Regional Perinatal Intensive Care Centers Handbook

AUGUST 2010

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1 INTRODUCTION

The Regional Perinatal Intensive Care Center (RPICC) Program is a comprehensive, statewide perinatal delivery system administered by Children's Medical Services (CMS) in the Florida Department of Health.

The RPICC Handbook has been developed by the Children's Medical Services (CMS) Central Office RPICC staff to familiarize RPICC facility staff with the RPICC Program and provide information about program policies and procedures.

1.1 Purpose

The RPICC Handbook was developed to ensure statewide standardization of the. RPICC Program. The RPICC Program Handbook outlines requirements, responsibilities and procedures for the operation of the Regional Perinatal Intensive Care Centers (RPICC) Program. The RPICC Handbook incorporates program standards that include criteria that establish medical and financial eligibility for sponsorship of patients under the RPICC Program, physical facility requirements of the obstetrical and neonatal intensive care units, and professional staffing requirements for RPICC facilities.

The Department of Health web address for CMS RPICC program where more information may be accessed is:
http://www.cms-kids.com/providers/rpicc_resources.html

Program Overview

The Regional Perinatal Intensive Care Centers (RPICC) Program is a regionalized health care delivery system designed to deliver optimal medical care to high risk pregnant women. A high risk pregnancy consists of one or more major medical conditions that can significantly alter the usual management of the pregnancy and sick or low birth weight neonates. Services will be also provided to neonates of a complicated pregnancy or delivery which puts the infant at risk for disease, death, or disability, or a newborn infant at high risk for disease, death or disability immediately after birth.

A. Legal Authority

The Regional Perinatal Intensive Care Centers Program operates under the authority of Section 383.15-383.21, Florida Statute (F.S.), and Chapter 64C-6 Florida Administrative Code (F.A.C.).

B. Scope of Service

The RPICC Program provides a full range of perinatal services to medically and financially eligible neonates and pregnant women. These services are provided through two interrelated components: Neonatal and Obstetrical.

1. Major Program Goals:

   a. To decrease neonatal mortality and morbidity rates through the provision of optimal medical care and through the early identification of infants at risk for death, disease, or handicapping conditions.

   b. To provide optimal prenatal care to women with high risk pregnancies at the earliest possible point in their pregnancies in order to protect their lives and the lives and health of their unborn and newborn infants, and to reduce maternal morbidity that may occur during the perinatal period.

1.2 History

1974-75	Initial appropriation for five Neonatal Intensive Care Centers.
1976-77	Statutory authority provided for the Regional Perinatal Intensive Care Centers Program and Advisory Council (Section 383.15-21, F.S.). This statute included the designation of ten centers and the provision of neonatal and high risk obstetrical services.
1980-81	On-line computerized data system implemented.
1982-83	Program expanded to include step down neonatal special care centers and provide limited inter-hospital air transportation services to facilitate patient access to needed intensive care services.
1985-86	The Neonatal Care Group (NCG) system, a prospective pricing system, was implemented for neonatal hospital services.
1986-87	First high risk Obstetrical (OB) satellite clinic established in Key West, Florida. Obstetrical Care Group (OBCG) system, a prospective pricing system, was implemented for both inpatient and outpatient obstetrical hospital services.
1987-88	Second high risk OB satellite clinic established in Naples, Florida. Developmental evaluation program expanded to include inpatient and home intervention services as a result of House Bill (HB) 1453. NCG and OBCG systems for neonatal and obstetrical professional services were implemented.
1988-89	Section 383.20, F.S., which authorizes the Perinatal Advisory Council, was repealed by the Legislature.
1989-90	The RPICC Program no longer includes step down neonatal special care centers. Physicians are reimbursed by Medicaid based on the OBCG/NCG methodology. Hospitals are reimbursed by Medicaid based on the current Medicaid per diem rate.
1991-92	Memorial Hospital of Hollywood became the tenth RPICC. Governor Chiles' Healthy Start initiative provided for the expansion of OB satellite clinic to twelve programs throughout Florida.
1992-93	Legislative funding received to expand the OB satellite clinic program to eighteen sites through Florida.

1993-94	Section 383.15-21, F.S., revised to increase the number of RPICC facilities to eleven and renumber the Early Intervention (EIP) Program section as a separate statute.
1994-95	Lee Memorial Hospital became the eleventh RPICC
2002-03	In response to Chapter 2002-394, Laws of Florida, concerning potential expansion of the number of RPICC, a report was written of recommendation made by the members of a RPICC Study Group.
2005-06	Twelve hospitals participated in the RPICC Program as eleven designated centers. Bayfront Medical Center and All Children's Hospital are designated as one center.
2006-2007	Sacred Heart hospital discontinued OB Satellite clinic services in Ft. Walton Beach and Panama City. In 2006, Sacred Heart began OB Satellite clinic in Miramar Beach.
2006-2007	Jackson Memorial Hospital began OB Satellite clinic in North Miami.
2008-2009	Jackson Memorial Hospital discontinued OB Satellite clinic in North Miami.
2009-2010	Orlando Health discontinued OB Satellite at Sebring in Highlands County.
2009-2010	Sacred Heart Hospital began OB Satellite clinic in Chipley.
2010-2011	RPICC Data System and RPICC Transportation contracts terminated due to budgetary shortfalls.

1.3 Range of Services

The RPICC Program provides a full range of perinatal services to medically and financially eligible neonates and pregnant women. These services are provided through two interrelated components.

A. The Neonatal component provides Level III neonatal intensive care services to eligible neonates suffering from catastrophic illnesses and/or low birth weight and/or extreme prematurity with follow-up Level II neonatal intensive care services, as appropriate, in a RPICC facility. Services to medically and financially eligible neonates are provided by CMS approved neonatologists in designated RPICC Level III and Level II Neonatal Intensive Care Units (NICU). Diagnostic and treatment services are provided with the goal of preventing mortality and morbidity.

B. The Obstetrical component provides services to pregnant women with major maternal or medical conditions which can significantly alter the usual management of the pregnancy and/or the newborn. Services to medically and financially eligible pregnant women are provided by CMS approved obstetricians at designated RPICC facilities. The goals of this component are to decrease the incidence of maternal and fetal mortality and to decrease the risk for developmental disabilities in their infants through early identification of high risk pregnancies.

    1. The obstetrical component also includes the high risk OB clinic care provided at each center. In addition, OB High Risk Satellite Clinics are available at some locations throughout the state, which provide:

a. community-based prenatal services for medically high risk pregnant women
b. consultative services by a perinatologist
c. targeted ultrasound and fetal monitoring for on-site patient evaluations

2. The two primary OB Satellite program goals are:

a. increase the number of high risk pregnant women receiving prenatal care and delivery in their local community, and
b. decrease the number of sick/low birth weight newborns born to these women who would require neonatal intensive care services. See High Risk OB Satellite Clinic Handbook for additional information at:

http://www.cms-kids.com/providers/rpicc_resources.html

1.4 Civil Rights

All services are provided to RPICC patients are protected from discrimination based on race, color, religion, sex or national origin.

A. More information on the Title VII of the Civil Rights Act of 1964 is available at http://www.eeoc.gov/policy/vii.html

B. Title VI of the Civil Rights Act of 1964 protects persons from discrimination based on their race, color or national origin in programs and activities that receive Federal financial assistance. More information is available at http://hhs.gov/ocr/civilrights/index.html

C. Section 504 of the Rehabilitation Act of 1973 forbids organizations from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services. It defines the rights of individuals with disabilities to participate in, and have access to program benefits and services. More information is available at http://hhs.gov/od/index.html

D. The American with Disabilities Act (ADA) of 1990 Title I and Title V prohibit employment discrimination against qualified individuals with disabilities in the private sector, and in state and local government. Title II of the ADA covers all the services, programs and activities conducted by public entities. More information is available at http://www.ada.gov/cguide.html

1.5 Transportation

The provision of a transport system to bring low birth-weight or sick newborn and high-risk pregnant women to the eleven centers is contractually required. Each center has a ground transport system for the inter-hospital transfer of patients within the center's general catchment area. The referring physician, who uses the emergency services providers available within the geographic area, arranges obstetrical/neonatal patient

transports. The statewide aspect of RPICC Program often means that patients must be transported long distances to access the nearest available intensive care bed.

The centers must comply with the standards for Neonatal Transfers as described in Section 401, F.S., Chapter 64J-1, F.A.C. available at: https://www.flrules.org/default.asp and the RPICC Transportation Standards which are available in APPENDIX F of this handbook and at: http://www.cms-kids.com/providers/rpicc_resources.html

1.6 Definitions

CMS Approved Physician	Health professional who meet the requirements of Chapter 64C-4.001 F.A.C.
Children's Medical Services Neonatal Nurse	The nurse in the local CMS area office designated to serve as the CMS program resource person to coordinate RPICC activities between CMS, the RPICC, and all of CMS Network programs including Newborn Screening and the Early Steps Program.
Children's Medical Services Central Office	The organizational unit within the Florida Department of Health which is responsible for general statewide administration of the Children's Medical Services Programs.
Children's Medical Service Network (CMSN)	A statewide managed system of care for children with special needs as defined in Chapter 391, F.S.
Children with Special Health Care Needs	Those children whose serious or chronic physical, behavioral or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children.
Fiscal Year	The period beginning on July 1 of given year and ending on June 30 of the subsequent year.
High Risk Infant	An infant of a complicated pregnancy or delivery which puts the infant at risk for disease, disability or death, or whose prematurity or illness places that infant at high risk for disease, disability or death, just after birth, and who meets the criteria for RPICC Program eligibility.

High Risk Pregnancy	A pregnancy with one or more major maternal medical conditions, which can significantly alter the usual management of pregnancy or the newborn.
Level II Neonatal Intensive Care	Services provided in a neonatal intensive care unit designated by the Florida Agency for Health Care Administration, which include the provision of ventilator services and at least 6 hours of nursing care per day.
Level III Neonatal Intensive Care	Services provided in a neonatal intensive care unit designated by the Agency for Health Care Administration, which include the provision of continuous cardiopulmonary support, 12 or more hours of nursing care per day, complex neonatal surgery, neonatal cardiovascular surgery, pediatric neurology and neurosurgery, and pediatric cardiac catheterization.
Low Birth Weight	Less than 2500 grams (5 lbs. 8 oz.) at birth.
Maternal Fetal Medicine Physician (MFM)	Must be board certified in Obstetrics-Gynecology or has passed the written OB-GYN examination and is an active candidate to take the oral exam, and must be board Certified in Maternal Fetal Medicine or have passed the written MFM exam and is an active candidate to take the oral exam.
Neonatal Care Group (NCG)	A prospective payment system developed by CMS that classifies neonatal illness into groups, expected to present similar medical needs, which will result in approximately equal use of resources. These groups are cross walked to HIPAA approved codes for billing Medicaid for RPICC services, in accordance with the Florida Medicaid Program Guidelines located: http://mymedicaid-florida.com/
Neonatal Mortality Rate	The neonatal mortality rate is equal to the number of neonatal deaths from

	birth to 28 days of life for a defined period multiplied by 1,000 and divided by the number of live births during the same period. In the RPICC Program, the mortality data is reported monthly by the center in the RPICC data system.
Neonate	An infant less than 29 days of age or, for the purpose of this Program, an infant past the age of 28 days who requires continuance of neonatal intensive care services.
Obstetrical Care Group (OBCG)	A prospective payment system developed by CMS that classifies neonatal illness into groups, expected to present similar medical needs, which will result in approximately equal use of resources. These groups are cross walked to HIPAA approved codes for billing Medicaid for RPICC services, in accordance with the Florida Medicaid Program Guidelines located at: http://mymedicaid-florida.com/
Obstetrical Satellite Clinic	A facility located outside the RPICC facility which provides comprehensive high risk obstetrical services in areas demonstrating a need based upon patient population, the distance to the RPICC, limited access to public transportation or the unavailability of medical expertise in high risk obstetrics for indigent women.
Pediatrician	A CMS approved physician who is board certified or board admissible within three years of completion of training and maintains recertification, if applicable, in the subspecialty of pediatrics.
Pediatric Cardiologist	A CMS approved physician who is board certified or board admissible within three years of completion of training and maintains recertification, if applicable, in the subspecialty of pediatric cardiology.
Pediatric Surgeon	A CMS approved physician who is board certified or board admissible within three years of completion of training in

	the specialty of surgery with special competence in pediatric surgery.
Perinatal Mortality Rate	The perinatal mortality rate is equal to the number of infant deaths of less than 28 days plus the number of fetal deaths during a defined period multiplied by 1,000 and divided by the number of live births plus the number of fetal deaths during the same period.
Perinatal Period	For the purposes of this Program, it is the period from medical diagnosis of pregnancy through birth and the neonatal period.
Physician	Any person who is licensed to practice medicine or osteopathic medicine in the State of Florida.
Premature	Less than 37 weeks gestation.
Quarter	A three month period beginning in July (first quarter), October (second quarter), January (third quarter) and April (fourth quarter) of the State fiscal year.
Regional Perinatal Intensive Care Centers	Specialized units within hospital facilities specifically designed to provide a full range of health services to women with high risk pregnancies and a full range of newborn intensive care services which have been designated by the Florida Department of Health, which meet the standards as defined herein for facilities, staffing and services or commit themselves to meeting and maintaining these standards within three years of designation as a center.
RPICC Data Specialist	The person designated by the RPICC facility to serve as a data information coordinator and is responsible for data entry and retrieval through the designated RPICC data system as required by Agency for Health Care Administration (AHCA).
RPICC Data System	A comprehensive automated microcomputer-based system which

	collects data from the components of the RPICC Program and provides a billing portal for the NCG and OBCG codes. The data system is administered by AHCA.
RPICC Neonatal Medical Director	A CMS approved physician who is board certified in Neonatology.
RPICC Neonatologist	A CMS approved physician who is board certified in Neonatology or eligible to take the written Neonatology examination and must demonstrate an active, continuing pursuit of board certification at the time of CMS re-approval review.
RPICC Obstetrical Medical Director	A CMS approved physician who is board certified in Obstetrics-Gynecology or has passed the written OB-GYN exam and is an active candidate to take the oral exam, and must be board Certified in Maternal Fetal Medicine or has passed the written MFM exam and is an active candidate to take the oral exam.
RPICC Obstetrician	A CMS approved physician who is board certified in Obstetrics or has passed the written examination of the OB/GYN board certification process and they must demonstrate an active, continuing pursuit of board certification at the time of CMS re-approval review.
RPICC Obstetric Satellite Clinic Physician	A CMS approved physician who is board certified in Obstetrics-Gynecology or has passed the written OB-GYN exam and is an active candidate to take the oral exam, and must be board Certified in Maternal Fetal Medicine or has passed the written MFM exam and is an active candidate to take the oral exam.
RPICC Insurance Eligible Patient (IE)	All neonates and pregnant women who meet both medical and financial criteria, as outlined in Chapter 64C-6, F.A.C., and in the RPICC Handbook, and who have been determined by the RPICC facility to have major insurance coverage.

RPICC Liaison(s)	The individual(s) designated by the RPICC facility to determine financial eligibility for patients, facilitate the RPICC application process, and be available to the patient as needed. The RPICC neonatal liaison(s) is responsible for the neonatal component. The RPICC obstetrical liaison(s) is responsible for the obstetrical component.
RPICC Medicaid Eligible Patient (EL)	All neonates and pregnant women who meet both medical and financial criteria as outlined in Chapter 64C-6, F.A.C., and in the RPICC Handbook, and who are eligible for Medicaid funding.
RPICC Medicaid Health Maintenance Organization Patient (HM)	All neonates and pregnant women who meet both medical and financial criteria, as outlined in Chapter 64C-6, F.A.C., and in the RPICC Handbook, and who have been determined by the RPICC facility to have medical coverage by a Medicaid health maintenance organization.
RPICC Non-eligible Patient (NN)	All neonates and pregnant women who do not meet the medical and/or financial criteria who are determined to be ineligible for the RPICC Program.
RPICC Program Coordinator	The individual(s) designated by the RPICC facility to oversee the programmatic operation of the RPICC Program at the facility. This person(s) is designated at the discretion of the RPICC facility.
RPICC Program Patient	All neonatal and obstetrical patients who meet medical and financial eligibility criteria.
RPICC Unfunded Patient (UF)	All neonates and pregnant women who meet medical and financial criteria in the RPICC Handbook, but who have no third party resources.
Unique Number	A number that corresponds to the mother's social security number and is assigned to each mother-child pair in the

	RPICC data system. It is the primary mechanism for identifying patient records in the RPICC data system.
Very Low Birth Weight	Less than 1500 grams (3 lbs. 8 oz.) at birth.
Waiver	A written or verbal statement, followed by written documentation by the Deputy Secretary of CMS which negates the enforcement of any specific requirement for a specified period of time.

1.7 Funding Resources

The RPICC Program does not have general revenue funding resources for entitlement earnings for hospital and professional services. With the expansion of Medicaid eligibility, all RPICC Program patients are potential Medicaid recipients. The funding source for RPICC Program services is the Medicaid Program.

A. Annual Poverty Guidelines

The Department of Health revises its sliding fee scales each year after the federal government has produced their annual poverty guidelines. The latest revisions are available at this website:
http://dohiws/divisions/planning_evaluation/FeeScale/index.htm

B. Medicaid Rates

OBCG/NCG Information located at: http://mymedicaid-florida.com/ Select Public Information for Providers. Select "provider support" then "fee schedules". The RPICC fee titles are listed under Physician - Regional Perinatal Care Center Codes for Neonatal and Obstetrical. The files contain the RPICC fees based on HIPAA-compliant codes which include CPT code, modifier and diagnosis codes.

