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

THE FULL TEXT OF THE PROPOSED RULE IS:

69L-7.020 Florida Workers' Compensation Health Care Provider Reimbursement Manual.

(1) The Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005 ~~2004 Second~~ Edition, is adopted by reference as part of this rule. The manual contains reimbursement policies, guidelines, codes and maximum reimbursement allowances for ~~medical~~ services and supplies provided by health care providers. Also, the manual includes reimbursement policies and payment methodologies for pharmacists and medical suppliers. ~~The Florida Workers' Compensation Health Care Provider Reimbursement Manual, incorporated above, is available for inspection during normal business hours at the Florida Department of Financial Services, Document Processing Section, 200 East Gaines Street, Tallahassee, Florida 32399-0311, or via the Department's web site at http://www.fldfs.com.~~

(2) The Physicians' Current Procedural Terminology (CPT®), 2004 Professional Edition, Copyright 2003, American Medical Association; the Current Dental Terminology (CDT-4), Fourth Edition, Copyright 2002, American Dental Association; and for D codes and for injectable J codes, and for other medical services and supply codes, the American Medical Association "Healthcare Common Procedure Coding System, Medicare's National Level II Codes, HCPCS 2004", Sixteenth Edition, Copyright 2003, Ingenix Publishing Group, are adopted by reference as part of this rule. When a health care provider performs a procedure or service, which is not listed in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005 Edition incorporated ~~in subsection (1)~~ above, the provider must use a code contained in the CPT®, CDT-4 or HCPCS ~~section~~ as specified in this section.

(3) The Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005 Edition incorporated above, is available for inspection during normal business hours at the Florida Department of Financial Services, Document Processing Section, 200 East Gaines Street, Tallahassee, Florida 32399-0311, or via the Department's web site at http://www.fldfs.com.

Specific Authority 440.13(14)(b), 440.591 FS. Law Implemented 440.13(7),(12),(14) FS. History–New 10-1-82, Amended 3-16-83, 11-6-83, 5-21-85, Formerly 38F-7.20, Amended 4-1-88, 7-20-88, 6-1-91, 4-29-92, 2-18-96, 9-1-97, 12-15-97, 9-17-98, 9-30-01, 7-7-02, Formerly 38F-7.020, 4L-7.020, Amended 12-4-03, 1-1-04, 7-4-04, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Dan Sumner, Deputy Director of Workers' Compensation, Division of Workers' Compensation, Department of Financial Services

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Tanner Holloman, Director of Workers' Compensation, Division of Workers' Compensation, Department of Financial Services

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: January 10, 2005

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 24, 2004

Section III
Notices of Changes, Corrections and Withdrawals

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND

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

PUBLIC SERVICE COMMISSION

DOCKET NO.: 040246-WS

RULE NO.:	RULE TITLE:
25-30.457	Limited Alternative Rate Increase

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rules in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 30, No. 32, August 6, 2004, issue of the Florida Administrative Weekly:

25-30.457 Limited Alternative Rate Increase.

(1) As an alternative to a staff assisted rate case as described in Rules 25-30.455 and 25-30.456, F.A.C., water ~~and wastewater~~ utilities whose total gross annual operating revenues are $150,000 or less for water service and wastewater utilities whose total gross annual operating revenues are ~~or~~ $150,000 or less for wastewater service~~, or $300,000 or less on a combined basis,~~ may petition the Commission for a limited alternative rate increase of up to 20 percent applied to metered or flat recurring rates of all classes of service by submitting a completed application that includes the information required by sections (8) and (9) ~~and (10)~~. In accordance with Section 367.0814(6), F.S., a utility that requests staff assistance waives its right to protest by agreeing to accept the final rates and charges approved by the Commission unless the final rates and charges would produce less revenue than the existing rates and

charges. The original and two ~~five~~ copies of the application shall be filed with the Division of the Commission Clerk and Administrative Services.

(2) through (6) No change.

~~(7) Any increase in operating revenues approved pursuant to this rule shall be limited to a maximum of 20 percent applied to metered or flat recurring rates of all classes of service.~~

(7)~~(8)~~ The Commission shall deny the application if a petitioner does not remit the fee, as provided by Section 367.145, F.S., and paragraph 25-30.020(2)(f), F.A.C., within 30 days after official acceptance of the application.

(8)~~(9)~~ No change.

(9)~~(10)~~ The petitioner shall provide a schedule showing:

(a) through (b) No change.

(11) through (13) renumbered (10) through (12) No change.

(13)~~(14)~~ In consideration of subsections (11) and (12) ~~and (13)~~, the utility agrees to hold any revenue increase granted under the provisions of this rule subject to refund with interest in accordance with Rule 25-30.360, F.A.C., for a period of 15 months after the filing of the utility's annual report required by Section 367.121, F.S., for the year the adjustment in rates was implemented.

(14)~~(15)~~ No change.

(15)~~(16)~~ If, within 15 months after the filing of a utility's annual report required by Section 367.121, F.S., the Commission finds that the utility exceeded the range of its last authorized rate of return on equity after an adjustment in rates, as authorized by this rule, was implemented within the year for which the report was filed, such overearnings, up to the amount held subject to refund ~~the Commission may order the utility to refund~~, with interest, shall be disposed of for the benefit of the customers as provided in Section 367.081(4)(d), Florida Statutes ~~the difference to the ratepayers and adjust rates accordingly~~.

(16)~~(17)~~ No change.

(17)~~(18)~~ In the event of a protest, the limit on the maximum increase provided in (1)~~(7)~~ above shall no longer apply.

(18)~~(19)~~ No change.

Specific Authority 350.127(2), 367.0814, 367.121(1)(a) FS. Law Implemented 350.123, 367.0814, 367.121, 367.145(2) FS. History–New _____.

DEPARTMENT OF CORRECTIONS

RULE NO.:	RULE TITLE:
33-601.737	Visiting – Forms

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 31, No. 2, (January 14, 2005), issue of the Florida Administrative Weekly:

Form DC6-111B, Visitor Information Summary, is being amended for consistency with rules governing inmate visiting. In Section 4.1.3 of the form, the authorized cash limit is changed to $50, in $1, $5, $10 and $20 denominations in accordance with paragraph 33-601.725(1)(d), F.A.C. The notice of proposed rulemaking incorrectly omitted the reference to $20.00 denominations.

WATER MANAGEMENT DISTRICTS

St. Johns River Water Management District

RULE NO.:	RULE TITLE:
40C-1.603	Fees

NOTICE OF CORRECTION

Notice is hereby given that the following correction is made to Rule 40C-1.603, F.A.C., published in Vol. 30, No. 48, November 24, 2004 Florida Administrative Weekly, pages 4929 and 4930.

In paragraphs (5)(h) and (8)(e), the $500 dollar amount was inadvertently stricken out.

WATER MANAGEMENT DISTRICTS

St. Johns River Water Management District

RULE NO.:	RULE TITLE:
40C-4.451	Emergency Authorization

NOTICE OF WITHDRAWAL

Notice is hereby given that the above rule, as noticed in Vol. 30, No. 48, November 24, 2004, Florida Administrative Weekly has been withdrawn.

WATER MANAGEMENT DISTRICTS

South Florida Water Management District

RULE NOS.:	RULE TITLES:
40E-3.051	Exemptions
40E-3.101	Content of Application
40E-3.321	Duration of Permits
40E-3.411	Well Completion Reports
40E-3.502	Construction Methods
40E-3.507	Casing and Liner Pipe Standards
40E-3.512	Well Construction Requirements
40E-3.521	Well Seals

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rules in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 30, No. 45, of the November 5, 2004 issue, Florida Administrative Weekly. The changes are in response to comments from the staff of the Joint Administrative Procedures Committee (JAPC). The Board, at its meeting held on January 12, 2005, voted to change the rules to address the comments from the JAPC. The changes are as follows:

40E-3.051 Exemptions.

(1) The following wells are exempt from Rule 40E-3.041, F.A.C.:

(a) through (c) No change.

(d) A well intended for use as an injection well, which has received a permit under Chapter 62-528 ~~62-28~~, F.A.C. Such wells are exempt from the construction standards in this chapter, provided the applicable standards of Chapter 62-28, F.A.C., are met.

