter the appropriate HCPCS "J" code in form Field 24D. When an appropriate HCPCS "J" code is not available for the injectable drug, enter the NDC number, in the universal 5-4-2 format in form Field 24D with each segment separated by a dash (-).

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

e. When dispensing durable medical equipment (DME):

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on form revision 3/1/2009.

II. Physicians and recognized practitioners shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply.

III. Hospitals shall bill on Form DFS-F5-DWC-90 using the applicable revenue codes.

IV. Home Medical Equipment Providers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in form Field 21 on form revision 3/1/2009.

f. When dispensing medical supplies which are not incidental to a service or procedure:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on form revision 3/1/2009.

II. Physicians and recognized practitioners shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply.

III. Hospitals shall bill on Form DFS-F5-DWC-90 under the applicable revenue codes.

IV. Home Medical Equipment Providers shall bill on Form DFS-F5-DWC-10 for DME supplies prescribed by a physician or recognized practitioner, and shall enter the applicable HCPCS code in Field 21 on form revision 3/1/2009.

g. Pharmacists who provide Medication Therapy Management Services shall bill for these services on Form DFS-F5-DWC-9 by entering the appropriate CPT[®] code(s) 99605, 99606 or 99607 that represent the service(s) rendered in form Field 24D, shall enter their Florida Department of Health license number in Field 33b and shall submit a copy of the physician's written prescription with the medical bill.

h. Pharmacists and medical suppliers may only bill on an alternate to Form DFS-F5-DWC-10 when an insurer has pre-approved use of the alternate form. Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be approved for use as the alternate form.

13. 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 worker's compensation unique code 99456-CN on the DFS-F5-DWC-9. Health care providers and other insurer authorized providers rendering services reimbursable under workers' compensation, whose billing requirements are not otherwise specified in this rule (e.g. home health agencies, independent, non-hospital based ambulance services, air-ambulance, emergency medical transportation, non-emergency transportation services, translation services, etc.) shall bill on their invoice or business letterhead. These providers shall not submit the Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90 as an invoice.

14. Health care providers receiving reimbursement under any payment plan (pre-payment, prospective pay, capitation, etc.) must accurately complete the Form DFS-F5-DWC-9 and submit the form to the insurer.

15. Parties that are not physicians or recognized practitioners authorized by an insurer to render services reimbursable under workers' compensation shall bill on their invoice or letterhead. These parties shall not bill using Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90 as an invoice.

(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 section and paragraph (4)(b) of this rule.

2. Billing elements required by the Division to be completed by a health care provider are identified in specific Form DFS-F5-DWC-9-A or Form DFS-F5-DWC-9-B (completion instructions), as appropriate for the date of the revised form, available at the following websites:

a. <http://www.myfloridacfo.com/WC/pdf/DWC-9instrHCP-3-1-091-1-07.pdf> <http://www.fldfs.com/wc/pdf/DWC-9instrHCP.pdf> when submitted by Licensed Health Care Providers;

b. http://www.myfloridacfo.com/WC/pdf/DWC-9instrASC_1-1-07.pdf ~~<http://www.fldfs.com/wc/pdf/DWC-9instrASC.pdf>~~ when submitted by Ambulatory Surgical Centers for dates of service up to and including 03/21/10;

c. http://www.myfloridacfo.com/WC/pdf/DWC-9instrWHPM_1-1-07.pdf ~~<http://www.fldfs.com/wc/pdf/DWC-9instrWHPM.pdf>~~ when submitted by Work Hardening and Pain Management Programs.

3. Billing elements required by the Division to be completed for Pharmaceutical or Medical Supplier Billing are identified in ~~specific~~ Form DFS-F5-DWC-10 (completion instructions), ~~as appropriate for the date of the revised form,~~ available at website: <http://www.myfloridacfo.com/WC/forms.html> ~~<http://www.fldfs.com/WC/forms.html#7>~~.

4. Billing elements required by the Division to be completed for Dental Billing are identified in ~~specific~~ Form DFS-F5-DWC-11-A or Form DFS-F5-DWC-9-B (completion instructions), ~~as appropriate for the date of the revised form,~~ available at website: <http://www.myfloridacfo.com/WC/forms.html> ~~<http://www.fldfs.com/WC/forms.html#7>~~.

5. Billing elements required by the Division to be completed for Form DFS-F5-DWC-90 Hospital Billing are identified in ~~the UB-92 Manual, the UB-04 Manual, and as follows: Form DFS-F5-DWC-90-B (completion instructions) and subparagraph (4)(b)4. of this rule.~~

a. For Hospital billing, Form DFS-F5-DWC-90-B (UB-04) – B Completion Instructions, Rev. 1/1/2009 and subparagraph (4)(b)4. of this rule.

b. For Ambulatory Surgical Center billing, Form DFS-F5-DWC-90-C (UB-04) – C Completion Instructions, New 1/1/2009 and subparagraph (4)(b)6. of this rule.

c. For Home Health Agency billing, Form DFS-F5-DWC-90-D (UB-04) – D Completion Instructions, New 1/1/2009 and subparagraph (4)(b)7. of this rule.

d. For Nursing Home Facility billing, Form DFS-F5-DWC-90-E (UB-04) – E Completion Instructions, New 1/1/2009 and subparagraph (4)(b)8. of this rule.