2 RPICC Program Personnel Roles and Responsibilities

2.1 RPICC Center Numbers and Contact Information

Center #	RPICC	CITY
01	Tampa General Hospital 1 Tampa General Circle Tampa, Florida 33606 (813) 844-7000 http://www.tgh.org	Tampa
02	Shands Teaching Hospital Gainesville, Florida 32610 (352) 395-0111 http://www.shands.org	Gainesville
03	Shands-Jacksonville 655 West Eighth Street Jacksonville, Florida 32209 (904) 244-0411 http://www.shandsjacksonville.com	Jacksonville
04	Jackson Memorial Hospital, Jackson Health System 1611 Northwest Twelfth Avenue Miami, Florida 33136 (305) 585-1111 http://www.um-jmh.org	Miami
05	Sacred Heart Hospital 5151 North Ninth Avenue Pensacola, Florida 32513 (850) 416-7000 http://www.sacred-heart.org	Pensacola
06	Winnie Palmer Hospital at Arnold Palmer Medical Center, Orlando Health 92 West Miller Street Orlando, Florida 32806 (407) 649-9111 http://orlandohealth.com/winniepalmerhospital/index.aspx	Orlando
07	NEO: All Children's Hospital 501 Sixth Avenue, South St. Petersburg, Florida 33701 (727) 898-7451	St. Petersburg

	http://www.allkids.org	
	OB: Bayfront Medical Center 701 Sixth Street, South St. Petersburg, Florida 33701 (727) 823-1234 http://www.bayfront.org	St. Petersburg
08	St. Mary's Medical Center 901 45th Street West Palm Beach, Florida 33416 (561) 844-6300 http://www.stmarysmc.com/CWSContent/StMarysMC	West Palm Beach
10	Broward General Medical Center 1600 S. Andrews Avenue Ft. Lauderdale, Florida 33316 (954) 355-5600 http://www.browardhealth.org	Ft. Lauderdale
11	Memorial Regional Medical Center- 3501 Johnson Street Hollywood, Florida 33021 (954) 987-2000 http://www.jdch.com	Hollywood
53	Lee Memorial Health System HealthPark Medical Center 9981 HealthPark Circle Ft. Myers, Florida 33908 (941) 433-7799 http://www.leememorial.org	Ft. Myers

2.2 RPICC Neonatal Program

RPICC Neonatal Program specific standards related to personnel, equipment, space, services, and staffing are outlined in 64C-6.001-6.003 and 59C-1.042, F A.C. Appendix E or https://www.flrules.org/default.asp

The RPICC Neonatal Medical Director is responsible for, but not limited to:

A. Assuring twenty-four hour coverage in the NICU by CMS RPICC neonatal physicians for patient care and for communication with physicians in other hospitals.

B. Assuring that each patient's medical record contains written comments by the CMS RPICC neonatal physicians, or a resident physician's note that is co-signed by the CMS RPICC neonatal physician. The note must contain information on

the patient's treatment and condition in order to document the RPICC neonatal physician's involvement in the neonate's care.

C. Determining medical eligibility for each neonate admitted to the hospital in the RPICC Program.

D. Assuring that a dictated hospital discharge summary or death summary is completed within six weeks following discharge of a RPICC Program patient.

E. Assuring that RPICC Program specific information for RPICC neonates is entered into the RPICC Data System as required by the Agency for HealthCare Administration (AHCA).

F. Documenting corrective actions, when applicable, to CMS Central Office regarding deficiencies cited on RPICC program on-site visit or desk review reports.

2.3 RPICC Obstetrics Program

RPICC Obstetrical Program specific standards related to personnel, equipment, space, services, and staffing are outlined in 64C-6.001-6.003, F.A.C. Appendix E or https://www.flrules.org/default.asp

The RPICC Obstetrical Medical Director is responsible for, but not limited to:

A. Assuring twenty-four hour coverage of the obstetrical services by CMS RPICC obstetrical physicians. In-house coverage on a twenty-four hour basis may be provided by senior residents in obstetrics in RPICC hospitals with obstetrical residency training programs.

B. Assuring that each patient record contains written comments by the CMS RPICC obstetrical physician, or a resident physician's note co-signed by the CMS RPICC obstetrical physician. The note will contain information on the patient's treatment and condition in order to document the continuing involvement of the RPICC physician in the patient's care.

C. Documenting in the patient records that a CMS RPICC obstetrical physician was in attendance at a cesarean delivery or other surgical procedures performed on a RPICC patient.

D. Determining medical eligibility for the RPICC Program of each high risk obstetrical patient referred to a RPICC hospital for care.

E. Assuring that the referral and/or discharge summary are completed, documented and signed by a RPICC physician.

F. Assuring that the RPICC specific obstetrical information for RPICC patients are entered into the RPICC Data System as required by AHCA.

G. Documenting corrective actions, when applicable, to \CMS Central Office regarding deficiencies cited on RPICC program on-site visit or desk review reports

2.4 RPICC Facility Staff

All RPICC facility staff are important to the provision of quality health care services to RPICC patients and their families.

A. **RPICC Physician**
Participating CMS RPICC physicians agree to provide or arrange to provide all medically necessary covered services including emergency services to CMS RPICC patients. The physician will render covered services to CMS patients in an efficient and professional manner, which shall be in accordance with the same standards and time availability as offered to non-CMS patients. For more information on the CMS Physician Handbook is available at: http://www.cms-kids.com/providers/index.html

B. **RPICC Coordinator**
An individual must be designated by the RPICC hospital to oversee the programmatic operation of each RPICC Program. There can be one coordinator for both the neonatal and obstetrical component or an individual coordinator for each component and the high-risk clinic. This person is the link between the RPICC hospital and the CMS Central Office for various activities and responsibilities. The RPICC Coordinator is responsible for dissemination of RPICC Program information at each RPICC hospital.

C. **RPICC Liaison**
There must be a liaison to serve as the initial contact person to provide to or obtain information from RPICC patients regarding the RPICC Program. This individual may have many different activities and responsibilities as needed by the RPICC hospital. Several individuals may serve in this capacity fulfilling various roles and responsibilities.

D. **RPICC Data Entry Operator**
An individual that is responsible for the input and integrity of data entered into the RPICC Data System as required by Agency for Healthcare Administration (AHCA) for RPICC NCG/OBCG reimbursement.

2.5 RPICC Data Entry

After August 15, 2010 the RPICC data system and billing component will no longer be administered by CMS. The information below is to serve as a guide for organizational purposes based on the present Medicaid reimbursement policy and current CMS requirements for RPICC programs. All questions regarding billing/claims and data entry should be directed to the RPICC Medicaid representative assigned by AHCA.

A. Neonatal Component Responsibilities

1. Admission Responsibilities.

a. Consult with the RPICC Neonatal Director, or designee, in determining medical eligibility for the RPICC Program. Evaluate within five (5) working days, all medically eligible neonates admitted to the RPICC-NICU for financial eligibility for the RPICC Program. Explain RPICC Program and CMS RPICC Partnership Agreement to the parent/guardian. Obtain parent's/guardian's signature on the CMS RPICC Partnership Agreement for all RPICC Program eligible neonates.

b. Refer all eligible patients to Economic Services by utilizing the CF-ES Form 2039, Medical Assistance Referral Form. Explain to the patient/parent that failure to complete the application process will result in the parent receiving all bills for RPICC services.

c. Work with Economic Services to enroll all eligible patients in the Medicaid Program.

d. Neonatal Data Information needed for tracking all RPICC Program neonates, to include the following:

1) Patient Name

2) Date of Birth

3) Hospital Number

4) Date RPICC Eligibility is Determined

5) Mother has Medicaid-Yes/No. (Indicate if the mother has Presumptive Eligibility for Pregnant Women (PEPW) or Regular Medicaid)

6) Date RPICC Neonate is referred to Economic Services (CF-ES Form 2039 is completed)

7) Identify if infant is referred to Economic Services for PEN number or regular Medicaid

8) Date Medicaid Number is obtained

9) Date CF-ES Form 2039 is returned

10) Number of Days to Receive Medicaid Number

e. Mandatory Documentation for the RPICC Data System:
Initiate the RPICC Birth/Demographic Data Template on any RPICC OB patients whose newborn was admitted to the RPICC NICU. If the neonate's mother did not participate in the Obstetrical Component, complete the RPICC Birth/Demographic Data Screen in the RPICC Data System within ten (10) working days of the neonate's admission to the RPICC NICU.

f. Initiate the RPICC Neonatal Component Data Screen in the RPICC Data System based on RPICC Neonatal Component Template (admission information) within ten (10) working days of a neonate's admission to the RPICC NICU.

g. The medical or financial records at each RPICC facility on each RPICC patient should include:

1) CMS RPICC Partnership Agreement

2) Hospital Discharge Summary

3) Copy of CF-ES Form 2039, Medical Assistance Referral Form

4) Documentation of follow-up with Economic Services regarding patient's Medicaid status

h. Required RPICC Data Screens in the RPICC Data System

1) RPICC Birth/Demographic Record

2) RPICC Neonatal Component Record

3) RPICC Fiscal Record

2. Discharge Responsibilities.

a. Complete the RPICC Neonatal Component Record in the RPICC Data System within ten (10) working days of the neonate's discharge.

b. Complete the RPICC Fiscal Record in the RPICC Data System within fourteen (14) working days of the neonate's discharge

c. Provide a copy of the hospital discharge summary, upon request, on the RPICC neonate to the designated Early Steps team member on each Early Steps eligible neonate within five (5) working days of discharge.

d. Provide a copy of the hospital discharge summary, upon request, on the RPICC neonate to the CMS Neonatal Nurse.

3. Transfer from RPICC to Non-RPICC Facility.

   Follow Discharge Responsibilities as outlined in Section 2.5.A.2.a. (above).

4. Transfer from RPICC to RPICC Facility - Transferring RPICC Neonatal Liaison.

   a. Notify the receiving RPICC Neonatal Liaison at the RPICC facility to which the neonate is transferred prior to or within one (1) working day of the transfer.

   b. Complete the RPICC Neonatal Component Record in the RPICC Data System within five (5) working days of the neonate's transfer.

   c. Forward to the receiving RPICC Neonatal Liaison, within five (5) working days of the neonate's transfer, a copy of the following data system information.

      1) RPICC Birth/Demographic Record

      2) RPICC Neonatal Component Record

      3) CMS RPICC Partnership Agreement

   d. Complete the RPICC Fiscal Data Record(s) within fourteen (14) working days of the neonate's transfer into the RPICC Data System.

   e. Forward a copy of the hospital discharge summary to the receiving RPICC Neonatal Liaison, within five (5) working days of discharge.

5. Transfer from RPICC to RPICC Facility - Receiving RPICC Neonatal Liaison.

   a. Neonatal Data Information needed for tracking all RPICC neonates transferred to a RPICC facility to include the following:

      1) From Transferring RPICC:

         a) RPICC Birth/Demographic Record

         b) RPICC Neonatal Component Record

         c) CMS RPICC Partnership Agreement

         d) Hospital Discharge Summary

         e) Documentation for Medicaid Number

2) Receiving RPICC:

a) RPCC Neonatal Component Record

b) RPICC Fiscal Records(s)

c) Hospital Discharge Summary

b. Update the RPICC Neonatal Component Record (admission information) in the RPICC Data System as necessary for the receiving RPICC within five (5) working days of the neonate's transfer.

c. When the neonate is ready for discharge from the receiving RPICC, follow Discharge Responsibilities as outlined in Section 2.5.A.2.a. If the neonate is transferred to another RPICC facility, follow responsibilities in Transfer from RPICC to RPICC Facility - Transferring RPICC Neonatal Liaison in Section 2.5.A.4.a.

B. Obstetrical Component Responsibilities

1. Admission Responsibilities

a. Obtain prenatal medical information prior to the RPICC prenatal examination. The prenatal information will be written on the RPICC OB Referral Template (Appendix C-1) or other OB referral documentation on all patients referred to the RPICC Program.

b. Assure that appointments for prenatal diagnostic examinations and high risk obstetrical clinic visits are scheduled.

c. Evaluate patients for financial eligibility after medical eligibility has been determined. Explain RPICC Program and the CMS RPICC Partnership Agreement to the patient. Obtain patient's signature on the CMS RPICC Partnership Agreement for all RPICC Program eligible patients. Enter the information on the RPICC Birth/Demographic Record in the RPICC Data System. Enter the patient's Medicaid number, if available, and their gross income.

d. If indicated, determine the patient's eligibility for Presumptive Eligibility for Pregnant Women. Forward the appropriate forms to Economic Services.

e. Refer all eligible patients to Economic Services by utilizing the CF-ES Form 2039, Medical Assistance Referral Form. Explain to the patient that failure to complete the application process will result in the patient receiving all bills for RPICC services.

f. Work with Economic Services to enroll all eligible patients onto the Medicaid Program.

g. Complete appropriate sections of the Obstetrical Component Record within ten (10) working days of the patient being determined RPICC Program eligible.

h. Complete the remainder of the information on the RPICC OB Referral Template or other OB referral documentation within five (5) working days of RPICC Program determination (whether eligible or non-eligible), and forward this information to the referring physician, clinic, or the local County Health Department (CHD). Document the date the OB referral documentation was forwarded to the referral source.

i. Enter information for the RPICC Obstetrical Component Record in the RPICC Data System and RPICC Birth/Demographic Record within ten (10) working days of determination of the patient's RPICC Program eligibility.

2. Discharge Responsibilities

   a. Complete within ten (10) working days of a patient's discharge, the RPICC Obstetrical Component Record and the RPICC Fiscal Record in the RPICC Data System.

   b. Forward to the RPICC Neonatal Liaison, within ten (10) working days of a RPICC patient's delivery, the completed RPICC Birth/Demographic Record for those patients whose newborns are admitted to the RPICC Neonatal Intensive Care Unit.

   c. Assure that an appointment is scheduled for the patient to be seen in the RPICC high risk obstetrical clinic, by the referring physician, another clinic, or the local CHD Clinic for a postpartum examination. This appointment should be clearly indicated on the discharge summary documentation that is forwarded to the referral source.

   d. Complete and forward a signed copy of the discharge summary documentation to the referring physician, clinic, or the local CHD within five (5) working days following a patient's hospital delivery/discharge.

   e. Information needed for tracking each RPICC patient which includes the following:

      1) RPICC OB Referral Form or OB referral documentation

      2) CMS RPICC Partnership Agreement

      3) RPICC Birth/Demographic Record

      4) RPICC Obstetrical Component Record

      5) RPICC Fiscal Record(s)

      6) OB Discharge Summary

7) Copy of the CF-ES Form 2039, Medical Assistance Referral Form

8) Documentation of follow-up with Economic Services regarding patient's Medicaid status

f. Obstetrical information needed for tracking for all RPICC Program patients to include the following information:

1) Patient Name

2) Hospital Number

3) Date RPICC Eligibility is Determined

4) Referral Source

5) Patient has Medicaid-Yes/No (Indicate if PEPW or Regular Medicaid.) Presumptive Eligible Pregnant Women (PEPW) is temporary presumptive eligibility established by county health departments, regional perinatal intensive care centers, and other qualified medical facilities for low-income pregnant women. This presumptive determination allows these women access to prenatal care while Department of Children and Families (DCF) makes regular determinations of eligibility. Definition from Florida Medicaid Program Summary Of Services available at http://www.fdhc.state.fl.us/Medicaid/index.shtml

6) PEPW Packet Completed By (Indicate RPICC or CHD)

7) Date Presumptive Eligibility Screening is Completed

8) Date Presumptive Eligibility is Approved/Denied

9) Reason for Denial of Presumptive Eligibility

10) Date Notification of Regular Medicaid Program Status Received

11) Date CF-ES Form 2039 Received (Indicating Regular Medicaid Program Status)

12) Medicaid Status - Eligible/Ineligible

13) Reason for Medicaid Denial of Regular Medicaid

3 DATA SYSTEM AND REPORTING

After August 15, 2010 the RPICC data system and billing component will no longer be administered by CMS. All questions regarding data entry policies and billing/claims should be directed to the RPICC Medicaid representative as assigned by AHCA. The templates are provided as organizational and information collection guidelines for current requirements of the RPICC data system. AHCA will notify the RPICCs of any changes in reporting.

3.1 RPICC Data Record Templates

The RPICC Data Record Templates are the tools by which mandatory data may be collected on RPICC Program patients. The data collected is entered into the RPICC Data System. The data collected may also be used for research purposes to evaluate the consequences of high risk birth and high risk care. In order to continue optimal perinatal care, the data is necessary to establish, expand, or revise medical procedures and principles in the care of high risk patients.

A. Mandatory Documentation for the RPICC Data System include the following:

1. Birth/Demographic Record - Provides information, such as family size, marital status, income and educational level on each RPICC Program patient/patient family (Appendix C-2).

2. Obstetrical Component Record - Provides program service data, obstetrical medical information, and infant outcome data (Appendix C-4).

3. Neonatal Component Record - Provides program service data and neonatal medical/diagnostic information (Appendix C-5).

4. Fiscal Record - Provides hospital and physician services and charges information and patient discharge status (Appendix C-3).

3.2 RPICC Deliverables and Reports

All written deliverables and reports will be submitted via email to the CMS RPICC contract/agreement manager.

A. Reports

1. Annual Outreach Education Report:
The provider will submit the RPICC Annual Education report on Attachment A, incorporated in this agreement. This report is due on August 31 each year. An outreach education program must consist of an

educational presentation that is developed by staff of the local RPICC Program, which addresses the care and services available for high-risk pregnant women and neonates. The duration should be at least 1 hour. The location and specifics of the targeted audience should be documented in the RPICC Annual Education report (Attachment A). A minimum of 4 outreach educational programs should be completed during the fiscal year. These programs shall be made available to hospital staff, CMS office staff, county health department staff and local community partners.

2. Annual mortality data reports:
This report due on August 31 of each fiscal year, includes a summary of mortality data for the period of July 1st– June 30th of each agreement year in the format provided by CMS at:
http://www.cms-kids.com/providers/rpicc_resources.html

3. Additional mortality reports may be requested as deemed necessary by CMS Central Office.

3.3 RPICC Data Handbook

Refer to the RPICC Data Handbook for specific information related specifically to the RPICC Perinatal Data System located at https//esteps.peds.ufl.edu.