(e) No change.

(2) No change.

Specific Authority 373.044, 373.113, 373.171 FS. Law Implemented 373.303, 373.308, 373.309, 373.313, 373.316, 373.326 FS. History–New 1-1-85, Amended _____.

40E-3.101 Content of Application.

(1) through (3) No change.

(4) In addition to the information required to be submitted on the District form, the District staff may specifically request such reasonable additional information as may be necessary to evaluate the hydrologic impacts of the withdrawal to ensure that the impacts will not be harmful to the water resource of the District as set forth in Chapter 40E-2, F.A.C., and that the withdrawals are in compliance with statutory and rule requirements. Pursuant to Section 373.314 ~~373.232~~, Fla. Stat., the District will cite a specific rule when requesting such additional information. Such requests for additional information will be made in compliance with Section 120.60, Fla. Stat. and Chapter 40E-1, F.A.C.

Specific Authority 373.044, 373.113, 373.171 FS. Law Implemented 373.308, 373.309, 373.313, 373.326, 373.342 FS. History–New 1-1-85, Amended 12-19-89, 11-8-99, _____.

40E-3.321 Duration of Permits.

(1) through (3) No change.

~~(4) Modifications of an existing permit may be granted by the District or delegated agency upon written application, if submitted by the permittee prior to the expiration date of the permit.~~

(4)~~(5)~~ A well construction permit may be transferred from one licensed water well contractor to another if the owner or his agent agree to the transfer prior to permit expiration.

Specific Authority 373.044, 373.113, 373.171 FS. Law Implemented 373.308, 373.309, 373.313, 373.326, 373.342 FS. History–New 1-1-85, Amended _____.

40E-3.411 Well Completion Reports.

(1) through (a) No change.

(b) Computer generated completion reports developed by the contractor may be used in place of District supplied forms ~~if these reports have been approved by the District prior to use~~.

(2) through (3) No change.

~~(4) The District may also require that samples be taken during construction and furnished along with the completion report.~~

(4)~~(5)~~ For water test wells, a report on the test results shall be submitted to the District within 30 days of completion of the testing. The report shall also include a request and a proposed schedule to either abandon the water test well or convert the water test well to a production well or monitoring well.

Specific Authority 373.044, 373.113, 373.171 FS. Law Implemented 373.308, 373.309, 373.313, 373.326, 373.342 FS. History–New 1-1-85, Amended _____.

40E-3.502 Construction Methods.

(1) through (a) No change.

(b) For public water supply wells or limited use public supply wells, which shall be constructed, repaired or abandoned in accordance with Chapter 62-555, ~~Chapter 62-532~~, or Chapter 64E-8, F.A.C. respectively, or

(c) through (e) No change.

(2) No change.

Specific Authority 373.044, 373.309, 373.171 FS. Law Implemented 373.113, 373.306, 373.308, 373.309 FS. History–New 1-1-85, Amended 12-19-89, _____.

40E-3.507 Casing and Liner Pipe Standards.

(1) Well casing, liner pipe, and well screen shall be new or in like new condition. Such well casing, liner pipe, and well screen shall not be used unless free of breaks, corrosion, and dents, ~~is~~ straight and true, and not out of round. Welded or seamless black or galvanized steel pipe or casing, or stainless steel pipe or casing, or approved types of nonmetallic pipe shall be used for well casing or liner pipe.

(a) through (b) No change.

(2) through (4) No change.

Specific Authority 373.044, 373.171, 373.309 FS. Law Implemented 373.113, 373.306, 373.308, 373.309 FS. History–New 1-1-85, Amended _____.

40E-3.512 Well Construction Requirements.

(1) through (2) No change.

(3) No change.

(a) The well screen shall be attached to the casing with a watertight seal;

(b)~~(a)~~ The well shall be constructed to prevent caving or pumping of sand. A filter pack shall be installed around the screened portion of the well;

(c) T~~t~~he well shall be adequately developed until clear of any drilling fluids, particulate material and turbidity.

(4) through (5) No change.

Specific Authority 373.044, 373.171, 373.309 FS. Law Implemented 373.113, 373.306, 373.308, 373.309 FS. History–New 1-1-85, Amended _____.

40E-3.521 Well Seals.

(1) No change.

(2) through (d) No change.

~~(e) An unobstructed inspection port equipped with a temporary removable watertight plug may be required for wells six (6) inches or greater in diameter.~~

Specific Authority 373.044, 373.171, 373.309 FS. Law Implemented 373.113, 373.306, 373.308, 373.309 FS. History–New _____.

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE NO.: RULE TITLE:
59G-9.070 Administrative Sanctions on Providers, Entities, and Persons

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 30, No. 9, February 27, 2004, issue of the Florida Administrative Weekly.

59G-9.070 Administrative Sanctions on Providers, Entities, and Persons.

(1) PURPOSE: The purpose of this rule is to provide notice of administrative sanctions and disincentives imposed upon a provider, entity, or person for each violation of any Medicaid-related law~~, rule, provision, handbook, or policy~~. The Agency shall have the authority to deviate from the guidelines for the reasons stated within this rule. Notice of administrative sanctions imposed will be by way of written correspondence and shall constitute Agency action pursuant to Chapter 120, F.S.

(2) DEFINITIONS: The following terms used within this rule shall have the meanings as set forth below:~~, or as otherwise specified in Medicaid related law, rule, or policy.~~

(a) "Abuse" is as defined in Section 409.913(1)(a), F.S.

(b) "Agency" is as defined in Section 409.901(2), F.S.

(c) "Claim" is as defined in Section 409.901(~~1~~5), F.S., and shall also include per diem payments and the payment of a capitation rate for a Medicaid recipient.

(d) "Complaint" is as defined in Section 409.913(1)(b), F.S.

(e) An act shall be deemed "Committed", as it relates to abuse or neglect of a patient, or of any act prohibited by Section 409.920, F.S., upon receipt by the Agency of reliable information of commission of patient abuse or neglect, or of violation of Section 409.920, F.S.

(f) "Comprehensive follow-up reviews" or "Follow-up reviews" shall have the same meaning throughout this rule, and can be used interchangeably. The two phrases mean evaluations of providers every 6 months, until the Agency determines that the reviews are no longer required. Such evaluations will result in a determination regarding whether a further compliance audit, or other regulatory action is required. ~~The Agency's decision to discontinue the reviews does not preclude future audits of any dates of service or issues, and shall not be used by the provider in any action should the Agency later determine overpayments existed.~~

(g) "Conviction" is as defined in Section 409.901(7), F.S.

(h) "Corrective action plan" means the process or plan by which the provider will ensure future compliance with state and federal Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement ~~rules, provisions, handbooks, and policies~~. A corrective action plan will remain in effect until the Agency determines that it is no longer necessary, but no longer than 3 years. For purposes of this rule, the sanction of a corrective action plan shall take the form of an "acknowledgement statement", "provider education", a "self audit", ~~a "compliance audit",~~ or a "comprehensive quality assurance program", all of which are further described in subsection (10) of this rule.

(i) An "erroneous" claim is an application for payment from the Medicaid program or its fiscal agent that contains an inaccuracy.

(j)~~(i)~~ "Fine" is a monetary sanction ~~under this rule~~. ~~Unless otherwise specified,~~ T~~t~~he amount of a fine shall be as set forth within this rule ~~the maximum amount allowed under Section 409.913(15), F.S~~.

(k) A "false" claim is as provided for in the Florida False Claims Act set forth in Chapter 68, F.S.

(l)~~(j)~~ "Fraud" is as defined in Section 409.913(1)(c), F.S.

(m)~~(k)~~ "Medical necessity" or "medically necessary" is as defined in Section 409.913(1)(d), F.S.

(n)~~(l)~~ "Medicaid-related record" is as defined in Section 409.901(19), F.S.

(o)~~(m)~~ "Overpayment" is as defined in Section 409.913(1)(e), F.S.

(p)~~(n)~~ "Patient Record Request" means a request by the Agency to a provider, entity, or person for Medicaid-related documentation or information. Such requests are not limited to Agency audits to determine overpayments or violations. Each requesting document constitutes a single Patient Record Request. The Agency is not limited to making one Patient Record Request at a time to a provider, entity, or person. Each request shall be considered separate and distinct for purposes of this rule.