6. ~~A An insurer can require a health care provider shall submit to complete additional data elements or supporting documentation that are not required by the insurer in writing pursuant to paragraph (5)(b) of this rule. Division on Form DFS-F5-DWC-9 or DFS-F5-DWC-11.~~

(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 medical bills claims are paid, adjusted and paid, disallowed, denied, or otherwise processed or submitted to the Division.

(b) At the time of authorization for medical service(s) or upon receipt of notification of emergency care ~~at the time a reimbursement request is received,~~ an insurer shall notify each health care provider, in writing, of additional form completion

requirements or supporting documentation that are necessary for reimbursement determinations that are in addition to the requirements of this rule and the applicable reimbursement manual.

(c) At the time of authorization for medical service(s), or upon receipt of notification of emergency care, an insurer shall inform ~~in-state and~~ out-of-state health care providers of the specific reporting, billing and submission requirements contained in subsection (4) (Health Care Provider Responsibilities) of this rule and provide in-state and out-of-state health care providers the specific address for submitting a reimbursement request.

(d) Insurers, service company/TPAs or entities acting on behalf of insurers and health care providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of an injured employee's medical treatment/status. ~~No Any~~ other reporting forms may ~~not~~ be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

(e) Required data elements on each Form 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 when the medical bill is paid, adjusted, disallowed or denied by the insurer, service company/TPA or any entity acting on behalf of the insurer. The 45-calendar day filing requirement includes initial submission and correction and re-submission of all errors identified in the "Medical Bill Claim Processing Report", as defined in the ~~date-appropriate~~ applicable Florida Medical EDI Implementation Guide (MEIG).

(f) An insurer shall be responsible for accurately completing required data filed with the Division, pursuant to the ~~date-applicable~~ applicable Florida Medical EDI Implementation Guide (MEIG) and subparagraphs (4)(c)2.-5. of this rule. Additionally, an insurer or entity acting on behalf of an insurer shall be responsible for correcting previously accepted data that is deemed inaccurate by the Division through monitoring, auditing, investigation or analysis, and resubmitting the corrected and accurate data in accordance with the requirements set forth in paragraph (6)(e) 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 web site: <http://www.myfloridacfo.com/WC/organization/odqc.html> ~~<http://www.fldfs.com/WC/organization/odqc.html>~~ (under Records Management) to obtain a division-assigned number prior to submitting the medical report to the Division.

(h) An insurer, service company/TPA or any entity acting on behalf of an insurer must report to the Division the procedure code(s), number of line-items billed, diagnosis code(s), modifier code(s), NDC number and amount(s) charged, as billed by the health care provider when reporting these data to the Division. However, the insurer, service

company/TPA or any entity acting on behalf of an insurer may correct the procedure code(s) or modifier code(s) or NDC number to effect payment and shall report both the provider billed code(s) and insurer adjusted code(s) pursuant to the date-appropriate MEIG. The insurer, service company/TPA or any entity acting on behalf of an insurer shall utilize the EOBR code "80" to notify the health care provider concerning any such billing errors and shall transmit EOBR code "80", in instances when the carrier corrects the provider coding, when reporting to the Division.

(i) An insurer, service company/TPA or any entity acting on behalf of the insurer shall manually or electronically date stamp accurately completed Forms 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 on the "date insurer received" as defined in paragraph (1)(~~l~~) of this rule.

(j)1. When a medical bill is submitted for reimbursement by a health care provider, the insurer, service company/TPA or entity acting on behalf of the insurer must review the medical bill to determine if any of the criteria in subparagraph (5)(j)5. of this rule are present. If a medical bill is deficient according to meets any of the criteria listed in subparagraph (5)(j)5. of this rule, the insurer, service company/TPA or entity acting on behalf of the insurer must either:

a. Secure and/or correct the information on the medical bill and proceed to make a reimbursement decision to pay, adjust, disallow or deny billed charges within 45-calendar days from the "date insurer received"; or

b. Return the medical bill to the provider within twenty-one (21) days of the "Date Insurer Received" with a written statement identifying the deficiency criteria under which the medical bill is being returned ~~within twenty-one (21) days of the "Date Insurer Received"~~. The written statement sent to the provider with the returned medical bill shall bear the following statement CAPITALIZED and in **BOLD** print: **"A HEALTH CARE PROVIDER MAY NOT BILL THE INJURED EMPLOYEE FOR SERVICES RENDERED FOR A COMPENSABLE WORK-RELATED INJURY"**.

2. If the insurer returns a medical bill to the provider pursuant to subparagraph (5)(j)5. of this rule, the written statement, which must accompany the returned bill must include all deficiency criteria upon which the return of the medical bill are based.

3. If the deficiency criteria upon which the return of the medical bill is based includes any of the deficiency criteria in sub-subparagraphs (5)(j)5.d.-g.-f. of this rule, the written statement must identify the information that is illegible, incorrect, or omitted.

4. An insurer may return a medical bill to a provider without issuance of an EOBR only on the basis of the deficiency criteria set forth in subparagraph (5)(j)5. of this rule.

