# Section I
# Notices of Development of Proposed Rules and Negotiated Rulemaking

**DEPARTMENT OF EDUCATION**

**State Board of Education**

RULE TITLE: RULE NO.:
Educational Facilities 6A-2.0010

PURPOSE AND EFFECT: The purpose of the proposed rule development is to propose amendments to the State Requirements for Educational Facilities to specify criteria for the Qualified Public Educational Facilities Private Bond Allocation Program. The effect will be consistent criteria established in rule.

SUBJECT AREA TO BE ADDRESSED: Public Educational Facilities Private Bond Allocation Program.

SPECIFIC AUTHORITY: Section 1(a) Article IX, State Constitution, 1001.02(1), 1013.02(2), 1013.37 FS.

LAW IMPLEMENTED: Section 1(a) Article IX, State Constitution, 50.011, 50.021, 50.031, 50.041, 50.051, 50.061, 50.071, 1001.02, 1001.42(9), 1001.453, 1011.09, 1011.74, 1301.01, 1013.03, 1013.31, 1013.35, 1013.37, 1013.371, 1013.60, 1013.61, 1013.64, 1013.735, 1013.736, 1013.737 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE TO BE ANNOUNCED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT, IF AVAILABLE, IS: Spessard Boatright, Office of Educational Facilities, 325 West Gaines Street, Room 1054, Tallahassee, Florida 32399-0400; (850)245-9229

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

**DEPARTMENT OF REVENUE**

**Sales and Use Tax**

RULE TITLE: RULE NO.:
Rentals, Leases, and Licenses to Use Transient Accommodations 12A-1.061

PURPOSE AND EFFECT: The purpose of this rule development is to: (1) establish guidelines for the tax treatment of transient accommodations provided to members of a hotel rewards points program; and (2) clarify that the provisions of Rule 12A-1.061, F.A.C. (Rentals, Leases, and Licenses to Use Transient Accommodations), govern the administration of the transient rentals tax imposed under Section 212.03, F.S., and any locally-imposed discretionary sales surtax, convention development tax, tourist development tax, tourist impact tax, or municipal resort tax imposed on transient accommodations.

SUBJECT AREA TO BE ADDRESSED: The subject area addressed is the application of state sales tax, local surtax, and any locally-imposed convention development tax, tourist development tax, tourist impact tax, or municipal resort tax on transient accommodations provided to members of a hotel rewards points program.

SPECIFIC AUTHORITY: 212.0305(3)(f), 125.0104(3)(k), 125.0108(2)(e), 212.17(6), 212.18(2), 213.06(1) FS.

LAW IMPLEMENTED: 92.525(1)(b), 125.0104, 125.0108, 212.02(2), (10)(a)-(g), (16), 212.03(1), (2), (3), (4), (5), (7), 212.0305, 212.031, 212.04(4), 212.06(2)(j), 212.08(6), (7)(i), (m), 212.054, 212.055, 212.11(1), (2), 212.12(8), (9), (13), 212.13(2), 212.15(1), 212.18(2), (3), 213.37, 213.756 FS., Chapter 67-930, L.O.F.

THE AGENCY ANTICIPATES CONDUCTING A RULE DEVELOPMENT WORKSHOP AT A FUTURE DATE. THE WORKSHOP WILL BE NOTICED IN THE FLORIDA ADMINISTRATIVE WEEKLY AND WILL INCLUDE, IF AVAILABLE, A PRELIMINARY DRAFT OF ANY PROPOSED RULE TEXT.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Gary Gray, Revenue Program Administrator, Technical Assistance and Dispute Resolution, Department of Revenue, P. O. Box 7443, Tallahassee, Florida 32314-7443, telephone (850)922-4729, e-mail grayg@dor.state.fl.us.

NOTICE UNDER THE AMERICANS WITH DISABILITIES ACT: Persons with hearing or speech impairments may contact the Department by using the Florida Relay Service, (800)955-8770 (Voice) and (800)955-8771 (TDD).

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

**BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND**

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

**PUBLIC SERVICE COMMISSION**

DOCKET NO: 050152-EU

RULE TITLE: RULE NO.:
Measuring Customer Service 25-6.049

PURPOSE AND EFFECT: The amendment would allow master metering for electric service for condominiums that operate like hotels.

SUBJECT AREA TO BE ADDRESSED: Exemption from the requirement for individual metering in Rule 25-6.049, F.A.C.

SPECIFIC AUTHORITY: 366.05(1) FS.

LAW IMPLEMENTED: 366.05(1), 366.80, 366.81, 366.82 FS.

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

TIME AND DATE: 9:30 a.m., December 16, 2005

PLACE: Betty Easley Conference Center, Room 148, 4075 Esplanade Way, Tallahassee, Florida

Any person requiring some accommodation at this workshop because of a physical impairment should call the Division of the Commission Clerk and Administrative Services at (850)413-6770 at least 48 hours prior to the hearing. Any person who is hearing or speech impaired should contact the Florida Public Service Commission by using the Florida Relay Service, which can be reached at: 1(800)955-8771 (TDD).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: David Wheeler, Division of Economic Regulation, Florida Public Service Commission, 2540 Shumard Oak Blvd., Tallahassee, FL 32399-0862, (850)413-6670

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

25-6.049 Measuring Customer Service.

(1) through (4) No change.

(5)~~(a)~~ Individual electric metering by the utility shall be required for each separate occupancy unit of new commercial establishments, residential buildings, condominiums, cooperatives, marinas, and trailer, mobile home and recreational vehicle parks. However, individual metering shall not be required for any such occupancy unit for which a construction permit was issued before, and which has received master-metered service continuously since, ~~is commenced after~~ January 1, 1981. In addition, ~~I~~individual electric meters shall not~~, however,~~ be required:

(a)~~1.~~ No change.

(b)~~2.~~ No change.

(c)~~3.~~ For electricity used in specialized-use housing accommodations such as hospitals, nursing homes, living facilities located on the same premises as, and operated in conjunction with, a nursing home or other health care facility providing at least the same level and types of services as a nursing home, convalescent homes, facilities certificated under Chapter 651, Florida Statutes, college dormitories, convents, sorority houses, fraternity houses, ~~motels, hotels,~~ and similar facilities;

(d) For lodging establishments such as hotels, motels, and similar facilities which are rented, leased, or otherwise provided to guests by an operator providing overnight occupancy as defined in paragraph (8)(b).

