FLORIDA: Summary of Fraud and Abuse Statutes and Regulations

Prepared by
Adam R. Maingot (adam.maingot@publix.com)
Publix Super Markets Inc.
Lakeland, FL

Joseph W.N. Rugg (JoeR@jpfirm.com)
Johnson Pope Bokor Ruppel & Burns LLP
Tampa, FL

CONTENT:
1) Anti-Kickback, Patient Brokering And Fee Splitting
2) Prohibitions On Self-Referral
3) Deceptive And Unfair Trade Practices
4) Corporate Practice Of Medicine
5) False Claims/Fraud & Abuse
6) General Whistleblower Protections
7) Helpful Links

1) ANTI-KICKBACK, PATIENT BROKERING, AND FEE SPLITTING

The Florida Anti-Kickback Statute, the Patient Brokering Act, and the cases and administrative decisions regarding fee splitting, must each be analyzed and applied to compensation and other financial arrangement between person and health care providers where there is a referral arrangement.

FS Section 456.054 — Kickbacks Prohibited
(Please note that this Statute has been revised effective 7/1/18, and the summary reflects the revisions.)

It is unlawful for any health care provider or any provider of health care services to offer, pay, solicit, or receive a kickback, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients.

For purposes of the statue, “‘kickback’ means a remuneration or payment, by or on behalf of a provider of health care services or items, to any person as an incentive or inducement to refer patients for past or future services or items, when the payment is not tax deductible as an ordinary and necessary expense.”

The 2018 revision makes the following revisions affecting clinical laboratories (see FS Section 483.803 for definition of “clinical laboratory”):
(1) It is unlawful for any person or entity to pay or receive, directly or indirectly, a commission, bonus, kickback, or rebate from, or engage in any form of a split-fee
arrangement with, a dialysis facility, health care practitioner, surgeon, person, or entity for referring patients to a clinical laboratory.

(2) It is unlawful for a clinical laboratory to (a) provide personnel to perform any functions or duties in a health care practitioner's office or dialysis facility for any purpose, including for the collection or handling of specimens, directly or indirectly through an employee, contractor, independent staffing company, lease agreement, or otherwise, unless the laboratory and the practitioner's office, or dialysis facility, are wholly owned and operated by the same entity; and (b) lease space within any part of a health care practitioner's office or dialysis facility for any purpose, including for the purpose of establishing a collection station where materials or specimens are collected or drawn from patients.

Violations are considered patient brokering and the punishment is as provided in that statute (FS 817.505(4)):

(1) Any person, including an officer, partner, agent, attorney, or other representative of a firm, joint venture, partnership, business trust, syndicate, corporation, or other business entity, who violates any provision of this section commits a felony of the third degree, punishable by a term of imprisonment not to exceed five years or ten years if a habitual felony offender, plus a fine of $50,000.

(2) However, if the prohibited conduct involves 10 or more patients but fewer than 20 patients, it is felony of the second degree, punishable by a term of imprisonment not to exceed 15 years or 30 years if a habitual felony offender, plus a fine of $100,000.

(3) And, if the prohibited conduct involves 20 or more patients, it is a felony of the first degree, punishable by a term of imprisonment not to exceed 30 years or life years if a habitual felony offender, plus a fine of $500,000.

Safe Harbors
There are no specific enumerated safe harbors or exceptions to the Florida Anti-Kickback Statute. However, in State of Florida v. Harden, 938 So. 2d 480 (Fla. 2006), the Florida Supreme Court stated that "[t]here is clear congressional intent to exempt compensation paid by employers to bona fide employees for providing covered items or services from those remunerations that constitute prohibited kickbacks under the federal statute. … [w]e agree … that the Florida anti-kickback statute is preempted [by the federal anti-kickback statute]". In addition, as discussed below, the Patient Brokering Statute incorporates the federal anti-kickback safe harbors.

**FS Section 817.505 — Patient Brokering Act**
In addition to FS 456.054 discussed above, Florida has enacted a prohibition against "patient brokering." This statute makes it unlawful for any person, including any health care provider or health care facility, to aid, abet, advise, or otherwise participate in an arrangement to offer, pay, solicit, or receive any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce or in return for the referral of patients or patronage, or acceptance or acknowledgment of treatment to or from, a health care provider or health care facility.
Any officer, partner, agent, attorney, or other representative of a firm, joint venture, partnership, business trust, syndicate, corporation, or other business entity, who violates the Florida Anti-Kickback Statute commits a felony of the third degree, punishable by a term of imprisonment not to exceed five years or ten years if a habitual felony offender, and subject to a fine not to exceed $5,000.

The terms "health care provider" and "health care facility" are broadly defined to include: (1) any person or entity subject to licensure from either the Florida Agency for Health Care Administration (AHCA) or the Florida Department of Health; or (2) any person or entity that has contracted with AHCA to provide goods or services to Medicaid recipients.

Exemptions and Safe Harbors
The Florida Patient Brokering Act does not apply to:
(1) Any payment practice not prohibited by the federal anti-kickback statute or regulations promulgated thereunder (i.e., practices that meet the statutory or regulatory safe harbors);
(2) Any financial arrangement between a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association;
(3) Professional consultation service payments to a health care provider or health care facility;
(4) Remuneration lawfully paid to insurance agents under the Florida Insurance Code;
(5) Payments by a health insurer who reimburses, provides, offers to provide, or administers health, mental health, or substance abuse goods or services under a health benefit plan;
(6) Payments to or by a health care provider, facility, or network entity, that has contracted with a health insurer, a health care purchasing group, or the Medicare or Medicaid program to provide health, mental health, or substance abuse goods or services under a health benefit plan;
(7) Insurance advertising merchandise valued at less than $25 provided to current or potential recipients;
(8) Commissions or fees paid to a nurse registry licensed for referring health care service providers to the nurse registry clientele;
(9) Payments by a health care provider or health care facility to a health, mental health, or substance abuse information service, provided that such information service: (a) does not attempt to steer consumers, or arrange for transportation to or from a particular health care provider or health care facility; (b) does not provide or represent itself as providing diagnostic or counseling services or assessments of illness or injury and does not make any promises of cure or guarantees of treatment; or (c) charges and collects fees from a health care provider or health care facility participating in its services set in advance, consistent with the fair market value for those information services, and not based on the potential value of a patient or patients to the health care provider or
health care facility or of the goods or services provided by the health care provider or health care facility; or

(10) Payments from an assisted living facility to (a) the assisted living facility’s employee or contractor for marketing services, so long as the individual clearly indicates that the individual works with the facility; (b) a facility resident who refers a personal contact, such as a family member or friend; and (c) a referral service that provides information, consultation, or referrals to non-Medicaid seniors or disabled adults, to help locate appropriate care or housing options for those individuals.

Prohibition against Fee Splitting
A number of Florida statutes and administrative code rules prohibit the respective health care provider from entering into a fee-splitting arrangement (see “Companion Statutes and Regulations”). There is no specific statutory definition of the term "fee-splitting," but the term has been discussed in a number of Florida Board of Medicine declaratory statements and in court cases. In Practice Management Associates, Inc. v. Orman (discussed below), a Florida appellate court stated that fee-splitting is “a dividing of a professional fee for specialist's medical services with the recommending physician.”

Compensation arrangements where a licensed health care provider is compensated on the basis of a percentage of the fees that he generates must be analyzed to determine the basis for the allocation of the fees and to determine the value of the services the provider receives in exchange for the percentage of the fees retained by his or her employer.

FS Section 456.0635 — Health Care Fraud and Disqualification for License
This statute provides that “Health care fraud in the practice of a health care profession is prohibited.” FS 456.0635(1). The statute goes on to prohibit the Department of Health from issuing or renewing the license of an individual who was convicted of, or entered a plea of nolo contendere to, regardless of adjudication, of certain felonies related to Medicaid, Medicare, fraud, or controlled substances. The statute contains a tiered system of exclusions based on the severity of the crime and the amount of time elapsed between the crime and the application for licensure.

