

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

(1) Purpose. This rule provides notice of administrative sanctions imposed upon a provider, entity, or person for each violation of any Medicaid-related law.

(2) Applying and reporting sanctions. Notice of the application of sanctions will be by way of written correspondence, and the final notice shall be the point of entry for administrative proceedings pursuant to Chapter 120, F.S. Satisfaction of an overpayment following a preliminary audit report, will not avoid the application of sanctions at a final audit report, unless the Agency for Health Care Administration (Agency) offers amnesty pursuant to section 409.913(25)(e), F.S. The Agency shall report all sanctions imposed upon any provider, entity, or person, or any principal, officer, director, agent, managing employee, or affiliated person of a provider, who is regulated by another state entity, regardless of whether enrolled in the Medicaid program, to that other state entity. Sanctions are imposed upon the Final Order being filed with the Agency Clerk.

(3) Definitions.

(a) "Audit report" is the written notice of determination that a violation of Medicaid laws has occurred, and where the violation results in an overpayment, it also shows the calculation of overpayments.

(b) "Claim" is as defined in section 409.901(6), F.S., and includes the total monthly payment to a provider for per diem payments, and the payment of a capitation rate for a Medicaid recipient.

(c) "Contemporaneous records" means records created at the time the goods or services were provided, unless otherwise specified in Medicaid laws, or the laws that govern the provider's profession.

(d) A "Corrective action plan" is an activity to address the specific areas of non-compliance, determined by the Agency, to reduce the risk of future non-compliance.

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

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

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

(h) "Offense" means the occurrence of one or more violations as set forth in a final audit report. For purposes of the progressive nature of sanctions under this rule, offenses are characterized as "first," "second," "third," or "subsequent" offenses; subsequent offenses are any occurrences after a third offense.

(i) "Patient record" means the patient's medical record, including all documentation maintained by the provider, entity, or person to document furnishing, ordering, or authorizing goods or services, and includes the documentation in multiple files if the practitioner maintains separate files for different types of documentation.

(j) "Patient record request" means a request by the Agency for Medicaid-related documentation or information. Such requests are not limited to Agency audits to determine overpayments or violations, and are not limited to enrolled Medicaid providers. Each requesting document constitutes a single patient record request.

(k) "Pattern of erroneous claims" is defined as when more than 5% of the claims reviewed are found to contain an error, or the reimbursements for the claims found to contain an error, are more than 5% of the total reimbursement for the claims reviewed.

(l) "Provider" is as defined in section 409.901(17), F.S., and includes all of the provider's locations that have the same base provider number (with separate locator codes).

(m) "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.

(n) "Sanction" shall be any monetary or non-monetary disincentive imposed pursuant to this rule; a monetary sanction may be referred to as a "fine."

(o) "Suspension" is a one-year preclusion from furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services that result in a claim for payment to the Medicaid program. Suspension applies to any person, corporation, partnership, association, clinic, group, or other entity, whether or not enrolled in the Medicaid program.

(p) "Termination" is a twenty-year preclusion from furnishing, supervising a person who is furnishing, or causing a person to furnish goods or services that result in a claim for payment to the Medicaid program. Termination applies to any person, corporation, partnership, association, clinic, group, or other entity, whether or not enrolled in the Medicaid program; however, if termination is imposed against a provider enrolled in the Medicaid program, the provider agreement shall also be terminated. A termination pursuant to this rule is also called a "for cause" or "with cause" termination.

(q) "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, or subsequent offenses under this rule, prior Agency actions during the preceding five years will be counted where the provider, entity, or person was deemed to have committed the same violation.

3. The failure to comply with a corrective action plan constitutes a violation, and is an ongoing violation, for each day following the deadline for submission of the corrective action plan that the failure continues.

4. For purposes of determining a violation regarding including an unallowed cost in a cost report (paragraph (7)(k) and section 409.913(15)(k), F.S.), if the unallowed cost or costs are the subject of an administrative hearing pursuant to Chapter 120, F.S., inclusion of the unallowed cost, or costs, in a cost report is not a violation until the conclusion of the administrative proceedings.