(e)~~4.~~ For separate, specially-designated areas for overnight occupancy, as defined in paragraph (8)(b), at trailer, mobile home and recreational vehicle parks and marinas where permanent residency is not established.

(f)~~5.~~ For new and existing time-share plans, provided that all of the occupancy units which are served by the master meter or meters are committed to a time-share plan as defined in Section 721, Florida Statutes, and none of the occupancy units are used for permanent occupancy. ~~When a time-share plan is converted from individual metering to master metering, the customer must reimburse the utility for the costs incurred by the utility for the conversion. These costs shall include, but not be limited to, the undepreciated cost of any existing distribution equipment which is removed or transferred to the ownership of the customer, plus the cost of removal or relocation of any distribution equipment, less the salvage value of any removed equipment.~~

(g) For condominiums that meet the following criteria:

1. The declaration of condominium requires that at least 95 percent of the units are used solely for overnight occupancy as defined in paragraph (8)(b) of this rule;

2. A registration desk, lobby and central telephone switchboard are maintained; and,

3. A record is kept for each unit showing each check-in and check-out date for the unit, and the name(s) of the individual(s) registered to occupy the unit between each check-in and check-out date.

(6) Master-metered condominiums.

(a) Initial Qualifications – In addition to the criteria in paragraph (5)(g), in order to initially qualify for master-metered service, the owner or developer of the condominium, the condominium association, or the customer must attest to the utility that the criteria in paragraph (5)(g) and in this subsection have been met, and that any cost of future conversion to individual metering will be the responsibility of the customer, consistent with subsection (7) of this rule. Upon request and reasonable notice by the utility, the utility shall be allowed to inspect the condominium to collect evidence needed to determine whether the condominium is in compliance with this rule. If the criteria in paragraph (5)(g) and in this subsection are not met, then the utility shall not provide master-metered service to the condominium.

(b) Ongoing Compliance – The customer shall attest annually, in writing, to the utility that the condominium meets the criteria for master metering in paragraph (5)(g). The utility shall establish the date that annual compliance materials are due based on its determination of the date that the criteria in paragraphs (5)(g) and (6)(a) were initially satisfied, and shall inform the customer of that date before the first annual notice

is due. The customer shall notify the utility within 10 days if, at any time, the condominium ceases to meet the requirements in paragraph (5)(g).

(c) Upon request and reasonable notice by the utility, the utility shall be allowed to inspect the condominium to collect evidence needed to determine whether the condominium is in compliance with this rule.

(d) Failure to comply – If a condominium is master metered under the exemption in this rule and subsequently fails to meet the criteria contained in paragraph (5)(g), or the customer fails to make the annual attestation required by paragraph (6)(b), then the utility shall promptly notify the customer that the condominium is no longer eligible for master-metered service. If the customer does not respond with clear evidence to the contrary within 30 days of receiving the notice, the customer shall individually meter the condominium units within six months following the date on the notice. During this six month period, the utility shall not discontinue service based on failure to comply with this rule. Thereafter, the provisions of Rule 25-6.105, F.A.C., apply.

(7) When a structure or building is converted from individual metering to master metering, or from master metering to individual metering, the customer shall be responsible for the costs incurred by the utility for the conversion. These costs shall include, but not be limited to, any remaining undepreciated cost of any existing distribution equipment which is removed or transferred to the ownership of the customer, plus the cost of removal or relocation of any distribution equipment, less the salvage value of any removed equipment.

(8)~~(b)~~ For purposes of this rule:

(a)~~1.~~ "Occupancy unit" means that portion of any commercial establishment, single and multi-unit residential building, or trailer, mobile home or recreational vehicle park, or marina which is set apart from the rest of such facility by clearly determinable boundaries as described in the rental, lease, or ownership agreement for such unit.

~~2. The construction of a new commercial establishment, residential building, marina, or trailer, mobile home or recreational vehicle park shall be deemed to commence on the date when the building structure permit is issued.~~

(b)~~3.~~ "Overnight Occupancy" means use of an occupancy unit for a short term such as per day or per week where permanent residency is not established.

~~4. The term "cost", as used herein means only those charges specifically authorized by the electric utility's tariff, including but not limited to the customer, energy, demand, fuel, and conservation charges made by the electric utility plus applicable taxes and fees to the customer of record responsible for the master meter payments. The term does not include late payment charges, returned check charges, the cost of the distribution system behind the master meter, the cost of billing, and other such costs.~~

(9)~~(6)~~(a) Where individual metering is not required under subsection (5) and master metering is used in lieu thereof, reasonable apportionment methods, including sub-metering may be used by the customer of record or the owner of such facility solely for the purpose of allocating the cost of the electricity billed by the utility. The term "cost", as used herein means only those charges specifically authorized by the electric utility's tariff, including but not limited to the customer, energy, demand, fuel, conservation, capacity and environmental charges made by the electric utility plus applicable taxes and fees to the customer of record responsible for the master meter payments. The term does not include late payment charges, returned check charges, the cost of the customer-owned distribution system behind the master meter, the customer of record's cost of billing the individual units, and other such costs.

(b) through (c) No change.

Specific Authority 366.05(1) FS. Law Implemented 366.05(1), ~~366.05(3),~~ 366.80, 366.81, 366.82 FS. History–Amended 7-29-69, 11-26-80, 12-23-82, 12-28-83, Formerly 25-6.49, Amended 7-14-87, 10-5-88, 3-23-97, _____.

## WATER MANAGEMENT DISTRICTS

### Northwest Florida Water Management District

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Consumptive Uses of Water 40A-2

PURPOSE AND EFFECT: The purpose and effect of the proposed rule development is to reduce the permitting requirements for certain water users whose withdrawals pose minimal impact to the water resources, expedite remediation of contaminated ground water, describe reservations, and clarify rule language.

SUBJECT AREA TO BE ADDRESSED: Permitting of water uses, describing of reservations, and providing of definitions.

SPECIFIC AUTHORITY: 373.044, 373.113, 373.171, 373.216, 373.219, 373.223 FS.

LAW IMPLEMENTED: 373.171, 373.216, 373.219, 373.223 FS.

IF REQUESTED IN WRITING WITHIN 14 DAYS OF THE DATE OF THIS NOTICE, AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW.