Companion Statutes and Regulations
Additional provider-specific guidance may be found throughout the Florida Statutes (FS) and the Florida Administrative Code (FAC) for specific health care providers, including the following:

- Abortion Referral or Counseling Agencies (FS 390.025)
- Assisted Living Facilities (FS 429.125)
- Behavioral Health (FS 490.009, 491.009), (FAC 64B4-5.001, 64B19-17.002, 64B21-504.001)
- Dentistry (FS 466.0235, 466.024), (FAC 64B5-16.0075)
- Hospital, ASC, Mobile Surgical Facility (FS 395.0185)
• Insurance Adjusters (FS 626.8698)
• Laboratories (FS 483.825), (FAC 59A-7.020, 59A-7.037, 64B3-12.001)
• Medical Practice (FS 458.331), (FAC 64B8-8.001, 64B8-30.010, 64B8-30.015, 64B8-44.03)
• Medicaid Providers (FS 409.920), (FAC 59G-1.050)
• Naturopathy (FS 462.14)
• Nursing Homes (FS 400.17, 400.176), (FAC 59A-4.150)
• Occupational Therapy (FS 468.217), (FAC 64B11-4.003)
• Osteopathic Medicine (FS 459.013, 459.015), (FAC 64B15-6.011, 64B15-7.010, 64B15-19.002)
• Pharmacies (FS 465.185), (64B16-27.104, 64B16-27.1042, 64B16-30.001)
  Podiatrists (FS 461.013), (64B18-14.002)
• Respiratory Therapy (FS 468.365), (FAC 64B32-5.001)
• Veterinarians (FS 474.214), (FAC 61G18-30.001)

Case Law
Facts: Bakarania considered the legality of a long term management agreement between Phymatrix, a practice management company, and a physician group practice. Under the agreement, the practice management company was paid an annual management fee equal to 30% of the group practice’s annual net income for (1) practice expansion by developing “relationships and affiliations with other physicians and other specialists, hospitals, networks, health maintenance organizations, and preferred provider organizations”; (2) physician provider network creation; and (3) managed care contract evaluation, negotiation, and administration.
Holding: Payment of fees to a practice management company based on revenue generated, at least in part, because of the referrals that the practice management company has helped to generate is a violation of Florida’s prohibition against fee splitting. However, payment of a reasonable flat fee in return for provision of management services, including practice enhancement, is appropriate and allowable under Florida law. Payment of a percentage of the revenue generated by management services and practice enhancement is not permissible.
Takeaway: Incentive-based practice management agreements are problematic when the practice management company performs revenue creation services, such as managed care contracting and patient marketing. Also, from a practical standpoint, practice management agreements must be drafted carefully to avoid being attacked later as unlawful under Bakarania as a way to get out of a bad deal.

Gold, Vann & White, P.A. v. Friedenstab, 831 So. 2d 692 (Fla. 4th DCA 2002)
Facts: A physician group practice entered into a turnkey service agreement with a practice management company covering facilities, equipment, supplies, support staff, physicians, and management services. The practice management company's
compensation was based on (1) an amount exceeding clinic operating expenses; (2) a set percentage of net clinic revenues; and (3) a percentage of "additional" managed care payments.

**Holding:** Citing *Bakariana*, the court held that the management agreement constituted improper fee splitting because it was based on a percentage of revenue that the practice management company's services and practice enhancement activities would generate. Absence of evidence that the company's activities actually increased the group practice's patient volume was dismissed as irrelevant.

**Takeaway:** Florida courts are suspicious of arrangements promoting an increase in health care revenues that permit a third-party management company to share in those increased revenues.

**State v. Rubio,** 917 So. 2d 383, 395 (Fla. 5th DCA 2005) aff'd in part, 967 So. 2d 768, 776 (Fla. 2007)

**Facts:** Drs. Guzman and Mendez were dentists who operated a dental clinic in Miami. The state prosecutor alleged that they were recruited to come to Orlando to provide dental services to Medicaid-eligible children. Rubio and Gustavo Fernandez provided marketing services to the dentists and solicited children primarily from public housing areas and transported them to and from the clinic. The dentists billed Medicaid and split the fees with Rubio. The defendants argued that Section 817.505 was unconstitutional because it: (1) is vague; (2) lacks a mens rea requirement; and (3) fails to impose a mens rea requirement of willfulness.

**Holding:** The Florida Supreme Court affirmed in part the appellate court's decision and held (1) the statute to be constitutional; and (2) that the arrangement between Rubio and the dentists constituted improper fee splitting because it was based on a percentage of revenue generated by the defendants' marketing services.

**Takeaway:** Unlike the Florida Anti-Kickback Statute, the Florida patient brokering law contains a list of exceptions/safe harbors that protects it from preemption under *Harden*.

**Medical Development Network, Inc. v. Professional Respiratory Care/Home Medical Equipment Services, Inc.,** 673 So. 2d 565 (Fla. 4th DCA 1996)

**Facts:** Appellee, Professional Respiratory Care/Home Medical Equipment Services, Inc., agreed to pay appellant, Medical Development Network, Inc., a marketing fee equal to a percentage of all the business developed for appellee by the appellant. Appellee breached the agreement, and appellant sued for breach. Appellee defended by arguing that the marketing agreement was illegal under the federal anti-kickback statute and thus the marketing agreement was not enforceable. The trial court agreed, and entered summary judgment in favor of the appellee.

**Holding:** Declining to follow *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir.1995), the Florida appellate court affirmed the trial court and held that the anti-kickback statute is “directed at punishment of those who perform specific acts and does not require that one engage in the prohibited conduct with the specific intent to violate the statute.
**Takeaway:** Although this case came after the enactment of the Patient Brokering Act, the court does not mention the act. Nevertheless, the case stands for the proposition that contracts with percentage based compensation with non-employee marketers constitute illegal kickback arrangements and will not be enforced.

**Additional Decisions**

*In re Lundy, 9 FALR 6289 (1987)*

**Summary:** Favorable administrative ruling that a business entity that provided office space, equipment, marketing services, and billing and collection services could retain a portion of the medical practice’s collections.

*In re Lozito, 9 FALR 6295 (1987)*

**Summary:** Favorable administrative ruling that a limited partnership (including physician partners) formed to own and lease a rehabilitation facility could base the lease on a percentage of the facility’s operating profits.

*In re Myers, 10 FALR 6272 (1988)*

**Summary:** Favorable administrative ruling that a physician could form and invest in a limited partnership that performed various peripheral vascular laboratory studies. According to the facts: (1) the return on investment was strictly based on the investment made by the limited partner and not on the number of referrals by a physician to the facility; and (2) the limited partner physician would notify each patient referred for the vascular study of the limited partner’s investment interest in the entity.

*In re Zeterberg, 12 FALR 1035 (1990) (distinguished from Lundy)*

**Summary:** Unfavorable administrative ruling where a management company: (1) leased clinic space from various physicians’ practices; (2) provided access to the leased space to an allergist client of the management company; and (3) charged the allergist client a portion of the allergist’s clinic space revenues.

*In re Speiller, 14 FALR 3942 (1992)*

**Summary:** Unfavorable administrative ruling finding that the owner/operator of a multispecialty clinic violated Florida’s fee-splitting prohibition by charging independent contractor physicians a flat per-procedure fee for services performed at the clinic. Although the fee charged incorporated costs related to clinic rent, staff, ancillary services, and advertising, the Florida Board of Medicine (Board) determined that the physicians were paying the clinic for establishing a patient relationship.

*In re Johnson and the Green Clinic, 14 FALR 3935 (1992)*

**Summary:** Unfavorable administrative ruling finding that partnership that contracted with individual physicians to provide clinic space, staff, equipment, and various administrative and management services in exchange for a percentage of physician collections constituted illegal fee splitting because the scope of collections included hospital-based services.
Prosper on the grounds that Prosper rendered no professional or technical services.

Facts: Each of the Practice Management Associates (PMA) cases involved a Florida choice-of-venue provision interpreting non-Florida law. PMA, a Florida corporation, entered into multiple practice-management arrangements with chiropractic practices across the country. Under the management agreements, PMA provided advice, education, and counseling to increase the growth and profits of the chiropractic practices. PMA's services included seminars, publications, call-in counseling, and in-person consultations. In return for PMA's services, the chiropractors were obligated to pay PMA 10% of their weekly gross income or a weekly fee of $75, whichever was greater, for 24 months.

Holding: The court (1) noted that the agreements made no reference to patient referrals or patient solicitation and that PMA did not engage in these activities; (2) construed "splitting fees" in the traditional meaning of dividing a professional fee with another person, professional or nonprofessional, for the referral of patients; (3) noted that traditional notions of fee splitting (i.e., the encouragement of superfluous medical treatment and other professional services solely for the profit of the practitioner) do not necessarily follow "staff training, advertising, insurance procedures, equipment selection, billing practices, [and] financial advice"; and (4) concluded that the plain language of the FS clearly prohibits fee splitting solely for the referral of patients, and because PMA did not refer patients to the physicians, the contract was not null or void.

Note—The PMA line of cases are often cited, but have been distinguished by the Bakarania progeny.