(q)~~(o)~~ "Pattern" is defined as follows:

1. As it relates to paragraph (7)(d) of this rule (generally~~,~~ failing to maintain Medicaid-related records), a pattern is sufficiently established if within a single Agency action:

a. There are five or more claims within a patient record for which supporting documentation is not maintained; or

b. There is more than one patient record for which no supporting documentation is maintained.

2. As it relates to paragraph (7)(e) of this rule (generally~~,~~ failure to comply with the provisions of Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement ~~and policies~~), a pattern is sufficiently established if within a single Agency action:

a. The number of individual claims found to be in violation is greater than 6.25 ~~ten~~ percent of the total claims that are the subject of the Agency action;

b. The number of individual claims found to be in violation is greater than 6.25 ~~ten~~ percent of the claims in a sample that are the subject of the Agency action, where a sample was used to determine the appropriateness of the claims to Medicaid;

~~c. The number of individual claims found to be in violation is greater than twenty;~~

c.~~d.~~ The overpayment determination by the Agency is greater than 6.25 ~~ten~~ percent of the amount paid for the total claims that are the subject of the Agency action; or,

d.~~e.~~ The overpayment determination by the Agency is greater than 6.25 ~~ten~~ percent of the amount paid for the claims in a sample that are the subject of the Agency action, where a sample was used to determine the appropriateness of the claims to Medicaid.

3. As it relates to section (7)(g) of this rule (generally~~,~~ failing to provide goods or services that are medically necessary), a pattern is sufficiently established if within a single Agency action:

a. The number of individual claims found to be in violation is greater than one-percent of the total claims that are the subject of the Agency action;

b. The number of individual claims found to be in violation is greater than one-percent of the claims in a sample that are the subject of the Agency action, where a sample was used to determine the appropriateness of the claims to Medicaid;

~~c. The number of individual claims found to be in violation is greater than five;~~

c.~~d.~~ The overpayment determination by the Agency is greater than one-percent of the amount paid for the total claims that are the subject of the Agency action; or,

d.~~e.~~ The overpayment determination by the Agency is greater than one-percent of the amount paid for the claims in a sample that are the subject of the Agency action, where a sample was used to determine the appropriateness of the claims to Medicaid.

4. As it relates to section (7)(h) of this rule (generally~~,~~ submitting erroneous claims), a pattern is sufficiently established if within a single Agency action:

a. The number of individual claims found to be erroneous is greater than 6.25 ~~ten~~ percent of the total claims that are the subject of the Agency action;

b. The number of erroneous claims identified is greater than 6.25 ~~ten~~ percent of the claims in a sample that are the subject of the Agency action, where a sample was used to determine the appropriateness of the claims to Medicaid;

~~c. The number of erroneous claims identified is greater than twenty claims that are the subject of the Agency action;~~

c.~~d.~~ The overpayment determination by the Agency, as a result of the erroneous claims, is greater than 6.25 ~~ten~~ percent of the amount paid for the total claims that are the subject of the Agency action; or,

d.~~e.~~ The overpayment determination by the Agency, as a result of the erroneous claims, is greater than 6.25 ~~ten~~ percent of the amount paid for the claims in a sample that are the subject of the Agency action, where a sample was used to determine the appropriateness of the claims to Medicaid.

(r)~~(p)~~ "Person" is as defined in Section 409.913(1)(f), F.S.

(s)~~(q)~~ "Provider" is as defined in Section 409.901(16), F.S. and for purposes of this rule, ~~may~~ includes all of the provider's ~~one or more~~ locations.

(t)~~(r)~~ "Provider Group" is more than one – individual providers~~,~~ practicing under the same tax identification number, enrolled in the Medicaid program as a group for billing purposes, and having one or more locations.

(u)~~(s)~~ "Sanction" shall be any monetary or non-monetary penalty imposed upon a provider, entity, or person (e.g., a provider, entity, or person being suspended from the Medicaid program.) A monetary sanction under this rule may be referred to as a "fine." A sanction may also be referred to as a disincentive.

(v) "Single Agency action" means an audit or review that results in notice to the provider of violations of Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement.

(w)~~(t)~~ "Suspension" is a one-year preclusion from ~~shall preclude participation in the Medicaid program for one year, unless otherwise specified in this rule, from the date of the Agency action, and is described further in section (10) of this rule. Suspension precludes~~ any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(x)~~(u)~~ "Termination" is a twenty-year preclusion from ~~shall preclude participation in the Medicaid program for twenty years from the date of the Agency action, may be with or without cause, and is described further in section (10) of this rule. Termination precludes~~ any action that results in a claim for payment to the Medicaid program as a result of furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services.

(y)~~(v)~~ "Violation" means any omission or act performed by a provider, entity, or person that is contrary to ~~any applicable federal or state law, rule, provision, handbook, or~~ Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement ~~policy~~.

1. For purposes of this rule, each day that an ongoing violation continues and each instance of an act or omission contrary to a Medicaid law, a law that governs the provider's profession, or the Medicaid provider agreement ~~the following~~ shall be considered a "separate violations~~"~~.~~:~~

~~a. Each day that an ongoing violation continues;~~

~~b. Each instance or date of improper billing of a Medicaid recipient;~~

~~c. Each instance of including an unallowable cost on Medicaid cost report after having been advised that the cost is not allowable;~~

~~d. Each instance of furnishing goods or professional services that are inappropriate or of inferior quality;~~

~~e. Each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, or cost report;~~

~~f. Each instance of inappropriately prescribing drugs for a Medicaid recipient; or,~~

~~g. Each false or erroneous Medicaid claim leading to an overpayment to a provider.~~

2. For purposes of determining first, second, third, fourth, fifth, or subsequent violations ~~under paragraph 10(c)~~ of this rule:

a. A violation existed even if the matter is ~~means a determination by the Agency~~ ~~whether~~ resolved by repayment of an overpayment, settlement agreement, or other means~~,~~ ~~wherein the person, provider, or entity is found to have violated a provision of state or federal Medicaid laws, rules, provisions, handbooks, or policies~~.

b. The same violation means a subsequent determination by the Agency, that ~~wherein~~ the person, provider, or entity is ~~determined by the Agency to be~~ in violation of the same provision of state or federal Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement ~~rules, provisions, handbooks, or policies~~. ~~For purposes of violations of section 7(e) of this rule (generally, failing to comply with the provision of Medicaid policies), the same violation means a subsequent determination by the Agency that the person, provider, or entity is found to be in violation of the same provision of state or federal Medicaid related law, rule, provision, handbook, or policy as in a prior Agency action.~~

(3) VIOLATIONS AND SANCTIONS: ~~Unless otherwise set forth in this rule, sanctions will be imposed as set forth in Section (10) of this rule.~~ The identification of violations given herein is descriptive only. The full language of each statutory provision cited must be consulted in order to determine the conduct included.

(4) FACTORS TO BE USED IN DETERMINING LEVEL OF SANCTION: Except for the mandatory suspension and termination provision in Section (6) of this rule, when determining the type, amount, and duration of the sanction to be applied, the Agency shall consider each of the factors set forth in Section 409.913(17)~~(16)~~, F.S., in conjunction with Section (10) of this rule. This rule does not give any one listed factor greater importance or weight over any other. However, the Agency shall have the discretion to rely upon the circumstances of the violation or violations in conjunction with any one or all of the listed factors to determine the sanction that is ultimately applied. These factors will also be utilized for any deviation by the Agency from the sanctions for each violation, as set forth in Section (10) of this rule.

(5) APPLICATION TO INDIVIDUALS OR LOCATIONS RATHER THAN TO A PROVIDER GROUP:

(a) Based upon the circumstances present in each individual matter, the Agency shall have the discretion to take action to sanction a particular Medicaid provider, entity, or person working for a Medicaid provider group, or to sanction ~~and may suspend or terminate participation in the Medicaid program at~~ a specific location, rather than, or in addition to, taking action against an entire Medicaid provider group.