4 QUALITY ASSURANCE/QUALITY IMPROVEMENT

4.1 Purpose

The RPICC quality assurance/quality improvement process is designed to assure optimal perinatal service delivery to RPICC Program patients. Quality assurance/quality improvement is a function of the CMS Central Office. Quality assurance is accomplished through annual on-site visits and/or desk reviews for each RPICC facility. In accordance with 383.21, F.S. quality assurance is monitored by CMS Central Office RPICC staff and the statewide RPICC perinatal consultants who are contracted by the Department of Health.

4.2 Objective

The objective of the quality assurance/quality improvement process is to assure that:

A. Patients receive services appropriate to their needs.

B. Center determination of medical and financial eligibility for RPICC Program patients is appropriately based on the established medical and financial criteria.

C. Decisions to terminate services are appropriate.

4.3 Review Process

A. CMS Central Office RPICC staff conducts annual on-site visits and/or desk reviews of each Regional Perinatal Intensive Care Center facility to assure compliance with RPICC Program standards, rules, and contractual requirements.

B. CMS approved physicians specializing in each discipline involved accompany the CMS Central Office RPICC staff on-site visits.

C. A comprehensive review, including chart reviews, a review of space, staff, equipment requirements, pre-site questionnaire, and review of reported data, is conducted on an annual basis. If deficiencies are cited during the annual review, additional visits may be required.

D. For annual RPICC quality reviews, the local CMS Regional Program Administrator, CMS Regional Medical Director, and the CMS Regional Nursing Director, RPICC Hospital Administration and RPICC staff at each facility will be notified of the scheduled visit.

E. On-site visits and desk reviews are conducted in accordance with a schedule established by the CMS Central Office RPICC staff.

F. Purpose of Reviews: Information from annual quality reviews is used to:

1. Identify problems in RPICC service delivery.

2. Identify areas of non-compliance requiring corrective action.

3. Identify issues that require technical assistance and/or consultation.

4. Determine training needs.

5. Review RPICC Program data.

6. Measure program efficiency and effectiveness.

G. Site Review Activities

1. Planning

a) Approximately three weeks prior to the review, the CMS Central Office provides written notification of the review to the RPICC contract providers and appropriate CMS regional management staff.

b) Written notification defines the scope of the review and includes the date, time and location of the review. The notification also includes lists of patient for chart review under each component of the RPICC Program.

c) Prior to the visit, previous site visit reports are reviewed by CMS Central Office RPICC staff.

d) One to two weeks prior to the visit, the RPICC facility being evaluated is responsible for submitting the completed pre-site questionnaires, with the appropriate attachments, to the CMS Central Office.

2. On-Site Review

a) A tour of the facility with the appropriate personnel is completed to observe the units. At this time any questions in response to the pre-site questionnaires and any changes which have occurred in the Program since the last review are discussed.

b) The review team completes a checklist appropriate for each component of the RPICC facility being reviewed.

c) A meeting is held with the RPICC Liaison(s), RPICC medical directors, nursing management, and other involved/interested persons. The focus of this meeting is to overview the Program, resolve problems, and exchange ideas to improve Program operation.

d) An exit conference is held to discuss current issues and problem solve with review team leader and the RPICC facility administration.

3. Post-Review Activities

   a) A site visit report is completed by the review team within 30 calendar days following the review.

   b) The site visit report includes the following:

      1) An overview of the RPICC Program operation at the facility.

      2) Findings of the visit, including Program strengths and weaknesses.

      3) Deficiencies cited for corrective actions to be taken and program recommendations. The appropriate individuals responsible for responding are identified in the monitoring report.

   c) A cover letter is attached to the monitoring report which provides a date on which a response to the recommendations and/or corrective action(s) is due.

   d) The site visit report is provided to the local CMS Regional Program Administrator, CMS Regional Medical Director, CMS Regional Nursing, Director of Hospital Administration, RPICC OB Medical Director, RPICC Neonatal Medical Director, and RPICC Program Coordinator.

5 PROGRAMMATIC ISSUES

5.1 General

The Medicaid Physician Coverage and Limitations Handbook is followed for RPICC billing. The Medicaid rates for physician reimbursements for NCG/OBCG can be accessed at http://mymedicaid-florida.com/ Select Public Information for Providers**.** Select "provider support". Select Fee Schedules. The RPICC fees are listed under Physician-Regional Perinatal Care Center Codes for Neonatal or Obstetrical. The files contain the RPICC fees based on HIPAA-compliant codes which include CPT code, modifier and diagnosis codes.

RPICC reimbursement is all inclusive for all services provided by the neonatology or obstetrical groups. Medicaid recipients enrolled in managed care groups are reimbursed by the managed care organization and not through NCG/OBCG methodology. Medically Needy are not eligible for the RPICC Program. For additional information related to RPICC billing contact your local Medicaid Area Office.

After August 15, 2010 the RPICC data system and billing component will no longer be administered by CMS. The information below is to serve as a guide for general billing purposes based on the present Medicaid reimbursement policy. All questions regarding billing/claims should be directed to the RPICC Medicaid representative as assigned by AHCA.

5.2 Neonatal Component

A. Patient Eligibility - Any birth with the diagnosis of "non-viable fetus" is **not** a RPICC Program eligible patient and they are not entered into the RPICC Data System.

B. NCG Billing

1. CMS approved neonatologists with a Medicaid provider number and a RPICC category of service are reimbursed by Medicaid based on the NCG methodology for RPICC Program patients who have Medicaid coverage and who are not enrolled in a managed care group.

2. If a neonate remains hospitalized beyond 365 days, the NCG will show a discharge date on the 365th day of admission. Medicaid, on a fee-for-service basis, can be billed for the additional days beyond 365, if the patient remains Medicaid eligible.

3. Neonates who are admitted to the newborn nursery in a RPICC facility after birth and are then moved to the NICU due to medical problems can be determined eligible for the RPICC Program. The NCG will begin on the date of admission to the RPICC hospital and should end on the date of discharge from the RPICC hospital. A CMS approved neonatologist must remain continuously involved during the neonatal hospitalization until discharge. Separate Medicaid fee-for-service billings for normal newborn nursery and/or transitional RPICC Level II neonatal intensive care are not appropriate. A singular NCG charge should be

billed to Medicaid that encompasses the entire admission. The only exception would be for services provided after the 365th day of admission, the date on which the NCG would end.

4. Neonates born at a non-RPICC hospital who are medically and financially eligible for the RPICC Program upon transfer to a RPICC Level III NICU are eligible for the RPICC Program, if they remain in the RPICC Level III NICU for a minimum of 48 hours or expire in the Level III NICU, regardless of their age.

5. RPICC neonates who are discharged from the RPICC Program are not eligible for NCG payments for readmissions. Readmissions are billed to Medicaid on a fee-for-service. Readmissions are not entered into the RPICC data system once a neonate has been discharged from the RPICC Program.

C. NCG Exceptions

1. A neonatal exception calculation is generated by the RPICC Data System for the following neonates:

   a) All RPICC neonates transferred from a RPICC to another RPICC.

2. If documentation for a neonatal exception calculation is not properly submitted by all Centers involved in the neonate's care, a RPICC electronic claim cannot be generated by the RPICC Data System. The claim must be billed manually.

3. If a Center fails to properly document in the RPICC Data System a Neonatal Exception on a neonate and bills Medicaid for a NCG for physician services, the other involved Center(s) will have its claim rejected. The NCG reimbursement must be voided prior to any rebilling for the exception.

4. The RPICC Data System will **not** generate a RPICC electronic claim for each neonatal exception for each Center. The claim must be billed manually.

5. NCG 385A with a one day length of service must be billed manually.

5.3 Obstetrical Component

A. The OB Discharge/Referral documentation should be received by the RPICC facility staff on all referrals to the RPICC High Risk Obstetrical Clinic by the CHD and other health care providers.

B. OBCG Billing

1. CMS approved obstetricians with a Medicaid provider number and a RPICC category of service are reimbursed by Medicaid based on the OBCG methodology for RPICC patients who have Medicaid coverage and are not enrolled in a managed care group.

2. All OBCGs that cannot be electronically billed through the RPICC Data System will need to be billed on a CMS-1500 form with the required Medicaid documentation for a hysterectomy or tubal ligation.

3. Gestational age less than a full 20 weeks is an antepartum hospitalization and not billed as a delivery.

4. Non-hospital delivery (i.e. parking lot, home) are billed as postpartum hospitalizations and not delivery hospitalizations.

5. Providers can be reimbursed only for Emergency Medicaid for Aliens (EMA). Aliens who do not meet citizenship or permanent residency requirements are eligible only for emergency services. Aliens are not eligible for Medicaid reimbursable sterilization. For more information review Florida Medicaid Coverage and Limitations Handbook and the Provider Reimbursement Handbooks available at http://mymedicaid-florida.com/

6 PATIENT RECORDS

6.1 Record Retention

All RPICC Program records are to be maintained by the RPICC facility liaison either electronically or by hard copy(s). The RPICC facility shall maintain a file, available for inspection by the CMS Central Office RPICC staff, containing at a minimum, RPICC related policies and procedures, data, committee meetings, documentation of personnel, time sheets, and all other documentation referenced in the contract/agreement. The file shall be maintained for a period of six (6) years

A. Maintain patient records in accordance with the RPICC Handbook or as required by Florida statute, rule or applicable professional standards.

B. Make available safety reports, utilization reports, and infection control reports for the monitoring team to review during the annual RPICC review either by desk review or on-site review as deemed necessary by CMS Central Office RPICC staff.

C. Make available documentation of all contract/agreement requirements for CMS Central Office staff to review when requested.

6.2 Confidentiality

A. All patient records are deemed privileged and confidential and are not open for public review.

B. A Consent for Release of Information from Medical Records form used by the provider must be signed prior to releasing or requesting confidential information. Information may be exchanged between programs without a signed Release of Information.

6.3 Forms

Certain forms will be maintained in the patient record by the RPICC facility liaison(s) for the neonatal and obstetrical components. Forms may be obtained through the local CMS Regional office. Forms pertinent to specific RPICC Program components will be listed under each component.

A. General RPICC Records - The following will be maintained for both the neonatal and obstetrical components:

1. Partnership Agreement Form

2. OB Discharge/Referral documentation

7 APPENDIX A – REGIONAL ELIGIBILITY CRITERIA

7.1 Neonatal Component

The following medical criteria will be considered by the director of neonatology, or designee, to determine medical eligibility for each neonate admitted to the RPICC facility under this program:

A. All low birth weight neonates under 1500 grams.

B. All low birth weight neonates from 1500 to 2500 grams with any of the following:

   1. Birth asphyxia or 5 minute Apgar of 6 or less.

   2. Oxygen dependent respiratory disease.

   3. A specific medical illness.

C. Neonates over 2500 grams birth weight with any of the following:

   1. Birth asphyxia or 5 minute Apgar of 6 or less.

   2. The need for supplemental oxygen for more than 24 hours.

   3. A specific medical illness.

All referred infants who meet at least one of the above criteria are medically eligible. Infants who are born at a RPICC facility must require more than 48 hours of care in a Level III intensive care bed to be medically eligible under any of the specific medical diagnostic categories. Inborn neonates who die prior to receiving 48 hours of care in a Level III intensive care bed may be medically eligible for the program.

Only neonates whose attending physician is a CMS approved neonatologist in a RPICC facility are eligible for the RPICC Program. Neonates who are patients of other physicians or neonates referred to other physicians by the neonatologist, are not eligible for the RPICC Program.

Any birth with the diagnosis of “non-viable fetus” should not be a RPICC Program patient.

7.2 Obstetrical Component

The Director of Obstetrics, or designee, shall consider major maternal conditions which can significantly alter the usual management of pregnancy or of the newborn when determining medical eligibility for the RPICC Program. Major maternal conditions to be considered include, but are not limited to the following:

A. Severe pregnancy induced hypertension (BP>160/110) or eclampsia.

B. Iso-immune disease in a patient who has had a previously affected infant.

C. Labor or ruptured membranes at less than 34 weeks gestation or, anticipated severe neonatal infection.

D. Uterine bleeding or central placenta previa at less than 34 weeks gestation, requiring delivery or continued intensive hospitalization.

E. Diabetes mellitus, requiring insulin.

Only patients whose attending physician is a CMS approved obstetrician in a RPICC facility are eligible for the RPICC Program.

The RPICC Obstetrical Director, or designated obstetrician, may terminate a patient's eligibility under the RPICC Program if the condition for which the patient was admitted no longer exists, provided referral is made to other appropriate medical care.

8 APPENDIX B – RPPIC Program Residency

8.1 Residency Criteria

RPICC Program services are provided to residents of Florida. A "Florida resident," for RPICC Program purposes, means anyone physically residing within the State of Florida, regardless of the length of that residency. A minor's residency is tied to the residency of the minor's parent, legal custodian, or legal guardian unless the applicant is age 18 through 20 years of age. "Florida resident" does not include a child and parent, legal custodian, or legal guardian, who is in the state temporarily or transiently, is in the state not for the purpose of establishing a permanent domicile or residence, or is an out-of-state child, who is temporarily in the state for a treatment program. People residing on Federal Indian Reservations within Florida's boundaries are considered Florida residents.

A. Residents include:

1. Individuals and their families domiciled in Florida.
2. Individuals/families living less than year-round in Florida, if they list Florida as their residence for tax purposes.
3. Resident aliens (should have an I-95 card which documents the INS status) who are residing in Florida.
4. Entrants and refugees (should have an I-95 card indicating INS status).
5. Migrants currently living in Florida.
6. Infants born in this country whose parent/guardian is a Florida resident or whose parent/guardian is residing in Florida on a work or education visa.
7. Individuals/families of U.S. military armed forces personnel who claim Florida as their legal residence.
8. Infants in the custody of private non-profit adoption agencies located in Florida.
9. Wards of the State (person in the custody of the state).
10. Infants of known illegal/undocumented aliens in Florida.
11. Illegal/undocumented pregnant aliens residing in Florida.

B. Individuals who are not residents include:

1. Individuals/families in the U.S. on a visa (education, work, tourist, etc.).
2. Individuals who are married to a Florida resident, but who are in the U.S. on a visa.

3. Individuals and their families who spend several months a year in Florida, but who list another state as their residence or pay personal taxes in another state.

4. Individuals and their families vacationing in Florida.

9 APPENDIX C – Templates

Printable templates are available at: http://www.cms-kids.com/providers/rpicc_resources.html

9.1 Discharge/Referral Template

Regional Perinatal Intensive Care Centers Program
Obstetrical Component
Discharge/Referral
(Circle one)

To: _____Date:_____
(Center/Physician/County Health Unit)
Address:
_____
_____

Referring Source*:* _____Telephone/Fax*:* _____
Address: _____

Patient Information

Name: _____Contact Number: _____

Address:_____

Admission Date: _____Discharge Date: _____Identifying Number: _____

Social Security Number:_____ Date of Birth(DOB): _____ Age:_____

Estimated Date of Confinement: _____ Last Menstrual Period: _____

Gravida/Parity/Abortions/Living Children: _____

Provide copy of History/Physical, Ultrasound reports, labs to include all screenings and insurance information (policy /authorization numbers) with medical release information

Diagnosis: _____
Reason for referral: _____
Questions: _____
Level of Care: ____ Consultation: _____ Transfer: _____
Newborn Outcome: DOB: _____Weight: _____Gestational Age: _____

Signature of referral staff/physician*:* _____

Date Received: _____ Patient's next appointment_____
Date/Location: _____
Return information from Referral Source_____
Signature

Place original to RPICC Liaison and provide copy to Referral Source

9.2 Birth/Demographic Record

State of Florida
___/___/___ (Date Completed)
Children's Medical Service Perinatal Data System
Birth/Demograhic Record

_____ Mother's Soc. Sec. No. (Unique Number)

_____ Center of Origin (for transfer)

Mother

_____ Mother's Hospital Number

_____ Mother's Name(last, first)

___/__/____ DOB

_____ Medicaid No.

_____ Name

_____ Mother's A.K.A.

Father's

_____ Street Address

_____ City

____ State

_____ County of Residence

_____ Phone (Home)

_____ Phone (Other)

____ Mother's Martial Status
1-Married
2-Divorced
3-Separated
4-Never Married
5-Widowed
6-Living Together
7- Unknown

____ Mother's Education
1 2 3 4 5 6
7 8 9 10 11 12
13 14 15 16-BD
17-BD+ 18-GD
19-Unknown
20-None

$_____ Family Gross Yearly Income
UNK-Unknown

Family Adults:_____
Family Children:____
Family Size:_____
Household Size____

____ Race
1-Black
2-White
5-Asian
6-Native Indian
9-Other

_____ Ethnic Origin
00-American
20-Haitian
82-Hispanic
81-Other
99-Unknown

Child

_____ Child's Hosp. No. Birth

_____ Child's Name (last, first)

___/___/___ DOB

Y / N

_____ Infant readmitted to RPICC

Weight (gm)

_____ Child also known as

_____ Sex
M-Male
F-Female
A-Ambiguous

_____ Gestational weeks

_____ # of this Gestation
1 2 3 4 5

_____ Birth Order

_____ Child's Soc. Sec. No.

_____ Code-Hospital of Birth

_____ Child's Medicaid No.

_____ Race
1-Black
2-White
5-Asian
6-Native Indian
9-Other

Completed by:_____

Date Entered in System____/_____/____

9.3 Fiscal Component

State of Florida
___/___/___ (Date Completed)
Children's Medical Service Perinatal Data System
Fiscal Component

_____
Mother's Soc. Sec. No.
(Unique Number)

Fiscal Record For: **OB**__ **NE**__

_____	_____	_____	_____
Mother's Hospital Number	Mother's Name (last, first)	Child's Name (last, first)	Child's Hospital No.