5. The deficiency criteria upon which a medical bill is to be reviewed by the insurer, service company/TPA or entity acting on behalf of the insurer for return to the provider pursuant to this sub-paragraph of paragraph (5)(j) of this rule are:

a. Services are billed on an incorrect medical billing form; or

b. The medical bill has been submitted to the incorrect insurer; or

c. The medical bill has been submitted to the incorrect service company/TPA or entity acting on behalf of the insurer; or

d. Claimant identification information required by this rule is illegible on the medical bill; or

e. Claimant identification information required by this rule is incorrect on the medical bill; or

f. Billing information required by this rule is illegible on the medical bill; or

g. ~~f.~~ Billing information required by this rule is omitted or incomplete on the medical bill.

6. An insurer, service company/TPA or entity acting on behalf of the insurer shall establish and maintain a process by which medical bills that have been returned and written statements identifying the reason for return are compiled. The compiled information must be sufficiently detailed to allow verification and review by the Division.

(k) An insurer, service company/TPA or any entity acting on behalf of the insurer shall pay, adjust, disallow or deny billed charges within 45-calendar days from the date insurer received, pursuant to Section 440.20(2)(b), F.S.

(l) In the medical bill claims-handling process, the receipt of medical bills may be based upon receipt by the insurer or there may be an "entity" acting on behalf of an insurer for purposes of receipt of medical bills. Likewise, the payment of medical bills may be based upon payment by the insurer or there may be an "entity" acting on behalf of an insurer for purposes of payment of medical bills. Therefore, to properly reflect receipt date and payment date of medical bills, the medical bill reporting process must accommodate various receipt and payment options.

1. The receipt and payment option utilized by an insurer and reported to the Division must meet one of the following:

a. Both receipt and payment of medical bills are handled by the insurer. This option may be utilized only when the "date insurer received" is the date the insurer gained possession of the health care provider's medical bill, and the "date insurer paid" is the date the health care provider's payment is mailed, transferred or electronically transmitted by the insurer. This option may not be utilized when a health care provider is required by the insurer to submit medical billings to any "entity" other than the insurer.

b. Both receipt and payment of medical bills are handled by any “entity” acting on behalf of the insurer. This option may be utilized only when the “date insurer received” is the date the “entity” acting on behalf of the insurer gained possession of the health care provider’s medical bill, and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer. This option may not be utilized when a health care provider is required by the insurer to submit medical billings directly to the insurer.

c. Receipt of medical bills is handled by the insurer and payment of medical bills is handled by the “entity” acting on behalf of the insurer. This option may be utilized only when the “date insurer received” is the date the insurer gained possession of the health care provider’s medical bill, and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer. This option may not be utilized when a health care provider is required by the insurer to submit medical billings to any “entity” other than the insurer.

d. Receipt of medical bills is handled by any “entity” acting on behalf of the insurer and payment of medical bills is handled by the insurer. This option may be utilized only when the “date insurer received” is the date the “entity” acting on behalf of the insurer gained possession of the health care provider’s medical bill, and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the insurer. This option may not be utilized when a health care provider is required by the insurer to submit medical billings directly to the insurer.

2. The insurer must:

a. Document the option(s) selected in subparagraph (5)(1)1. of this rule,

b. Document the specific effective date for each option selected,

c. Document the specific role of each “entity” acting on the insurers behalf in the option selected,

d. Make this written documentation available to the Division for audit purposes pursuant to Section 440.525, F.S.,

e. Maintain written documentation from the “entity” acknowledging its responsibilities concerning “date insurer received” and “date insurer paid” for each option when the insurer selects options b., c., or d. from subparagraph (5)(1)1. of this rule, and

f. Maintain written documentation identifying the applicability of the options selected in sufficient detail to allow verification of the coding of each medical bill under subparagraph (5)(1)4. of this rule.

3. An insurer and entity may select multiple options for medical bill claims handling between the insurer and the entity based on business practices or whether medical bills are submitted to the insurer electronically or on paper.

4. The option in subparagraph (5)(1)1. of this rule selected by the insurer must be identified on each medical report electronic submission to the Division and must utilize the following coding methodology:

a. If the “date insurer received” is the date the insurer gains possession of the health care provider’s medical bill and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code “x” 1 must be transmitted on each individual form-type electronic submission. (“x” must equal ‘R’, ‘M’ or ‘C’ as denoted in Appendix D of the date-appropriate Florida Medical Implementation EDI Guide (MEIG).) When submitting Payment Code “x” 1 to the Division, the insurer is declaring that no “entity” as defined in paragraph (1)(~~t~~)(~~u~~) of this rule is involved in the medical bill claims-handling processes related to “date insurer received” or “date insurer paid”.

b. If the “date insurer received” is the date the “entity” acting on behalf of the insurer gains possession of the health care provider’s medical bill and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer, then Payment Code “x” 2 must be transmitted on each individual form-type electronic submission. (“x” must equal ‘R’, ‘M’ or ‘C’ as denoted in Appendix D of the date-appropriate Florida Medical Implementation EDI Guide (MEIG).) When submitting Payment Code “x” 2 to the Division, the insurer is declaring that the specified “entity” as defined in paragraph (1)(~~t~~)(~~u~~) of this rule is acting on behalf of the insurer for purposes of the medical bill claims-handling processes related to “date insurer received” and “date insurer paid”.