TIME AND DATE: 9:00 a.m., December 19, 2005

PLACE: Northwest Florida Water Management District, 81 Water Management Drive, Governing Board Conference Room, Havana, Florida 32333-4711

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Terri Peterson, Northwest Florida Water Management District, 152 Water Management Drive, Havana, Florida 32333, (850)539-5999, (850)539-2777 (fax)

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

**AGENCY FOR HEALTH CARE ADMINISTRATION**

**Medicaid**

RULE TITLE: RULE NO.:
Optometric Services 59G-4.210

PURPOSE AND EFFECT: The purpose of the proposed rule amendment is to incorporate by reference the revised Florida Medicaid Optometric Services Coverage and Limitations Handbook, January 2006. The coverage and limitations handbook revisions include policy clarifications and updated billing information. The effect will be to incorporate by reference in the rule the Florida Medicaid Optometric Services Coverage and Limitations Handbook, January 2006.

SUBJECT AREA TO BE ADDRESSED: Optometric Services.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.906, 409.907, 409.908, 409.9081 FS.

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

TIME AND DATE: 10:00 a.m., Monday, December 19, 2005

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Jason Ottinger, Agency for Health Care Administration, Bureau of Medicaid Services, 2727 Mahan Drive, MS 20, Tallahassee, Florida 32308, (850)922-7314

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59G-4.210 Optometric Services.

(1) No change.

(2) All optometric practitioners enrolled in the Medicaid program must be in compliance with the provisions of the Florida Medicaid Optometric Services Coverage and Limitations Handbook, January 2006 ~~2005, updated January 2005~~, which is incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 ~~and Child Health Check-Up 221~~, which is incorporated by reference in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

Specific Authority 409.919 FS. Law Implemented 409.906, 409.907, 409.908, 409.9081 FS. History–New 4-13-93, Amended 7-1-93, Formerly 10C-7.069, Amended 12-21-97, 10-13-98, 5-24-99, 4-23-00, 7-5-01, 2-20-03, 8-5-03, 5-24-05, 8-18-05,_____.

**AGENCY FOR HEALTH CARE ADMINISTRATION**

**Medicaid**

RULE TITLE: RULE NO.:
Transportation Services 59G-4.330

PURPOSE AND EFFECT: The purpose of this rule amendment is to incorporate by reference the Florida Medicaid Non-Emergency Transportation Services Coverage and Limitations Handbook, July 2005. The revised handbook includes the provision of non-emergency transportation services through a contracted vendor. The effect will be to incorporate the Florida Medicaid Non-Emergency Transportation Services Coverage and Limitations Handbook, July 2005, into rule.

SUBJECT AREA TO BE ADDRESSED: Transportation Services.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.902, 409.905, 409.907, 409.908, 409.9081, 409.910, 409.913 FS.

IF REQUESTED WITHIN 14 DAYS BY AN AFFECTED PERSON AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW.

TIME AND DATE: 2:00 p.m., Monday, December 19, 2005

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Glen Davis, Medicaid Services, 2727 Mahan Drive, Building 3, Mail Stop 20, Tallahassee, Florida 32308-5407, (850)922-7305

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59G-4.330 Transportation Services.

(1) No change.

(2) All non-emergency transportation providers who provide transportation to Medicaid recipients must comply with the provisions of the Florida Medicaid Non-Emergency Transportation Services Coverage and~~,~~ Limitations ~~and Reimbursement~~ Handbook, July 2005 ~~1997~~, incorporated by reference. The handbook is available from the Medicaid fiscal agent.

(3) All ambulance transportation providers enrolled in the Medicaid program must comply with the provisions of the Florida Medicaid Ambulance Transportation Services Coverage, Limitations and Reimbursement Handbook, July 2005, incorporated by reference. The handbook is available from the Medicaid fiscal agent.

(4) The following forms that are included in the Florida Medicaid Ambulance Transportation Services Coverage, Limitations and Reimbursement Handbook are incorporated by reference: the Emergency Transportation 131 Claim Form,

10/2003, and the Non-Emergency Transportation 131-A Claim Form, 10/2003. The forms are available from the Medicaid fiscal agent.

Specific Authority 409.919 FS. Law Implemented 409.902, 409.905, 409.907, 409.908, 409.9081, 409.910, 409.913 FS. History–New 1-1-77, Amended 10-1-77, 1-27-81, 8-28-84, Formerly 10C-7.45, Amended 4-13-93, Formerly 10C-7.045, Amended 1-7-98,_____.

**AGENCY FOR HEALTH CARE ADMINISTRATION**

**Medicaid**

RULE TITLE: RULE NO.:
Visual Services 59G-4.340

PURPOSE AND EFFECT: The purpose of the proposed rule amendment is to incorporate by reference the revised Florida Medicaid Visual Services Coverage and Limitations Handbook, January 2006. The coverage and limitations handbook revisions include policy clarifications and updated billing information. The effect will be to incorporate by reference in the rule the Florida Medicaid Visual Services Coverage and Limitations Handbook, January 2006.

SUBJECT AREA TO BE ADDRESSED: Visual Services.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.906, 409.908, FS.

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

TIME AND DATE: 10:00 a.m., Monday, December 19, 2005

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Jason Ottinger, Agency for Health Care Administration, Bureau of Medicaid Services, 2727 Mahan Drive, MS 20, Tallahassee, Florida 32308, (850)922-7314

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59G-4.340 Visual Services.

(1) No change.

(2) All visual services practitioners enrolled in the Medicaid program must be in compliance with the provisions of the Florida Medicaid Visual Services Coverage and Limitations Handbook, January 2006 ~~2004, updated January 2005~~, which is incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

Specific Authority 409.919 FS. Law Implemented 409.906, 409.908 FS. History–New 7-30-80, Formerly 10C-7.521, Amended 4-20-93, 8-25-93, Formerly 10C-7.0521, Amended 12-21-97, 10-13-98, 6-10-99, 4-23-00, 1-23-02, 2-20-03, 8-5-03, 10-12-04, 8-18-05,_____.

**AGENCY FOR HEALTH CARE ADMINISTRATION**

**Medicaid**

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

PURPOSE AND EFFECT: This rule shall provide notice of administrative sanctions and disincentives imposed upon a provider, entity, or person who either directly or indirectly causes monies to be improperly expended by the Medicaid program of the sanctions that can be imposed for each violation of any Medicaid-related law, rule, provision, handbook, or policy. The Agency shall have the authority to deviate from the sanctions for the reasons stated within this rule

SUBJECT AREA TO BE ADDRESSED: Rule 59G-9.070, F.A.C.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.907, 409.913, 409.9131, 409.920, 812.035 FS.