5. For purposes of violations under paragraph (7)(n) of this rule, regarding purchase shortages (as opposed to shortages of time), each good found to be short, by units of each type of goods, such as each tablet of a particular drug, is a violation.

6. For purposes of violations under paragraph (7)(q) of this rule (generally, non-payment on a payment plan), a second, third, or subsequent offense occurs when there has been a prior violation on any repayment agreement.

(4) Limits on sanctions.

(a) Where a sanction is applied for violations of Medicaid laws (under paragraph (7)(e) of this rule), for a pattern of erroneous claims (under paragraph (7)(h) of this rule), or shortages of goods (under paragraph (7)(n) of this rule), and the violations are a "first offense" as set forth in this rule, if the cumulative amount of the fine to be imposed as a result of the violations giving rise to that overpayment exceeds 20% of the amount of the overpayment, the fine shall be adjusted to 20% of the amount of the overpayment.

(b) Where a sanction is applied for violations of Medicaid laws (under paragraph (7)(e) of this rule), for a pattern of erroneous claims (under paragraph (7)(h) of this rule), or shortages of goods (under paragraph (7)(n) of this rule), and the violations are a "second offense" as set forth in this rule, if the cumulative amount of the fine to be imposed as a result of the violations giving rise to that overpayment exceeds 40% of the amount of the overpayment, the fine shall be adjusted to 40% of the amount of the overpayment.

(c) Where a sanction is applied for violations of Medicaid laws (under paragraph (7)(e) of this rule), for a pattern of erroneous claims (under paragraph (7)(h) of this rule), or shortages of goods (under paragraph (7)(n) of this rule), and the violations are a "third" or "subsequent" offense, if the cumulative amount of the fine for violations giving rise to the overpayment exceeds 50% of the amount of the overpayment, the fine shall be adjusted to 50% of the amount of the overpayment.

(d) Where the audit report does not include an overpayment determination, it only applies a sanction, and where a fine is assessed for violations that are a "first offense" as set forth in this rule, the cumulative amount of the fine shall not exceed \$20,000; where the violations are a "second offense" as set forth in this rule, the cumulative amount of the fine shall not exceed \$50,000; where the violations are a "third or subsequent offense" as set forth in this rule, there are no limits on the cumulative amount of the fine to be applied.

(e) Where a sanction would apply pursuant to this rule, no sanction will be imposed if the Agency has instituted an amnesty pursuant to section 409.913(25)(e), F.S.

(5) Mandatory termination or suspension. Whenever the Agency is required to terminate or suspend participation in the Medicaid program and the required period of time for the exclusion exceeds one year, the sanction of termination shall apply.

(6) Additional requirements regarding suspension and termination.

(a) For purposes of this rule a "suspension" precludes participation for one year, or such shorter period of time as is set forth in this rule. The suspension period begins from the date of the Final Order that imposes the Agency action.

1. To resume participation following the suspension period, a written request must be submitted to the Agency's Bureau of Medicaid Program Integrity seeking to be reinstated in the Medicaid program. The request must include a copy of the notice of suspension and a statement regarding whether the violation(s) that brought rise to the suspension have been remedied. If the provider, entity, or person was not enrolled in the Medicaid program at the time of the suspension, the request must also include a complete and accurate provider enrollment application, even if the person or entity seeks only to prescribe, or otherwise order or authorize goods or services, and does not seek to directly furnish goods or services to Medicaid recipient; the application will be processed, and accepted or denied in the standard course of business by the Agency.

2. Participation in the Medicaid program may not resume until written confirmation is issued from the Agency indicating that

participation has been authorized. Where a Medicaid provider application is required, authorization is at the point where the person or entity is enrolled as a provider; if the application is not granted, the person or entity may not resume participation.