_____ _____
Mother's Medicaid Number **Fiscal Status**

EL-Medicaid Eligible **IE**-Insurance Eligible
UF-Unfunded **NN**-Non-Eligible PEPW: Y / N
HM-Medicaid HMO

Ongoing Medicaid: Y / N

Hospital

$_____	__/__/__	__/__/__	_____	
Hospital Charge (Include Transport Charges)	date Hosp. Admission	date Hosp. Discharge	Provider # or Code	
$_____	___/__/__	__/__/__	_____	Physician
Charges Physician Charges Began		Physician Charges Ended	Provider Name	

Transport

Incoming Transport Mode: ____
Outgoing Transport Mode: ____

2- In Utero 6- Special Vehicle
3- Ambulance 7- Private Auto
4- Helicopter 8- Other Mode
5- Airplane 9- Military Aircraft

Discharge

Neonatal Forms only:

_____
Discharge status
U-unknown
4-Other NICU
5-Stepdown
6-Normal Nursery
7-Other Nursery
8-Child's Home
9-Adoptive Home
10-Foster Care
11-Died, Autopsied
12-Died, No Autopsy
13-Institution
14-Other

Discharge Weight (gm)_____

Completed by:_____

Date Entered in System___/___/___

9.4 Obstetrical Component

State of Florida

___/___/___ (Month/Day/Year Date completed)

Children's Medical Services Perinatal Data System

Obstetrical Component

Mother's Social Security Number_____

_____	_____	_____
Mother's Hospital Number	Mother's Last Name	Mother's First Name

__/__/__ Month/Day/Year	__/__/__ Month/Day/Year
Date Declared Program Eligible	Expected Date of Delivery

_____	_____	_____	_____	_____
Mother's Status Code	Gravida	Term	Premature	Living

EL IE UF NN HM (Code Gravida & Parity 99 if missing)

___/___/___	_____	_____	_____	_____
Month/Day/Year	Total Number		RPICC Prenatal	Postpartum Visits
Date of First	Prenatal Visits		Visits before	**Maternal Referral**:
Prenatal Visit	before Delivery		Delivery	1=County Health Unit
				2=Private
			3=Center Clinic	
				4=Other
				5=None

_____	___/___/___
Mother's Discharge Status	Month/Day/Year
1=Discharge Home	Program Discharge Date
3=Expired	
4=Other (allows omission of infant data)	
5=Lost to Follow-Up ICD_9's Antepartum_____	Delivery_____
6=Not Medically Eligible (omits infant data requirement)	Postpartum_____

COMPLICATIONS

A1 Abnormal Labor pattern
A2 Abnormal presentation (after 25 weeks)
A3 Acquired Immune Deficiency Syndrome
A4 Alcohol Abuse
A5 Amnionitis
A6 Abruption
C1 Cardiovascular Disease (organic)
C2 Collagen Vascular Disease
__ Diabetes Class A=**DA**; B=**DB**; C=**DC**; D=**DD**; R=**DR**; F=**DF**; A2=**DT**
D2 Dilatation/Curettage
D3 Diminished Renal Function/Kidney Disease
E1 Eclampsia
E2 Endometritis
E3 Epilepsy/Seizure Disorders
F1 Fetal Distress and/or Acidosis
G1 Gastrointestinal Problems
H1 Hemoglobinopathies (other than HIV)
H2 Hemorrhage
M1 Maternal Death
M2 Meconium Staining
M3 Mild Preeclampsia
M4 Multiple Gestation
O1 Oligohydramnios
P1 Polyhydramnios
P2 Post Term (42+)
P3 Pregnancy Induced Hypertension
P4 (PROM) Pre. Rupture of Membranes >6Hrs before Labor
P5 Previous Caesarean Section
P6 Previous Low Birth Weight/Preemie
P7 Previous Perinatal Death
P8 Psychological Disorders
P9 Pulmonary Dysfunction
R1 Rh Sensitized/Irregular Antibodies
S1 Severe Preeclampsia
S2 Sexually Transmitted Diseases
S3 Shoulder Dystocia

AV HIV Disease
H3 Hyperemesis with Ketonuria
H4 Hypertension: Chronic (140+/90+)
H5 Hysterectomy
I1 Incompetent Cervix
I2 Intrauterine Fetal Demise (IUFD)
I3 Intrauterine Growth Retardation
S4 Spontaneous Premature Labor (=36 weeks)
S5 Substance Abuse (other than Alcohol)
S6 Smoking
T1 Thyroid Disease
T2 Tubal Ligation
V1 Vaginal Bleeding
V2 Viral Infections, not sexually transmitted

DELIVERY DATA

_____	_____	**Y / N**	_____	
Delivery Type	Birth Complications	Resuscitation at	Disposition of Fetus	
1=Vaginal During Labor	1=Forceps	Birth (Intubation)	1=RNICC	5=Expired
4=Caesarean Section	2=Breech		2=Newborn	
	3=Vacuum Extraction		3=Intermediate Care	
			4=Expired Before	
			5=Expired During Labor	
			6=Expired After Delivery	
			7=Expired/Time Unknown	
			8=Other Disposition	

Completed by_____Date Entered in System_____

9.5 Neonatal Component

State of Florida
___/___/___ Date completed
Children's Medical Services Perinatal Data System
Neonatal Component

_____
Mother's Social Security Number
(Unique Number)

_____ _____ _____
Mother's Hospital Number | Mother's Last Name | Mother's First Name

_____ _____ _____
Child's Hospital Number | Child's Last Name | Child's First Name

NEONATAL ADMITTING DATA

_____ _____ _____/_____/_____
Child's Status Code | Birth County Number | Month/ Day /Year

EL IE UF HM NN | Hospital Admission Date

DISCHARGE DATA

_____ _____/_____/_____ _____/_____/_____
Weight (Grams) at | Month/ Day /Year | Month/ Day /Year

NICU Discharge | Date of Discharge | Date of Discharge

From Level 3 NICU | From Center

RESPIRATORY ASSISTANCE AND SURGERY

Codes
14 Assisted Ventilation
If coded 14 then

Y/N

____Ventilation >48 hours
____Total Hours on Ventilation
____Total Hours on Oxygen >40%

15 Oxygen >4 Hours

16 Continuous Positive Airway Pressure (CPAP)
18 Surgery Major (See Procedures)
19 Extracorporeal Membrane Oxygenation (ECMO)

DISCHARGE DIAGNOSIS PROCEDURES

ENTER ICD-9 CODES (Code 779.9 for Infant Mortality)

A_____ F_____
B_____ G_____
C_____ H_____
D_____ I_____
E_____ J_____

*If 18 (Surgery, Major is Coded) A Surgical ICD-9 Procedure Code Must Be Entered

A_____
B_____
C_____

Completed by_____

Date entered in System_____/_____/_____

10 APPENDIX D – Partnership Agreement

Printable Partnership Agreements available at: http://www.cms-kids.com/providers/rpicc_resources.html

10.1 English Partnership Agreement

CHILDREN'S MEDICAL SERVICES
REGIONAL PERINATAL INTENSIVE CARE CENTER
PARTNERSHIP AGREEMENT

Patient's Name:

_____

Patient's S.S. No.: _____

The Regional Perinatal Intensive Care Centers, (RPICC) Program is made up of certain hospitals which provide special care to women with high risk pregnancies and to sick or low-birth weight infants. The program is directed by Children's Medical Services.
I give RPICC staff permission to examine _____ (patient/child's name), and to perform all medical treatments that are in my/his/her best interest without regard to race, color, or national origin (Title VI of Civil Rights of 1964). I also understand that information: name, address, medical condition, etc., will be gathered in a computer and analyzed by CMS.

A. RPICC staff and families will work together to make appointments concerning RPICC clinics, doctor's offices, lab, etc., to meet the scheduling needs of both parties whenever possible.

B. RPICC staff and families will work together to make sure that all medical records are kept up to date. RPICC staff will send records to referring clinics or other doctors no more than two weeks after discharge from the RPICC program.

C RPICC staff will make every attempt to provide services in a family-centered manner that respects individual and cultural needs and increases family independence.

D. In an effort to increase family independence, families may request and receive copies of their medical records.

E. Families will notify RPICC staff of any changes in Name, Address, Phone Number, Caregiver, Medicaid Eligibility/Number or Health Insurance coverage.

F. Families will notify RPICC staff of any changes in their income.

G. Families are required to apply for and continue available health care coverage, including Medicaid. Families will allow RPICC to bill health insurance for services covered under the insurance policy.

H. The family and doctor will work closely to create a plan of care/services that is agreeable to everyone and meets the individual current needs of the patient/family.

I. Families will be given information on how to resolve differences and disagreements with the RPICC program (Fair Hearing Process, 409.285 F.S.).

I, _____ being the (circle one) parent, guardian, patient understand and agree to the above information.
Date: _____RPICC Representative: _____

10.2 Spanish Partnership Agreement

SERVICIOS MÉDICOS PARA NIÑOS

CENTRO DE CUIDADO INTENSIVO PERINATAL REGIONAL
ACUERDO ENTRE SOCIOS

Nombre del Paciente:

_____

S.S.N. del Paciente: _____

El Programa de Centros de Cuidado Intensivo Perinatal Regional, (RPICC) está formado por ciertos hospitales que proporcionan cuidado especial a mujeres con embarazos de alto riesgo y para los infantes enfermos o con bajo peso. El programa está dirigido por Los Servicios Médicos para Niños.
Le doy permiso al personal del RPICC para examinar a _____ (nombre del paciente/niño), y para realizar todos los tratamientos médicos por así convenir a mis/sus interese, sin importar la raza, color o país de origen (Título VI de los Derechos Civiles de 1964). Yo también entiendo que información como: nombre, dirección, condición médica, etc., se pondrá en una computadora y se analizará por CMS.

A. El personal de RPICC y familias trabajarán juntos para hacer las citas concernientes a las visitas médicas del RPICC, al consultorio del doctor, laboratorio, etc., para satisfacer las necesidades de horarios de ambas partes cada vez que sea posible.

B. El personal de RPICC y familias trabajarán juntos para estar seguros que todos los expedientes médicos estén actualizados. El personal de RPICC enviará los expedientes a otros doctores o clínicas en no más de dos semanas después de que fué dado de alta del programa RPICC.

C. El personal de RPICC hará todos los intentos posibles para proveer servicios considerando a la familia y respetando las necesidades individuales y culturales e incrementando la independencia familiar.

D. En un esfuerzo de promover la independencia familiar, las familias pueden pedir y recibir copias de sus expedientes médicos.

E. Las familias notificarán al personal del RPICC de cualquier cambio en el Nombre, Dirección, Número Telefónico, Persona al Cuidado del Niño, Número/Elegibilidad del Medicaid, o en la Cobertura del Seguro de Salud.
F. Las Familias notificarán al personal del RPICC de cualquier cambio en sus ingresos.

G. Se requiere que las Familias soliciten y mantengan activa su cobertura de cuidado médico, incluyendo Medicaid. Las Familias permitirán al RPICC que facture por los servicios cubiertos sobre la póliza de seguro.

H. La Familia y el doctor trabajarán juntos para crear un plan de cuidado/servicios en el que todos estén de acuerdo y que cubra las necesidades actuales particulares del paciente/familia.

I. Las Familias darán información de cómo resolver las diferencias y desacuerdos con el programa RPICC (Proceso de Audiencia, 409.285 F.S.).

Yo, _____ siendo el/la (circule uno) padre/madre, tutor, paciente entiendo y estoy de acuerdo con la información anterior.

Fecha: _____

Representante RPICC: _____

10.3 Creole Partnership Agreement

SÈVIS MEDIKAL POU TIMOUN
PWOGRAM LOPITAL NAN FLORIDA KI BAY SWEN POU TI BEBE (RPICC)
PAPYE KI DI NOU DAKÒ AK PWOGRAM LAN

Siyati moun lan:

Nimewo Sosyal moun lan:

Pwogram lopital nan Florida ki bay swen pou ti bebe (RPICC) genyen yon kantite lopital ki okipe fi ki ansent ki genyen anpil pwoblem , RPICC genyen yon kantite lopital ki okipe ti bebe ki malad oubyen ti bebe ki fèt anvan lè yo epi ki pa peze anyen. Se Sèvis Medikal pou Timoun (CMS) ki okipe pwogram sa. Mwen bay anplwaye RPICC pèmisyon pou li ekzamine (siyati moun lan/timoun lan), epi mwen bay yo pèmisyon fè tou sa ki bon pou mwen/bon pou manman timoun lan/bon pou timoun lan san yo pa gade sou ki ras mwen ye, ki koulè po mwen ye oubyen nan ki peyi mwen soti (Chapit 6 Dwa Sivil 1964). Mwen konprann tou ke tout enfòmasyon mwen bay (siyati mwen, adrès lakay mwen, maladi mwen genyen …) prale nan yon kompyutè kote CMS prale analyze li.

A. Anplwaye RPICC ansanmb ak fanmi yo prale antann yo pou pran randevou pou ale nan klinik RPICC, nan biro doktè, nan laboratwa…, pou wè si yo kapab jwenn yon lè ki bon pou tout moun.

B. Anplwaye RPICC ansanmb ak fanmi yo prale antann yo pou tout papye doktè genyen tout dènye enfòmasyion. Anplwaye RPICC prale voye papye doktè yo nan klinik yo oubyen yo prale voye papye yo bay lòt doktè. Pi ta pou papye yo ale se kenz (15) jou apre pwogram RPICC lan voye nou lakay nou.

C. Anplwaye RPICC prale fè tout efò yo kapab pou bay fanmi yo sèvis ki rekonèt sa malad lan bezwen, pou bay fanmi sèvis yon jan ki respekte kilti moun lan epi yon jan ki pèmèt fanmi a deside ki sa ki bon pou li.

D. Pou ede fanmi yo deside ki sa ki bon pou yo; fanmi yo kapab mande epi resevwa kopi papye doktè yo genyen sou fanmi a.

E. Fanmi yo fèt pou di anplwaye RPICC lè yo chanje siyati, adrès, nimewo telefon, doktè, si yo kalifye pou Medicaid/Nimewo Medicaid oubyen nimewo asirans.

F. Fanmi yo fèt pou di anplwaye RPICC lè yo fè plis lajan oubyen lè yo fè mwens lajan. G. Fanmi yo fèt pou aplike pou epi tou yo fèt pou kenbe asirans doktè yo genyen an, si yo genyen Medicaid yo fèt pou yo kontinye li tou. Fanmi yo prale pèmèt RPICC bil konpayi asirans yo pou sèvis asirans lan peye.

H. Fanmi a ansanm ak doktè a prale travay men nan la men pou yo dakò sou yon plan pou vizit lopital ak sèvis lopital ki bon pou tout moun. Plan sa fèt pou li bon pou moun malad la epi pou fanmi a tou.

I. Fanmi yo prale resevwa enfòmasyon sou kòman pou rezoud pwoblèm lè yo pa dakò ak sa RPICC pwogram la di. (Fair Hearing Process, 409.285 F. S.).

Mwen menm, paran , gadyen, malad
mwen konprann epi mwen dakò ak enfòmasyon ki ekri piwo a.

Dat:_____ Reprezantan RPICC: _____

11. APPENDIX E - Florida Statutes and Florida Administrative Code

11.1 385.15 -383.21, F.S.

383.15 Legislative intent; perinatal intensive care services.

The Legislature finds and declares that many perinatal diseases and disabilities have debilitating, costly, and often fatal consequences if left untreated. Many of these debilitating conditions could be prevented or ameliorated if services were available to the public through a regional perinatal intensive care centers program. Perinatal intensive care services are critical to the well-being and development of a healthy society and represent a constructive, cost-beneficial, and essential investment in the future of our state. Therefore, it is the intent of the Legislature to develop a regional perinatal intensive care centers program. The Legislature further intends that development of a regional perinatal intensive care centers program shall not reduce or dilute the current financial commitment of the state, as indicated through appropriation, to the existing regional perinatal intensive care centers. It is the intent of the Legislature that any additional regional perinatal intensive care center authorized under s. 383.19 after July 1, 1993, shall not receive payments authorized under s. 409.9112 unless specific appropriations are provided to expand such payments to additional hospitals.

383.16 Definitions; 383.15-383.21.

As used in 383.15-383.21, the term:

(1) "Department" means the Department of Health.

(2) "Regional perinatal intensive care center" or "center" means a unit designated by the department, located within a hospital, and specifically designed to provide a full range of health services to its patients.

(3) "Patient" means a woman who is experiencing a high-risk pregnancy and who has been declared financially and medically eligible or a newborn infant who needs intensive care and who is declared financially and medically eligible.

383.17 Regional perinatal intensive care centers program; authority.

The department may contract with health care providers in establishing and maintaining centers in accordance with F.S. 383.15-383.21. The cost of administering the regional perinatal intensive care centers program shall be paid by the department from funds appropriated for this purpose.

383.18 Contracts; conditions.

Participation in the regional perinatal intensive care centers program under F.S. 383.15-383.21 is contingent upon the department entering into a contract with a provider. The contract shall provide that patients will receive services from the center and that parents or guardians of patients who participate in the program and who are in compliance with Medicaid eligibility requirements as determined by the department are not additionally charged for treatment and

care which has been contracted for by the department. Financial eligibility for the program is based on the Medicaid income guidelines for pregnant women and for children under 1 year of age. Funding shall be provided in accordance with F.S. 383.19 and 409.908.

383.19 Standards; funding; ineligibility.--

(1) The department shall adopt rules that specify standards for development and operation of a center which include, but are not limited to:

(a) The need to provide services through a regional perinatal intensive care center and the requirements of the population to be served.

(b) Equipment.

(c) Facilities.

(d) Staffing and qualifications of personnel.

(e) Transportation services.

(f) Data collection.

(g) Definitions of terms.

(2) The department shall designate at least one center to serve a geographic area representing each region of the state in which at least 10,000 live births occur per year, but in no case may there be more than 11 regional perinatal intensive care centers established unless specifically authorized in the appropriations act or in this subsection. Medicaid reimbursement shall be made for services provided to patients who are Medicaid recipients. Medicaid reimbursement for in-center obstetrical physician services shall be based upon the obstetrical care group payment system. Medicaid reimbursement for in-center neonatal physician services shall be based upon the neonatal care group payment system. These prospective payment systems, developed by the department, must place patients into homogeneous groups based on clinical factors, severity of illness, and intensity of care. Outpatient obstetrical services and other related services, such as consultations, shall be reimbursed based on the usual Medicaid method of payment for outpatient medical services.