Novick v. Department of Health, 816 So. 2d 1237, 1238 (Fla. 5th DCA 2002)

Facts: The President of New Interlachen Pediatrics, PA (Interlachen) appealed an order rendered by the Board, which declined to determine whether a management service agreement between Interlachen and Pediatric Physician Alliance, Inc. (PPA), violated Section 817.505. The Board took the position that it was not required to make a ruling on the legality of the contract in light of Bakarania.

Holding: Affirmed. The Board is not required to rule on the merits of every petition seeking a declaration of rights of a party under a contract, which may be affected by its ruling in a prior case. The Board had already announced its decision on these types of arrangements in Bakarania, and therefore, Interlachen was not seeking direction based on a new rule or law.

Prosper Diagnostic Centers, Inc. v. Allstate Insurance Company, 964 So.2d 763 (Fla. 4th DCA 2007)

Facts: Allstate's insured was referred to Prosper for an MRI following an automobile accident. Prosper had a block lease arrangement to use the MRI equipment and related professional and technical staff. Allstate refused to pay claims submitted by Prosper on the grounds that Prosper rendered no professional or technical services.
The trial court agreed with Allstate and concluded that the block lease arrangement constituted improper fee splitting and patient brokering. 

**Holding:** Affirmed. The Court stated in its opinion that section 456.0635(3)(a) provides an opportunity for certain first-time offenders to be able to renew their medical license as long as they are progressing in a drug court treatment program and would not have to wait for the expiration of the time periods set forth in the statute. However, if an applicant either does not qualify for such a program or chooses not to enter into such a program, the applicant must wait for the expiration of the requisite time period regardless of any prior disciplinary proceeding for the same offense.

**Paylan v. Dep’t of Health, 226 So.3d 296 (Fla. 2d DCA 2017)**

**Facts:** License applicant, Christina Paylan, had been convicted of obtaining a controlled substance by fraud and fraudulent use of personal information in connection with getting the prescription. Each count was a third degree felony. Dr. Paylan made several arguments that the Department of Health abused its discretion. **Holding:** argued that she was unable to take part in the drug diversion program, which would have been a mitigating factor in the refusal by the Department of Health to issue her a medical license, .,

### 2) PROHIBITIONS ON SELF-REFERRAL

**FS Section 456.053—Patient Self-Referral Act of 1992 Statute**

**Generally**

The Patient Self-Referral Act of 1992 (Act) was modeled after the Federal Physician Self-Referral Law (Stark law), but it has not piggy-backed on the many statutory and regulatory changes to Stark. As a result, the Act has many differences from Stark, and Florida physicians must understand that complying with Stark does not mean that they also have complied with the Act. In fact, it is important to note that the Act is more restrictive than Stark in many significant respects. The definitions of the operative terms are critical to interpreting the Act correctly, and those are discussed in [Key Definitions](#) below.

1. **Prohibited Referrals.** A health care provider may not refer a patient for the provision of Florida designated health services (DHS) to an entity in which the health care provider is an investor or has an investment interest, unless an exception applies.

2. **Claims Prohibited; Timely Refund Required.** An entity may not present a claim for payment to any individual, third-party payer, or other entity for a service furnished pursuant to a referral prohibited under the Act. If an entity collects any amount billed in violation of this section, the entity shall refund such amount on a timely basis to the payer or individual.

3. **Accepting Outside Diagnostic Imaging Referrals.** A group practice or sole provider accepting outside referrals for diagnostic imaging services is required to comply with the following conditions:
(4) **Physician/Employee.** A group practice physician or a full-time or part-time employee of the group practice or of the sole provider's practice must exclusively provide diagnostic imaging services;

(5) **Option A: Physicians Hold Equity + Provide 75% of Services.** The physicians comprising the group practice or the sole provider's practice, each of whom must provide at least 75% of their professional services to the group, must hold all equity in the group practice or sole provider's practice; or

(6) **Option B: Not-for-Profit Foundation.** Alternatively, the group must be a not-for-profit corporation, incorporated under Florida state law and must be exempt under the provisions of Internal Revenue Code Section 501(c)(3) and be part of a foundation in existence prior to January 1, 1999 created for the purpose of patient care, medical education, and research;

(7) **Management Company: Financial Incentives Not Tied to Revenue Enhancement.** A group practice or sole provider may not enter into, extend, or renew any contract with a practice management company that provides any financial incentives, directly or indirectly, based on an increase in outside referrals for diagnostic imaging services from any group or sole provider managed by the same practice management company;

(8) **Group Bills for Professional and Technical Components.** A group practice or sole provider must bill for both the professional and technical component of the service on behalf of the patient, and may not share any portion of the payment, or any type of consideration, either directly or indirectly, with the referring physician;

(9) **Medicaid Providers Service Medicaid Recipients.** A group practice or sole provider that has a Medicaid provider agreement with AHCA must furnish diagnostic imaging services to their Medicaid patients and may not refer a Medicaid recipient to a hospital for outpatient diagnostic imaging services unless the physician furnishes the hospital with documentation demonstrating the medical necessity for such a referral. If necessary, AHCA may apply for a federal waiver to implement this subparagraph;

(10) **AHCA Annual Report; Attestation.** A group practice or sole provider must (1) report annually to AHCA the number of outside referrals accepted for diagnostic imaging services and the total number of all patients receiving diagnostic imaging services; and

(2) submit a signed attestation under oath from the group practice managing physician member and the sole provider confirming that the group practice or sole provider complies with the percentage limitations for accepting outside referrals and the requirements for accepting outside referrals; and

(11) **15% Limit.** A group practice or sole provider may accept no more than 15% of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services (see Key Definitions below).

**Penalties.** Any person who presents or causes to be presented a bill or a claim for service that such person knows or should know is for a service for which payment may not be made, or for which a refund has not been made, shall be subject to a civil penalty of not more than $15,000 for each such service to be imposed and collected by the appropriate licensing board.
Any health care provider or other entity that enters into an arrangement or scheme, such as a cross-referral arrangement, which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil penalty of not more than $100,000 for each such circumvention arrangement or scheme to be imposed and collected by the appropriate board.

A violation of this section by a health care provider or hospital shall constitute grounds for disciplinary action taken by the applicable board or agency.

Exceptions. A health care provider may not refer a patient for the provision of any other health care item or service to an entity in which the health care provider is an investor unless:

(1) Publicly Traded Investment Interest. The provider's investment interest is in registered securities purchased on a national exchange or over-the-counter market and issued by a publicly held corporation whose:
   
   (a) Shares are traded on a national exchange or on the over-the-counter market; and
   
   (b) Total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million.

(2) Small/Private Investment Interest:
   
   (a) 50% Rule. No more than 50% of the value of the investment interests are held by investors in a position to make referrals to the entity (the percentage of referrals is not limited as under the federal anti-kickback statute investment safe harbor);
   
   (b) Same Terms. The terms under which an investment interest is offered to an investor in a position to make referrals to the entity do not differ from the terms offered to investors not in a position to make such referrals;
   
   (c) Unrelated to Volume/Value of Referrals. The terms under which an investment interest is offered to an investor in a position to make referrals to the entity are not related to the previous or expected volume of referrals from that investor to the entity; and
   
   (d) No Referral Requirement. There is no requirement that an investor make referrals or be in a position to make referrals to the entity as a condition for becoming or remaining an investor.

(3) With Respect to Either Investment Entity:
   
   (a) No Loans or Guaranties. The entity does not loan funds to or guarantee a loan for an investor in a position to make referrals to the entity if the investor uses any part of such loan to obtain the investment interest;
   
   (b) Return on Investment. The amount distributed to an investor representing a return on the investment interest is directly proportional to the amount of the capital investment, including the fair market value of any preoperational services rendered, invested in the entity by that investor; and
   
   (c) Required Disclosure:
      
      (1) A health care provider may not refer a patient to an entity in which such provider is an investor unless, prior to the referral, the provider furnishes the patient with a written disclosure form, informing the patient of:
         
         (a) The existence of the investment interest;
(b) The name and address of each applicable entity in which the referring health care provider is an investor;
(c) The patient’s right to obtain the items or services for which the patient has been referred at the location or from the provider or supplier of the patient’s choice, including the entity in which the referring provider is an investor; and
(d) The names and addresses of at least two alternative sources of such items or services available to the patient.