IF REQUESTED IN WRITING WITHIN 14 DAYS BY AN AFFECTED PERSON AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW.

TIME AND DATE: 9:00 a.m. – 10:00 a.m., Friday, January 6, 2006

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Kimberly Noble, Medicaid Program Integrity, 2727 Mahan Drive, Building 3, Mail Stop 6, Tallahassee, Florida 32308-5407, (850)413-9290

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

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. 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:

(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(5), F.S., and shall also include per diem payments and the payment of a capitation rate for a Medicaid recipient. For the purposes of this rule, "per diem payments" means the total monthly payment to the provider for a specific 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.

(g) "Contemporaneous", as it relates to a provider's requirement to maintain records and produce records upon request, means records created within the standard and customary timeframe applicable to the provider's trade or profession; but not longer than any timeframe specified in Medicaid laws or the laws that govern the provider's profession.

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

(i)~~(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. 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", or a "comprehensive quality assurance program", all of which are further described in subsection (10) of this rule.

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

(k)~~(j)~~ "Fine" is a monetary sanction. The amount of a fine shall be as set forth within this rule.

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

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

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

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

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

(q) "Patient Record" means the file maintained by the provider to document the delivery of goods or services; the file shall be maintained in the standard and customary practice applicable to the provider's trade or profession; but not in a fashion that is contrary to Medicaid laws or the laws that govern the provider's profession.

(r)~~(p)~~ "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.

(s)~~(q)~~ "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 any one ~~a~~ patient record for which ~~supporting~~ documentation is not maintained; or

(b) There is more than one patient ~~record~~ for which no patient record ~~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), 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 percent of the total claims that were reviewed to support ~~are the subject of~~ the Agency action; or

~~b. The number of individual claims found to be in violation is greater than 6.25 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;~~

b.~~c.~~ The overpayment determination by the Agency is greater than 6.25 percent of the amount paid for the ~~total~~ claims that were reviewed to support ~~are the subject of~~ the Agency action.~~; or,~~

~~d. The overpayment determination by the Agency is greater than 6.25 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 paragraph (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 instances ~~individual claims~~ found to be in violation is greater than one. ~~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 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. 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 paragraph (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 percent of the total claims that were reviewed to support ~~are the subject of~~ the Agency action; or

~~b. The number of erroneous claims identified is greater than 6.25 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;~~

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

~~d. The overpayment determination by the Agency, as a result of the erroneous claims, is greater than 6.25 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.~~

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

(u)~~(s)~~ "Provider" is as defined in Section 409.901(16), F.S. and for purposes of this rule, includes all of the provider's locations that have the same base provider number (with separate locator codes).

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

(w)~~(u)~~ "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.

(x)~~(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.

(y)~~(w)~~ "Suspension" is a one-year preclusion from 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.

(z)~~(x)~~ "Termination" is a twenty-year preclusion from 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.

(aa)~~(y)~~ "Violation" means any omission or act performed by a provider, entity, or person that is contrary to Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement.

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 shall be considered a "separate violation".

2. For purposes of determining first, second, third, fourth, fifth, or subsequent violations of this rule:

a. A violation existed even if the matter is resolved by repayment of an overpayment, settlement agreement, or other means.

b. The same violation means a subsequent determination by the Agency, that the person, provider, or entity is 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.

(3) VIOLATIONS AND SANCTIONS: 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:

(a) Except for the mandatory suspension and termination provision in subsection (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), F.S., as mitigation to the sanction set forth in ~~conjunction with subsection (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 subsection (10) of this rule.~~

(b) For the first agency action against a provider after July 1, 2005, where a final overpayment is identified and a fine is to be imposed as a result of the violations giving rise to that overpayment, the cumulative amount of the fine shall not exceed thirty-percent of the amount of the overpayment. Where the fine does exceed thirty-percent of the amount the overpayment, the fine shall be adjusted to thirty-percent of the amount of the overpayment.

(c) For the second agency action against a provider after July 1, 2005, where a final overpayment is identified and a fine is to be imposed as a result of the violations giving rise to that overpayment, the cumulative amount of the fine shall not exceed fifty-percent of the amount of the overpayment. Where the fine does exceed fifty-percent of the amount the overpayment, the fine shall be adjusted to thirty-percent of the amount of the overpayment.

(d) For all subsequent agency actions against a provider after July 1, 2005, where a final overpayment is identified and a fine is to be imposed as a result of the violations giving rise to that overpayment, the cumulative amount of the fine shall not exceed the amount of the overpayment. Where the fine does exceed the amount the overpayment, the fine shall be adjusted to the amount of the overpayment.

(e) Sanctions only apply at the final agency action.

(f) Where the final agency action results in a final overpayment determination that is less than $5,000, any fine that is to be imposed as a result of the violations giving rise to that overpayment shall be waived.

1. However, where waiving the fine results in no sanction being imposed, the sanction of a corrective action plan in the form of a provider acknowledgement statement shall be imposed.

2. Fines that are to be imposed as a result of violations that do not give rise to an overpayment are not waived.

(g) Where the Agency has instituted an amnesty program pursuant to Section 409.913(25)(e), F.S., sanctions will not apply.

(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 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 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), the provider's participation in the Florida Medicaid program for a period no less than that imposed by the federal government or the 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), F.S.]

(7) SANCTIONS: Except when the Secretary of the Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S., sanctions 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)(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 Medicaid-related records sought by any investigator. [Section 409.913(15)(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)(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)(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, 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. [Section 409.913(15)(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 excessive, of inferior quality, or that are found to be harmful to the recipient. [Section 409.913(15)(f), F.S.];

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

(h) Submitting, or causing to be submitted, false or a pattern of erroneous Medicaid claims. [Section 409.913(15)(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)(i), F.S.];

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

(k) Including costs in a cost report that are not authorized ~~allowed~~ under the Medicaid state ~~reimbursement~~ plan or that are authorized but were disallowed during the audit process, 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. Additionally, a provider is only considered to have been previously advised that the costs were not allowable if the provider was advised in writing via an audit exit conference that the cost is not allowed or has been issued an audit report, either of which were provided in the previous five years. [Section 409.913(15)(k), F.S.];

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

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

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

(q) Failure to comply with any of the terms of a previously agreed-upon repayment schedule. [Sections 409.913(15)(q), 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)(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)(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)(c), F.S. (generally, a provider is found by a court, administrative law judge, hearing officer, administrative or regulatory board, or final agency action 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)(c), 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 days, suspension; and, where the provider remains out of compliance for more than 180 days , termination.