c. If the “date insurer received” is the date the insurer gains possession of the health care provider’s medical bill and “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer, then Payment Code “x” 3 must be transmitted on each individual form-type electronic submission. (“x” must equal ‘R’, ‘M’ or ‘C’ as denoted in Appendix D of the date-appropriate Florida Medical Implementation EDI Guide (MEIG).) When submitting Payment Code “x” 3 to the Division, the insurer is declaring that no “entity” as defined in paragraph (1)(~~t~~)(~~u~~) of this rule is involved in the medical bill claims-handling process related to “date insurer received”.

d. If the “date insurer received” is the date the “entity” acting on behalf of the insurer gains possession of the health care provider’s medical bill and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code “x” 4 must be transmitted on each individual form-type electronic submission. (“x” must equal ‘R’, ‘M’ or ‘C’ as denoted in Appendix D of the date-appropriate Florida Medical

Implementation EDI Guide (MEIG).) When submitting Payment Code “x” 4 to the Division, the insurer is declaring that no “entity” as defined in paragraph (1)(t)(u) is involved in the medical bill claims-handling processes related to “date insurer paid”.

(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 dollar amount paid by the insurer or reimbursed to the employee, the employer or other insurer for healthcare service(s) or supply(ies). When reporting disallowed or denied charges, the dollar amount paid shall be reported as \$0.00.

(n) An insurer, service company/TPA or any entity acting on behalf of the insurer is not required to report electronically as medical payment data to the Division, those payments made for ~~failed appointments for scheduled independent medical examinations, for federal facilities billing on their usual form, for duplicate medical bills, for medical bills outside the authority of Florida’s workers’ compensation system,~~ or for health care providers in subparagraph (4)(b)15.13, who bill on their invoice or letterhead.

(o) A submitter, 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 code descriptors as follows up through the date for reporting production data with the Medical Data System in the Claim Record Layout Revision “D” as required in subparagraph (6)(f) of this rule:~~

~~a. 01 Services not authorized, as required.~~

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

~~e. 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, frequency, duration or provision of service(s) billed. (Insurer must specify to the health care 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 fee schedule.~~

~~i. 09 Reimbursement is based on any contract.~~

~~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 health care 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 health care provider.)~~

~~n. 14 Itemized statement not submitted with billing form.~~

~~o. 15 Invalid code. (Use only when other valid 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 health care 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 Form DFS-F5-DWC-25 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 descriptor. Use of EOBR code “20” is restricted to circumstances when an above listed EOBR code does not explain the reason for payment, adjustment and payment, disallowance or denial of payment. When using EOBR code “20”, an insurer must reflect code “20” and include the specific explanation of the code on the EOBR sent to the health care provider. The insurer, service company/TPA or any entity acting on behalf of the insurer must maintain a standardized EOBR code descriptor list.~~

~~2.3. When reporting production data with the Medical Data System in the Claim Record Layout-Revision “E” “D” as required in paragraph (6)(f) of this rule, the insurer shall comply with the following instructions pertaining to EOBRs: In completing an Explanation of Bill Review (EOBR) an insurer shall, for each line item billed, select the EOBR code(s) from the list below which identifies(y) the reason(s) for the insurer’s reimbursement decision for each line item. The insurer may utilize up to three EOBR codes for each line item billed. When utilizing more than one EOBR, the insurer shall list the EOBR codes that describe the basis for its reimbursement decision in descending order of importance. An insurer, service company/TPA or any entity acting on behalf of the insurer shall submit to the Division the Explanation of Bill Review (EOBR) code, relating to the adjudication of each line item billed, in descending order of importance. The EOBR code list is as follows:~~

~~06 – Payment disallowed: location of service(s) is not consistent with the level of service(s) billed.~~

~~10 – Payment denied: compensability: injury or illness for which service was rendered is not compensable.~~

~~21 – Payment disallowed: medical necessity: medical records reflect no physician’s order was given for service rendered or supply provided.~~

~~22 – Payment disallowed: medical necessity: medical records reflect no physician’s prescription was given for service rendered or supply provided.~~

23 – Payment disallowed: medical necessity: diagnosis does not support the service rendered.

24 – Payment disallowed: medical necessity: service rendered was not therapeutically appropriate.

25 – Payment disallowed: medical necessity: service rendered was experimental, investigative or research in nature.

26 – Payment disallowed: service rendered by healthcare practitioner outside scope of practitioner’s licensure.

30 – Payment disallowed: lack of authorization: no authorization given for service rendered or notice provided for emergency treatment pursuant to Section 440.13(3), F.S.

34 – Payment disallowed: no modification to the information provided on the medical bill. No payment made pursuant to contractual arrangement.

38 – Payment disallowed: insufficient documentation: documentation does not support this supply was dispensed to the patient.

39 – Payment disallowed: insufficient documentation: documentation does not support this medication was dispensed to the patient.

40 – Payment disallowed: insufficient documentation: documentation does not substantiate the service billed was rendered.

41 – Payment disallowed: insufficient documentation: level of evaluation and management service not supported by documentation. (Insurer must specify missing components of evaluation and management code description.)