(b) If the Agency chooses to sanction a particular (individual) provider, entity, or person working with a Medicaid provider group or in a particular location, the other members of the Medicaid provider group and the providers in the other locations must fully cooperate in the audit or investigation conducted by the Agency, and the Agency must determine if:

1. The individual provider, entity, or person working with the Medicaid provider group is directly responsible for the violation(s);

2. The Medicaid provider group was unaware of the actions of the individual provider, entity, or person; and,

3. The Agency has not previously taken a preliminary or final Agency action against the group provider for the same violation(s) within the past five years from the date of the violation, unless the Agency determines that the individual provider, entity, or person was responsible for the prior violation.

(6) MANDATORY TERMINATION OR SUSPENSION: Whenever a ~~If the~~ provider has been suspended or terminated from participation in the Medicaid or Medicare program by the federal government or any state or territory, the Agency shall immediately suspend (if suspended) or terminate (if terminated), ~~as appropriate,~~ the provider's participation in the Florida Medicaid program for a period no less than that imposed by the federal government or the ~~any other~~ state or territory, and shall not enroll such provider in the Florida Medicaid program while such foreign suspension or termination remains in effect. Additionally, all other remedies provided by law, including all civil remedies, and other sanctions, shall apply. [Section 409.913(14)~~(13)~~, F.S.]

(7) ~~MANDATORY~~ SANCTIONS: Except when the Secretary of the Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S., s~~S~~anctions shall be imposed for the following:

(a) The provider's license has not been renewed by the licensing agency in Florida, or has been revoked, suspended, or terminated, by the licensing agency of any state. [Section 409.913(15)~~(14)~~(a), F.S.];

(b) Failure to make available within the timeframe requested by the Agency or other mutually agreed upon timeframe, or to refuse access to ~~all~~ Medicaid-related records sought by any investigator. [Section 409.913(15)~~(14)~~(b), F.S.];

(c) Failure to make available or furnish all Medicaid-related records, to be used by the Agency in determining whether Medicaid payments are or were due, and what the appropriate corresponding Medicaid payment amount should be within the timeframe requested by the Agency or other mutually agreed upon timeframe. [Section 409.913(15)~~(14)~~(c), F.S.];

(d) Failure to maintain contemporaneous Medicaid-related records and prior authorization records, if prior authorization is required, that demonstrate both the necessity and appropriateness of the good or service rendered. [Section 409.913(15)~~(14)~~(d), F.S.];

(e) Failure to comply with the provisions of the Medicaid provider publications that have been adopted by reference as rules, Medicaid laws, ~~and handbooks, applicable federal, or state laws, rules or regulations,~~ the requirements and provisions in the provider's Medicaid provider agreement, or the certification found on claim forms or transmittal forms for electronically submitted claims by the provider or authorized representative. [409.913(15)~~(14)~~(e), F.S.];

(f) Furnishing or ordering goods or services that are out of compliance with the practice standards governing the provider's profession, are ~~inappropriate, unnecessary or~~ excessive, of inferior quality, or that are found to be harmful to the recipient. [Section 409.913(15)~~(14)~~(f), F.S.];

(g) A pattern of failure to provide goods or services that are medically necessary. [Section 409.913(15)~~(14)~~(g), F.S.];

(h) Submitting, or causing to be submitted, ~~a single~~ false ~~Medicaid claim,~~ or a pattern of erroneous Medicaid claims~~, that results in an overpayment finding or that results in actual payment exceeding what is appropriate under the Medicaid program~~. [Section 409.913(15)~~(14)~~(h), F.S.];

(i) Submitting, or causing to be submitted, a Medicaid provider enrollment application or renewal forms, a request for prior authorization for Medicaid services, or a Medicaid cost report containing information that is either materially false or materially incorrect. [Section 409.913(15)~~(14)~~(i), F.S.];

(j) Collecting or billing a recipient or a recipient's responsible party for goods or services improperly. [Section 409.913(15)~~(14)~~(j), F.S.];

(k) Including costs in a cost report that are not allowed under the ~~a Florida Title XIX (~~Medicaid~~)~~ reimbursement plan, even though the provider or authorized representative had previously been advised via an audit exit conference or audit report that the costs were not allowable. However, if the unallowed costs are the subject of an administrative hearing pursuant to Chapter 120, F.S., sanctions shall not be imposed. [Section 409.913(15)~~(14)~~(k), F.S.];

(l) Being charged, whether by information or indictment, with fraudulent billing practices. [Section 409.913(15)~~(14)~~(l), F.S.];

(m) A finding or determination that a provider, entity, or person is negligent for ordering or prescribing a good or service to a patient, which resulted in the patient's injury or death. [Section 409.913(15)~~(14)~~(m), F.S.];

(n) During a specific audit or review period, failure to demonstrate sufficient quantities of goods, or sufficient time in the case of services, that support the corresponding billings or claims made to the Medicaid program. [Section 409.913(15)~~(14)~~(n), F.S.];

(o) Failure to comply with the notice and reporting requirements of Section 409.907, F.S. [Section 409.913(15)~~(14)~~(o), F.S.];

(p) A finding or determination that a provider, entity, or person committed ~~Committing~~ patient abuse or neglect, or any act prohibited by Section 409.920, F.S. [Section 409.913(15)~~(14)~~(p), F.S.];

(q) Failure to comply with any of the terms of a previously agreed-upon repayment schedule. [Sections 409.913(15)~~(14)~~(q), F.S. ~~and, 409.913(24)(b), F.S.~~];

(8) ADDITIONAL VIOLATIONS SUBJECT TO TERMINATION: In addition to the termination authority, the Agency shall have the authority to concurrently seek civil remedies or impose other sanctions.

(a) The Agency shall impose the sanction of termination for each violation of:

1. Section 409.913(13)~~(2)~~(a), F.S. (generally, a provider is convicted of a criminal offense related to the delivery of any health care goods or services);

2. Section 409.913(13)~~(2)~~(b), F.S. (generally, a provider is convicted of a criminal offense relating to the practice of the provider's profession); or

3. Section 409.913(13)~~(2)~~(c), F.S. (generally, a provider is found to have neglected or physically abused a patient).

(b) For non-payment or partial payment where monies are owed to the Agency, and failure to enter into a repayment agreement, in accordance with Section 409.913(25)~~(24)~~(c)~~(b)~~, F.S. (generally, a provider who has a debt to the Agency, who has not made full payment, and who fails to enter into a repayment schedule), the Agency shall impose the sanction of a $5,000 fine; and, where the provider remains out of compliance for 30 ~~60~~ days, suspension; and, where the provider remains out of compliance for more than 180 days ~~one year~~, termination.

(c) For failure to reimburse an overpayment, in accordance with Section 409.913(30)~~(29)~~, F.S. (generally, a provider that fails to repay an overpayment within 35 days after the date of a final order), the Agency shall impose the sanction of a $5,000 fine; and, where the provider remains out of compliance for 30 ~~60~~ days, suspension; and, where the provider remains out of compliance for more than 180 days ~~one year~~, termination.

(9) REPORTING SANCTIONS: The Agency shall report sanctions in accordance with Section 409.913(24)~~(23)~~, F.S.

(10) GUIDELINES FOR ~~MANDATORY~~ SANCTIONS.

(a) The Agency's authority to impose sanctions on a provider, entity, or person shall be in addition to the Agency's authority to recover a determined overpayment, other remedies afforded to the Agency by law, appropriate referrals to other agencies, and any other regulatory actions against the provider.

(b) In all instances of violations ~~of Medicaid laws, rules, and policies~~ that are subject to this rule, the Agency shall have the authority to impose liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, including fees and costs, upon entry of an order determining that such moneys are due or recoverable.

(c) A violation is considered a:

1. First Violation – If, within the five years prior to the alleged violation date(s), the provider, entity, or person has not been deemed by the Agency in a prior Agency action to have committed the same violation;

2. Second Violation – If, within the five years prior to the alleged violation date(s), the provider, entity, or person has once been deemed by the Agency in a prior Agency action to have committed the same violation.

3. Third Violation – If, within the five years prior to the alleged violation date(s), the provider, entity, or person has twice been deemed by the Agency in prior Agency actions to have committed the same violation.