(c) For failure to reimburse an overpayment, in accordance with Section 409.913(30), F.S. (generally, a provider that fails to repay an overpayment or enter into a repayment agreement 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 days, suspension; and, where the provider remains out of compliance for more than 180 days, termination.

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

(10) GUIDELINES FOR 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 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) For purposes of determining whether a violation of paragraph (7)(e) of this rule is a first, second, third, fourth, fifth, or subsequent violation, previous violations of any provision of a provisions of the Medicaid provider publications that have been adopted by reference as rules, Medicaid laws, 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 shall be considered a same violation.

(c)~~(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, unless the table in paragraph (10)(j) specifies otherwise, 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).

(f)~~(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", 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 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.

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 Medicaid policy compliance individuals for the provider, and must include treating providers involved with the areas of non-compliance as well as billing staff, who must successfully complete the required education.

b. The provider 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 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. 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 self-audit must be completed within 90 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. 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 "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.

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. Failure to timely comply with any of the timeframes set forth by the Agency, or to adhere to 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, the provider shall be terminated from the Medicaid program.

(g)~~(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.

(h)~~(g)~~ 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 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.

(i)~~(h)~~ 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. A provider who is terminated 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.

(j)~~(i)~~ 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 |
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| (7)(a) The provider's license has not been renewed by the licensing agency; or the license has been revoked, suspended, or terminated, by the licensing agency of any state. [409.913(15)(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)(b), F.S.]; | A $1,000 fine per record request or instance of refused access; if after 30 days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days, the provider is still in violation, termination. | A $2,500 fine per record request or instance of refused access; if after 30 days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days, the provider is still in violation, termination. | A $5,000 fine per record request or instance of refused access; if after 30 days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days, the provider is still in violation, termination. | A $5,000 fine per record request or instance of refused access; if after 30 days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days, the provider is still in violation, termination. | A $5,000 fine per record request or instance of refused access; if after 30 days, the provider is still in violation, suspension until the records are made available or access is granted; if after 180 days, the provider is still in violation, termination. |
| (7)(c) Failure to furnish records, within time frames established by the Agency. [409.913(15)(c), F.S.]; | A $500 fine per record request; if after 30 days, the provider is still in violation, suspension until the records are made available; if after 180 days, the provider is still in violation, termination. | A $1,000 fine per record request; if after 30 days, the provider is still in violation, suspension until the records are made available; if after 180 days, the provider is still in violation, termination. | A $2,500 fine per record request; if after 30 days, the provider is still in violation, suspension until the records are made available; if after 180 days, the provider is still in violation, termination. | A $5,000 fine per record request; if after 30 days, the provider is still in violation, suspension until the records are made available; if after 180 days, the provider is still in violation, termination. | A $5,000 fine per record request; if after 30 days, the provider is still in violation, suspension until the records are made available; if after 180 days, the provider is still in violation, termination. |

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| (7)(d) Failure to maintain contemporaneous Medicaid-related records. [409.913(15)(d), F.S.]; | A $100 fine per claim for which supporting documentation is not maintained, not to exceed $1,500 per agency action. For a pattern: a $1000 fine per patient record for which any of the supporting documentation is not maintained, not to exceed $3,000 per agency action; 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, not to exceed $3,000 per agency action. For a pattern: a $2000 fine per patient record for which any of the supporting documentation is not maintained, not to exceed $6,000 per agency action; and submission of a corrective action plan in the form of provider education. | A $300 fine per claim for which supporting documentation is not maintained, not to exceed $4,500 per agency action. For a pattern: a $3000 fine per patient record for which any of the supporting documentation is not maintained, not to exceed $9,000 per agency action; 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. [409.913(15)(e), F.S.]; | A $500 fine per provision, not to exceed $1,500 per agency action. For a pattern: a $1,000 fine per provision, not to exceed $3,000 per agency action; and submission of a corrective action plan in the form of an acknowledgement statement. | A $1,000 fine per provision, not to exceed $3,000 per agency action. For a pattern: a $2,000 fine per provision, not to exceed $6,000 per agency action; and submission of a corrective action plan in the form of provider education. | A $2,000 fine per provision, not to exceed $6,000 per agency action; and submission of a corrective action plan in the form of an acknowledgement statement. For a pattern: a $3,000 fine per provision, not to exceed $9,000 per agency action; and submission of a corrective action plan in the form of a comprehensive quality assurance program. | A $3,000 fine per provision, not to exceed $12,000 per agency action; and submission of a corrective action plan in the form of provider education. For a pattern: a $4,000 fine per provision, not to exceed $16,000 per agency action; and suspension. | A $5,000 fine per provision, not to exceed $20,000 per agency action; 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)(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 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 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 instance and suspension. | Termination. | Termination. |
| (7)(g) A pattern of failure to provide goods or services that are medically necessary. [409.913(15)(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. |

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| (7)(h) Submitting false or a pattern of erroneous Medicaid claims. [409.913(15) (h), F.S.]; | For false claims: Termination. For a pattern of erroneous claims: a $2,500 ~~$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 $5,000 ~~$2,000~~ fine ~~for each claim in the pattern;~~ and 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)(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)(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)(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)(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) (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)(n), F.S.]; | A $5,000 fine. | A $5,000 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 s. 409.907. [409.913(15)(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 s. 409.920. [409.913(15)(p), 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)(q), F.S.]; | A $1,000 fine; and, where the provider remains out of compliance for 30 days, suspension; and, where the provider remains out of compliance for more than 180 days, termination. | A $2,000 fine; and, where the provider remains out of compliance for 30 days, suspension; and, where the provider remains out of compl iance for more than 180 days, termination. | A $3,000 fine and suspension until in compliance; where the provider remains out of compliance for more than 180 days, termination. | A $4,000 fine and suspension until in compliance; where the provider remains out of compliance for more than 180 days, termination. | A $5,000 fine and suspension until in compliance; where the provider remains out of compliance for more than 180 days, termination. |

Specific Authority Section 409.919 FS. Law Implemented Sections 409.907, 409.913, 409.9131, 409.920, 812.035 FS. History–New 4-19-05, Amended _____

**DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION**

**Construction Industry Licensing Board**

RULE TITLE: RULE NO.:
Written Examination for Swimming Pool Specialty Contractors 61G4-16.002

PURPOSE AND EFFECT: The Board proposes to describe written examinations for Swimming Pool Specialty Contractors.