42 – Payment disallowed: insufficient documentation: intensity of physical medicine and rehabilitation service not supported by documentation.

43 – Payment disallowed: insufficient documentation: frequency of service not supported by documentation.

44 – Payment disallowed: insufficient documentation: duration of service not supported by documentation.

45 – Payment disallowed: insufficient documentation: fraud statement not provided pursuant to Section 440.105(7), F.S.

46 – Payment disallowed: insufficient documentation: required itemized statement not submitted with the medical bill.

47 – Payment disallowed: insufficient documentation: invoice or certification not submitted for implant.

48 – Payment disallowed: insufficient documentation: invoice not submitted for supplies.

49 – Payment disallowed: insufficient documentation: invoice not submitted for medication.

50 – Payment disallowed: insufficient documentation: specific requested documentation requested in writing at the time of authorization not submitted with the medical bill. (Insurers must specify omitted documentation.)

51 – Payment disallowed: insufficient documentation: required DFS-F5-DWC-25 not submitted.

52 – Payment disallowed: insufficient documentation: supply(ies) incidental to the procedure. (Insurer must specify which supply is incidental to which procedure.)

53 – Payment disallowed: insufficient documentation: required operative report not submitted with the medical bill.

54 – Payment disallowed: insufficient documentation: required narrative report not submitted with the medical bill.

59 – Payment disallowed: billing error: Correct Coding Initiative guidelines indicate this code is mutually exclusive to code XXXXX billed for service(s) provided on the same day (Insurer must specify inclusive procedure code).

60 – Payment disallowed: billing error: line item service previously billed and reimbursement decision previously rendered processed on prior medical bill.

61 – Payment disallowed: billing error: duplicate bill. (Shall not be transmitted electronically to the Division.) same service billed multiple times on same date of service.

62 – Payment disallowed: billing error: incorrect procedure, modifier, units, ~~or~~ supply code or NDC number.

63 – Payment disallowed: billing error: service billed is integral component of another procedure code. (Insurer must specify inclusive procedure code.)

64 – Payment disallowed: billing error: service “not covered” under applicable workers’ compensation reimbursement manual.

65 – Payment disallowed: billing error: multiple providers billed on the same form.

66 – Payment disallowed: billing error: omitted procedure, modifier, units, supply code or NDC number.

67 – Payment disallowed: billing error: Same service billed multiple times on same date of service.

68 – Payment disallowed: billing error: Rental value has exceeded purchase price per written fee agreement.

69 – Payment disallowed: billing error: Correct Coding Initiative guidelines indicate this code is a comprehensive component of code XXXXX billed for service(s) provided on the same day (Insurer must specify inclusive procedure code.)

71 – Payment adjusted: insufficient documentation: level of evaluation and management service not supported by documentation.

72 – Payment adjusted: insufficient documentation: intensity of physical medicine and rehabilitation service not supported by documentation.

73 – Payment adjusted: insufficient documentation: frequency of service not supported by documentation.

74 – Payment adjusted: insufficient documentation: duration of service not supported by documentation.

75 – Payment adjusted: insufficient documentation: specific requested documentation requested in writing at the time of authorization not submitted with the medical bill.

80 – Payment adjusted: billing error: correction of procedure, modifier, supply code, units, or NDC number.

81 – Payment adjusted: billing error: payment modified pursuant to a charge audit.

~~82 – Payment adjusted: payment modified pursuant to carrier charge analysis.~~

83 – Payment adjusted: medical benefits paid apportioning out the percentage of the need for such care attributable to preexisting condition (Section 440.15(5)(b), F.S.).

84 – Payment adjusted: co-payment applied pursuant to Section 440.13(14)(c), F.S.

85 – Payment adjusted: no modification to the information provided on the medical bill. Payment made pursuant to a fee agreement between the health care provider and the carrier.

90 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Health Care Provider Reimbursement Manual.

91 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers.

92 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Reimbursement Manual for Hospitals.

93 – Paid: no modification to the information provided on the medical bill: payment made pursuant to written contractual arrangement (network or PPO name required).

94 – Paid: Out-of-State Provider: payment made pursuant to the Out-of-State Provider section of the applicable Florida reimbursement manual.

95 – Paid: Reimbursement Dispute Resolution: payment made pursuant to receipt of a Determination or Final Order on a Petition for Resolution of Reimbursement Dispute, pursuant to Section 440.13(7), F.S.

96 – Paid: Payment made pursuant to a write-off by a health care provider self-insured employer.

(p) 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 the electronic form equivalents or 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 the insurer written documentation required in subparagraphs (5)(j)6. and (5)(l)2. of this rule.

(q) An insurer, service company/TPA or any entity acting on behalf of the insurer to pay, adjust, disallow or deny a filed bill shall submit to the health care provider an Explanation of Bill Review detailing the adjudication of the submitted bill by line item, utilizing only the EOBR codes and code descriptors per line item, as set forth in paragraph (o) of this section, and shall include the insurer name, Division issued insurer number and corresponding specific insurer mailing address contact information. However, an insurer may choose to append an internal reason code to the EOBR it submits to the health care

provider, when utilizing an EOBR code set forth in paragraph (o) that includes a code descriptor requiring the insurer to provide additional specification. An insurer, service company/TPA or any entity acting on behalf of the insurer shall notify the health care provider of notice of payment or notice of adjustment, disallowance or denial only through an EOBR. An EOBR shall specifically state that the EOBR constitutes notice of disallowance or adjustment of payment within the meaning of Section 440.13(7), F.S. An EOBR shall specifically identify the name and mailing address of the entity the carrier designates to receive service on behalf of the "carrier and all affected parties" for the purpose of receiving the petitioner's service of a copy of a petition for reimbursement dispute resolution by certified mail, pursuant to Section 440.13(7)(a), F.S.