4. Fourth Violation – If, within the five years prior to the alleged violation date(s), the provider, entity, or person has three times been deemed by the Agency in prior Agency actions to have committed the same violation.

5. Fifth Violation – If, within the five years prior to the alleged violations date(s), the provider, entity, or person has four times been deemed by the Agency in prior Agency actions to have committed the same violation.

6. Subsequent Violation – If, within the five years prior to the alleged violation date(s) the provider, entity, or person has, five or more times, been deemed by the Agency in prior Agency actions to have committed the same violation.

(d) Multiple violations shall result in an increase in sanctions such that:

1. In the event the Agency determines in a single Agency action that a provider, entity, or person has committed violations of more than one section of this rule, the Agency shall cumulatively apply the sanction guideline associated with each section violated.

2. In the event the Agency determines in a single action that a provider, entity, or person has committed multiple violations of one section of this rule, the Agency shall cumulatively apply the applicable sanctions for each separate violation of the section. However, the Agency shall not apply multiple violations to increase the level of violation (e.g., – from First Violation to Second Violation).

~~3. In the event the Agency determines that a provider, entity, or person committed violations of more than one provision of this rule in at least three separate Agency actions within the past five years, the Agency shall cumulatively apply the sanctions. Additionally, if the cumulative sanctions do not otherwise result in a suspension of the provider, entity, or person for at least 1 year, the sanction shall also include a 1 year suspension. This sanction shall be in addition to the applicable sanctions and disincentives set forth in this rule.~~

(e) For purposes of this rule, as used in the table below, a "corrective action plan" shall be a written document, submitted to the Agency, and shall either be an "acknowledgement statement", "provider education", "self audit", ~~"compliance audit",~~ or a "comprehensive quality assurance program". The Agency will specify the type of corrective action plan required.

1. An "acknowledgement statement" shall be a typed document submitted within 15 ~~30~~ days of the date of the Agency action that brought rise to this requirement. The document will acknowledge a requirement to adhere to the specific state and federal Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement that are the subject of the Agency action. The Agency will confirm receipt of the statement and either accept or deny it as complying with this rule. If the acknowledgement statement is not acceptable to the Agency, the provider, entity, or person will be advised regarding the deficiencies. The provider will have 10 days to amend the statement. ~~The statement shall:~~

~~a. Identify the areas of non-compliance as determined by the Agency in the Agency action; and,~~

~~b. Acknowledge a requirement to adhere to the specific state and federal Medicaid laws, rules, provisions, handbooks, and policies that are at issue in the Agency action.~~

2. "Provider Education" shall be successful completion of an educational course or courses that address the areas of non-compliance as determined by the Agency in the Agency action.

a. The provider, entity, or person will identify one or more individuals who are the ~~key~~ Medicaid policy compliance individuals for the provider, and must include ~~appropriate~~ treating providers involved with the areas of non-compliance as well as billing staff, who must successfully complete the required education ~~course(s)~~.

b. The provider~~, entity, or person~~ will, within 30 days of the date of the Agency action that brought rise to this requirement, submit for approval the name of the course, contact information, and a brief description of the course intended to meet this requirement.

c. The Agency will confirm receipt of the course information and either accept or deny it as complying with this rule. If the course is denied by the Agency, the provider, entity,

or person will be advised regarding the reasons for denial. The provider will have 10 days to submit additional course information.

d. Proof of successful completion of the provider education must be submitted to the Agency within 90 ~~180~~ days of the date of the Agency action that brought rise to this requirement.

3. A "self-audit" is an audit of the provider's claims to Medicaid for a specified period of time (the audit period) performed by the provider.

a. A self-audit is a detailed and comprehensive evaluation of the provider's claims to Medicaid. The audit may be focused on particular issues or all state and federal Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement ~~rules, provisions, handbooks, and policies~~. The Agency will specify the audit period as well as issues to be addressed. A summary of the audit work plan, including the audit methodology, must be submitted to the Agency within 30 days of the date of the Agency action that brought rise to this requirement. The ~~A~~ self-audit must be completed within 90 ~~180~~ days of the date of the Agency action that brought rise to this requirement, or such other timeframe as mutually agreed upon by the Agency and the provider. The self-disclosure of violations will not result in additional sanctions imposed pursuant to this rule.

b. The provider is required to submit a detailed listing of paid claims found to be out of compliance with the specified state and federal Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement ~~rules, provisions, handbooks, and policies~~. The listing shall include the date of service, type of service (e.g., procedure code), treating provider, pay-to provider, date the claim was paid, transaction control number (TCN) for the claim, description of non-compliance, and any other information that would allow the Agency to verify the claim(s). The provider is also required to submit a detailed description regarding the audit methodology and overpayment calculation. The Agency will evaluate the self-audit and determine whether it is a valid evaluation of the provider's claims.

c. If the self-audit is accepted by the Agency, the provider shall be deemed to have been overpaid by the determined amount, and shall be required to repay that amount in full, or enter in and adhere to a repayment plan with the Agency, within 30 days of the date of the acceptance of the self-audit.

d. If the self-audit is not accepted, the provider will be advised regarding the reasons for denial. The provider will have 30 days to submit additional information to correct the deficiencies.

~~4. A "compliance audit" will consist of annual audits conducted by an accounting firm that is not affiliated with or related to the provider, entity, or person subject to the audit.~~

~~a. Within 30 days of the date of the Agency action that brought rise to this requirement, the provider, entity, or person shall submit in writing a request for approval of the accounting firm. The request shall include contact information so that the Agency may verify the credentials of the company as well as affiliations. The request shall also include a brief description of the anticipated audit.~~

~~b. The Agency will confirm receipt of the audit information and either accept or deny it as complying with this rule. If the accounting firm or proposed audit process is denied by the Agency, the provider, entity, or person will be advised regarding the reasons for denial. The provider will have 30 days to submit additional audit information.~~

~~c. All draft, preliminary, and final reports prepared by the accounting firm shall be submitted to the Agency within 10 days of the report issuance. The final report must be submitted to the Agency within 180 days of the date of the Agency action that brought rise to this requirement. All reports must identify any discrepant Medicaid claims, and include the date of service, type of service (e.g., procedure code), treating provider, pay-to provider, date the claim was paid, transaction control number (TCN) for the claim, description of non-compliance, and any other information that would allow the Agency to verify the claim(s).~~

4.~~5.~~ A "comprehensive quality assurance program" shall monitor the efforts of the provider, entity, or person in their internal efforts to comply with state and federal Medicaid laws, the laws that govern the provider's profession, and the Medicaid provider agreement ~~rules, provisions, handbooks, and policies~~.

a. The program shall contain at a minimum the following elements: identification of the physical location where the provider, entity, or person takes any action that may cause a claim to Medicaid to be submitted; contact information regarding the individual or individuals who are responsible for development, maintenance, implementation, and evaluation of the program; a separate process flow diagram that includes a step-by-step written description or flow chart indicating how the program will be developed, maintained, implemented, and evaluated; a complete description and relevant time frames of the process for internally maintaining the program, including a description of how technology, education, and staffing issues will be addressed; a complete description and relevant time frames of the process for implementing the program; and a complete description of the process for monitoring, evaluating, and improving the program.

b. A process flow diagram regarding the development of the program must be submitted to the Agency within 30 days from the date of the Agency action and must be updated every 30 days until the comprehensive quality assurance program is approved by the Agency. A process flow diagram regarding the maintenance, implementation, and evaluation of the program must be submitted to the Agency within 90 days from the date

of the Agency action and must be updated every 30 days until the comprehensive quality assurance program is approved by the Agency.

c. The evaluation process must contain processes for conducting internal compliance audits, which include reporting of the audit findings to specific individuals who have the authority to address the deficiencies, and must include continuous improvement processes. The plan must also include the frequency and duration of such evaluations.

d. The Agency will review the process flow diagram and description of the development of the program and either approve the program or disapprove the program. If the Agency disapproves the program, specific reasons for the disapproval will be included, and the provider, entity, or individual shall have 30 days to submit an amended development plan.

e. Upon approval by the Agency of the development process of the program, the provider, entity, or person shall have 45 days to implement the program. The provider shall provide written notice to the Agency indicating that the program has been implemented.

f. The program must remain in effect for the time period specified in the Agency action and the provider must submit written progress reports to the Agency every 120 days, for the duration of the program.