(2) The physician or health care provider shall post a copy of the disclosure forms in a conspicuous public place in the physician’s or provider’s office; and
(3) A violation of this section shall constitute a misdemeanor of the first degree, in addition to any other penalties or remedies provided, and be subject for disciplinary action by the respective board.
(4) Declaratory Statements. Each board and, in the case of hospitals, AHCA, is required to encourage the use by licensees of the declaratory statement procedure to determine the applicability of this section or any rule adopted pursuant to the section as it applies solely to the licensee. Boards are required to submit to AHCA the name of any entity in which a provider investment interest has been approved pursuant to this section.

Key Definitions
Designated Health Services include:
   (1) Clinical laboratory services;
   (2) Physical therapy services;
   (3) Comprehensive rehabilitative services, including speech, occupational, or physical therapy services, on an outpatient or ambulatory basis;
   (4) Diagnostic imaging services, including magnetic resonance imaging (MRI), nuclear medicine, angiography, arteriography, computed tomography, positron emission tomography, digital vascular imaging, bronchography, lymphangiography, splenography, ultrasound, electroencephalogram (EEG), electrocardiogram (EKG), nerve conduction studies, and evoked potentials; and
   (5) Radiation therapy services.

Direct Supervision means supervision by a physician present in the office suite and immediately available to provide assistance and direction throughout the time of services performed. "Present in the office suite" means that the physician is actually physically present; provided, however, that the health care provider is considered physically present during brief unexpected absences as well as during routine absences of a short duration if the absences occur during time periods in which the health care provider is otherwise scheduled and ordinarily expected to be present, and the absences do not conflict with any other requirement in the Medicare program for a particular level of health care provider supervision.

Entity means any individual, partnership, firm, corporation, or other business entity.

Fair Market Value means value in arm’s length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use, and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.
Group Practice means:

1. Two Provider Minimum. A group of two or more health care providers legally organized as a partnership, professional corporation, or similar association;
2. Full Range of Services. Each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;
3. Substantially All; Billed by Group. Substantially all services of the health care providers who are members of the group are provided through the group and are billed in the name of the group, and amounts so received are treated as receipts of the group; and
4. Distributions Previously Determined. The overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group.

Health Care Provider means:

1. Any physician licensed under Chapter 458 (Medical Practice), Chapter 459 (Osteopathic Medicine), Chapter 460 (Chiropractic Medicine), or Chapter 461 (Podiatric Medicine); or
2. Any health care provider licensed under Chapter 463 (Optometry) or Chapter 466 (Pharmacy).

Investment Interest means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity interests or debt instruments.

Specific Exclusions. The following interests are specifically excluded from the definition of Investment Interest:

1. Rural Area. An investment interest in an entity that is the sole provider of DHS in a county with a population density no greater than 100 persons per square mile, as defined by the U.S. Census;
2. Debt. An investment interest in notes, bonds, debentures, or other debt instruments issued by an entity which provides DHS as an integral part of a plan by such entity to acquire such investor's equity investment interest in the entity, provided that the interest rate is consistent with fair market value, and that the maturity date of the instruments issued by the entity to the investor is not later than October 1, 1996;
3. Real Property. An investment interest in real property resulting in a landlord-tenant relationship between the health care provider and the entity in which the equity interest is held, unless the business volume or profitability of the tenant, in whole or in part, determines the rent, or the rent exceeds fair market value; or
4. Hospital; Nursing Home. An investment interest in an entity which owns or leases and operates a hospital licensed under Chapter 395 or a nursing home facility licensed under Chapter 400.

Investor means a person or entity owning a legal or beneficial ownership or investment interest, directly or indirectly, including, without limitation, through a health care provider's spouse, child, child's spouse, grandchild, grandchild's spouse, parent, parent-in-law, or sibling, or trust, or another entity related to the investor within the meaning of 42 C.F.R. § 413.17, in an entity.

Patient (of a group practice/sole provider) means a patient who receives a physical examination, evaluation, diagnosis, and development of a treatment plan if medically
necessary by a physician who is a member of the group practice or the sole provider’s practice.

Referral means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies DHS or any other health care items or services; or
2. The request or establishment of a plan of care by a health care provider, which includes the provision of DHS or other health care items or services.

Specific Exclusions: The following orders, recommendations, or plans are specifically excluded from the definition of Referral:

a. Radiology. By a radiologist for diagnostic imaging services;
b. Radiation Therapy. By a physician specializing in radiation therapy services for such services;
c. Oncology. By a medical oncologist for intravenous drugs, solutions, equipment, and supplies related to the oncologist’s treatment of patients for cancer or the complications thereof;
d. Cardiac Catheterization. By a cardiologist for cardiac catheterization services;
e. Pathology. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician;
f. Group Practice. By a health care provider who is the sole provider or member of a group practice for DHS or other health care items or services prescribed or provided solely for such referring health care provider’s or group practice’s own patients, and provided or performed by or under the direct supervision of such referring health care provider or group practice;
g. Diagnostic Imaging:
   1. By a licensed physician for diagnostic imaging services, excluding radiation therapy services, to a sole provider or group practice for which the sole provider or group practice billed both the technical and the professional fee for or on behalf of the patient, if the referring physician has no investment interest in the practice; and
   2. 15% Referral Rule. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more than 15% of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services. Note—this provision in the Act was adopted in light of the decision in Agency for Health Care Admin. v. Wingo, 697 So. 2d 1231 (Fla. 1st DCA 1997).
h. Ambulatory Surgery Centers (ASCs). By a health care provider for services provided by an ASC licensed under Chapter 395;
i. Lithotripsy. By a urologist for lithotripsy services;
j. Dentistry. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member;
k. Infusion Therapy. By a physician for infusion therapy services to a patient of that physician or a member of that physician’s group practice;
(l) **Dialysis.** By a nephrologist for renal dialysis services and supplies, except laboratory services;

(m) **ALFs; Patient’s Home.** By a health care provider whose principal professional practice consists of treating patients in their private residences for services rendered in such private residences, except for services rendered by a home health agency (HHA) licensed under Chapter 400. For purposes of this sub-subparagraph, the term "private residences" includes patients' private homes, independent living centers, and assisted living facilities, but does not include skilled nursing facilities; and

(n) **Sleep Studies.** By a health care provider for sleep-related testing.

(o) **Sole Provider** means one physician, who maintains a separate medical office and a medical practice separate from any other health care provider and who bills for his services separately from the services provided by any other health care provider. A sole provider shall not share overhead expenses or professional income with any other person or group practice.

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**Case Law**

**Fresenius Medical Care Holdings, Inc. v. Tucker, 704 F.3d 935 (11th Cir. 2013)**

**Facts:** Appellants challenged FS Section 456.053 as unconstitutional on the grounds that it is preempted by federal law, violative of the dormant Commerce Clause, and violative of substantive due process.

**Holding:** The court determined that (1) the conflict preemption doctrine did not apply; (2) Section 456.053 did not discriminate against or impose an undue burden on interstate commerce; and (3) appellant's substantive due process or equal protection claim did not overcome rational basis scrutiny.

**Takeaway:** The Physician Self-Referral Act is constitutional.

**Morales v. Perez, 952 So. 2d 605 (Fla. 3d DCA 2007)**

**Summary:** Medical practice owned by a holding company could compel its former shareholder physician employee to submit to binding arbitration to resolve his claim that the practice’s compensation arrangement violated Section 456.053 because the holding company’s operating agreement contained an arbitration provision.

**Adventist Health System/Sunbelt, Inc. v. Agency for Health Care Admin., 955 So. 2d 1173 (Fla. 1st DCA 2007)**

**Facts:** Licensee that offered an integrated health care delivery system through affiliated hospitals, nursing homes, home health agencies, and physician office practices sought a declaratory statement approving the formation of a multi-specialty group practice that would provide patients with an integrated and multi-disciplinary approach to diagnosis and treatment of cancer. AHCA refused to issue a declaratory statement on the ground that the licensee's question was purely hypothetical.

**Holding:** Reversed and remanded. Section 456.053(5)(b)4 specifically states that in the case of "hospitals," AHCA shall encourage the use of declaratory statements regarding the applicability of Section 456.053. Because AHCA administers hospitals and facilities under Chapter 395, AHCA is the agency given the statutory authority to
regulate the licensee. As such, AHCA has a number of responsibilities under the Act, including the authority to interpret the Act and issue declaratory statements regarding the Act's application.


**Facts:** Defendants argued that the Act does not provide a private right of action.

**Holding:** According to Sections 456.503(5)(c)–(d), "[n]o claim for payment may be presented . . . for a service furnished pursuant to a referral prohibited under this section. . . . If an entity collects any amount that was billed in violation of this section, the entity shall refund such amount on a timely basis to the payor or individual, whichever is applicable." Because the language of Section 456.503(5)(d) clearly establishes a payer's right to a refund, the payer therefore has a private right of action under the Act.