(r) Copies of hospital medical records shall be subject to charges allowed pursuant to Section 395.3025, F.S. and Section 440.13, F.S.

(s) When an insurer, service company/TPA or any entity acting on behalf of the insurer renders reimbursement as pre-payment for medical services, goods or supplies, reimbursement of employee payment or payment for pharmacy first-fill services, the required data elements, optionally including the appropriate Pre-Payment/Employee Payment/First Fill Indicator as described in the MEIG, shall be submitted to the Division within 45 calendar days of the insurer, service company/TPA or any entity acting on behalf of the insurer receipt date of the medical billing form, regardless of the date of payment.

(t) When an insurer, service company/TPA or any entity acting on behalf of the insurer renders reimbursement following receipt of a Determination or Final Order in response to a petition to resolve a reimbursement dispute filed pursuant to Section 440.13(7), F.S., the insurer shall:

1. Submit the required data elements to the Division within 45 calendar days of rendering reimbursement; and

2. Submit the data as a replacement submission pursuant to the date-appropriate MEIG; and

3. Submit the cumulative, not the supplemental, payment information at the line-item level utilizing EOBR 95 for each line-item reflecting a payment amount differing from the payment amount reported on the original submission; and

4. Report the "Date Insurer Received" as 22 days after the date the Determination was received by certified mail, in instances where the insurer has waived its rights under Chapter Section 120, F.S., or report the "Date Insurer Received" as the date the carrier received the Final Order by certified mail, in instances where the insurer has invoked its rights pursuant to Chapter Section 120, F.S., whichever occurs first.

(u) When an insurer, service company/TPA, submitter or any entity acting on behalf of the insurer has reported medical claims data to the Division which was not required, the insurer shall withdraw the previously reported data as described in the MEIG.

(v) When an insurer, service company/TPA, any entity acting on behalf of the insurer renders reimbursement for multiple bills received from a health care provider, the insurer shall report required data elements to the Division for each individual bill, including “Date Insurer Received” and “Date Insurer Paid”, submitted by the health care provider and shall not combine multiple bills received from a health care provider into a single medical bill data submission (~~i.e. a single bill equals a single datum transmission~~).

(6) Insurer Electronic Medical Report Filing to the Division.

(a) Effective 3/16/05, all required medical reports shall be electronically filed with the Division by all insurers.

(b) Required data elements shall be submitted in compliance with the instructions and formats as set forth in the date-appropriate Florida Medical EDI Implementation Guide (MEIG).

(c) The Division will notify the insurer on the “Medical ~~Bill 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.

(d) 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 or electronic request within 15 business days after the catastrophic event to the Division for approval to submit in an alternative reporting method and an alternative filing timeline. The request shall contain a detailed explanation of the nature of the event, date of occurrence, and measures being taken to resume electronic submission. The request shall also provide an estimated date by which electronic submission of affected EDI filings will be resumed. Approval must be obtained from the Division’s Office of Data Quality and Collection, 200 East Gaines Street, Tallahassee, Florida 32399-4226. Approval to submit in an alternative reporting method and an alternative filing timeline shall be granted by the Division if a catastrophic event prevents electronic submission.

(e) When filing any medical report replacement that corrects a rejected medical report bill or replaces a previously accepted medical report bill, the submitter shall use the same control number as the original submission. The replacement report submission shall contain all information necessary to process the medical report bill including all services and charges from the medical bill claim as billed by the health care provider and all payments made by the insurer to the health care provider. Additionally, an insurer or entity acting on behalf of an insurer shall follow the EDI medical bill replacement methodology specified in the 2009 Florida Medical EDI Implementation Guide (MEIG), using Report Reason Code “03” (See Appendix C), after being notified by the Division that data previously accepted has been deemed

inaccurate and responding to a written request from the Division to review, correct, and re-submit accurate data. Each Division written request shall have a specified timeline to which the insurer or entity acting on behalf of an insurer shall adhere. Information contained on the original submission is deemed independent and is not considered as a supplement to information contained in the replacement submission.