(b) For purposes of this rule, a “termination” shall preclude participation in the Medicaid program for twenty years from the date of the Agency action. The termination period begins from the date of the Final Order that imposes the Agency action, unless the termination is an “immediate termination.” An immediate termination period begins from the date of notice of the termination. To resume participation, the provider, entity, or person must submit a complete and accurate provider enrollment application, which will be processed, and accepted or denied in the standard course of business by the Agency. In addition to the application, the provider, entity, or person 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.

(7) Sanctions. In addition to the recoupment of the overpayment, if any, the Agency will impose sanctions as outlined in this subsection. 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 as follows:

(a) A required license is not renewed, or is revoked, suspended, or terminated: For a first offense of suspension, suspension for the duration of the licensure suspension; for all other violations, including suspension after a first offense, termination (section 409.913(15)(a), F.S.).

(b) For failure to make available, or refused access to Medicaid-related records necessary to review, investigate, analyze, audit, or any combination thereof, to determine if care, services, or goods were provided in compliance with applicable Medicaid laws, regulations, and policy. Making available only partial records or access is a violation: For a first offense, \$2,500 fine, per record request or instance of refused access, and suspension until the records are made available or access is granted; if after 10 days the violation continues, an additional \$1,000 fine, per day; and, if after 30 days the violation remains ongoing, termination. For a second offense, \$5,000 fine, per record request or instance of refused access, and suspension until the records are made available or access is granted; if after 10 days the violation continues, an additional \$2,000 fine, per day; and, if after 30 days the violation remains ongoing, termination. For a third, or subsequent offense, termination (section 409.913(15)(b), F.S.).

(c) For failure to make available or furnish all Medicaid-related records necessary to be used in determining whether, and what amount should have, or should be, reimbursed. Submission of partial or incomplete records does not comply with the records request and is a violation: For a first offense, \$2,500 fine, per record request, and suspension until the records are made available; if after 10 days the violation continues, an additional \$1,000 fine, per day; and, if after 30 days the violation remains ongoing, termination. For a second offense, \$5,000 fine, per record request, and suspension until the records are made available; if after 10 days the violation continues, an additional \$2,000 fine, per day; and, if after 30 days the violation remains ongoing, termination. For a third, or subsequent offense, termination (section 409.913(15)(c), F.S.).

(d) For failure to maintain contemporaneous documentation if the records not maintained are necessary to know that care, services, or goods were provided. Contemporaneous records that are partial or incomplete are a violation: For a first offense, \$250 fine, per claim; however, if there are more than two claims for the same patient without records, or more than two patients for which no records are maintained, \$2,500 fine, per patient for which there are any claims without records. For a second offense, \$500 fine, per claim; however, if there are more than two claims for the same patient without records, or more than two patients for which no records are maintained, \$5,000 fine, per patient for which there are any claims without records. For a third or subsequent offense, termination (section 409.913(15)(d), F.S.).

(e) For failure to comply with the provisions of the Medicaid laws: For a first offense, \$1,000 fine, per claim found to be in violation. For a second offense, \$2,500 fine, per claim found to be in violation. For a third, or subsequent offense, \$5,000 fine, per claim found to be in violation. For a violation of law that would mandate exclusion, termination; for a violation of law that could result in patient harm, termination; for violations of prerequisites to enrollment, termination (sections 409.907(10), and 409.913(14) and (15)(e), F.S.).

(f) For furnishing, authorizing, or ordering goods or services that are inappropriate, unnecessary, excessive, of inferior quality, or harmful: For a first offense, \$1,000 fine; however, if there is more than one instance, \$5,000 fine, per instance; For a second offense, \$5,000 fine; however, if there is more than one instance, \$5,000 fine per instance, and suspension; For a third and subsequent offense, \$5,000 fine per instance, and suspension, however; if there is more than one instance, termination (section 409.913(15)(f), F.S.).

(g) For a pattern of failure to provide necessary care: For a first offense, \$5,000 fine for each instance, and suspension. For a second or subsequent offense, termination (section 409.913(15)(g), F.S.).