**In Re: Petition For Declaratory Statement -- Tallahassee Neurological Clinic, P.A., Final Order No. DOH 04-0921DS-MQA (August 17, 2004)**

**Facts:** The petitioner, Tallahassee Neurological Clinic, P.A., sought a declaratory statement from the Florida Board of Medicine as to whether its referring to its wholly-owned laboratory subsidiary would violate the Patient Self-Referral Act.

**Holding:** Following the January 4, 2001 Stark commentary, the Florida Board of Medicine determined that the Patient Self-Referral Act “should, like the Stark Act, be interpreted to permit a ‘group practice’ to wholly own a separate legal entity which provides diagnostic imaging services to the group practice or other patients, without losing the ‘group practice’ exemption to the definition of ‘referral.’ “ In reaching this conclusion, the Board following the finding in In re: Petition for Declaratory Statement of Alan Levin. M.D. and Ameripath. Inc., 19 F.A.L.R. 4525, 4528 (Fla. Bd. of Med. 1997) that “it is reasonable for the Board to look to the federal standards implementing the Stark Bill when interpreting the provisions of Florida’s Self-Referral Act, where it would not be inconsistent with the plain meaning of and legislative intent of the Florida Act.”

**Previously Discussed Cases that Reference FS Section 456.053:**

*State v. Rubio, 917 So. 2d 383, 395 (Fla. 5th DCA 2005) aff'd in part, 967 So. 2d 768, 776 (Fla. 2007); and Harris, et al. v. Gonzalez, et al., 789 So. 2d 405 (Fla. 4th DCA 2001).*

**FS Section 456.052—Disclosure of Financial Interest Statute**

A health care provider shall not refer a patient to an entity in which such provider is an investor unless, prior to the referral, the provider furnishes the patient with a written disclosure form, informing the patient of:

1. The existence of the investment interest;
2. The name and address of each applicable entity in which the referring health care provider is an investor;
3. The patient's right to obtain the items or services for which the patient has been referred at the location or from the provider or supplier of the patient's choice, including the entity in which the referring provider is an investor; and
The names and addresses of at least two alternative sources of such items or services available to the patient.

Disclosure Forms
The physician or health care provider shall post a copy of the disclosure forms in a conspicuous public place in the physician’s or health care provider’s office.

Penalties
A violation constitutes a first-degree misdemeanor, punishable by up to a $1,000 fine and up to one year’s imprisonment. A violation is grounds for disciplinary action by the applicable licensing board.

Case Law
Aarmada Prot. Sys. 2000, Inc. v. Yandel, 73 So. 3d 893 (Fla. 4th DCA 2011)
Facts: Appellants claim that the trial court erred in denying their motion for a directed verdict as to the charges made by an adverse physician for diagnostic testing performed at a facility owned by the physician, as such a referral violated the Act.
Holding: FS 456.052 states that “[a] health care provider shall not refer a patient to an entity in which such provider is an investor unless, prior to the referral, the provider furnishes the patient with a written disclosure form, informing the patient of the interest, the identity of the entity in which the provider has an interest, the patient’s rights to alternative services, and the identities of at least two alternative sources of the services. However, FS 456.053(3)(o)(3)(f) contains an exemption for internal referrals of diagnostic imaging services to the group practice.
Takeaway: To the extent that a health care provider qualifies for the diagnostic imaging exception under FS 456.053(3)(o)(3)(f), the provider is not required to meet the notice requirements under FS 456.052 for intra-group practice referrals.

FS Section 400.518—Prohibited Referrals to Home Health Agencies Statute
- Physicians. Physicians are specifically required to comply with FS 456.053 in connection with any referrals to HHAs.
- Hospitals, ASCs. A hospital or an ASC that has a financial interest in an HHA is prohibited from requiring any physician on its staff to refer a patient to the HHA.
- Penalties. Violations by a physician, hospital, or an ASC are (1) punishable by an administrative fine not to exceed $15,000; (2) grounds for physician disciplinary action by the applicable licensing board; and (3) subject to an additional fine of $1,000 with a recommendation by AHCA to the appropriate licensing board that disciplinary action be taken for a hospital or ASC.
- Home Health Agencies. It is unlawful for an HHA to provide nurses, certified nursing assistants, home health aides, or other staff without charge to an assisted living facility, adult family care home, adult day care center, or other assisted care facility licensed under FS Chapter 429 in return for patient referrals from the facility.
- Penalties. Violations by the HHA are punishable by an administrative fine not to exceed $15,000.
**FS Section 400.9935—Health Care Clinic Director Referrals Statute -- Generally**
The medical or clinic director of a health care clinic may not refer a patient to the health care clinic if the clinic performs MRI, static radiographs, computed tomography, or positron emission tomography. (For more on the Health Care Clinic Act (HCCA), see The HCCA below.)

**Key Definitions**
- **Medical Director** means a physician who is employed or under contract with a clinic and who maintains a full and unencumbered physician license in accordance with Chapter 458 (Medical Practice), Chapter 459 (Osteopathic Medicine), Chapter 460 (Chiropractic Medicine), or Chapter 461 (Podiatric Medicine).
- **Clinic Director.** If the clinic does not provide services pursuant to the respective physician practice acts under FS chapters 458-461, it may appoint a Florida-licensed health care practitioner who does not provide services pursuant to such acts to serve as a clinic director responsible for the health care clinic's activities.
- **Health Care Practitioner.** A health care practitioner may not serve as the clinic director if the services provided at the clinic are beyond the scope of that practitioner's license, except that speech pathology, audiology, occupational therapy, or physical therapy licensees may serve as clinic director of an entity providing such services.
- **Refer a Patient** means the referral of one or more patients of the medical or clinical director or a member of the medical or clinical director's group practice to the clinic for MRI, static radiographs, computed tomography, or positron emission tomography.

*Note—AHCA has determined that if the health care clinic otherwise qualifies as a group practice and the medical director is a member of such practice, referrals by the medical director do not constitute a prohibited referral under FS Section 400.9935.*

**Penalties**
An HCCA violation is a third-degree felony punishable by a $5,000 fine and five years' imprisonment. In addition, the clinic is subject to an administrative fine of $5,000 per violation and adverse licensure action. The medical or clinic director also may be subject to disciplinary action under the applicable practice act.

**Case Law**
**Allstate Ins. Co. v. Vizcay, 826 F.3d 1326 (11th Cir. 2016)**
**Background:** Allstate brought an action against a medical director and seven health care clinics to avoid several million dollars' worth of no-fault/personal injury protection claims that Allstate alleged were not properly payable to the clinics. Specifically, Allstate alleged that defendants engaged in fraudulent billing practices, in addition to failing to comply with HCCA licensing requirements. According to
Allstate, all claims for services performed by the clinics in violation of the HCCA were not properly payable.

**Holding:** Under Florida law, an insurer is entitled to seek a judicial remedy to recover past payments, and avoid future payments due on outstanding invoices, when health care clinics fail to comply with the licensing requirements of the HCCA.

4) CORPORATE PRACTICE OF MEDICINE

**Practice of Medicine Defined**

**FS Section 458.305(3)—Practice of Medicine**

*Practice of Medicine* means the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition.

**FS Section 456.065—Unlicensed Practice of Medicine**

The unlicensed practice of a health care profession or the performance or delivery of medical or health care services to patients in this state without a valid, active license to practice that profession, regardless of the means of the performance or delivery of such services, is strictly prohibited.

**Analysis Under Florida Law and HCCA**

The application of the Corporate Practice of Medicine (CPM) doctrine, which prohibits, among other things, the practice of medicine by entities not organized under FS Chapter 621 relating to professional service corporations, limited liability companies, and the ownership of medical practices by persons not licensed as physicians, has never been finally decided by the Florida courts. 8 F.A.L.R 6299 (1987). **See also The Petition for Declaratory Statement of Conrad Goulet, M.D, 15 F.A.L.R (1989); See AHCA No. 95-00645 (1995); But see Rush v. City of St. Petersburg, 205 So.2d 11 (Fla. 2d DCA 1967) (holding that city hospital had not engaged in the unauthorized practice of medicine, despite its corporate structure); In re Urban, 138 B.R. 632 (Fla. M.D. 1992) (holding that a medical practice’s corporate stock could be transferred to an individual who does not practice medicine).** For a detailed discussion of the corporate practice of medicine doctrine in Florida, see Jacobs and Goodman, “Splitting Fees or Splitting Hairs? Fee Splitting and Health Care - The Florida Experience,” 8 Annals Health L. 239 (1999).