(3) Failure to comply with the standards established under this section constitutes grounds for terminating the contract.

(4) The department shall give priority to establishing centers in hospitals that demonstrate an interest in perinatal intensive care by meeting program standards.

(5) A private, for-profit hospital that does not accept county, state, or federal funds or indigent patients is not eligible to participate under 383.15-383.21.

(6) Each hospital which contracts with the department to provide services under the terms of F.S. 383.15-383.21 shall prepare an annual report that includes, but is not limited to, the number of clients served and the costs of services.

383.21 Program review.

At least annually during the contract period, the department shall evaluate the services rendered by each center. The department shall submit an annual programmatic and financial evaluation report, by center, to the Legislature no later than December 1 of each year.

11.2 CHAPTER 64C-6, FLORIDA ADMINISTRATIVE CODE

64C-6.001 Definitions - General.
64C-6.002 Standards - General.
64C-6.003 Standards - Specific.

64C-6.001 Definitions - General.

(1) "Neonate" – An infant less than 29 days of age or, for the purpose of this program, an infant past the age of 28 days who requires continuance of neonatal intensive care services.
(2) "Neonatologist" – A CMS consultant physician, as defined in Rule 64C-4.001, F.A.C., who is certified, or is eligible for certification by an appropriate board in the area of neonatal-perinatal medicine.
(3) "Regional Perinatal Intensive Care Centers (RPICC or centers)" Specialized units within hospitals specifically designed to provide a full range of health services to women with high risk pregnancies and a full range of newborn intensive care services, which have been designated by the Department of Health, and which meet the standards as defined herein for facilities, staffing and services or commit themselves to meeting and maintaining these standards within three years of designation as a center.
(4) "RPICC Data System" – A comprehensive automated information system which collects and correlates data from all 3 components of the Regional Perinatal Intensive Care Centers Program and provides periodic analysis of RPICC Program data.
(5) "RPICC Level II Neonatal Intensive Care Bed" – A patient care station in a RPICC with the capability of delivering special care to newborns including oxygen therapy, supplemental parenteral alimentation, constant electronic monitoring of vital signs, and with a minimum ratio of one member of the nursing staff to four patients.
(6) "RPICC Level III Neonatal Intensive Care Bed" – A patient care station with the capability of delivering total intensive care to newborns including total respiratory support, supplemental parenteral alimentation, constant electronic monitoring of vital signs, long term arterial catheterization, and with a minimum ratio of one member of the nursing staff to two patients, at all times, for the critical care of unstable neonates.
(7) "Waiver" – A written statement or verbal statement, followed by written documentation, by the Assistant Secretary for Children's Medical Services which abandons the enforcement of any specific requirement of these standards for a specified period f time. *Specific Authority 120, 383.19(1)(f), (g) FS. Law Implemented 383.19 FS. History–New 9-1-81, Amended 4-25-83, Formerly 10J-7.01, Amended 6-13-87, 5-15-96, Formerly 10J-7.001.*

64C-6.002 Standards - General.

(1) The CMS RPICC Program represents the basic unit required for all other Children's Medical Services authorized regional programs which include spina bifida, craniofacial anomalies, hematology and oncology, complex surgery, cardiac, and transplantation.

(2) The Regional Perinatal Intensive Care Centers (RPICC) Program provides services in designated hospitals through two interrelated components:

(a) Neonatal including Level II and Level III neonatal intensive care;
(b) Obstetrical.

The standards set forth in this section pertain to the RPICC Program in general.

(3) Facilities and Location.

(a) Upon review of available information or upon the request of an individual or institution the CMS Program office shall make a determination of the need for the establishment of a center within a geographic area. This determination shall be based upon the following factors:

1. The number of live births per year, as required in Section 383.19, F.S.
2. The access of patients (infants and pregnant women) in the area to established RPICC services.

(b) Upon the determination of the need for a center within a geographic area, the CMS Program office shall review the hospitals within the geographic area to determine which facility should be considered for designation as a RPICC.

(c) CMS Program office staff and RPICC Program consultants shall conduct an on-site review of the hospital to ascertain the extent to which the hospital's facilities, personnel, and services comply with the standards set forth herein. Based on this review a recommendation shall be made for appropriate designation as a center.

(d) .In order to be designated a center, a hospital must be approved by the Assistant Secretary for Children's Medical Services, based on the recommendation from the on-site review.

(e) In order to be designated as a center, the maternal and neonatal intensive care services must be present in the same complex and must be located in close proximity.

(f) Institutions designated as centers shall meet all standards for facilities, personnel, and services, asset forth herein, within 3 years of designation as a center.

(g) If all standards for facilities, staffing, and services, as set forth herein, are not met without appropriate waiver, then designation as a center shall be removed unless the Assistant Secretary for CMS determines that removal will reduce essential services.

(4) Personnel.

(a) Each center shall designate one or more RPICC liaisons to provide coordination between the center, the CMS Program office and local CMS offices. This person shall keep all records, interview patients for CMS eligibility, and maintain statistical records for review.

(b) Each center shall provide one registered nurse who will be responsible for coordinating staff development and continuing education programs for perinatal nursing staff at that center, and for coordinating educational outreach activities of the RPICC to other hospitals and health care professionals.

(5) Patient Eligibility.

(a) Patients who have been determined medically eligible, as defined in paragraph 64C-6.003(1)(c) or 64C-6.003(3)(c), F.A.C., for the RPICC Program shall have their financial eligibility for the RPICC Program determined. A patient shall be considered financially eligible for the RPICC Program if the applicant meets the Medicaid

requirement for pregnant women and newborns in Section 409.903(5), Florida Statutes.

(6) Waivers.

(a) In the event that compliance with any facility or personnel standard is not attained, a provider may request a waiver of that standard.
(b) All requests for waiver of a specific standard shall be made in writing to the Children's Medical Services Program office and shall include documentation of the need of the waiver.
(c) A waiver of a specific standard shall be granted only for a specific period of time.
(d) Final approval or disapproval of all requests for waiver shall be made by the Assistant Secretary for Children's Medical Services. The Assistant Secretary for CMS shall base the decision to grant or deny a specific request for waiver of a standard upon the documentation submitted with the request.

Specific Authority 120, 383.19 FS. Law Implemented 120, 383.171, 383.19 FS. History– New 9-1-81, Amended 4-25-83, Formerly 10J-7.02,Amended 6-13-87, 5-15-96, Formerly 10J- 7.002.

64C-6.003 Standards - Specific.

(1) Standards for Neonatal Component – Level III Neonatal Intensive Care – The following standards pertain to the facilities, services, and population to be served under the neonatal component for Level III neonatal intensive care services.
(a) Personnel
1. Physicians
a. The director of the RPICC neonatal unit shall be a CMS consultant neonatologist.
b. Each center shall have available a CMS consultant pediatric surgeon available at all times.
c. Each RPICC neonatal unit shall have 24-hour coverage by CMS consultant neonatologists for patient care and for communication with physicians in other hospitals.
d. Each center shall have a CMS consultant pediatric cardiologist available at all times.
e. Two neonatologists are required within 3 years of designation of a unit as a RPICC.
2. Nurses
a. A head nurse, who is registered by the State of Florida, as defined in Chapter 464, F.S., with training and experience in neonatal intensive care nursing, shall be responsible for the organization and quality of nursing care provided in the RPICC neonatal unit.
b. Additional staffing for each shift for infants requiring intensive care shall include, as a minimum, a ratio of one member of the nursing staff to two patients for the critical care of unstable neonates. Half of the nursing personnel must be registered nurses. This ratio of nurses to infants shall be maintained at all times.
3. Respiratory Therapy Technician – At least one certified respiratory therapy technician, with expertise in the care of neonates, shall be available in the hospital at all times. One therapist for every four infants receiving assisted ventilation is required.

(b) Area and Equipment – All standards in subsection 59C-1.042(10), F.A.C., which is hereby incorporated by reference, are required. In addition, the following standards are also required.

1. Each patient station in the RPICC Level III neonatal intensive care unit shall have:
   a. Availability of continuous blood pressure measurement.
   b. Availability of devices capable of measuring continuous arterial oxygenation in the patient.
2. Each RPICC neonatal unit shall have one ventilator available for every three intensive care beds.

(c) Patient Eligibility.

1. Eligibility for funding under the RPICC Program shall be limited to neonates admitted to the Level III neonatal intensive care unit in one of the designated RPICCs. All neonates who meet the established medical criteria upon direct referral by the attending physician, must be admitted to the center, regardless of geographic origin in Florida or financial eligibility. The only valid grounds for refusal of admission to a center shall be the lack of functional bed space or unavailability of transport. Admission to a center does not constitute acceptance of a patient for eligibility under the RPICC Program.
2. All neonates admitted to a center shall be evaluated for RPICC Program eligibility. Only those patients who meet both the medical and financial criteria shall be eligible for the RPICC Program.
3. The following medical criteria will be considered by the RPICC director of neonatology, or designee, to determine medical eligibility for each neonate admitted to the center or under this program:
   a. All low birth weight neonates under 1500 grams.
   b. All low birth weight neonates from 1500 to 2500 grams with any of the following:
      (I) Birth asphyxia or 5 minute Apgar of 6 or less.
      (II) Oxygen dependent respiratory disease.
      (III) A specific medical illness.
   c. Neonates over 2500 grams birth weight with any of the following:
      (I) Birth asphyxia or 5 minute Apgar of 6 or less.
      (II) The need for supplemental oxygen for more than 24 hours.
      (III) A specific medical illness.
4. All referred infants who meet at least one of the above criteria are medically eligible. Infants who are born at a center hospital must require more than 48 hours of care in an intensive care bed to be medically eligible under any of the specific medical diagnostic categories. Inborn neonates who die prior to receiving 48 hours of care in an intensive care bed may be medically eligible for the program.
5. Only neonates whose attending physician is a CMS consultant neonatologist in a RPICC center are eligible for the RPICC Program. Neonates who are patients of other physicians or neonates referred to other physicians by the neonatologist, are not eligible for the RPICC Program.

(d) Services.

1. Physician Services – The patient record shall contain written comments on the patient's treatment and condition by the CMS

consultant neonatologist or a resident's note co-signed by the CMS consultant documenting the neonatologist's continuing involvement in the care of the neonate.

2. Nursing Services – Nurses working in the neonatal intensive care unit (NICU) shall have knowledge and skills in the following:
   a. Cardio-respiratory monitoring.
   b. Assisting in ventilation and administering I.V. fluids.
   c. Pre-operative and post-operative care of newborns requiring surgery.
   d. Providing emergency treatment of conditions such as apnea and seizures.
   e. Management of neonates being transported to the center.
3. Laboratory and X-Ray Services.
4. Nutrition Services – Each center shall have a dietician or nutritionist to provide information on patient dietary needs while in the center and to provide the patient or patient's family instruction or counseling regarding the appropriate nutritional and dietary needs of the patient after discharge.
5. Respiratory Therapy Services.
6. Social Services.
7. Each center shall provide a written discharge plan for each RPICC Program neonate.

(2) Standards for Neonatal Component – Level II neonatal intensive care unit – The following standards pertain to the facilities, services, and population to be served under the neonatal component for Level II neonatal intensive care services of the RPICC Program.

(a) Personnel.

1.Physicians.

a. Each Level II neonatal intensive care unit shall have 24 hour consultation and primary coverage by CMS consultant neonatologists for patient care.

2. Nurses.

a. A head nurse, who is registered by the State of Florida, as defined in Chapter 464, F.S., with specialized training and experience in the care of sick infants, will be responsible for the organization and quality of nursing care in the Level II neonatal intensive care unit. The head nurse of the Level III neonatal intensive care unit may assume this role.

b. Additional staffing for each shift for infants in the Level II neonatal intensive care unit must include one member of nursing staff for every four such infants, with a minimum of half of such nursing personnel being registered nurses. This ratio of nurses to infants must be maintained at all times.

3. Respiratory Therapy Technician – A certified respiratory therapy technician with expertise in the care of neonates shall be available to the Level II neonatal intensive care unit at all times.

(b) Area and Equipment – All standards in subsection 59C-1.042(9), F.A.C., which is hereby incorporated by reference, are required. In addition, the following standards are also required:

1. Each Level II neonatal intensive care unit shall have available to the unit on demand the availability of continuous blood pressure measurement.

2. Each Level II neonatal intensive care unit shall have available the capability for short-term assisted ventilation until return to a RPICC Level III neonatal intensive care unit is available.

(c) Patient Eligibility.

1. Eligibility for funding under the RPICC Program shall be limited to neonates admitted to the Level II neonatal intensive care unit from one of the designated RPICC Level III neonatal intensive care units.
2. Infants served in Level II neonatal intensive care units shall be under the care of a CMS consultant neonatologist, must have received CMS RPICC Program Level III NICU care, and may require specialized nutritional support, or may require oxygen which does not exceed 40 percent at ambient pressure, or whose weight or medical or surgical diagnosis precludes discharge to recovery care.

(d) Services.

1. Physician Services.
2. Nursing Services.
3. Laboratory and X-Ray Services.
4. Nutrition Services.
5. Respiratory Therapy Services.
6. Social Services.

(3) Standards for Obstetrical (OB) Component – The following standards pertain to the facilities, services, and population to be served under the obstetrical component of the RPICC Program.

(a) Personnel.

1. Physicians.

a. The obstetrical service shall have 24-hour coverage by a CMS consultant obstetrician for patient care and for communication with physicians in other hospitals.
b. An anesthesiologist, with special training or experience in maternal-fetal anesthesia, shall direct anesthesia services.
c. Specialists in pediatrics, internal medicine, cardiology, surgery, and genetics shall be available to provide consultation.

2. Nurses.

a. The nursing supervisor for obstetrics, registered by the State of Florida, as defined in Chapter 464, F.S., shall have training and experience in the nursing care of normal and high risk obstetric patients, and shall preferably be certified as a clinical nurse specialist or advanced registered nurse practitioner.
b. Each outpatient, antepartum, postpartum, and labor and delivery area shall have a registered nurse, with experience in the specific area and experience in the management of high risk obstetrical patients, who shall be responsible for the organization and quality of nursing care provided in that area.

(b) Area and Equipment.

1. Outpatient Area.

a. The outpatient area shall have available a waiting room of adequate size. Each patient shall be afforded privacy during the examination and there shall be available a dressing area which assures the patient privacy. Toilet facilities shall be located near the examining rooms. An area for displaying patient education materials shall be available.

b. Equipment necessary for pre or postnatal examinations shall be available in the clinic area.
c. An emergency cart with the necessary medications and equipment for maternal and infant resuscitation and an emergency delivery set shall be available in the clinic area.

2. Labor and Delivery Area – The labor and delivery area shall have, as a minimum:
a. An observation area available for patients who are not in active labor, but who are being observed for labor and a room available and equipped for patients requiring obstetrical intensive care.

b. One fetal monitor per five hundred deliveries per year or two fetal monitors for less than one thousand five hundred deliveries per year for continuous direct and indirect electronic fetal monitoring.
c. Equipment for continuous electronic cardiac monitoring.
d. EKG equipment with printout capability.
e. Intravenous solutions and infusion pumps.
f. Equipment for obtaining fetal scalp blood samples.
g. An emergency cart with the necessary medications and equipment for maternal and infant resuscitation and an emergency delivery set.
h. Each labor room shall have, as a minimum:
(I) A labor bed with adjustable side rails and a foot stool.
(II) A sphygmomanometer and stethoscopes, both regular and fetal.
(III) Oxygen and suction equipment.
i. Each delivery room shall have, as a minimum:
(I) A delivery table that will allow variation in position for delivery.
(II) A sphygmomanometer and stethoscopes, both regular and fetal.
(III) Equipment for inhalation and regional anesthesia, including equipment for emergency resuscitation.
(IV) Oxygen and suction for mother and infant.
(V) Instruments and equipment for normal or operative delivery.
(VI) Necessary medications for mother and infant.
(VII) Heated infant examination and resuscitation unit, including laryngoscopes, endotracheal tubes, drugs, and suction catheters, and the necessary equipment for the adequate identification of the infant.
(VIII) Wall clock with second hand.
3. OB Recovery Room
a. A separate recovery room shall be available for patients following deliver and shall be located in close proximity to the delivery room.
b. The recovery room shall have as a minimum:
(I) Oxygen and suction equipment at each patient station.
(II) Sphygmomanometers and stethoscopes.
(III) Emergency drugs and resuscitation equipment.
(IV) EKG equipment.
4. Antepartum and Postpartum Area
a. A separate bed area shall be available for undelivered patients who are designated as “high risk”.
b. The antepartum and postpartum unit shall have, as a minimum:
(I) Sphygmomanometers and stethoscopes.
(II) Fetoscopes or external fetal monitoring equipment.
(III) Sterile amniocentesis tray, available at all times.