5.~~6.~~ Failure to timely comply with any of the timeframes set forth by the Agency, or to adhere to ~~maintain~~ the corrective action plan in accordance with this section, shall result in a $1000 fine per day of non-compliance. If a provider remains out of compliance for 30 days, the provider shall also be suspended from the Medicaid program until the provider is in compliance. If a provider remains out of compliance for 180 days ~~one year~~, the provider shall be terminated from the Medicaid program. ~~The termination may be with or without cause. The program must remain in effect for the time period specified in the Agency action and the provider must submit written progress reports to the Agency every 120 days, for the duration of the program.~~

(f) The Agency's decision to discontinue follow-up reviews does not preclude future audits of any dates of service or issues, and shall not be used by the provider in any action should the Agency later determine overpayments existed.

(g)~~(f)~~ For purposes of this rule, as used in the table below, a "suspension" shall preclude participation in the Medicaid program for one year from the date of the Agency action. A provider~~(s)~~ that is suspended shall not resume participation in the Medicaid program until the completion of the one-year term. To resume participation, the provider must submit a written request to the Agency, Bureau of Medicaid Program Integrity, to be reinstated in the Medicaid program. The request must include a copy of the notice of suspension issued by the Agency, and a written acknowledgement regarding whether the violation(s) that brought rise to the suspension has been remedied. The provider may not resume participation in the Medicaid program until they receive written confirmation from the Agency indicating that participation in the Medicaid program has been authorized.

(h)~~(g)~~ For purposes of this rule, as used in the table below, a "termination" shall preclude participation in the Medicaid program for twenty years from the date of the Agency action. ~~"Termination" shall be with or without cause.~~ A provider~~(s)~~ who is terminated ~~(regardless of whether with or without cause)~~ shall not resume participation in the Medicaid program until the completion of the twenty-year term. To resume participation, the provider must submit a complete and accurate provider enrollment application, which will be accepted or denied in the standard course of business by the Agency. In addition to the application, the provider must include a copy of the notice of termination issued by the Agency, and a written acknowledgement regarding whether the violation(s) that brought rise to the termination has been remedied.

(i)~~(h)~~ Sanctions and disincentives shall apply in accordance with this rule, as set forth in the table below:

Violation Type/Section of Rule	First violation	Second violation	Third violation	Fourth violation	Fifth and Subsequent violations
~~For each violation of Medicaid laws, rules or policies not otherwise listed in this rule:~~	~~A $1,000 fine; and submission of a corrective action plan.~~	~~A $2,000 fine; and submission of a corrective action plan.~~	~~A $3,000 fine; and suspension. Upon expiration of the suspension, submission of a corrective action plan.~~	~~A $4,000 fine; and suspension. Upon expiration of the suspension, submission of a corrective action plan.~~	~~Termination.~~

(7)(a) The provider's license has not been renewed by the licensing agency ~~of any state~~; or the license has been revoked, suspended or terminated, by the licensing agency of any state. [409.913(15)~~(14)~~(a), F.S.];	For licensure suspension: suspension from the Medicaid program for the duration of the licensure suspension; however, if the licensure suspension is to exceed 1 year and for all other violations: termination.	For licensure suspension: suspension from the Medicaid program for the duration of the licensure suspension; however, if the licensure suspension is to exceed 1 year and for all other violations: termination.	Termination.	Termination.	Termination.
(7)(b) Failure, upon demand, to make available or refuse access to, Medicaid-related records. [409.913(15)~~(14)~~(a), F.S.];	A $1,000 fine per record request or instance of refused access; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days ~~one year~~, the provider is still in violation, termination.	A $2,500 fine per record request or instance of refused access; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days ~~one year~~, the provider is still in violation, termination.	A $5,000 fine per record request or instance of refused access; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days ~~one year~~, the provider is still in violation, termination.	A $5,000 fine per ~~for each~~ record request or instance of refused access; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days ~~one year~~, the provider is still in violation, termination.	A $5,000 fine ~~of~~ per ~~for each~~ record request or instance of refused access; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days ~~one year~~, the provider is still in violation, termination.
(7)(c) Failure to furnish records, within time frames established by the Agency. [409.913(15)~~(14)~~ (c), F.S.];	A $500 fine per record request; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available; if after 180 days ~~one year~~, the provider is still in violation, termination.	A $1,000 fine per record request; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available; if after 180 days ~~one year~~, the provider is still in violation, termination.	A $2,500 fine per record request; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available; if after 180 days ~~one year~~, the provider is still in violation, termination.	A $5,000 fine per record request; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available; if after 180 days ~~one year~~, the provider is still in violation, termination	A $5,000 fine per ~~of for each~~ record request; if after 30 ~~60~~ days, the provider is still in violation, suspension until the records are made available; if after 180 days ~~one year~~, the provider is still in violation, termination

(7)(d) Failure to maintain contemporaneous Medicaid-related records. [409.913(15) ~~(14)~~(d), F.S.];	A $100 fine per claim for which supporting documentation is not maintained. For a pattern: a $1,000 fine per patient record for which any of the supporting documentation is not maintained; and submission of a corrective action plan in the form of an acknowledgement statement.	A $200 fine per claim for which supporting documentation is not maintained. For a pattern: a $2,000 fine per patient record for which any of the supporting documentation is not maintained; and submission of a corrective action plan in the form of provider education.	A $300 ~~3,000~~ fine per claim ~~patient record~~ for which ~~any of the~~ supporting documentation is not maintained; and suspension. For a pattern: a $3,000 fine per patient record for which any of the supporting documentation is not maintained; submission of a corrective action plan in the form of a comprehensive quality assurance program; and suspension.	Termination.	Termination.
(7)(e) Failure to comply with the provisions of Medicaid publications that have been adopted by reference as rules ~~policies, procedures, or law~~. [409.913(15) ~~(14)~~(e), F.S.];	A $500 fine per provision. For a pattern: a $1,000 fine per provision; and submission of a corrective action plan in the form of an acknowledgement statement.	A $1,000 fine per provision. For a pattern: a $2,000 fine per provision; and submission of a corrective action plan in the form of provider education.	A $2,000 fine per provision; and submission of a corrective action plan in the form of an acknowledgement statement. For a pattern: a $3,000 fine per provision; and submission of a corrective action plan in the form of a comprehensive quality assurance program~~; and suspension~~.	A $3,000 fine per provision; and submission of a corrective action plan in the form of provider education. For a pattern: a $4,000 fine per provision; ~~submission of a corrective action plan~~ and suspension.	A $5,000 fine per provision; and, suspension. For a pattern: termination.

(7)(f) Furnishing or ordering goods or services that are inappropriate, unnecessary or excessive, of inferior quality, or that are harmful. [409.913(15) ~~(14)~~(f), F.S.];	For harmful goods or services: a $5000 fine for each instance, and suspension. For all others: a $1,000 fine for each ~~individual~~ instance and submission of a corrective action plan in the form of provider education.	For harmful goods or services: a $5,000 fine for each instance, and termination. For all others: a $2,000 fine for each ~~individual~~ instance and submission of a corrective action plan in the form of a comprehensive quality assurance program.	For harmful goods or services: a $5,000 fine for each instance, and termination. For all others: a $3,000 fine for each ~~individual~~ instance and suspension.	Termination.	Termination.
(7)(g) A pattern of failure to provide goods or services that are medically necessary. [409.913(15) ~~(14)~~(g), F.S.];	A $5,000 fine and submission of a corrective action plan in the form of provider education.	A $5,000 fine for each instance; and suspension as well as the submission of a corrective action plan in the form of a comprehensive quality assurance program.	A $5,000 fine for each instance; and suspension as well as the submission of a corrective action plan in the form of a comprehensive quality assurance program.	Termination.	Termination.
(7)(h) Submitting false ~~Medicaid claims,~~ or a pattern of erroneous Medicaid claims. [409.913(15) ~~(14)~~(h), F.S.];	For false claims: T~~t~~ermination. For a pattern of erroneous claims: a $1,000 fine for each claim in the pattern; and submission of a corrective action plan in the form of a comprehensive quality assurance program.	For false claims: Termination. For a pattern of erroneous claims: A $2,000 fine for each claim in the pattern; suspension; and upon the conclusion of the suspension, submission of a corrective action plan in the form of a comprehensive quality assurance program.	Termination.	Termination.	Termination.