SUBJECT AREA TO BE ADDRESSED: Written examinations for Swimming Pool Specialty Contractors.

SPECIFIC AUTHORITY: 120.53, 455.217(1), 489.113(6), 489.115(5) FS.

LAW IMPLEMENTED: 120.53, 455.217(1), 489.113(6), 489.115(5) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Tim Vaccaro, Executive Director, Construction Industry Licensing Board, Northwood Centre, 1940 N. Monroe Street, Tallahassee, Florida 32399-0750

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

**DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION**

**Board of Employee Leasing Companies**

RULE TITLE: RULE NO.:
Requirements for Evidence of Workers' Compensation Coverage 61G7-10.0014

PURPOSE AND EFFECT: The Board proposes development of this rule to determine whether changes are necessary.

SUBJECT AREA TO BE ADDRESSED: Requirements for Evidence of Workers' Compensation Coverage.

SPECIFIC AUTHORITY: 468.522, 468.525, 468.529 FS.

LAW IMPLEMENTED: 468.3525, 468.529 FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: John Knap, Executive Director, Board of Employee Leasing Companies, 1940 North Monroe Street, Tallahassee, Florida 32399-0783

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

**DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION**

**Building Code Administrators and Inspectors Board**

RULE TITLE: RULE NO.:
Voluntary Certification Categories 61G19-6.016

PURPOSE AND EFFECT: The Board proposes to review the rule to determine whether amendments are necessary.

SUBJECT AREA TO BE ADDRESSED: The Board proposes to delete rule language pertaining to specialty licenses.

SPECIFIC AUTHORITY: 468.606, 468.609(10) FS.

LAW IMPLEMENTED: 468.609(10) FS.

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Robyn Barineau, Executive Director, Building Code Administrators and Inspectors Board, Northwood Centre, 1940 N. Monroe Street, Tallahassee, Florida 32399-0750

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

61G19-6.016 Voluntary Certification Categories.

The following voluntary certification categories are created. ~~All specialty licenses require a standard certification.~~

(1) through (6) No change.

Specific Authority 468.606, 468.609(10) FS. Law Implemented 468.609(10) FS. History–New 7-5-95, Amended 7-7-96, 8-6-97, 6-25-98, 12-28-00, 2-28-02, 4-7-03, 9-3-03,_____.

**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 CHILDREN AND FAMILY SERVICES**

RULE CHAPTER TITLE: RULE CHAPTER NO.:
Human Resources 65-30
RULE TITLES: RULE NOS.:
Disciplinary Standards 65-30.001
General Principles 65-30.002
Status Upon Appointment 65-30.003

PURPOSE AND EFFECT: The purpose of this rulemaking is to implement, by rule, the recommendation of the Governor's Blue Ribbon Panel on Child Protection concerning re-hiring of certain specified former agency employees. Upon approval of the Administration Commission, the department will not hire,

re-hire, appoint or re-appoint persons former members of the Other-Personal-Service Temporary Employment System, the Career Service System, the Selected Exempt Service System, or the Senior Management Service System whose previous employment was terminated for cause, or pursuant to their resignation in lieu of termination or while the subject of a pending agency investigation.

SUBJECT AREA TO BE ADDRESSED: (NOTE: Notices of Development formerly published in the Florida Administrative Weekly identified these proposed rules as "65C-32, Appointments and Status", "65C-32.001, Disciplinary Standards", "65C-32.002, General Principles", and "65C-32.003, Status Upon Appointment". Pursuant to Rule 1S-1.001(9)(a), F.A.C., these rules have been renumbered to clarify their application to all Department employees.)

The Department of Management Services is given specific authority to adopt rules governing the administration of the State Personnel System. Pursuant to its authority, the Department of Management Services promulgated chapters 60L-33 and 60L-36. Chapter 60L-33, including Rule 60L-33.002(2), does not address the future employability or qualifications of persons previously determined by the Department of Children and Family Services and, where appropriate, the Public Employees Relations Commission, not to be a good candidate for employment with the Department of Children and Family Services. The Governor's Blue Ribbon Panel on Child Protection recommended that employees whose employment relationship with the Department of Children and Family Services is terminated either for cause, or pursuant to their resignation in lieu of dismissal, not be employed or re-employed. The Department of Children and Family Services implemented this recommendation of the Governor's Blue Ribbon Panel on Child Protection. These rules complete the implementation of the recommendations.

SPECIFIC AUTHORITY: 110.201, 110.217 FS.

LAW IMPLEMENTED: 110.131, 110.201, 110.211, 110.213, 110.227, 110.403, 110.604, 110.605 FS.

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

TIME AND DATE: 10:00 a.m., Thursday, December 22, 2005

PLACE: Department of Children and Family Services, 1317 Winewood Boulevard, Building 1, Room 103, Tallahassee, FL 32399-0700

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: David R. DiSalvo, Human Resources Director-DCF, 1317 Winewood Blvd., Building 1, Rm. 106C, Tallahassee, Florida 32301

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

65-30.001 Disciplinary Standards.

(1) This rule sets forth the minimal standards of conduct that apply to all employees in the State Personnel System, violation of which may result in dismissal.

(2) Agencies within the State Personnel System perform a vast array of functions and deliver a wide variety of services. Some employees perform routine tasks in a safe office environment, while others engage in unpredictable life-threatening situations under the most demanding circumstances. Breach of a particular standard in one context might be less serious, while in another it might result in the loss of life or property. Accordingly, each agency shall have primary authority and responsibility for managing the conduct of its employees. If an agency deems it necessary to discipline an employee for violation of this rule, the agency may impose any discipline up to and including dismissal, taking into account the agency's unique mission and the individual facts and circumstances.

(3) Employees outside the permanent career service may be dismissed at will. Permanent career service employees may be suspended or dismissed only for cause, which shall include, but not be limited to, the following. Examples under the categories listed below are not exhaustive.

(a) Poor performance. Employees shall strive to perform at the highest level of efficiency and effectiveness; they shall do more than "just get by."

1. Employees are expected to be reliable and dependable, for example: to show up for work, ready to work, on a reliable basis; to observe established work hours and scheduled appointments; to complete work on time; and to obtain permission before being off work and to schedule leave in a manner that minimizes work disruption.

2. Employees are expected to be effective, for example: to organize their work; to stay focused on job related activities during work hours; to provide the level of effort necessary to get the job done; to demonstrate willingness and ability to make decisions and exercise sound judgment; to produce work that consistently meets or exceeds expectations; to accept responsibility for their actions and decisions; to adapt to changes in work assignments, procedures, and technology; and to be committed to improving individual performance.