(f) Each ~~Additionally, an insurer shall be responsible for accurately completing the electronic record-layout programming requirements for the reporting of the Form DFS-F5-DWC-9 Claim-Detail Record Layout – Revision “E” “D”, Form DFS-F5-DWC-10 Claim-Detail Record Layout – Revision “E” “D”, Form DFS-F5-DWC-11 Claim-Detail Record Layout – Revision “E” “D” and Form DFS-F5-DWC-90 Claim-Detail Record Layout – Revision “E” “D” in accordance with the Florida Medical EDI Implementation Guide (MEIG), 2007, to the Division in accordance with the phase-in schedule as denoted below in subparagraphs 1., 2., and 3. of this section. The electronic record layout for Form DFS-F5-DWC-90 in the MEIG 2009 adds the new fields for Provider Facility National Provider Identification (NPI) number, Florida Agency for Health Care Administration facility license number for Ambulatory Surgical Centers, Home Health Care Agencies, and Nursing Home Facilities, procedure, service or supply code modifier 2 as billed by the provider, procedure, service or supply code modifier 3 as billed by the provider, procedure, service or supply code modifier 4 as billed by the provider, procedure, service or supply code as paid by the insurer, procedure, service or supply code modifier 1 as paid by the insurer, procedure, service or supply code modifier 2 as paid by the insurer, procedure, service or supply code modifier 3 as paid by the insurer, procedure, service or supply code modifier 4 as paid by the insurer, and the line item amount paid by the insurer. The electronic record layout for Form DFS F5 DWC 9 in the MEIG, 2007, adds the new fields for gender, date of birth, up to three new modifiers and a maximum of three EOBR codes per line item from the revised code set. The electronic record layout for Form DFS F5 DWC 10 in the MEIG, 2007, adds the new fields for gender, date of birth, pharmacist’s Florida Department of Health license number, and, medical supply and equipment HCPCS code(s), quantity, purchase or rental date, usual charge, amount paid, prescriber’s license number and a maximum of three EOBR codes per line item from the revised code set. The electronic record layout for Form DFS F5 DWC 11 in the MEIG, 2007, adds the new fields for gender, date of birth and a maximum of three EOBR codes per line item from the revised code set. The electronic record layout for Form DFS F5 DWC 90 in the MEIG, 2007, adds the new form locators for gender, date of birth, designation of surgery as scheduled or unscheduled, implant amount, up to three External Cause of Injury codes, four additional ICD 9 diagnostic codes, four other procedure codes, operating physician’s Florida DOH license number and a~~

~~maximum of three EOBR codes per line item from the revised code set. The conversion implementation schedule is as follows:~~

1. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision “D” “C”), between ~~04/01/2007 4/25/05~~ and ~~06/15/2007 2/24/06~~ shall begin testing on ~~11/2/2009 4/2/07~~ and shall complete the testing process with the new Revision “E” “D” record layouts no later than ~~12/16/2009 5/14/07~~.

2. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision “D” “C”), between ~~06/16/2007 2/25/06~~ and ~~08/07/2007 3/31/06~~ shall begin testing on ~~12/17/2009 5/15/07~~ and shall complete the testing process with the new Revision “E” “D” record layouts no later than ~~02/03/2010 6/26/07~~.

3. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision “D” “C”), between ~~08/08/2007 4/1/06~~ and the effective date of this rule shall begin testing on ~~02/04/2010 6/27/07~~ and shall complete the testing process with the new Revision “E” “D” record layouts no later than ~~03/18/2010 8/8/07~~.

4. The Division will, resources permitting, allow submitters that volunteer to complete the test transmission processes earlier than the schedule denoted above. Each voluntary submitter shall have six weeks to complete test transmission to production transmission processes, for all electronic form equivalents, that comply with requirements set forth in the Florida Workers’ Compensation Medical EDI Implementation Guide (MEIG), 20097.

(g) All submitters shall be in production with the new Revision “E” “D” record layouts on ~~03/22/2010 8/9/07~~. ~~Optionally, after successful completion of the testing process and continuing up to and including 8/8/07, submitters may elect to submit all required medical reports as required in the new Revision “D” record layouts, as required in the current Revision “C” record layouts, or, as required in the Revision “C” record layouts for billings on the current medical claim forms and as required in the Revision “D” record layouts for billings on the new medical claim forms.~~

(h) Submitters who do not accurately complete and maintain electronic record-layout programming requirements of this rule shall not submit medical reports electronically until the submitter has been approved for reporting production data with the Medical Data System as necessary to meet the filing requirements of paragraph (5)(e) of this rule.

(7) Insurer Administrative Penalties and Administrative Fines for Untimely Health Care Provider-Payment or Disposition of Medical Bills.

(a) The Department shall impose insurer administrative penalties for failure to comply with the payment, adjustment, 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 form category that was received within a specific calendar month.

(b) 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 applied as follows:

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

2. Insurers are required to report all medical reports timely pursuant to paragraph (5)(e) of this rule. Insurers that fail to submit a minimum of 95% of all medical reports timely are subject to an administrative fine. Each untimely filed medical report which falls below the 95% requirement is subject to the following penalty schedule:

- a. 1 – 30 calendar days late \$5.00;
- b. 31 – 60 calendar days late \$10.00;
- c. 61 – 90 calendar days late \$25.00;
- d. 91 or greater calendar days late \$100.00.

3. Each medical report that does not pass the electronic reporting edits shall be rejected by the Division and considered not filed pursuant to paragraph (5)(e) of this rule. If the medical report remains rejected and not corrected, resubmitted and accepted by the Division for greater than 90 days, an administrative fine shall be assessed in the amount of \$100.00 for each such medical report. Rejected and not resubmitted medical reports will not be included in the 95% timely reporting requirement.