However, the Board has issued the following favorable declaratory statements approving the employment of doctors by various business entities:

- In *The Petition for Declaratory Statement of John W. Lister*, the Board concluded that FS 458.327(1)(a), which prohibits the unlicensed practice of medicine, does not prohibit the practice of medicine by duly licensed medical doctors as employees of a corporation.
- In *In re Petition for Declaratory Statement of Steven R. Cohen, M.D.*, the Board concluded that FS 458.327(1)(a) did not prohibit the employment of a physician by a limited liability company.
The HCCA
In 2003, the Florida legislature enacted the HCCA (FS 400.990, et. seq.). The HCCA, as subsequently amended, does impose prohibitions like the CPM doctrine. The HCCA requires that clinics (not otherwise exempt) be licensed. Under FS 400.9905(4), "Clinic" means an entity where health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. Clinics are required to be licensed. AHCA interprets the statutory language "tenders charges for reimbursement" to mean clinics that take payment from Medicare, Medicaid, or any other any third-party payer. Health care providers that only accept cash are not "clinics" under the HCCA.

However, there are a number of exemptions to the licensure requirements, including, among others, clinics owned exclusively by licensed health care providers, their spouses, children, grandchildren, and siblings. Whenever there is an owner, regardless of the percentage owned, who is not a licensed health care provider, licensure is required. Certificates for exemption of licensure are valid for up to two years.

3) DECEPTIVE AND UNFAIR TRADE PRACTICES

The Florida Deceptive and Unfair Trade Practices Act (FDUTPA) was established to protect the consuming public and legitimate business enterprises from those who engage in either: (1) unfair methods of competition; or (2) unconscionable, deceptive, or unfair acts or practices in the conduct of any trade or commerce. The intent of the Florida legislature is that "due consideration and great weight" be given to the interpretations of the Federal Trade Commission and the federal courts relating to Section 5(a)(1) of the Federal Trade Commission Act, 15 U.S.C. 45(a)(1). Violations may be based upon any violation of (a) any rules promulgated pursuant to the Federal Trade Commission Act, 15 U.S.C. ss. 41 et seq.; (b) the standards of unfairness and deception set forth and interpreted by the Federal Trade Commission or the federal courts; or (c) any law, statute, rule, regulation, or ordinance which proscribes unfair methods of competition, or unfair, deceptive, or unconscionable acts or practices. Health care providers are subject to FDUTPA.

Consumers may file private causes of action for legal or equitable relief. The prevailing party, after judgment in the trial court and exhaustion of all appeals, if any, may receive reasonable attorney's fees and costs from the non-prevailing party. FDUTPA imposes civil penalties of up to $10,000 per violation in general, and up to $15,000 per violation if the violation victimizes a senior citizen, a person who has a disability, a military service member, or the spouse or dependent child of a military service member.
Key Definitions

- **Deceptive Act or Practice** encompasses a representation, omission, or practice likely to mislead the consumer acting reasonably in the circumstances, to the consumer’s detriment.
- **Trade or Commerce** means the advertising, soliciting, providing, offering, or distributing, whether by sale, rental, or otherwise, of any good or service, or any property, whether tangible or intangible, or any other article, commodity, or thing of value, wherever situated. **Trade or Commerce** includes the conduct of any trade or commerce, however denominated, including any nonprofit or not-for-profit person or activity.
- **Unfair Act or Practice** is one that (1) is substantial; (2) must not be outweighed by any countervailing benefits to consumers or competition that the practice produces; and (3) must be an injury that consumers themselves could not have avoided.

Case Law Relating to Health Care Providers


**Background:** Defendant allegedly engaged in a scheme to improperly maximize Medicare inpatient outlier payments by artificially inflating charges.

**Legal Analysis:** To state a cause of action under FDUTPA, a FDUTPA plaintiff must only allege facts sufficient to show that the plaintiff was actually aggrieved by the unfair and deceptive conduct.

**Holding:** FDUTPA does not apply to any acts or practices required or specifically permitted by federal or state law. However, an alleged deceptive act does not need to violate a specific rule or regulation to be considered deceptive.


**Background:** Corporate records filed with the State of Florida and Application for Exemption from HCCA licensure identified salaried chiropractor as owner, officer, director, and registered agent of a health care clinic. Automobile insurer sued clinic under FDUTPA alleging that the clinic was actually owned by an individual who was not a licensed health care provider.

**Legal Analysis:** In State Farm Fire & Cas. Co. v. Silver Star Health & Rehab, 739 F.3d 579, the Eleventh Circuit determined that a health care clinic owner may delegate responsibilities to a managing licensed health care professional, yet still not cede actual ‘ownership’ to that licensee.

**Holding:** FDUTPA does apply when a clinic fraudulently seeks to circumnavigate the HCCA licensure requirements by designating a salaried health care licensee as its owner, when said licensee does not possess sufficient control over the clinic’s operations.
Related Statutes

**FS Section 400.17—Nursing Homes—Certain Solicitations Prohibited**
No person shall, in connection with the solicitation of contributions to nursing homes, willfully misrepresent or mislead anyone, by any manner, means, practice, or device whatsoever, to believe that the receipts of such solicitation will be used for charitable purposes, if such is not the fact. Solicitation of contributions of any kind in a threatening, coercive, or unduly forceful manner by or on behalf of a nursing home by any agent, employee, owner, or representative of a nursing home shall be grounds for denial, suspension, or revocation of the license for any nursing home on behalf of which such contributions were solicited.

**FS Section 400.464—Home Health Agencies—Licensure Required; Unlawful Acts; Penalties**
Organizations offering or advertising to the public any services for which licensure or registration is required under FS Chapter 400 Part III must include their license or registration number in their advertisements for these services. Failing to include the number when submitting the advertisement for publication, broadcast, or printing is punishable by fine of not less than $100, and $500 for a second or subsequent offense. The license holder may not advertise or indicate to the public that it holds an HHA license (or nurse registry license) other than the one issued. A violation is a second-degree misdemeanor, punishable by up to a $500 fine, and 60 days' imprisonment. Second or subsequent violations are a first-degree misdemeanor, punishable by up to a $1,000 fine and one year's imprisonment. Violations constitute a deceptive and unfair trade practice subject to additional penalties and damages under FDUTPA.

FS 400.464 cross-references FS 408.812, which provides that it is unlawful: (1) to offer or advertise services requiring licensure without first obtaining a valid license; and (2) for a license holder to advertise or hold out to the public that the license holder holds a license for anything beyond the license actually held.

**FS Section 400.93—Home Medical Equipment Providers—Licensure Required; Exemptions; Unlawful Acts; Penalties**
Any person or entity that holds itself out to the public as providing home medical equipment and services or accepts physician orders for home medical equipment and services is subject to licensure under FS Chapter 400 Part VII (Home Health Agencies) and FS Chapter 408 Part II (Health Care Administration), including Section 408.812.

A violation of FS 400.93 constitutes a second-degree misdemeanor, punishable by up to a $500 fine, and 60 days' imprisonment. Second or subsequent violations are increased to a first-degree misdemeanor and are punishable by up to a $1,000 fine and one year's imprisonment.

Similar to FS 400.464, violations of Section 400.93 constitute a deceptive and unfair trade practice subject to additional penalties and damages under FDUTPA.
Each day of a continuing violation constitutes a separate offense.

**FS Section 483.305—Multiphasic Health Testing Centers—Advertisement**

- *Multiphasic Health Testing Center* means any fixed or mobile facility where specimens are taken from the human body for delivery to registered clinical laboratories for analysis and where certain measurements such as height and weight determinations, blood pressure determinations, limited audio and visual tests, and EKGs are made.
- *Signage Requirement.* Each center must prominently display on its report of the tests, on all advertising and promotional materials, and in a place in clear and unobstructed public view within the center, a notice in one inch (or greater) block letters which reads: "Health screening tests may or may not alert you and your doctor to serious medical problems and are not intended to be a substitute for a physician’s examination."

Centers may not use advertisement or promotional materials that tend to deceive prospective purchasers concerning personnel, equipment, care, and services, or the quality thereof, provided by the center. Violations are subject to FDUTPA.

**FS Section 456.072—Health Care Licensees—Grounds for Discipline**

Health care licensees are subject to specific grounds for discipline including, without limitation:

1. Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee’s profession;
2. Making deceptive, untrue, or fraudulent representations in or related to the practice of a profession;
3. Employing a trick or scheme in or related to the practice of a profession; or
4. Exercising influence on the patient or client for the purpose of financial gain of the licensee or a third party.