(b) Negligence. Employees shall exercise due care and reasonable diligence in the performance of job duties.

(c) Inefficiency or inability to perform assigned duties. Employees shall, at a minimum, be able to perform duties in a competent and adequate manner.

(d) Insubordination. Employees shall follow lawful orders and carry out the directives of persons with duly delegated authority. Employees shall resolve any differences with management in a constructive manner.

(e) Violation of law or agency rules. Employees shall abide by the law and applicable rules and policies and procedures, including those of the employing agency and the

rules of the State Personnel System. All employees are subject to Part III of Chapter 112, Florida Statutes, governing standards of conduct, which agencies shall make available to employees. An agency may determine that an employee has violated the law even if the violation has not resulted in arrest or conviction. Employees shall abide by both the criminal law, for example, drug laws, and the civil law, for example, laws prohibiting sexual harassment and employment discrimination.

(f) Conduct unbecoming a public employee. Employees shall conduct themselves, on and off the job, in a manner that will not bring discredit or embarrassment to the state.

1. Employees shall be courteous, considerate, respectful, and prompt in dealing with and serving the public and co-workers.

2. Employees shall maintain high standards of honesty, integrity, and impartiality. Employees shall place the interests of the public ahead of personal interests. Employees shall not use, or attempt to use, their official position for personal gain or confidential information for personal advantage.

3. Employees shall protect state property from loss or abuse, and they shall use state property, equipment and personnel only in a manner beneficial to the agency.

(g) Misconduct. Employees shall refrain from conduct which, though not illegal or inappropriate for a state employee generally, is inappropriate for a person in the employee's particular position. For example, cowardice may be dishonorable in people generally, but it may be entirely unacceptable in law enforcement officers. By way of further example, people are generally free to relate with others, but it may be entirely unacceptable for certain employees to enter into certain relations with others, such as correctional officers with inmates.

(h) Habitual drug use. Agencies shall not tolerate violations of Florida's Drug Free Workplace Act, Section 112.0455, Florida Statutes, or other misuse of mood- or mind-altering substances, including alcohol and prescription medications.

(i) Conviction of any crime, including a plea of nolo contendere and a plea of guilty with adjudication withheld.

(4) Agencies are responsible for identifying instances of unacceptable behavior and for taking appropriate action. Before taking corrective action, an agency shall have evidence that the employee failed to comply with a standard or expectation.

(5) Agencies shall make known to permanent career service employees the procedures specified in Section 110.227, Florida Statutes. Section 110.227(5)(a), Florida Statutes, establishes procedures for suspension, reduction in pay, demotion, or dismissal of permanent career service employees. An agency taking such action shall, in addition to furnishing notice of intent to take such action, furnish the employee with written notice of final action. The written notice of final action shall advise the employee of appeal rights under Section 110.227(5)(a), Florida Statutes, under any applicable collective bargaining agreements, and under any other applicable statutory provisions, such as Parts VI or VIII of Chapter 112, Florida Statutes. The fourteen-day deadline for appeal established in Section 110.227(5)(a), Florida Statutes, shall be measured from the date the employee receives the written notice of final action.

(6) Employees whose employment relationship with the Department of Children and Family Services is terminated either for cause, or pursuant to their resignation in lieu of dismissal or while the subject of a Department investigation, will not be employed or re-employed.

Specific Authority 110.201 FS. Law Implemented 110.131, 110.201, 110.211, 110.213, 110.227, 110.403, 110.604, 110.605 FS. History–New_____.

65-30.002 General Principles.

(1) The Department of Children and Family Services shall fill established positions with one of the following types of appointments: original, promotion, demotion, or reassignment. All non-career service appointments shall be original appointments.

(2) Any person appointed to a position must meet any licensure, certification or registration requirements established for the position, and any required knowledge, skills, abilities, and any other requirements the Department establishes for the position, unless the appointment is with trainee or temporary status in accordance with paragraphs 65-30.002(2)(b) or (c), F.A.C.

(3) Employees on military leave shall be treated as if they had been continuously employed for purposes of status, pay, and other benefits.

(4) The Department of Children and Family Services may make an acting appointment of a current state employee to fill a vacancy within the senior management service or the selected exempt service. The employee shall continue to earn leave and receive benefits of the employee's permanent position. The Department may grant the employee a temporary salary increase during the acting appointment.

(5) Every employee not permanent in a position shall serve at the pleasure of the agency and shall be subject to any personnel action, including but not limited to, suspension, dismissal, reduction in pay, demotion, or reassignment, at the discretion of the Department. Except when taken with respect to career service employees permanent in their position, such personnel actions are exempt from the provisions of Section 110.227 and Chapter 120 of the Florida Statutes.

(6) An employee who has been terminated for cause, or has resigned in lieu of termination or while the subject of a Department investigation shall not be employed or re-employed by the Department of Children and Family Services.

Specific Authority 110.201, 110.217 FS. Law Implemented 110.131, 110.201, 110.211, 110.213, 110.227, 110.403, 110.604, 110.605 FS. History–New_____.

65-30.003 Status Upon Appointment.

(1) An employee appointed to fill a position in the career service shall be given status in accordance with the following:

(a) Overlap Status – An employee shall be given overlap status when appointed to perform the duties of another employee in a filled position. Time spent on overlap status shall count toward completion of a probationary period if, while on overlap status, the employee performed all of the duties of the position.

(b) Temporary Status – An employee shall be given temporary status when temporarily appointed to fill a vacant position. The appointment shall be for no more than 1040 hours during any twelve-month period, absent the Department of Management Services' approval of a written request for extension. Time spent on temporary status shall not count toward completion of a probationary period.

(c) Trainee Status – An employee appointed to a position as a trainee shall be given trainee status in accordance with the trainee program developed by the agency. The program shall include an outline of the proposed pay schedule for the training period, including justification for the proposed schedule. Upon successful completion of the trainee program, the employee may be appointed to a position in the same broadband level requiring the same licensure, certification or registration requirement and required knowledge, skills, and abilities. An agency may approve appointments with trainee status in the following programs: cooperative education program; vocational rehabilitation or blind services program; agency trainee program; or return to work program. Time spent on trainee status shall not count toward completion of a probationary period.