4. Untimely filed medical reports for a given month will be excluded from the administrative fine set forth in subparagraph (7)(b)3. above as falling within the performance standard between 100% and 95% in the following order:

- a. Medical Reports filed 1 – 30 calendar days late; then
- b. Medical Reports filed 31 – 60 calendar days late; then
- c. Medical Reports filed 61 – 90 calendar days late; then
- d. Medical Reports filed 91+ calendar days late.

Rulemaking 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), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS. History—New 1-23-95, Formerly 38F-7.602, 4L-7.602, Amended 7-4-04, 10-20-05, 6-25-06, 3-8-07,_____.

NAME OF PERSON ORIGINATING PROPOSED RULE:
Sam Willis, Office of Medical Services, Division of Workers’ Compensation, Department of Financial Services

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Alex Sink, Chief of Financial Officer, Department of Financial Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 25, 2009
 DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: December 19, 2008

Section III
Notices of Changes, Corrections and Withdrawals

DEPARTMENT OF EDUCATION

State Board of Education

RULE NO.: RULE TITLE:
 6A-4.0021 Florida Teacher Certification Examinations

NOTICE OF CORRECTION

Notice is hereby given that the following correction has been made to the proposed rule in Vol. 35, No. 21, May 29, 2009 issue of the Florida Administrative Weekly. The notice of change as advertised on May 29, 2009, referenced the incorrect edition of the Florida Administrative Weekly in which the rule had originally been noticed as the April 10, 2009 edition. The correct edition is April 24, 2009, Vol. 35, No 21.

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND

Notices for the Board of Trustees of the Internal Improvement Trust Fund between December 28, 2001 and June 30, 2006, go to <http://www.dep.state.fl.us/> under the link or button titled "Official Notices."

AGENCY FOR HEALTH CARE ADMINISTRATION

Certificate of Need

RULE NO.: RULE TITLE:
 59C-1.008 Certificate of Need Application Procedures

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made in accordance with subparagraph 120.54(3)(d)1., F.S., to the proposed rule published in Vol. 34, No. 48, November 26, 2008 issue of the Florida Administrative Weekly and subsequently amended by notice of change published in the March 6, 2009, Florida Administrative Weekly, Vol. 35, No. 9 and May 22, 2009, Florida Administrative Weekly, Vol 35, No. 20.

59C-1.008 Certificate of Need Application Procedures

(1)(f) Certificate of Need Application Submission. An application for a certificate of need shall be submitted on AHCA Forms 3150-0001 Application for a Certificate of Need, March 2009 or 3150-0003 Transfer of a Certificate of Need, March 2009, ~~CON-1, July 2009~~, which includes a Cover Page, Cover Page-TRN Schedules A ~~or A-TRN~~, B or B-TRN, C, D, D-1, 1 or 1-TRN, 2, 3, 4, 5, 6, 6A, 7, 7A, 7B, 8, 8A, 9, 10 or

10-TRN, 11-TRN, and 12-TRN, which are incorporated by reference herein. An application for a General Hospital shall be submitted on AHCA Form 3150-0002, March 2009 Application For A General Hospital Certificate of Need which include Schedules 11, A(H), B(H), C, D(H) in addition to a Cover (H) Page, which are incorporated by reference herein. A Paper copies or copies on electronic media copy of AHCA Form 3150-0001 Application For A Certificate of Need, March 2009 AHCA Form 3150-0002, March 2009 Application For A General Hospital Certificate of Need or AHCA Form 3150-0003 Transfer of A Certificate of Need, March 2009 ~~CON-1~~ and the Schedules may be obtained from:

Agency for Health Care Administration,
 Certificate of Need
 2727 Mahan Drive, ~~Building 1~~, Mail Stop 28
 Tallahassee, FL 32308.

~~An~~ Electronic versions of AHCA Forms 3150-0001, 3150-0002 and 3150-0003 ~~CON-1~~ and the Schedules are also available at <http://ahca.myflorida.com/MCHO/CON FA/ Application/index.shtml> ~~www.fche.state.fl.us~~.

1. The application must be actually received by the agency by 5:00 p.m. local time on or before the application due date.
2. Applications for projects which exceed the proposed number of beds contained in the letter of intent shall not be deemed complete for review by the agency and shall be withdrawn from further review.
3. Applications may propose a lesser number of beds than that contained in the letter of intent.

AGENCY FOR HEALTH CARE ADMINISTRATION

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

RULE NO.: RULE TITLE:
 59E-7.012 Inpatient Data Reporting and Audit Procedures

NOTICE OF CORRECTION

Notice is hereby given that the following correction has been made to the proposed rule in Vol. 35, No. 12, March 27, 2009 issue of the Florida Administrative Weekly. This corrects the Notice of Withdrawal rule as noticed in Vol. 35, No. 17, March 27, 2009 issue of the Florida Administrative Weekly in place of rule as noticed in Vol. 35, No. 18, May 8, 2009 issue of the Florida Administrative Weekly.

AGENCY FOR HEALTH CARE ADMINISTRATION

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

RULE NO.: RULE TITLE:
 59E-7.024 Reporting Instructions

NOTICE OF CORRECTION

Notice is hereby given that the following correction has been made to the proposed rule in Vol. 35, No. 12, March 27, 2009 issue of the Florida Administrative Weekly.