Disciplinary measures include, without limitation: restriction, suspension, or revocation of license; practice restrictions; and up to a $10,000 fine per count or offense. If the violation is for fraud or making a false or fraudulent misrepresentation, the $10,000 per offense fine is mandatory.

**These prohibitions apply to:**

- Acupuncture ([FS 457.109](#))
- Athletic Training ([FS 468.719](#))
- Behavioral Health ([FS 490.009, 491.009](#))
- Chiropractic Medicine ([FS 460.413](#))
- Clinical Laboratory Personnel ([FS 483.825](#))
- Dentistry ([FS 466.028](#))
- Dietetics and Nutrition Practice ([FS 468.518](#))
- Dispensing Optical Devices and Hearing Aids ([FS 484.056](#))
- Electrolysis ([FS 478.52](#))
- Massage Practice ([FS 480.046](#))
5) FALSE CLAIMS/FRAUD & ABUSE

**FS Sections 68.081–68.092—Florida False Claims Act Statute** Generally
The Florida False Claims Act (FFCA) is very similar to the federal False Claims Act (FCA). Under FS 68.082(2), liability is imposed on any person who:
(1) Knowingly presents or causes to be presented to an agent or employee of a state executive branch agency, a false or fraudulent claim for payment or approval;
(2) Knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;
(3) Conspires to commit a violation of this subsection;
(4) Has possession, custody, or control of property or money used or to be used by the state and knowingly delivers or causes to be delivered less than all of that money or property;
(5) Is authorized to make or deliver a document certifying receipt of property used or to be used by the state and, intending to defraud the state, makes or delivers the receipt without knowing that the information on the receipt is true;
(6) Knowingly buys or receives, as a pledge of an obligation or a debt, public property from an officer or employee of the state who may not sell or pledge the property; or
(7) Knowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the state, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state.

The FFCA provides for treble damages, which the court may reduce to double damages under specific extenuating circumstances, and imposes a civil penalty of not less than $5,500 but not more than $11,000.
The court may reduce the treble damages, to no less than two times the damages sustained by the State, if the court establishes:

(1) The person committing the violation furnished the department with all information known to the person about the violation within 30 days after the date on which the person first obtained the information;

(2) The person fully cooperated with any official investigation of the violation; or

(3) At the time the person furnished the information about the violation, no criminal prosecution, civil action, or administrative action had begun with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation.

Specific intent to defraud is not required for liability and “knowing” and “knowingly” includes actual knowledge, deliberate ignorance, or reckless disregard of truth or falsity.

A civil action under the FFCA may not be brought:

(1) More than six years after the date on which the FFCA violation is committed; or

(2) More than three years after the date when facts material to the right of action are known or reasonably should have been known, but in no event, more than ten years after the date on which the violation is committed, whichever occurs last.

**Statutory Procedures**

The procedures for civil actions under FS 68.083 also are similar to the federal FCA.

Florida’s Department of Legal Affairs or Department of Financial Services may bring a civil action under FFCA. An individual also may bring a civil qui tam action in the name of the state. Qui tam actions must be so identified and are filed under seal. A copy of the complaint and written disclosure of substantially all material evidence and information the qui tam plaintiff possesses must be served on the specified Florida officials. The state may elect to intervene and proceed with the action, on behalf of the state, within 60 days after it receives both the complaint and the material evidence and information. If the state proceeds with the action, the state is not bound by any action of the person bringing the complaint, and may voluntarily dismiss, notwithstanding any objections by the initiating party.

**Qui Tam Plaintiffs**

- *State Intervenes (10–25%).* Florida law permits relators to recover between 15% to 25% of the proceeds or settlement of the FFCA claim, depending on the extent to which the relator substantially contributed to the prosecution of the action. However, if the court finds the action primarily turned on specific information obtained from a source other than the relator (i.e., investigative reporting, defendant self-disclosure, etc.), the court may not award the relator more than 10% of the proceeds (taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation.);

- *State Does Not Intervene (25–30%).* If the state does not intervene, the relator receives between 25% to 30% of the proceeds of the action or settlement;
• **Attorneys' Fees and Costs.** Relators are permitted to receive an amount for reasonable expenses that the court finds were necessarily incurred, plus reasonable attorney fees and costs. All such expenses, fees, and costs are awarded against the defendant;

• **Unclean Hands.** If the court finds that the relator planned and initiated the FFCA violation, the court may reduce the award based on the role of the person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the relator is convicted of criminal conduct arising from the relator’s role in the FFCA violation, the relator shall not receive any share of the proceeds of the action; or

• **Retaliation Prohibited.** Under FS 68.088, any employee discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against by an employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the FFCA has a cause of action under Sections 112.3187, the Florida Whistleblower’s Act (see Florida Whistleblower’s Act, below).

### Case Law
The following cases contain discussions relating to the application of both the federal FCA and the FFCA to the particular facts:

- **U.S. v. All Children's Health Sys., Inc.**, 941 F. Supp. 2d 1332 (M.D. Fla., 2013);
- **Barys v. Vitas Healthcare Corporation**, No. 07-13720 (11th Cir., Nov. 3, 2008);
- **United States ex rel. Westlund v. Lab. Corp. of America Holdings**, No. 8:10-cv-2882-T-23TGW (M.D. Fla., Dec. 29, 2011);
- **United States ex rel. Dittmann v. Adventist Health Sys./Sunbelt, Inc.**, No. 6:10-cv-1062-Ori-28GJK (M.D. Fla., July 30, 2012) (Judge's Order Denying Motion to Dismiss);
- **United States ex rel. Watine v. Cypress Health Sys. Florida, Inc.**, No. 1:09cv137-SPM-GRJ (N.D. Fla., Feb. 14, 2012) (Judge's Order Granting in Part and Denying in Part the Motion to Dismiss the Amended Complaint); and
- **United States v. HPC Healthcare, Inc.**, No. 16-16670 (11th Cir. Jan. 24, 2018) (affirming that complaint lacked the “indicia of reliability” because it did not include the underlying factual bases for her assertions and that District Court did not abuse its discretion when it dismissed the complaint with prejudice); **United States v. LifePath Hospice, Inc.**, No. 8:10-CV-1061-T-30TGW (M.D. Fla. Sept. 22, 2016).
- **United States v. Aids Healthcare Found., Inc.**, 262 F. Supp. 3d 1353 (S.D. Fla. 2017) (holding that bonuses which fall under the AKS’s employee safe harbor cannot be the basis for Relators’ claims under the Florida False Claims Act).
Related Statutes

FS Section 409.913—The Medicaid Audit Statute Generally

Section 409.913 requires that AHCA take affirmative steps to minimize fraud and abuse of the Medicaid Program and the neglect of Medicaid recipients. AHCA is statutorily armed to accomplish these goals through each Medicaid provider’s affirmative duty to appropriately bill Medicaid claims, AHCA’s investigative and audit powers to detect provider non-compliance, and AHCA’s disciplinary powers.

Penalties: AHCA may impose the following sanctions:
(1) Up to one year suspension from the Medicaid program;
(2) Up to 20-year termination from the Medicaid program;
(3) A fine of up to $5,000 for each violation. "Violation" means:
   (a) Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records;
   (b) Each instance of improper billing of a Medicaid recipient;
   (c) Each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after an audit exit conference or previous audit report has advised the provider or authorized representative of the cost not being allowed;
   (d) Each instance of furnishing a Medicaid recipient with goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment;
   (e) Each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report (Note—Penalty is increased to $10,000 for violations of this subsection);
   (f) Each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and
   (g) Each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation.
(4) Immediate suspension, if AHCA has received information of patient abuse or neglect or of any act prohibited by FS 409.920;
(5) A fine, not to exceed $10,000, for each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost report;
(6) Liens against provider assets, including, but not limited to, financial assets and real property, not to exceed the amount of fines or recoveries sought, upon entry of an order determining that such moneys are due or recoverable;
(7) Prepayment reviews of claims for a specified period of time;
(8) Comprehensive follow-up reviews of providers every six months to ensure that they are billing Medicaid correctly; and
(9) Corrective-action plans that remain in effect for up to three years and that AHCA monitors every six months while in effect.

Costs Recoverable: AHCA is entitled to recover all investigative, legal, and expert witness costs if the provider does not contest AHCA’s findings or, if contested,
AHCA ultimately prevailed. AHCA has the burden of documenting the costs, which include salaries, employee benefits, and out-of-pocket expenses. The amount of costs AHCA may recover must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors. The provider may pay the costs over a period determined by AHCA if AHCA determines that an extreme hardship would result to the provider from immediate full payment. Any default in payment of costs may be collected by any means authorized by law.