(7)(i) Submitting certain documents containing information that is either materially false or materially incorrect. [409.913(15) ~~(14)~~(i), F.S.];	A $10,000 fine for each separate violation; and suspension.	Termination.	Termination.	Termination.	Termination.
(7)(j) Collecting or billing a recipient improperly. [409.913(15) ~~(14)~~(j), F.S.];	A $1,000 fine for each instance.	A $2,500 fine for each instance.	A $5,000 fine for each instance; and suspension.	A $5,000 fine for each instance; and suspension.	Termination.
(7)(k) Including unallowable costs after having been advised. [409.913(15) ~~(14)~~(k), F.S.];	A $5,000 fine for each unallowable cost.	A $5,000 fine for each unallowable cost.	A $5,000 fine for each unallowable cost.	A $5,000 fine for each unallowable cost.	A $5,000 fine for each unallowable cost.
(7)(l) Being charged with fraudulent billing practices. [409.913(15) ~~(14)~~(l), F.S.];	Suspension for the duration of the indictment. If the provider is found guilty, termination.	Suspension for the duration of the indictment. If the provider is found guilty, termination.	Suspension for the duration of the indictment. If the provider is found guilty, termination.	Suspension for the duration of the indictment. If the provider is found guilty, termination.	Suspension for the duration of the indictment. If the provider is found guilty, termination.
(7)(m) Negligently ordering or prescribing, which resulted in the patient's injury or death. [409.913(15) ~~(14)~~(m), F.S.];	Termination.	Termination.	Termination.	Termination.	Termination.
(7)(n) Failure to demonstrate sufficient quantities of goods or sufficient time to support the corresponding billings or claims made to the Medicaid Program. [409.913(15) ~~(14)~~(n), F.S.];	A $5,000 ~~1,000~~ fine ~~and submission of a corrective action plan~~.	A $5,000 ~~2,500~~ fine and submission of a corrective action plan in the form of a comprehensive quality assurance program.	A $5,000 fine and suspension.	Termination.	Termination.

(7)(o) Failure to comply with the notice and reporting requirements of Section 409.907. [409.913(15) ~~(14)~~(o), F.S.];	A $1,000 fine.	A $2,000 fine.	A $3,000 fine.	A $4,000 fine.	A $5,000 fine.
(7)(p) Committing patient abuse or neglect, or any act prohibited by Section 409.920. [409.913(15) ~~(14)~~(p), F.S.~~, and 409.913(24)(b), F.S.~~];	A $5,000 fine per instance, and suspension.	Termination.	Termination.	Termination.	Termination.
(7)(q) Failure to comply with an agreed-upon repayment schedule. [409.913(15) ~~(14)~~(q), F.S.];	A $1,000 fine; and, where the provider remains out of compliance for 30 ~~60~~ days, suspension; and, where the provider remains out of compliance for more than 180 days ~~one year~~, termination.	A $2,000 fine; and, where the provider remains out of compliance for 30 ~~60~~ days, suspension; and, where the provider remains out of compliance for more than 180 days ~~one year~~, termination.	A $3,000 fine and suspension until in compliance; where the provider remains out of compliance for more than 180 days ~~one year~~, termination.	A $4,000 fine and suspension until in compliance; where the provider remains out of compliance for more than 180 days ~~one year~~, termination.	A $5,000 fine and suspension until in compliance; where the provider remains out of compliance for more than 180 days ~~one year~~, termination.

Specific Authority 409.919 FS. Law Implemented 409.907, 409.913, 409.9131, 409.920, 812.035 FS. History–New _____.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Division of Florida Land Sales, Condominiums and Mobile Homes

RULE NO.: RULE TITLE:
61B-82.003 Answer

NOTICE OF WITHDRAWAL

Notice is hereby given that the above rule, as noticed in Vol. 30, No. 40, of the October 1, 2004, Florida Administrative Weekly has been withdrawn.

DEPARTMENT OF ENVIRONMENTAL PROTECTION

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

DEPARTMENT OF HEALTH

Bureau of Community Environmental Health

RULE NOS.: RULE TITLES:
64E-18.002 Definitions
64E-18.003 Requirements for Certification
64E-18.007 Standards of Practice
64E-18.008 Disciplinary Guidelines

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made in the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 30, No. 40, October 1, 2004, of the Florida Administrative Weekly:

The changes were made in response to written comments received from the Florida Legislature Joint Administrative Procedures Committee.

Subsection 64E-18.002(5), F.A.C., has been changed so that when adopted it will read: "Florida Environmental Health Association – a not for profit professional association located online at www.feha.org which provides training, testing, and educational services for environmental health professionals working in Florida."

Subparagraph 64E-18.003(3)(a)8., F.A.C., has seen the number 8 deleted.

The last sentence in paragraph 64E-18.003(3)(a), F.A.C., has been changed so that when adopted it will read: "~~A~~reas of study listed are examples of courses which would meet the coursework requirements for environmental health, environmental science or public health: public health law, environmental law, health planning, soil science, food science, or epidemiology and would be determined by the Department. Determining coursework allowable in environmental health, environmental science or public health will be based on an evaluation of official transcripts for the courses which earned college credit at an accredited university with academic majors in these areas. If a determination is unable to be made from the official transcripts or a course would otherwise not be allowed the Department will request the applicant to provide a course syllabus to clarify the courses in question."

The last sentence in subsection 64E-18.003(4), F.A.C., has been changed so that when adopted it will read: "In order to be complete, the application must have all spaces correctly completed, be signed by the applicant, include a money order, cash, the voucher schedule from a journal transfer or a sufficiently funded check in the correct amount as specified in paragraph 64E-18.010(1)(a), F.A.C., and if employed on or after September 21, 1994, shall include official copies of transcripts from the colleges or universities from which the applicant graduated."

Paragraph 64E-18.003(6)(a), F.A.C., has been changed so that when adopted it will read: "successfully complete a minimum of 24 hours of department provided pre-certification course work. At a minimum this course work shall include training and testing on soil classification, system design and theory, system material and construction standards, and regulatory requirements, and;"

Paragraph 64E-18.003(7)(a), F.A.C., has been changed so that when adopted it will read: "Applicants seeking certification in the Food Protection Program must: successfully complete a minimum of 24 hours of department provided pre-certification course work. At a minimum this course work shall include training and testing on food microbiology, foodborne illness investigations, and basic hazard analysis and critical control points (HACCP) and;"

Paragraph 64E-18.003(7)(b), F.A.C., has been changed so that when adopted it will read: "successfully pass the precertification coursework and certification examinations administered by the department. Minimum passing score shall be a 70 percent correct response to all questions comprising the exam."

Subsection 64E-18.007(1), F.A.C., has been changed so that when adopted it will read: "It shall be the responsibility of persons certified under this rule to see that work for which they are responsible and work which has been performed by them or under their supervision is carried out in conformance with the requirements of Chapters 500, 386, or 381, F.S., and Chapters 64E-6 or 64E-11, F.A.C."

Subsection 64E-18.008(1), F.A.C., has been changed so that when adopted it will read: "The following guidelines shall be used in disciplinary cases subject to other provisions of this rule."

Subsection 64E-18.008(4), F.A.C., has been deleted.

Subsection 64E-18.008(5), F.A.C., has been deleted.

DEPARTMENT OF FINANCIAL SERVICES

Division of Insurance Agents and Agency Services

RULE NOS.:	RULE TITLES:
69B-220.051	Conduct of Public Adjusters
69B-220.201	Ethical Requirements

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 30, No. 44, October 29, 2004, of the Florida Administrative Weekly. These changes are being made to address concerns expressed at the public hearing.

69B-220.051 Conduct of Public Adjusters.

(1) through (2) No change.

(a) through (b) No change.

(c) "Financial Interest" means direct or indirect ownership.

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

(3) through (5) No change.

(6) Required Contract Terms. Public adjusters shall ensure that all contracts for their services contain the following terms:

(a) No change.