(d) Probationary or Permanent Status – An employee shall be given probationary status or permanent status in accordance with the following:

1. Upon original appointment, promotion or demotion to a different broadband level, or any time an employee moves between agencies, an employee shall be given probationary status unless a demotion is to a position in which the employee has previously held permanent status in the agency or unless the legislature has designated that an employee shall be moved but shall not have status as a new employee.

2. An employee appointed on probationary status shall attain permanent status in the career service upon successful completion of the designated probationary period.

3. Time spent on military leave shall count toward completion of the employee's probationary period, and an employee on military leave can attain permanent status while on such leave.

4. Part-time employees and employees filling shared employment positions shall attain permanent status in the same manner as full-time employees.

Specific Authority 110.201, 110.217, F.S. Law Implemented 110.131, 110.201, 110.211, 110.213, 110.227, 110.403, 110.604, 110.605 FS. History–New .

**DEPARTMENT OF FINANCIAL SERVICES**

**Division of State Fire Marshal**

RULE CHAPTER TITLE: RULE CHAPTER NO.:
The Florida Fire Prevention Code 69A-60
RULE TITLE: RULE NO.:
Non-Binding Interpretations of the Florida Fire Prevention Code 69A-60.011

PURPOSE AND EFFECT: To adopt a rule providing for informal non-binding interpretations of the Florida Fire Prevention Code, as directed by Section 633.26, Florida Statutes.

SUBJECT AREA TO BE ADDRESSED: Informal non-binding interpretations of the Florida Fire Prevention Code.

SPECIFIC AUTHORITY: 633.01, 633.26 FS.

LAW IMPLEMENTED: 633.26 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW. IF A WORKSHOP IS NOT REQUESTED, NO WORKSHOP WILL BE HELD.

TIME AND DATE: 9:00 a.m., December 19, 2005

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Jim Goodloe, Chief, Bureau of Fire Prevention, 200 East Gaines Street, Tallahassee, Florida 32399-0342, tel. (850)413-3173, Fax (850)414-6119, email: Jim.Goodloe@FLDFS.COM.

Pursuant to the provisions of the Americans with Disabilities Act and Section 286.26, Florida Statutes, any person requiring special accommodations to participate in this program, please advise the Department at least 48 hours before the program by contacting Millicent King, (850)413-3173.

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

69A-60.011 Non-Binding Interpretations of the Florida Fire Prevention Code.

(1) Definitions. For purposes of this rule section:

(a) "Code" means the Florida Fire Prevention Code.

(b) "State Fire Marshal" means the Chief Financial Officer of the State of Florida acting as State Fire Marshal, or the Division of State Fire Marshal, as the context requires.

(c) "Organization" means the entity with which the State Fire Marshal enters into a contract to provide administrative services in support of informal, non-binding interpretations as described in Section 633.26, F.S.

(d) "Regional Interpretations Committee," or "RIC," means each committee providing an informal interpretations.

(2) Procedures. The following procedures apply to the organization and to each RIC.

(a) At least annually, the organization shall provide to the Division a list of all certified firesafety inspectors that are authorized to serve on a RIC in rendering interpretations, including proof of at least five-years' experience in performing firesafety inspections as a certified firesafety inspector.

(b) Each person to serve on a RIC must have on file with the Division Form DFS XX-XXX, rev. 09/05, which is hereby adopted and incorporated herein, and which may be obtained by writing to the Division of State Fire Marshal, 200 East Gaines Street, Tallahassee, Florida 32399-0340, or by visiting the State Fire Marshal's website located at http://www.fldfs.com/SFM/index.htm.

(c) The name of each person to serve on a RIC must be on file with the Division at least 30 days before that person is permitted to voice an opinion or cast a vote as a member of a RIC on a request for a non-binding interpretation.

(d) Any RIC rendering an informal interpretation involving a public school must include at least one member employed by or who represents the local school board, or who was recommended by the Department of Education.

(e) Requests for non-binding interpretations of the Code shall be made as directed at the Division of State Fire Marshal website.

(f) The organization through its designated representative or representatives shall review each request for an informal interpretation.

1. If the request for informal interpretation does not qualify for consideration by the RIC, the organization shall so advise the requestor.

2. If the request for informal interpretation is proper, the organization shall assign it to a RIC.

3. If the RIC deems it appropriate or necessary, it is permitted to initiate a review process which solicits comments for development of a response.

(g) The RIC is not permitted to consider any comment unless the comment includes the name, employer if any, and contact information of the submitter. Anonymous comments shall not be presented to or considered by the RIC.

(h) The RIC shall prepare a response that is the result of a vote of at least a majority of the persons on the RIC.

(i) Each person on the RIC reviewing a request must be identified in the response including the results of any vote.

(j) Each meeting of each RIC must be recorded and such recordings shall be retained in accordance with the contract between the State Fire Marshal and the organization.

(k) Each meeting shall be in-person, or by phone, teleconference, video conference, or such other means that permit interactive communication among the RIC, the requesting party, and any other person or entity deemed appropriate by the RIC.

(l)1. The RIC shall submit its response to the organization which shall forward the response without comment or amendment to the requestor via electronic mail (email), if available and, if not available, by facsimile transmission or regular mail within 14 days of receipt of the question.

2. If a response will not or cannot for any reason be sent to the requestor within 14 days of receipt, the requestor shall be so notified by email, if available and, if not available, by facsimile transmission or regular mail. Such response shall be provided thereafter as soon as reasonably practicable, but not later than 30 days after submission of the request.

3. Each response shall also be sent via email to the Division of State Fire Marshal at the email address in the contract.

(m) Each response shall be posted on the organization's website.

(n) Each response is the opinion of each RIC rendering the same or a majority of the members of such RIC, and not the State Fire Marshal nor the organization, and shall create no legal right on the part of any person nor any legal duty on the part of the RIC, the organization, any individual, the State Fire Marshal, the State of Florida, nor any other person or entity.

(3)(a) No person is permitted to serve on any RIC considering any matter involving such person's own jurisdiction if he or she is the firesafety inspector for that jurisdiction whose duties by law, rule, or ordinance require or permit him or her to inspect any building or structure which is the subject of the request to the RIC, or if that person has provided input on the matter for the building or structure that is the subject of the request.

(b) Each person serving on a RIC shall serve at the pleasure of the State Fire Marshal or the organization and no person has any recourse against the State Fire Marshal or the organization for removal from the RIC except as otherwise provided by federal or state law.

Specific Authority 633.01, 633.26 FS. Law Implemented 633.26 FS. History–New_____.