(h) For false, or a pattern of erroneous, Medicaid claims:

1. For false claims, termination.

2. For a first offense of a pattern of erroneous claims, \$1,000 fine, per claim found to be erroneous. For a second offense of a pattern of erroneous claims, \$2,500 fine, per claim found to be erroneous. For a third, or subsequent offense of a pattern of erroneous claims, \$5,000 fine, per claim found to be erroneous (section 409.913(15)(h), F.S.).

(i) For an application, renewal, prior authorization, drug exception request, or cost report with materially false or materially incorrect information: For a first offense, \$10,000 fine, for each instance of false or incorrect information, and suspension. For a second, and subsequent offense, termination (section 409.913(15)(i), F.S.).

(j) For improperly collecting or billing a recipient: For a first offense, \$5,000 fine, per instance, and suspension; for a second, and subsequent offense, termination (section 409.913(15)(j), F.S.).

(k) For including costs in a cost report that are not authorized under the Medicaid state plan, or that were disallowed during the audit process, after having been advised that the costs were not allowable: For a first offense, \$5,000 fine; however, if after 30 days the violation continues, suspension, and \$1,000 fine, per day that the violation continues. For a second offense, \$5,000 fine; however, if after 30 days the violation continues, suspension, and \$5,000 fine, per day that the violation continues. For a third, and subsequent offense, termination (section 409.913(15)(k), F.S.).

(l) For being charged by information or indictment under federal law or the law of any state relating to the practice of the provider's profession, or an offense as referenced in section 409.913(13), F.S., or a criminal offense referenced in section 408.809(4), 409.907(10), or 435.04(2), F.S.: Immediate suspension for the duration of the indictment and, if convicted, termination (section 409.913(15)(l), F.S.).

(m) For negligently ordering or prescribing, which resulted in the patient's injury or death: immediate termination (section 409.913(15)(m), F.S.).

(n) For shortages of time: For a first offense, \$5,000 fine, per day found to have shortages, not to exceed the total Medicaid reimbursement for the day(s) with shortages; For a second offense, \$5,000 fine, per day found to have shortages, not to exceed two-times the total Medicaid reimbursement for the day(s) with shortages; For a third or subsequent offense, termination. For shortages of goods: For a first offense, \$1,000 fine, per type of good found to be short. For a second offense, \$2,500 fine, per type of good found to be short. For a third, or subsequent offense, \$5,000 fine, per type of good found to be short (section 409.913(15)(n), F.S.).

(o) For failure to comply with the notice and reporting requirements of section 409.907, F.S.: For a first offense, \$2,500 fine. For a second offense: \$5,000 fine. For a third, and subsequent offense: termination (section 409.913(15)(o), F.S.).

(p) For a finding of patient abuse or neglect, or any act prohibited by section 409.920, F.S.: Immediate suspension, and if convicted: termination (section 409.913(15)(p), F.S.).

(q) For failure to comply with any of the terms of a previously agreed-upon repayment schedule: For a first offense: \$5,000 fine, and suspension until the violation is corrected; if after 30 days the violation continues: termination. For a second offense: \$5,000 fine, and suspension until the violation is corrected, and, if the violation is not corrected within 5 calendar days, an additional \$1,000 fine, per day for which the violation continues; if after 30 days the violation continues: termination. For a third, and subsequent offense: termination (sections 409.913(15)(q) and 409.913(25)(c), F.S.).

(r) For violations under sections 409.913(13), F.S. (generally, criminal offenses related to the delivery of health care, the practice of the provider's profession, and patient abuse or neglect), the Agency shall consider the violations identified in sections 435.04 and 408.809, F.S., as related to the provider's profession, and shall impose immediate termination.

(s) For non-payment or partial payment where monies are owed to the Agency, and failure to enter into a repayment agreement, in accordance with sections 409.913(25)(c) and 409.913(30), F.S., the Agency shall impose the sanction of termination.

(8) Additional sanctions for multiple violations under the sanction rule. In the event the Agency issues an audit report wherein it has determined that violations of more than one provision of this rule (the sanction rule) have been committed, the Agency shall cumulatively apply the sanction associated with each section; if the violations invoke three or more provisions of this rule (the sanction rule), a corrective action plan will also be required.

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