(b) All public adjuster contracts shall show the public adjuster's:

1. Permanent business address and phone number; and

2. Florida Department license number.

(c) through (d) No change.

(e)1. through 2. No change.

3. Any costs to be reimbursed to the public adjuster out of the proceeds shall be specified in an addendum to the contract.

(7)~~(6)~~ All contracts for public adjuster services must be in writing. The contract must be signed by the public adjuster who solicited the contract. If the public adjuster is licensed by the Department ~~Office~~ as an emergency public adjuster, the contract shall show the public adjuster's permanent home address and home phone number, and permanent home state business address and phone number and Florida Department ~~Office~~ license number.

(7) through (8) No change.

69B-220.201 Ethical Requirements.

~~(1) Purpose. This rule sets forth the various ethical considerations and constraints for various classes of insurance adjusters.~~

(1) No change.

(2)~~(3)~~ Violation.

(a) through (b) No change.

(3)~~(4)~~ Code of Ethics. The work of adjusting insurance claims engages the public trust. An adjuster shall ~~must~~ put the duty for fair and honest treatment of the claimant above the adjuster's own interests~~,~~ in every instance. The following are standards of conduct that define ethical behavior, and shall constitute a code of ethics which shall be binding on all adjusters:~~.~~

(a) An adjuster shall ~~disclose all financial interest in any direct or indirect aspect of an adjusting transaction. For example~~: ~~an adjuster shall~~ not directly or indirectly refer or steer any claimant needing repairs or other services in connection with a loss to any person with whom the adjuster has an undisclosed financial interest, or who ~~which person~~ will or is reasonably anticipated to provide the adjuster any direct or indirect compensation for the referral or for any resulting business.

(b) An adjuster shall treat all claimants equally.

1. An adjuster shall not provide favored treatment to any claimant.

2. An adjuster shall adjust all claims strictly in accordance with the insurance contract.

(c) An adjuster shall not ~~never~~ approach investigations, adjustments, and settlements in a manner prejudicial to the insured.

(d) An adjuster shall make truthful and unbiased reports of the facts after making a complete investigation.

(e) An adjuster shall handle every adjustment and settlement with honesty and integrity, and allow a fair adjustment or settlement to all parties without any remuneration to himself except that to which he is legally entitled.

(f) An adjuster, upon undertaking the handling of a claim, shall act with dispatch and due diligence in achieving a proper disposition of the claim ~~thereof~~.

(g) An adjuster shall promptly report to the Department any conduct by any licensed insurance representative of this state~~,~~ which ~~conduct~~ violates any provision of the Insurance Code ~~insurance law~~ or Department rule or order.

(h) An adjuster shall exercise extraordinary care when dealing with elderly clients~~,~~ to assure that they are not disadvantaged in their claims transactions by failing memory or impaired cognitive processes.

(i)1. An adjuster shall not negotiate or effect settlement directly or indirectly with any third-party claimant represented by an attorney, if the ~~said~~ adjuster has knowledge of such representation, except with the consent of the attorney.

2. For purposes of this subsection, the term "third-party claimant" does not include the insured or the insured's resident relatives.

(j)1. An adjuster is permitted to interview any witness, or prospective witness, without the consent of opposing counsel or party. In doing so, however, the adjuster shall scrupulously avoid any suggestion calculated to induce a witness to suppress or deviate from the truth, or in any degree affect the witness's ~~their~~ appearance or testimony during deposition or at the trial ~~or on the witness stand~~.

2. If any witness making or giving a signed or recorded statement so requests, the witness shall be given a copy of the statement ~~thereof~~.

(k) An adjuster shall not advise a claimant to refrain from seeking legal advice, nor advise against the retention of counsel to protect the claimant's interest.

(l)1. An adjuster shall not attempt to negotiate with or obtain any statement from a claimant or witness at a time that the claimant or witness is, or would reasonably be expected to be, in shock or serious mental or emotional distress as a result of physical, mental, or emotional trauma associated with a loss.

2. ~~Further,~~ T~~t~~he adjuster shall not conclude a settlement when the ~~such~~ settlement would be disadvantageous to, or to the detriment of, a claimant who is in the traumatic or distressed state described above in (m)1.

(m)1. An adjuster shall not knowingly fail to advise a claimant of the claimant's ~~their~~ claim rights in accordance with the terms and conditions of the contract and of the applicable laws of this state.

2. An adjuster shall exercise care not to engage in the unlicensed practice of law as prescribed by the Florida Bar.

(n)1. A company or independent adjuster shall not draft~~, unless approved in writing in advance by the insurer and such written communication can be demonstrated to the department,~~ special releases called for by the unusual circumstances of any settlement or otherwise draft any form of release, unless advance written approval by the insurer can be demonstrated to the Department.

2. Except as provided above, a company or independent adjuster is ~~only~~ permitted only to fill in the blanks in a release form approved by the insurer they represent.

(o) An adjuster shall not undertake the adjustment of any claim concerning which the adjuster is not currently competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current expertise.

(p)1. No person shall, as a public adjuster, represent any person or entity whose claim the adjuster has previously adjusted while acting as an adjuster representing any insurer or independent adjusting firm.

2. No person shall, as a company or independent adjuster, represent him- or herself or any insurer or independent adjusting firm against any person or entity that the adjuster previously represented as a public adjuster.

(q)1. A public adjuster shall not represent or imply to any client or potential client that insurers, company adjusters, or independent adjusters routinely attempt to, or do in fact, deprive claimants of their full rights under an insurance policy.

2. No insurer, independent adjuster, or company adjuster shall represent or imply to any claimant that public adjusters are unscrupulous, or that engaging a public adjuster will delay or have other adverse effect upon the settlement of a claim.

(r)1. No public adjuster, while so licensed in the Department's records, may represent or act as a company adjuster, independent adjuster, or general lines agent.

2. No independent adjuster or company adjuster, while so licensed in the Department's records, may represent or act as a public adjuster.

(4)~~(5)~~ Public Adjusters, Other Ethical Constraints. In addition to considerations set out above for adjusters, the following ethical considerations are specific to public adjusters and shall be binding upon public adjusters:~~.~~

(a) through (b) No change.

2. ~~and~~ T~~t~~he insured or claimant may exercise veto power of any of these persons, in which case that person shall not be used in estimating costs.

(c) The public adjuster shall ensure that if a contractor, architect, engineer, or other ~~licensed~~ professional is used in formulating estimates or otherwise participates in the adjustment of the claim, the professional shall ~~must~~ be licensed by the Florida Department of Business and Professional Regulation.

(d) through (e) No change.

(f)1. No change.

2. Except as between licensed public adjusters, ~~or licensed public adjusters and members of the Florida Bar,~~ no public adjuster shall ~~may~~ compensate any person, whether directly or indirectly, for the principal purpose of referring business to the public adjuster.

(g)1. A public adjuster's contract with a client shall be revocable or cancellable by the insured or claimant, without penalty or obligation, for at least 3 business days after the contract is executed~~, should the insured elect to settle the claim directly with an adjuster representing the insurer~~.

2. through 4. No change.

(h) No change.

(i) A public adjuster shall ensure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement, including the terms required by subsection 69B-220.051(6), F.A.C.

The remainder of the rule reads as previously published.

Section IV
Emergency Rules

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND

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

DEPARTMENT OF ENVIRONMENTAL PROTECTION

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

Section V
Petitions and Dispositions Regarding Rule Variance or Waiver

DEPARTMENT OF LAW ENFORCEMENT

Notice is hereby given that the Officer Professionalism Program, Florida Department of Law Enforcement has received from Brad Hudson on December 28, 2004, a petition for Waiver of subparagraph 11B-20.0014(2)(d)9., F.A.C., pursuant to Section 120.542, F.S. Petitioner has requested that the Department waive certain course sequencing requirements for criminal justice instructors.

Comments on this Petition should be filed with the Office of General Counsel, Florida Department of Law Enforcement, P. O. Box 1489, Tallahassee, Florida 32302, Attention: Assistant General Counsel, Grace A. Jaye.

A copy of the Petition may be obtained by contacting Assistant General Counsel Grace A. Jaye at the above address or by calling (850)410-7676.