(IV)Oxygen and suction at each patient station.
(V) I.V. solutions and supplies.
(VI)Emergency drugs and resuscitation equipment.
(VII)An emergency delivery set.
(c) Patient Eligibility.
1. Eligibility for RPICC Program sponsorship shall be limited to pregnant women residing in the State of Florida who meet both current CMS financial eligibility criteria and medical eligibility criteria.
2. Determination of medical eligibility of pregnant women for RPICC sponsorship shall be made by the RPICC director of obstetrics or CMS obstetrician consultant designee at the time of referral or following the initial examination at the center. The final medical decision for admission of a patient to a center shall be made by the director of obstetrics or CMS obstetrician consultant designee.
3. Demographic, medical, and fiscal data shall be collected on all RPICC Program patients, and entered into the RPICC data system.
4. The director of obstetrics or designee shall consider major maternal conditions which may significantly alter the usual management of pregnancy or of the newborn when determining medical eligibility for RPICC Program sponsorship. Major maternal conditions to be considered include, but are not limited to the following:
a. Severe pregnancy induced hypertension (BP 160/110) or eclampsia.
b. Isoimmune disease in a patient who has had a previously affected infant.
c. Labor or ruptured membranes at less than 34 weeks gestation or, anticipated severe neonatal infection.
d. Uterine bleeding or central placenta previa at less than 34 weeks gestation, requiring delivery or continued intensive hospitalization.
e. Diabetes mellitus, requiring insulin.
5. Only patients whose attending physician is a CMS consultant obstetrician in a center are eligible for RPICC Program funding.
6. A patient record on each RPICC Program pregnant woman shall be maintained by the center liaison and shall include patient eligibility information and patient demographic, medical, and fiscal data.
7. Termination of Program Eligibility.
a. Financial Eligibility.
(I) A patient’s financial status may be reviewed at any time following her acceptance into the RPICC Program.
(II) If a patient is determined financially ineligible for RPICC Program sponsorship, the patient’s enrollment in the program shall be terminated, only if referred elsewhere for medical care, as documented in the record.
b. Medical Eligibility.
(I) The obstetric director, or obstetrician designee, may terminate a patient’s sponsorship under the program if the condition for which the patient was admitted to the RPICC Program no longer exists, only if the patient is referred elsewhere for medical care, as documented in the record.
(II) The obstetrician or designee shall provide written notification to the patient and referring physician or clinic of the termination of RPICC Program sponsorship.
(d) Services.
1. Physician.

a. Patient management at designated centers shall include, but not be limited to, availability of the following tests:
(I) Amniocentesis.
(II) Ultrasound.
(III) Antepartum and intrapartum electronic fetal monitoring.
(IV) Intrauterine transfusion.
(V) Fetal scalp blood sampling.
b. Performance or interpretation of these tests shall be made by, or under the supervision of the CMS consultant obstetrician.
2. Nursing services shall include, but not be limited to:
a. Assessment of the patient's health status during the antepartum, intrapartum and postpartum periods of hospitalization.
b. Monitoring the patient's condition, oxytocin induction management and fetal monitoring interpretation.
c. Nursing management of complications occurring during antepartum, intrapartum, and postpartum periods of hospitalization.
d. Patient education, including but not limited to, dietary and family planning counseling, postpartum instruction and infant care.
e. In addition to other routine functions, the nurse shall have knowledge and skills in:
(I) Initiation of fluid replacement by I.V. catheter or needle and management of intravenous infusions, including medications.
(II) Managing blood transfusions.
(III) Administering oxygen.
(IV) Performing external cardiac massage.
(V) Maintaining respiration and patent airway.
(VI) Management of spontaneous delivery and third stage of labor.
(VII) Newborn resuscitation.
3. Twenty-four hour anesthesia services.
4. Capability for performing cesarean sections in the delivery room, within 15 minutes.
5. Capability for obtaining intra-arterial blood pressure.
6. Ancillary health services to include:
a. Twenty-four hour blood bank services.
b. Twenty-four hour routinely available X-ray services, with capability for performing diagnostic ultrasound examinations capable of determining placental position and fetal cephalometry, if this service is not provided by the obstetric department.
c. Twenty-four hour laboratory services, with capabilities for performing amniotic fluid analysis, including studies of fetal maturity and fetal well-being; and bio-chemical tests of fetal placental well-being, such as either estriol or human placental lactogen measurements.
d. Twenty-four hour respiratory therapy services to include twenty-four hour blood gas determination with capability for microcapillary technique for scalp blood pH determination.
e. Nutrition Services – Each center shall have a dietician or nutritionist to provide information on patient dietary needs relating to pregnancy and fetal nutrition and information on infant nutritional needs.
f. Social Services – Each center shall make available the services of the hospital's social services department to patients and their families which shall

include, but are not limited to, patient and family counseling and referral to appropriate agencies for services. Each designated center liaison shall refer all eligible women to the Medicaid Program for consideration of funding.

g. Psychological Services – Each center shall provide for or arrange for access to psychological services to patients and their families which include, but are not limited to patient or family counseling and referral to appropriate mental health agencies for services.
h. Prenatal classes – Each center shall provide for or arrange for access to prenatal classes for patients, as recommended by the CMS consultant obstetrician.

Specific Authority 383.19 FS. Law Implemented 383.19 FS. History–New 9-1-81, Amended 8-25-85, Formerly 10J-7.03, Amended 6-13-87, 5-15-96, Formerly 10J-7.003.

11.3 59C-1.042 F.A.C.

Neonatal Intensive Care Services.

(1) Agency Intent. This rule implements the provisions of subsections 408.032(20), 408.034(3), 408.034(4), and paragraphs 408.036(1)(a), (d) and (g), F.S. In addition, Section 408.036(1)(k), specifically requires the agency to regulate the establishment of tertiary health services, which include neonatal intensive care services, under the certificate of need program. It is the intent of the agency to regulate the establishment of Level II and Level III neonatal intensive care services as defined in this rule. This rule defines the minimum requirements for personnel, equipment, and support services for the two levels of neonatal intensive care services as defined in this rule. In addition, this rule includes need methodologies for determining the need for additional neonatal intensive care unit beds for each level of care. A separate inventory for each level of neonatal intensive care unit beds shall be established by the agency. It is the intent of the agency to regulate the establishment of neonatal intensive care services which include ventilation to preterm and severely ill neonates.

(2) Definitions.

(a) “Approved Neonatal Intensive Care Bed.” A proposed Level II bed or Level III bed for which a certificate of need, a letter of intent to grant a certificate of need, a signed stipulated agreement, or a final order granting a certificate of need was issued, consistent with the provisions of paragraph 59C-1.008(2)(b), F.A.C., as of the most recent published deadline for agency initial decisions prior to publication of the fixed need pool, as specified in paragraph 59C-1.008(1)(g), F.A.C.

(b) “Complex Neonatal Surgery.” Any surgical procedure performed upon a neonate by a surgically-credentialled practitioner licensed under the provisions of Chapter 458 or 459, F.S., which is associated with entry into or traversing a body cavity, such as the abdomen, thorax, or cranium, with a requirement for either general anesthesia or conscious sedation. Such procedures shall be performed only in hospitals licensed under the provisions of Chapter 395, F.S., which are also authorized to provide Level III neonatal services under the provisions of Rules 59A-3.200 to 59A-3.231, F.A.C.

(c) “Department.” The Agency for Health Care Administration.

(d) “District.” A district of the agency as defined in Section 408.032(5), F.S.

(e) “Fixed Bed Need Pool.” The fixed bed need pool defined in subsection 59C-1.002(20), F.A.C.

(f) “Local Health Councils.” The councils referenced in Section 408.033, F.S.

(g) “Neonatal Care Services.” The aspect of perinatal medicine pertaining to the care of neonates. Hospital units providing neonatal care are classified according to the intensity and specialization of the care which can be provided. The agency distinguishes three levels of neonatal care services:

1. “Level I Neonatal Services.” Well-baby care services which include sub-ventilation care, intravenous feedings, and gavage to neonates are defined as Level I neonatal services. Level I neonatal services do not include ventilator assistance except for resuscitation and stabilization. Upon beginning ventilation, the hospital shall implement a patient treatment plan which shall include the transfer of the neonate to a Level II or Level III neonatal intensive care service at such time that it becomes apparent that ventilation assistance will be required beyond the neonate’s resuscitation and stabilization. The hospital shall establish a triage procedure to assess the need for transfer of obstetrical patients to facilities with Level II or Level III neonatal intensive care services prior to their delivery where there is an obstetrical indication that resuscitation will be required for their neonates. Facilities with Level I neonatal services may only perform Level I neonatal services.

2. “Level II Neonatal Intensive Care Services.” Services which include the provision of ventilator services, and at least 6 hours of nursing care per day, shall be defined as Level II neonatal intensive care services. Level II services shall be restricted to neonates of 1000 grams birth weight and over with the following exception. Ventilation may be provided in a facility with Level II neonatal intensive care services for neonates of less than 1,000 grams birth weight only while waiting to transport the baby to a facility with Level III neonatal intensive care services. All neonates of 1,000 grams birth weight or less shall be transferred to a facility with Level III neonatal intensive care services. Neonates weighing more than 1,000 grams requiring one or more of the Level III services, as defined by this rule, shall also be transferred to a facility with Level III neonatal intensive care services. If a facility with a Level III neonatal intensive care service refuses to accept the transfer patient, the facility with the Level II neonatal intensive care service will be found in compliance with this subparagraph upon a showing of continuous good faith effort to transfer the patient as documented in the patient’s medical record. Facilities with Level II neonatal intensive care services may perform only Level I neonatal services and Level II neonatal intensive care services as defined by this rule.

3. “Level III Neonatal Intensive Care Services.” Services which include the provision of continuous cardiopulmonary support services, 12 or more hours of nursing care per day, complex neonatal surgery, neonatal cardiovascular surgery, pediatric neurology and neurosurgery, and pediatric cardiac catheterization, shall be classified as Level III neonatal intensive care services. These services cannot be performed in a facility with Level II neonatal intensive care services only. Facilities with Level III neonatal intensive care services may perform all neonatal care services. A facility with a Level III neonatal intensive care service that does not provide treatment of complex major congenital anomalies that require the services of a pediatric surgeon, or pediatric cardiac catheterization and cardiovascular surgery shall enter into a written agreement with a facility providing Level III neonatal intensive care services in the same or nearest service area for the provision of these services. All other services shall be provided at each facility with Level III neonatal intensive care services. The provision of pediatric cardiac catheterization or pediatric open heart surgery each requires a separate certificate of need.

(h) “Neonatal Intensive Care Unit Bed.” A patient care station within a Level II neonatal intensive care unit or Level III neonatal intensive care unit that includes, at a minimum, an incubator or other moveable or stationary devices which support the ill neonate. Beds in Level II or Level III neonatal intensive care units shall be separately listed in a hospital’s licensed bed inventory.

1. “Level II Bed.” A patient care station within a neonatal intensive care unit with the capability of providing neonatal intensive care services to ill neonates of 1,000 grams birth weight or over, and which is staffed to provide at least 6 hours of nursing care per neonate per day, and which has the capability of providing ventilator assistance, and the services as defined in subparagraph (2)(e)2. of this rule.

2. “Level III Bed.” A patient care station within a neonatal intensive care unit with the capability of providing neonatal intensive care services to severely ill neonates regardless of birth weight, and which is staffed to provide 12 or more hours of nursing care per neonate per day, and the services as defined in subparagraph (2)(e)3. of this rule.

(i) “Neonatologist.” A physician who is certified, or is eligible for certification, by an appropriate board in the area of neonatal-perinatal medicine.

(j) “Planning Horizon.” The planning horizon for applications submitted between January 1 and June 30 of each year shall be July 2 years into the future subsequent to the application submission deadline; the planning horizon for applications submitted between July 1 and December 31 of each year shall be January 2 years into the future subsequent to the

application deadline.

(k) “Regional Perinatal Intensive Care Center Program (RPICC).” The program authorized by Section 383.17, F.S.

(l) “Specialty Beds.” Specialty beds include comprehensive medical rehabilitation beds, psychiatric beds, substance abuse beds, as specified in subsection 59C-1.002(1), F.A.C, and neonatal intensive care services beds as specified by this rule.

(m) “Specialty Children’s Hospitals.” The hospitals referenced in Rule 59G-6.020, F.A.C., without maternity units in the same facility.

(n) “Step-Down Neonatal Special Care Unit.” The step-down neonatal special care units affiliated with the Regional Perinatal Intensive Care Center Program as referenced in Rule 10J-7.004, F.A.C.

(3) Need Determination.

(a) Applications for proposed Level II or Level III neonatal intensive care services shall be reviewed competitively within each district in accordance with the applicable review criteria in Section 408.035, F.S., and the standards and need determination criteria set forth in this rule. Hospitals proposing to provide both Level II and Level III neonatal intensive care services shall require separate certificate of need approval for each level of care. A favorable need determination for Level II or Level III beds will not normally be made unless a numeric bed need exists according to the need methodology specified in paragraphs (c) and (e) of this subsection.

(b) The future need for Level II and Level III neonatal intensive care services shall be determined twice a year and published as a fixed bed need pool by the agency for the respective planning horizon.

(c) Level II Bed Need. The net bed need for Level II neonatal intensive care unit beds shall be calculated as follows:

NN2 = ((PD2 × PB/AB)/(365 × .80)) – LB2 – AB2

where:

1. NN2 equals the net need for Level II beds in a district.

2. PD2 equals the number of patient days in Level II beds in a district for the most recent 12-month period ending 6 months prior to the beginning date of the quarter of the publication of the fixed bed need pool.

3. AB is the total number of resident live births in a district for the most recent calendar year available from the Department of HRS’ Office of Vital Statistics at least 3 months prior to the beginning date of the quarter of the publication of the fixed bed need pool.

4. PB is the projected number of resident live births for the applicable planning horizon. To determine the number of births projected for each district, a 3-year average resident live-birth rate for each district shall be calculated using the sum of the resident live births for the 3 most recent calendar years available from the Department of HRS’ Office of Vital Statistics at least 3 months prior to the beginning date of the quarter of the publication of the fixed bed need pool. The projected number of resident live births in each district shall be determined by multiplying the 3-year average resident live birth rate by the district’s estimated population of females aged 15 to 44 for the applicable planning horizon. The population estimate used to compute the 3-year average resident live birth rate shall be the sum of the July 1 estimates of the population of females aged 15 to 44 for the 3 years that are included in the 3-year total of resident livebirths. Population estimates for each year shall be the most recent population estimates published by the Office of the Governor at least 3 months prior to publication of the fixed bed need pool.

5. (.80) equals the desired district average occupancy standard of 80 percent.

6. LB2 equals the number of licensed Level II beds as of the most recent published deadline for agency initial decisions prior to the publication of the fixed bed need pool.

7. AB2 equals the number of approved Level II beds, as determined consistent with the

provisions of paragraph (2)(a) of this rule.

(d) Regardless of whether bed need is shown under the need formula above, the establishment of new Level II neonatal intensive care unit beds within a district shall not normally be approved unless the average occupancy rate for Level II beds in the district equals or exceeds 80 percent for the most recent 12-month period ending 6 months prior to the beginning date of the quarter of the publication of the fixed bed need pool.

(e) Level III Bed Need. The net bed need for Level III neonatal intensive care unit beds shall be calculated as follows:

NN3 = ((PD3 × PB/AB) / (365 × .80)) – LB3 – AB3

where:

1. NN3 equals the net need for Level III beds in a district.

2. PD3 equals the number of patient days in Level III beds in a district for the most recent 12-month period ending 6 months prior to the beginning date of the quarter of the publication of the fixed bed need pool.

3. AB is the total number of resident live births in a district for the most recent calendar year available from the Department of HRS' Office of Vital Statistics at least 3 months prior to the beginning date of the quarter of the publication of the fixed bed need pool.

4. PB is the projected number of resident live births for the applicable planning horizon. To determine the number of births projected for each district, a 3-year average resident live-birth rate for each district shall be calculated using the sum of the resident live births for the 3 most recent calendar years available from the Department of HRS' Office of Vital Statistics at least 3 months prior to the beginning date of the quarter of the publication of the fixed bed need pool. The projected number of resident live births in each district shall be determined by multiplying the 3-year average resident live birth rate by the district's estimated population of females aged 15 to 44 for the applicable planning horizon. The population estimate used to compute the 3 year average resident live birth rate shall be the sum of the July 1 estimates of the population of females aged 15 to 44 for the 3 years that are included in the 3-year total of resident live births. Population estimates for each year shall be the most recent population estimates published by the Office of the Governor at least 3 months prior to publication of the fixed bed need pool.

5. (.80) equals the desired district average occupancy standard of 80 percent.

6. LB3 equals the number of licensed Level III beds as of the most recent published deadline for agency initial decisions prior to the publication of the fixed bed need pool.

7. AB3 equals the number of approved Level III beds, as determined consistent with the provisions of paragraph (2)(a) of this rule.

(f) Regardless of whether bed need is shown under the need formula above, the establishment of new Level III neonatal intensive care unit beds within a district shall not normally be approved unless the average occupancy rate for Level III beds in the district equals or exceeds 80 percent for the most recent 12-month period ending 6 months prior to the beginning date of the quarter of the publication of the fixed bed need pool.

(g) Special Circumstances for the Approval of Additional Neonatal Intensive Care Unit Beds at Existing Providers. Need for additional Level II neonatal intensive care beds at hospitals with Level II neonatal intensive care services seeking additional Level II beds is demonstrated in the absence of need shown under the formula specified in paragraph (3)(c) of this rule if the occupancy rate for their Level II beds exceeded an average of 90 percent as computed by the agency for the same time period specified in subparagraph (3)(c)2. Need for additional Level III neonatal intensive care beds at hospitals with Level III neonatal intensive care services seeking additional Level III beds is demonstrated in the absence of need shown under the formula specified in paragraph (3)(e) of this rule if occupancy rate for their Level III beds exceeded an average of 90 percent as computed by the agency for the same time period specified in

subparagraph (3)(e)2.

(h) Consistency With Local Health Council and State Health Plans. Applicants shall provide evidence in their applications that the number of proposed Level II or Level III neonatal intensive care unit beds is consistent with the needs of the community as stated in Local Health Council Plans and the State Health Plan.

(i) Regional Perinatal Intensive Care Centers and Step-Down Neonatal Special Care Units. Hospitals which are under contract with the Department of HRS' Children's Medical Services Program for the provision of regional perinatal intensive care center or step-down neonatal special care unit care will be given priority over other applicants to expand or establish new neonatal intensive care services when a need is indicated for additional Level II or Level III neonatal intensive care unit beds.

(j) Conversion of Under-utilized Acute Care Beds. New Level II or Level III neonatal intensive care unit beds shall normally be approved only if the applicant converts a number of acute care beds as defined in Rule 59C-1.038, F.A.C., excluding specialty beds, which is equal to the number of Level II or Level III beds proposed, unless the applicant can reasonably project an occupancy rate of 75 percent for the applicable planning horizon, based on historical utilization patterns, for all acute care beds, excluding specialty beds. If the conversion of the number of acute care beds which equals the number of proposed Level II or Level III beds would result in an acute care occupancy exceeding 75 percent for the applicable planning horizon, the applicant shall only be required to convert the number of beds necessary to achieve a projected 75 percent acute care occupancy for the applicable planning horizon, excluding specialty beds.

(k) Services to Medically Indigent and Medicaid Patients. In a comparative review, preference shall be given to hospitals which propose to provide neonatal intensive care services to Children's Medical Services patients, Medicaid patients, and non-Children's Medical Services patients who are defined as charity care patients according to the Health Care Board, Florida Hospital Uniform Reporting System Manual, Chapter III, Section 3223. The applicant shall estimate, based on its historical patient data by type of payer, the percentage of neonatal intensive care services patient days that will be allocated to:

1. Charity Care Patients;

2. Medicaid patients;

3. Private pay patients, including self pay; and

4. Regional Perinatal Intensive Care Center Program and Step Down Neonatal Special Care Unit patients.

(4) Level II and Level III Service Continuity. To help assure the continuity of services provided to neonatal intensive care services patients:

(a) The establishment of Level III neonatal intensive care services shall not normally be approved unless the hospital also provides Level II neonatal intensive care services. Hospitals may be approved for Level II neonatal intensive care services without providing Level III services. In a comparative review, preference for the approval of Level II beds shall be given to hospitals which have both Level II neonatal intensive care unit beds and Level III neonatal intensive care unit beds.

(b) Applicants proposing to provide Level II or Level III neonatal intensive care services shall ensure developmental follow-up on patients after discharge to monitor the outcome of care and assure necessary referrals to community resources.

(5) Minimum Unit Size. Hospitals proposing the establishment of new Level III neonatal intensive care services shall propose a Level III neonatal intensive care unit of at least 15 beds, and should have 15 or more Level II neonatal intensive care unit beds. A provider shall not normally be approved for Level III neonatal intensive care services only. Hospitals proposing the

establishment of new Level II neonatal intensive care services only shall propose a Level II neonatal intensive care unit with a minimum of 10 beds. Hospitals under contract with the Department of HRS' Children's Medical Services Program for the provision of regional perinatal intensive care center or step-down neonatal special care unit care are exempt from these requirements.

(6) Minimum Birth Volume Requirement. A hospital shall not normally be approved for Level III neonatal intensive care services unless the hospital had a minimum service volume of 1,500 live births for the most recent 12-month period ending 6 months prior to the beginning date of the quarter of the publication of the fixed bed need pool. Hospitals applying for Level II neonatal intensive care services shall not normally be approved unless the hospital had a minimum service volume of 1,000 live births for the most recent 12-month period ending 6 months prior to the beginning date of the quarter of the publication of the fixed bed need pool. Specialty children's hospitals are exempt from these requirements.

(7) Geographic Access. Level II and Level III neonatal intensive care services shall be available within 2 hours ground travel time under normal traffic conditions for 90 percent of the population in a service district.

(8) Quality of Care Standards for Level II and Level III Neonatal Intensive Care Services.

(a) Physician Staffing.

1. Level II neonatal intensive care services shall be directed by a neonatologist or a group of neonatologists who are on active staff of the hospital with unlimited privileges and provide 24-hour coverage, and who are either board certified or board eligible in neonatal-perinatal medicine.

2. Level III neonatal intensive care services shall be directed by a neonatologist or a group of neonatologists who are on active staff of the hospital with unlimited privileges and provide 24 hours coverage, and who are either board certified or board eligible in neonatal-perinatal medicine. In addition, facilities with Level III neonatal intensive care services shall be required to maintain a maternal fetal medical specialist on active staff of the hospital with unlimited staff privileges. A maternal fetal specialist is defined as a board-certified obstetrician who is qualified by training, experience, or special competence certification in maternal-fetal medicine. Specialty children's hospitals are exempt from this provision.

(b) Nursing Staff. The nursing staff in Level II and Level III neonatal intensive care units shall be under the supervision of a head nurse with experience and training in neonatal intensive care nursing. The head nurse shall be a registered professional nurse. At least one-half of the nursing personnel assigned to each work shift in Level II and Level III neonatal intensive care units must be registered nurses.

(c) Special Skills of Nursing Staff. Nurses in Level II and Level III neonatal intensive care units shall be trained to administer cardio-respiratory monitoring, assist in ventilation, administer I.V. fluids, provide pre-operative and post-operative care of newborns requiring surgery, manage neonates being transported, and provide emergency treatment of conditions such as apnea, seizures, and respiratory distress.

(d) Respiratory Therapy Technician Staffing. At least one certified respiratory care practitioner therapist with expertise in the care of neonates shall be available in hospitals with Level II or Level III neonatal intensive care services at all times. There shall be at least one respiratory therapist technician for every four infants receiving assisted ventilation.

(e) Blood Gas Determination. Blood gas determination shall be available and accessible on a 24-hour basis in all hospitals with Level II or Level III neonatal intensive care services.

(f) Ancillary Service Requirements. Hospitals providing Level II or Level III neonatal intensive care services shall provide on-site, on a 24-hour basis, x-ray, obstetric ultrasound, and clinical laboratory services. Anesthesia shall be available on an on-call basis within 30 minutes. Clinical

laboratory services shall have the capability to perform microstudies.

(g) Nutrition Services. Each hospital with Level II or Level III neonatal intensive care services shall have a dietician or nutritionist to provide information on patient dietary needs while in the hospital and to provide the patient's family instruction or counseling regarding the appropriate nutritional and dietary needs of the patient after discharge.

(h) Social Services. Each hospital with Level II or Level III neonatal intensive care services shall make available the services of the hospital's social services department to patients' families which shall include, but not be limited to, family counseling and referral to appropriate agencies for services. Children potentially eligible for the Medicaid, Children's Medical Services, or Developmental Services Programs shall be referred to the appropriate eligibility worker for eligibility determination.

(i) Developmental Disabilities Intervention Services. Each hospital that provides Level II or III neonatal intensive care services shall provide in-hospital intervention services for infants identified as being at high risk for developmental disabilities to include developmental assessment, intervention, and parental support and education.

(j) Discharge Planning. Each hospital that provides Level II or Level III neonatal intensive care services shall have an interdisciplinary staff responsible for discharge planning. Each hospital shall designate a person responsible for discharge planning.

(9) Level II Neonatal Intensive Care Unit Standards. The following standards shall apply to Level II neonatal intensive care services:

(a) Nurse to Neonate Staffing Ratio. Hospitals shall have a nurse to neonate ratio of at least 1:4 in Level II neonatal intensive care units at all times. At least 50 percent of the nurses shall be registered nurses.

(b) Requirements for Level II Neonatal Intensive Care Unit Patient Stations. Each patient station in a Level II neonatal intensive care unit shall have, at a minimum:

1. Fifty square feet per infant;

2. Two wall mounted suction outlets preferably equipped with a unit alarm to signal loss of vacuum;

3. Eight electrical outlets;

4. Two oxygen outlets and an equal number of compressed air outlets and adequate provisions for mixing these gases;

5. An incubator or radiant warmer;

6. One heated humidifier and oxyhood;

7. One respiration or heart rate monitor;

8. One resuscitation bag and mask;

9. One infusion pump;

10. At least one oxygen analyzer for every three beds;

11. At least one non-invasive blood pressure monitoring device for every three beds;

12. At least one portable suction device; and

13. Not less than one ventilator for every three beds.

(c) Equipment Required to be Available to Each Level II Neonatal Intensive Care Unit. Each Level II neonatal intensive care unit shall have available to the unit on demand:

1. An EKG machine with print-out capability;

2. Transcutaneous oxygen monitoring equipment; and

3. Availability of continuous blood pressure measurement.

(10) Level III Neonatal Intensive Care Unit Standards. The following standards shall apply to Level III neonatal intensive care services:

(a) Pediatric Cardiologist. A facility providing Level III neonatal intensive care services shall have a pediatric cardiologist, who is either board certified or board eligible in pediatric

cardiology, available for consultation at all times.

(b) Nurse to Neonate Staffing Ratio. Hospitals shall have a nurse to neonate ratio of at least 1:2 in Level III neonatal intensive care units at all times. At least 50 percent of the nurses shall be registered nurses.

(c) Requirements for Level III Neonatal Intensive Care Unit Patient Stations. Each patient station in a Level III neonatal intensive care unit shall have, at a minimum:

1. Eighty square feet per infant;

2. Two wall mounted suction outlets preferably equipped with an alarm to signal loss of vacuum;

3. Twelve electrical outlets;

4. Two oxygen outlets and an equal number of compressed air outlets with adequate provision for mixing these gases;

5. An incubator and radiant warmer;

6. One heated humidifier and oxyhood;

7. One respiration or heart rate monitor;

8. One resuscitation bag and mask;

9. One infusion pump;

10. At least one non-invasive blood pressure monitoring device for every three beds;

11. At least one portable suction device; and

12. Availability of devices capable of measuring continuous arterial oxygenation in the patient.

(d) Equipment Required in Each Level III Neonatal Intensive Care Unit. Each Level III neonatal intensive care unit shall be equipped with:

1. An EKG machine with print-out capability;

2. Portable suction equipment; and

3. Not less than one ventilator for every three beds.

(11) Emergency Transportation Services. Each hospital providing Level II neonatal intensive care services or Level III neonatal intensive care services shall have or participate in an emergency 24-hour patient transportation system.

(a) Provision of Emergency Transportation. Hospitals providing Level II or Level III neonatal intensive care services must operate a 24-hour emergency transportation system directly, or contract for this service, or participate through a written financial or non-financial agreement with a provider of emergency transportation services.

(b) Requirements for Emergency Transportation System. Emergency transportation systems, as defined in paragraph (11)(a), shall conform to Rule 10D-66.052, F.A.C.

(12) Transfer Agreements. A hospital providing only Level II neonatal intensive care services shall provide documentation of a transfer agreement with a facility providing Level III neonatal intensive care services in the same or nearest service district for patients in need of Level III services. Facilities providing Level III neonatal intensive care services shall not unreasonably withhold consent to transfer agreements which provide for transfers based upon availability of service in the Level III facility, and which will be applied uniformly to all patients requiring transfer to Level III, as defined in subparagraph 2(e)2. An applicant for Level II or Level III neonatal intensive care services shall include, as part of the application, a written protocol governing the transfer of neonatal intensive care services patients to other inpatient facilities.

(13) Data Reporting Requirements. All hospitals with Level II or Level III neonatal intensive care services shall provide the agency or its designee with patient utilization and fiscal reports which contain data relating to patient utilization of Level II and Level III neonatal intensive care services. The following data shall be provided to the agency or its designee.

(a) Utilization Data. Level II or Level III neonatal intensive care services providers shall

report the number of admissions and patient days by type of payer for Level II and Level III neonatal intensive care services. Payer types shall include Medicaid, Regional Perinatal Intensive Care Center Program, Insurance, Self-Pay, and Charity Care as defined by the Health Care Board, Florida Hospital Uniform Reporting Manual, Chapter III, Section 3223. These data shall be reported to the agency or its designee within 45 days after the end of each calendar quarter.

(b) Patient Origin Data. Level II or Level III neonatal intensive care services providers shall report patient origin data for Level II and Level III neonatal intensive care services patients. The mother's county of residence shall be reported for patients born in the hospital and also for patients who were transferred to the hospital from other hospitals. These data shall be reported to the agency or its designee within 45 days after the end of each calendar quarter.

(14) Providers Authorized by the Agency to Operate Level II and Level III Neonatal Intensive Care Services. Providers shall be authorized by the agency to implement, or to continue to operate Level II or Level III neonatal intensive care services if they are found to be in compliance with the conditions specified in paragraphs (14)(a), (14)(b), or (14)(f) below.

(a) Providers Holding a Valid Certificate of Need or Providers with Approved Construction Documents. Providers which have obtained a certificate of need for provision of services regulated under this rule or providers with construction documents approved by the Department of Health and Rehabilitative Services prior to October 1, 1987 which show neonatal intensive care beds shall be restricted to the total number of neonatal intensive care unit beds by level of care for which certificate of need or construction document approval was granted unless the provisions of paragraph (14)(d) authorize a greater number. The authorization in this paragraph based on construction document approval shall not apply to a provider who initiated and subsequently terminated neonatal intensive care services prior to October 1, 1987.

(b) Providers With Licensed Acute Care Beds Which Include Level II or Level III Neonatal Intensive Care Unit Beds. Facilities providing Level II or Level III neonatal intensive care services prior to October 1, 1987 and continuously since then under the direction of a neonatologist or a group of neonatologists, as described in subparagraph (14)(f)1. and (14)(f)2. below, shall be limited to the total number of neonatal intensive care unit beds accepted by the agency in its approval of the most recent application for a license, unless the provisions of paragraph (14)(d) authorize a greater number.

(c) Number of Neonatal Intensive Care Unit Beds on October 1, 1988. In establishing the number of Level II or Level III neonatal intensive care unit beds to be authorized for a facility, the agency will determine the number of beds by level of care on October 1, 1988 based on the following calculation:

$$\mathbf{PD = \text{Number of Beds by Level of Care}}$$
$$\mathbf{365 \times .80}$$

where:

1. PD equals the number of Level II or Level III neonatal intensive care services patient days at the facility for the period October 1, 1987 through September 30, 1988.

2. .80 equals the desired occupancy standard.

(d) Authorized Number of Neonatal Intensive Care Unit Beds. The number of neonatal intensive care unit beds authorized by level of care for the facilities meeting the requirement of paragraphs (14)(a) or (14)(b) will be the largest of the three numbers identified in paragraphs (14)(a), (14)(b), or (14)(c), except that:

1. In all cases the number of beds authorized for Level II or Level III neonatal intensive care services will be at least five; and

2. In no case will a facility's combined number of authorized Level II and Level III neonatal intensive care unit beds be greater than the largest of the combined totals of Level II and Level

III neonatal intensive care unit beds identified in paragraphs (14)(a), (14)(b) and (14)(c). The allocation of the combined total to the separate levels of neonatal intensive care at a facility will be the same as the allocation in paragraphs (14)(a), (14)(b) or (14)(c), whichever is the basis for the total authorized. Provided, however, that an authorized combined total based on an application for licensure which identified all neonatal intensive care unit beds as one level of care will be allocated in the same proportions as the number of beds calculated by the formula in paragraph (14)(c).

(e) Existing Providers Which were in Operation prior to October 1, 1987. Providers claiming to have operated Level II or Level III neonatal intensive care services, as defined under this rule, continuously since October 1, 1987, shall submit the following documentation to the agency, which shall be subject to verification by the agency:

1. The number of Level II and Level III neonatal intensive care unit beds as of September 30, 1987.

2. The number of Level II and Level III neonatal intensive care services admissions and total patient days for the period October 1, 1986 through September 30, 1987.

3. Staffing and equipment for each level of care for the period October 1, 1986 through September 30, 1987.

4. Proof that the hospital prior to October 1, 1987 and continuously since October 1, 1987 has provided Level II or Level III neonatal intensive care services, as defined by this rule, and that the services have been directed by a board certified or board eligible neonatologist or group of neonatologists, consistent with the provisions of paragraph (8)(a).

5. Medicaid and Charity Care Patient Days for the period October 1, 1986 through September 30, 1987.

6. Number of Level II and Level III neonatal intensive care services admissions by DRG and ICD codes.

7. Number of admissions to Level II and Level III neonatal intensive care services of less than 1,000 grams birth-weight and equal to or greater than 1,000 grams birth-weight for the period October 1, 1986 through September 30, 1987.

8. Number of Level II and Level III neonatal intensive care services patients transferred to Level II or Level III beds at other facilities providing neonatal intensive care services, for the period October 1, 1986 through September 30, 1987.

9. Number of Level II and Level III neonatal intensive care services patient days by level of care for the period October 1, 1987 through September 30, 1988.

(f) Providers Not Authorized Under Certificate of Need, Construction Document Approval, or Licensure Provisions. Providers claiming to have provided Level II or Level III neonatal intensive care services prior to October 1, 1987 and continuously since then, but which were not authorized by certificate of need or construction document approval consistent with paragraph (14)(a) or by license consistent with paragraph (14)(b), will be authorized to provide Level II or Level III neonatal intensive care services provided the conditions of subparagraphs (14)(f)1. or (14)(f)2., below, are met.

1. A provider will be deemed to have had operational Level II neonatal intensive care services prior to October 1, 1987 if Level II neonatal intensive care services were being provided on or before September 30, 1987 under the direction of a neonatologist or a group of neonatologists who were on the active staff of the hospital with unlimited privileges and provided 24-hour coverage, and who were either board certified or board eligible in neonatal-perinatal medicine.

2. A provider will be deemed to have had operational Level III neonatal intensive care services prior to October 1, 1987 if:

a. Level III neonatal intensive care services were being provided on or before September

30, 1987 under the direction of a neonatologist or a group of neonatologists who were on the active staff of the hospital with unlimited privileges and provided 24-hour coverage, and who were either board certified or board eligible in neonatal-perinatal medicine; and

b. The provider submits documentation that for the period October 1, 1986 through September 30, 1987 at least one of the following was true:

(I) The average length of stay for all neonatal intensive care services patients, regardless of reported Level II or III status, was at least 10 days; or

(II) At least 5 percent of all neonates admitted to neonatal intensive care services, regardless of reported Level II or Level III status, weighed less than 1000 grams at birth; or

(III) At least 50 percent of all neonates admitted to neonatal intensive care services, regardless of reported Level II or Level III status, were classified into Diagnosis Related Groups (DRGs) 385, 386, 387 or 388.

(g) Neonatal Intensive Care Unit Beds Authorized for Providers Not Having Previous Approval. For providers deemed to have been providing Level II or Level III neonatal intensive care services consistent with the provisions of paragraph (14)(f) above, the number of authorized Level II or Level III neonatal intensive care unit beds on October 1, 1988 will be determined consistent with the formula in paragraph (14)(c) above, except that in all cases the number of beds authorized for Level II neonatal intensive care services or Level III neonatal intensive care services will be at least five.

(h) Licensing of Authorized Neonatal Intensive Care Unit Beds. The number of neonatal intensive care unit beds authorized by this subsection shall be included in the facility's acute care bed complement and shall not increase the total number of licensed hospital beds.

(i) Time Limit for Compliance With the Provisions of this Rule. Facilities authorized to provide Level II or Level III neonatal intensive care services under the provisions of this subsection shall have 1 year subsequent to the effective date of this rule to come in compliance with the provisions specified in subsections (8), (9), (10), (11) and (12).

(15) Inventorying Process of Level II and Level III Neonatal Intensive Care Services. The agency shall notify all hospitals providing obstetrical services and specialty children's hospitals by mail and through publication in the Florida Administrative Weekly of its intent to file this rule. Providers claiming to operate neonatal intensive care services as defined by this rule shall provide the agency with documentation as specified in paragraph (14)(e), within 45 days of the publication of this rule in the Florida Administrative Weekly. The agency shall publish a preliminary inventory in the Florida Administrative Weekly of all facilities with authorized neonatal intensive care services based on the provisions of paragraphs (14)(a) through (14)(g). Providers shall have 21 days after the initial publication of the inventory to contest the inventory. Subsequent to the resolution of any issues pertaining to the authorization to provide neonatal intensive care services the agency shall publish a final inventory. Hospitals without authorization shall not provide Level II or Level III neonatal intensive care services.

(16) Providers Required to Apply for a Certificate of Need. Providers who did not have authorized Level II or Level III neonatal intensive care services as of September 30, 1987 and continuously-operated Level II or Level III neonatal intensive care services since October 1, 1987 as determined by the agency under this rule shall be subject to certificate of need review.

Specific Authority 408.034(3), (5), 408.039(4)(a), 408.15(8) FS. Law Implemented 408.034(3), 408.035, 408.036(1)(a), (c), (e), (m), 408.039(4)(a) FS. History–New 1-1-77, Amended 11-1-77, 6-5-79, 4-24-80, 2-1-81, 4-1-82, 11-9-82, 2-14-83, 4-7-83, 6-9-83, 6-10-83, 12-12-83, 3-5-84, 5-14-84, 7-16-84, 8-30-84, 10-15-84, 12-25-84, 4-9-85, Formerly 10-5.11, Amended 6-19-86, 11-24-86, 1-25-87, 3-2-87, 3-12-87, 8-11-87, 8-7-88, 8-28-88, 9-12-88, 4-19-89, 10-19-89, 5-30-90, 7-11-90, 8-6-90, 10-10-90, 12-23-90, Formerly 10-5.011(1)(v), 10-5.042, Amended 1-4-93, 8-24-93, 2-22-95, 4-10-96.

12. APPENDIX F – RPICC Transportation Standards

Standards for RPICC Program: Transportation Services

August 2010

1. General

a. Emergency Medical Services (EMS) providing transport to Medicaid Eligible patients shall be Medicaid providers to assure maximum utilization of financial resources.

b. Each RPICC shall follow the protocols for authorization for payment of transportation services for Medicaid eligible patients.

c. Patients shall be transported to a RPICC upon request of a referring physician and hospital based on consultation and approval by a CMS RPICC consultant neonatologist or CMS RPICC consultant obstetrician to a designated RPICC subject to bed availability. Place of residence in Florida or ability to pay shall not be used to determine eligibility for transport.

2. Authority

a. Transport services for the RPICC Program authorized under Section 383.19, F.S. and 59C-1.042 F.A.C. Neonatal Transport, shall be provided by qualified personnel in a licensed vehicle which is operated by a licensed Emergency Medical Services (EMS) provider in accordance with section 401, F.S., and Chapter 64J-1, F.A.C. and

b. Transport providers shall follow licensure, equipment, and staffing requirements in accordance with Chapter 64J-1, F.A.C.

3. Personnel

a. Each RPICC shall designate appropriate medical, nursing, and respiratory therapy staff to provide neonatal and obstetrical transportation services.

b. Each RPICC shall designate a liaison to provide coordination of transport services between the RPICC, the referring hospital, and EMS providers. This person will maintain records and information on patient transport services.

c. Each RPICC shall designate appropriate medical, nursing, and respiratory therapy staff to provide continuing education programs for RPICC transport staff.

d. The Neonatal/Obstetrical Medical Director of the RPICC transport program shall be a CMS approved consultant, as defined in Chapter 64C-6.001, F.A.C.

4. Standards for Neonatal Transport Component

a. Neonatal Personnel

1) Registered Nurses (RN) shall be licensed in Florida in accordance with section 464, F.S., has a minimum of 4,000 hours of RN experience, which includes 2,000 hours of Level II or Level III Neonatal Intensive Care Unit

(NICU) nursing experience: has an American Heart Association (AHA) Neonatal Resuscitation Program (NRP) Certification and has accompanied a minimum of six Neonatal Transports prior to staffing a Neonatal Transport as the only RN in attendance.

2) Respiratory Therapists (RT) shall be registered by the National Board of Respiratory Care with a minimum of 2,000 hours of Level II or Level III NICU experience or is certified as a RT with a minimum of 3,000 hours of Level II or Level III NICU experience. The medical Director shall also confirm that the RT has an AHA NRP Certification and accompanied a minimum of six Neonatal Transports prior to staffing a transport as the only RT in attendance.

3) Registered Nurses, Paramedics, and Respiratory Therapists shall meet the most current requirements in accordance with Chapter 64J-1, F.A.C.

4) Registered Nurses, Paramedics, and Respiratory Therapists shall have a minimum of six (6) hours of continuing education in neonatal care annually.

5) Registered Nurses, Paramedics, and Respiratory Therapists shall demonstrate to the CMS approved Neonatal and Obstetrical Medical Directors a working knowledge of transport equipment and necessary skills to safely transport high-risk pregnant women and neonates.

6) Registered Nurses and Respiratory Therapists must provide certification of completion for a neonatal transport course of a minimum of twenty hours presented by an appropriate provider and approved by the RPICC Neonatal Director.

b. Neonatal Services

1) Transport of neonates returning to referring hospitals or other appropriate hospitals shall be conducted according to Chapter 64J-1.006, F.A.C., and only if the patient can not be discharged from hospital care.

2) Each neonatal transport vehicle shall be staffed with a minimum of one registered nurse (RN) and one registered respiratory therapist (RT) on each neonatal transport, as determined by the Director of the RPICC neonatal transport program.

3) The Medical Director of the neonatal transport program may make staff substitutions with individuals of comparable skills when the condition of the neonate warrants such substitution.

4) Protocols for the transport team shall be established by the RPICC defining the responsibilities of each team member. Protocols/Standing Orders will be made available to each EMS Medical Director upon request, in accordance with 64J-1.006, F.A.C.

5) Transport Protocols shall be established by the RPICC NEO/OB Medical Directors and available for reference during each transport.

6) Standing orders for management of patient problems must accompany each transport. Such orders shall be reviewed and signed by a CMS consultant neonatologist prior to or immediately following each instance of neonate transportation.

7) Continuous nursing care observations and progress notes shall be written by the transporting Registered Nurse.

8) All transport records will be reviewed by the transport staff supervisor and/or the Medical Director of the RPICC neonatal transport program at least monthly. Each RPICC will develop its own criteria of quality assurance for review by the medical director. Each RPICC will maintain an active quality assurance program which includes documentation of these reviews and quality assurance meetings.

9) CMS RPICC Partnership Agreement for the parent's signature will be taken by the RPICC transport team to the referring hospital to obtain the parent's signature. This will assist the RPICC liaison in completing the neonate's eligibility for eligibility in the RPICC Program.

5. Medical indications for neonatal transports:

a. Neonates with birth weight less than 1,000 grams.

b. Neonates requiring intubation and ventilation.

c. Neonates who have oxygen dependent respiratory distress with the requirement greater than 40%.

d. Neonates who are physiologically unstable.

e. Neonates referred for extracorporeal membrane oxygenation (ECMO).

f. Neonates in need of pediatric surgery, invasive pediatric cardiology, or neurosurgery.

g. Neonates with complex congenital anomalies.

h. Neonates with complex medical needs exceeding the resources of the referring facility.

i. Neonatal transports that have been reviewed and approved by the Transportation Medical Director of the contracted provider as necessary to open a NICU bed for a critically ill neonate.

6. Two Point Transports/Three Point Transports

a. Each RPICC shall provide two point transportation services for distances less than 75 miles one way between the referring hospital and the receiving RPICC for neonates who are medically eligible for the RPICC Program.

b. A transport agreement shall be executed between the RPICC and any EMS providers utilized for ground and air two and three point neonatal transports. The agreement(s) shall be made available for review by the CMS Program Office upon request.

c. The referring RPICC shall maintain the responsibility for arranging the appropriate level of ground transportation services with a Florida licensed EMS provider for the RPICC neonate and RPICC transport team to and from the airport serving the referral hospital.

d. The receiving RPICC shall maintain the responsibility for arranging the appropriate level of ground transportation services with a Florida licensed EMS provider for the RPICC neonate and RPICC transport team to and from the airport serving the city the RPICC is located.

7. Maternal Transports Component

a. The Director of the RPICC maternal transport program shall be a CMS consultant obstetrician, as defined in Chapter 64C-6.001, F.A.C.

b. The Director of the RPICC maternal transport program, or designee, shall determine the number and composition of the RPICC transport team required for each maternal transport which is provided by a RPICC maternal transport team.

c. The Director of the RPICC maternal transport program shall be responsible for reviewing all maternal transports on a monthly basis and developing quality assurance criteria. The medical director shall also be responsible for documenting the review of these cases in quality assurance meetings.

END OF TEXT

12.1 Neonatal Transports 64J-1.006 F.A.C.

64J-1.006 Neonatal Transports.

(1) A Neonatal Ambulance shall meet the requirements listed in Table V, paragraphs 64J-1.006(1)(c) and (d) and subsections 64J-1.006(2) and (3), F.A.C., and shall be exempt from meeting the equipment and medical supply requirements listed in Rule 64J-1.002, F.A.C., Table I and in Rule 64J-1.003, F.A.C., Table II.

(2) For any Neonatal transport, the Medical Director and the receiving neonatologist shall confirm that the level of care, staffing, and equipment is commensurate to the needs of the Neonate being transported.

(3) The Neonatal Ambulance shall have exterior wording or marking which identifies that the ambulance is only for Neonatal Transport. The wording shall be such that the public cannot mistake a neonatal vehicle as an ambulance for general patient care.

(4) Any EMS provider operating a Neonatal Ambulance shall have a Medical Director for all Neonatal Transports who meets the requirements of paragraphs 64J-1.004(1)-(4)(a)-(f), F.A.C., except as follows:

(a) The Medical Director shall be board certified and active in Neonatal-Perinatal Medicine, and shall demonstrate and have available for review by the department documentation of active participation on a national, regional or statewide physician group involved in Neonatal Transport;

(b) The Medical Director is not required to have prehospital care experience;

(c) All references to “patients” and “BLS and ALS procedures” shall be understood as referring to “neonates” and “neonatal advanced life support procedures” respectively;

(d) All references to “paramedics” and “EMTs” shall be understood as referring to persons staffing the Neonatal Transport as referenced in subsection (5), below; and

(e) The Medical Director shall participate in direct contact time with the transport staff while transporting a neonate for a minimum of 10 hours per year.

TABLE V
(Reference Section 64J-1.006, F.A.C.)
Neonatal Transports

ITEM	QTY.
1. Direct two-way communications with the designated neonatologist or attending physician and or receiving ICU.	
2. A standby or backup power source other than the one contained in the isolette.	One.
3. A source of electrical power sufficient to operate the isolette and ancillary electrically powered equipment.	One.
4. A transport incubator with portable power supply, portable oxygen tanks or liquid oxygen, and a source of compressed air, including appropriate valves, meters, and fittings.	One.
5. Portable heart rate monitor with visual or audible display and alarm	One per patient.

system.		
6. Portable blood pressure monitor with assortment of cuff sizes suitable for infants.		One each.
7. Battery powered mechanical I.V. pumps capable of delivering as low as 1 cc. increments for I.V. fluids.		Two.
8. Battery or self-powered oxygen sensor and transcutaneous oxygen monitor or oxygen saturation monitor.		One.
9. Oxygen delivery device and tubing capable of administering high concentrations of oxygen.		One.
10. Temperature monitoring device.		One.
11. Portable ventilator appropriate for neonatal patients.		One.
12. Anesthesia and/or self-inflating bag with oxygen reservoir less than 750 ml and manometer (pressure gauge); premature, newborn and infant size clear masks.		
13. Laryngoscope handle.		One.
14. Blades.		Miller 00, Miller 0.
15. Bulbs and batteries.		Two each.
16. Endotracheal tubes.		2.0, 2.5, 3.0, 3.5, 4.0.
17. Stylet.		Two each.
18. Adapters.		Assortment of sizes.
19. Oral Airways.		Assortment of sizes.
20. Suction equipment with low suction capabilities of less than 80 mm of hg.		One.
21. Sterile Gloves assorted sizes. for all crew members.		Sufficient quantity
22. Suction catheters.	Size 5.0, 6.0, 8, & 10.	Two each.
23. Syringes sizes 1 cc. through 60 cc.		Assortment of sizes.
24. Medication access device.		Two each.
25. Vascular access devices 23-27 gauge.		Assortment of sizes.
26. I.V. extension tubing.		Sufficient length to administer I.V.
27. Securing device.		Assorted sizes.
28. I.V. filters.		Two.
29. Umbilical catheters.	Size 3.5 & 5.	Two.
30. Antiseptic solution.		Ten.
31. Blood sugar device.		One.
32. Lancets.		Five.
33. Neonatal stethoscope.		One.
34. Flashlight.		One.

35. Gauze pads.		Assortment of sizes.
36. No. 5 & No. 8 French feeding tubes.		One each.
37. High intensity light capable of transillumination.		One.
38. Approved biomedical waste plastic bag or impervious container and used sharps container per Chapter 64E-16, F.A.C.		One each.
39. Gloves – latex or other suitable materials.		Sufficient quantity for all crew members.
40. Respiratory face masks.		Sufficient quantity for all crew members.
41. Special procedure tray or instruments with capability for performing umbilical catheterization, venous cutdown and thoracostomy.		One.
42. Bulb syringe. (Additional to OB kit)		One.
43. Cord clamp.		One.
44. Chest tube evacuation device.		One.
45. Needle aspiration device or chest tubes.		Appropriate sizes for neonate.

MEDICATION	WT/VOL	QTY.
1. Atropine Sulfate.	1 mg./10 ml.	One.
2. Injectable Vitamin K.	1 mg./0.5 ml.	One.
3. Antibiotics, to be determined by medical director.		
4. Calcium Gluconate.	10% - 10- ml.	One.
5. Digoxin ped.	0.1 mg./ml.	One.
6. Anticonvulsant as required by medical director.		
7. Dextrose.	50% 50 cc.	One.
8. Dopamine or dobutamine.	Depends on medication	One.
9. Epinephrine.	1:10,000	One.
10. Eye prophylaxis.		One.
11. Furosemide (Lasix).	20 mg./2 ml.	One.
12. Heparin.		One.
13. Lidocaine.	1%/2 mg.	One.
14. Naloxone (Narcan).	1.0 mg./ml or .4 mg./ml.	One.
15. Paralyzing agent.		One.
16. Phenobarbital.		One.
17. Prostin VR. (available for	500 mcg/ml.	One.

transport)		
18. Sodium Bicarbonate.	4.2% soln.	One.
19. Sedative as determined by the medical director.		One.
20. Volume expander.		One.
21. I.V. fluid.	Bags of D5W and D10W	One each.
22. Injectable non-preservative sterile water.		One.
23. Injectable non-preservative normal saline.		One.

(5) Each Neonatal Transport shall be staffed with a minimum of two persons, excluding the driver or pilot. One person shall be a Registered Nurse (RN), the second person shall be either an RN, a respiratory therapist (RT), or a paramedic. Physicians may be substituted by the Medical Director for either of the two persons. The staffing for each Neonatal Transport shall be determined by the Medical Director The Medical Director shall confirm that the staffing for each Neonatal Transport is capable of performing neonatal advanced life support procedures, as referenced by the American Academy of Pediatrics in *Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients, 3rd ed, 2007,* which is incorporated by reference and available at http://www.aap.org.

(a) The Medical Director shall confirm the RN is licensed in accordance with Chapter 464, F.S.; has a minimum of 4,000 hours RN experience, which includes 2,000 hours of Level II or Level III Neonatal Intensive Care Unit (NICU) nursing experience; has an American Heart Association (AHA) Neonatal Resuscitation Program (NRP) Certification and has accompanied a minimum of six Neonatal Transports prior to staffing a Neonatal Transport as the only RN in attendance.

(b) The Medical Director shall confirm the RT is registered by the National Board of Respiratory Care with a minimum of 2,000 hours of Level II or Level III NICU experience or is certified as a RT with a minimum of 3,000 hours of Level II or Level III NICU experience. The Medical Director shall also confirm that the RT has:

1. An AHA NRP Certification; and

2. Accompanied a minimum of six Neonatal Transports prior to staffing a transport as the only RT in attendance.

(c) The Medical Director shall confirm the paramedic is a Florida-licensed paramedic with a minimum of 5,000 hours experience and has an AHA NRP Certification.

(d) The Medical Director may make medical staff substitutions with individuals of comparable skills when the condition of the neonate warrants such substitution.

(6) Treatment protocols for the management of the neonate from the receiving neonatologist shall accompany each Neonatal Transport.

Rulemaking Authority 381.0011, 383.19, 395.405, 401.251(6), 401.35 FS. Law Implemented 381.001, 383.15, 395.405, 401.24, 401.25, 401.251, 401.252, 401.26, 401.265, 401.27, 401.30, 401.31, 401.35, 401.41, 401.411, 401.414, 401.421 FS. History–New 11-30-93, Amended 1-26-97, Formerly 10D-66.0525, Amended 8-4-98, 9-3-00, 12-18-06, Formerly 64E-2.006, Amended 2-16-10.