**Provider Affirmative Duty**

When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

1. The provider has actually furnished to the recipient prior to submitting the claim;
2. Are Medicaid-covered goods or services that are medically necessary;
3. Are of a quality comparable to those furnished to the general public by the provider’s peers;
4. Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered.

Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

*Note—Billing agents or others preparing Medicaid claims may not be paid based on amounts billed to or received from Medicaid.

**Audit Power**

Under [FS 409.913(2)](https://www.revisor.myflorida.com/), AHCA must conduct reviews, investigations, analyses, or audits to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and report the findings of any overpayments in audit reports as appropriate.

- For the purposes of this section, *Fraud* is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term also includes any act that constitutes fraud under applicable federal or state law.
• The term *Abuse* includes: (1) Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or (2) Recipient practices that result in unnecessary cost to the Medicaid program.

• *Overpayment* means any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

• *Random Audits.* AHCA must conduct at least 5% of all audits on a random basis.

• *Statistical Modeling.* As part of its ongoing fraud detection activities, AHCA must identify and monitor patterns of overutilization of Medicaid services based on state averages. AHCA conducts reviews of provider exceptions to peer group norms and, using statistical methodologies, provider profiling, and analysis of billing patterns, detects and investigates abnormal or unusual increases in billing or payment of claims for Medicaid services and medically unnecessary provision of services.

• *Medical Necessity Monitoring.* AHCA tracks Medicaid provider prescription and billing patterns and evaluates them against Medicaid medical necessity criteria and coverage and limitation guidelines adopted by rule.

**Prepayment Review**
AHCA may conduct prepayment review of provider claims to ensure cost-effective purchasing that the provider is billing in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and federal, state, and local law; and that appropriate care is rendered to Medicaid recipients.

• *Review at Will.* Prepayment reviews may be conducted as determined appropriate by AHCA, without any suspicion or allegation of fraud, abuse, or neglect, and may last for up to one year.

• *Timing of Payment 90–180 Days.* Unless AHCA has reliable evidence of fraud, misrepresentation, abuse, or neglect, claims are to be adjudicated for denial or payment within 90 days after receipt of complete documentation for review. If there is reliable evidence of fraud, misrepresentation, abuse, or neglect, claims must be adjudicated for denial of payment within 180 days after receipt of the documentation.

**Medicaid Fraud Control Unit**
Any suspected criminal violation identified by AHCA must be referred to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General (AG) for investigation, which has two primary areas of criminal and civil enforcement responsibility. Enforcement is structured to prevent, detect, and prosecute fraud perpetrated against the Medicaid program and patient abuse, neglect, and exploitation. MFCU conducts a statewide program for the investigation of fraud and abuse in the Medicaid program. Under this program, MFCU is authorized to investigate possible criminal violations.
Case Law

Summary: Defendant physician operated a pain management clinic that treated Medicaid patients. MFCU determined that defendant excessively prescribed controlled substances outside the normal course of professional medical practice and recommended the case for further investigation. Defendant ultimately pled guilty to crimes involving health care fraud and unlawful dispensing of controlled substances and was sentenced to a term of 240 months’ imprisonment.

Summary: Nursing home failed to protect its Medicaid provider number from revocation by filing bankruptcy. The court held that the bankruptcy court did not have jurisdiction to enter the injunction.

U.S. v. Merrill, 513 F.3d 1293 (11th Cir., 2008)
Summary: Osteopath convicted of various counts of wire fraud, health care fraud, and illegally prescribing narcotics outside the course of professional practice under the Controlled Substance Act. Nine of the counts in the indictment alleged that death resulted from either the health care fraud or the use of the narcotics prescribed outside the course of professional practice. Physician was sentenced to life imprisonment.

Adolfo s. Galvez v. Agency for Health Care Administration, Case No. 00-3556 (DOAH Oct. 24, 2011)
Summary: The Florida Division of Administrative Hearings (DOAH) administrative law judge (ALJ) determined that an overpayment determination may be primarily based on hearsay audit reports.

FS Section 409.9131—Special Provisions Relating to Integrity of Medicaid Program Generally
According to FS Section 409.9131, AHCA may conduct on-site inspection of a provider’s Medicaid records upon 24 hours’ notice. In determining overpayments, AHCA must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof.

• Statistical Methods. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, other generally accepted statistical methods, review of medical records, and a consideration of the physician’s client case mix. Before performing a review of the physician's Medicaid records, however, AHCA must make every effort to consider the physician's patient case mix, including, but not limited to, patient age and whether individual patients are clients of the Children’s Medical Services Network established in FS Chapter 391.
• **Medical Necessity Reviews.** AHCA also must refer all physician service claims for peer review when evaluation of medical necessity, appropriateness, and quality of care is needed to determine a potential overpayment. "Peer" means a Florida-licensed physician who is, to the maximum extent possible, of the same specialty or subspecialty, licensed under the same practice act, and in active practice.

**Case Law**

*Agency for Health Care Administration v. Alfred Ivan Murciano, M.D., Case No. 13-0795MPI (DOAH May 22, 2014)*

**Summary:** The Florida DOAH ALJ dismissed AHCA's $1.051 million dollar medical necessity overpayment claim against a pediatrician because AHCA failed to obtain a medical necessity review by an individual who met the statutory definition of a "peer" in accordance with FS 409.9131.

**FS Section 409.920—Medicaid Provider Fraud Generally**

According to the Medicaid Provider Fraud Statute, a person may not:

1. Knowingly make, cause to be made, or aid and abet in the making of any false statement or false representation of a material fact, by commission or omission, in any claim submitted to AHCA, AHCA’s fiscal agent, or a managed care plan for payment;
2. Knowingly make, cause to be made, or aid and abet in the making of a claim for items or services not authorized for reimbursement by the Medicaid program;
3. Knowingly charge, solicit, accept, or receive anything of value, other than an authorized copayment from a Medicaid recipient, from any source in addition to the amount legally payable for an item or service provided to a Medicaid recipient under the Medicaid program or knowingly fail to credit AHCA or AHCA’s fiscal agent for any payment received from a third-party source;
4. Knowingly make or in any way cause to be made any false statement or false representation of a material fact, by commission or omission, in any document containing items of income and expense that AHCA uses or may use to determine a general or specific rate of payment for an item or service provided by a provider;
5. Knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program; Knowingly submit false or misleading information or statements to the Medicaid program for the purpose of acceptance as a Medicaid provider; or
6. Knowingly use or endeavor to use a Medicaid provider's identification number or a Medicaid recipient's identification number to make, cause to be made, or aid and abet in the making of a claim for items or services not authorized for reimbursement by the Medicaid program.
Definitions
• **Knowingly** means that the act was done voluntarily and intentionally and not because of mistake or accident and includes the word "willfully" or "willful" meaning that an act was committed voluntarily and purposely, with the specific intent to do something that the law forbids, and that the act was committed with bad purpose, either to disobey or disregard the law.
• **Item or Service** includes:
  o Any particular item, device, medical supply, or service claimed to have been provided to a recipient and listed in an itemized claim for payment; or
  o In the case of a claim based on costs, any entry in the cost report, books of account, or other documents supporting such claim.

**FS 456.0635--Health care fraud; disqualification for license, certificate, or registration**
This statute was discussed earlier. Please note that FS 456.0635(3)(d) prohibits, among other things, the Department of Health from “renew[ing] a license, certificate, or registration of any applicant if the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant” … “[h]as been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application.”

**Statewide Medicaid Fraud Control Program**
The AG is required to conduct a statewide program of Medicaid fraud control and to accomplish this, the AG must:
(1) Investigate the possible criminal violation of any applicable state law pertaining to fraud in the administration of the Medicaid program, in the provision of medical assistance, or in the activities of providers of health care under the Medicaid program;
(2) Investigate the alleged abuse or neglect of patients in health care facilities receiving payments under the Medicaid program, in coordination with AHCA;
(3) Investigate the alleged misappropriation of patients’ private funds in health care facilities receiving payments under the Medicaid program;
(4) Refer to the Office of Statewide Prosecution or the appropriate state attorney all violations indicating a substantial potential for criminal prosecution;
(5) Refer to AHCA all suspected abusive activities not of a criminal or fraudulent nature;
(6) Safeguard the privacy rights of all individuals and provide safeguards to prevent the use of patient medical records for any reason beyond the scope of a specific investigation for fraud or abuse, or both, without the patient’s written consent; and
(7) Publicize to state employees and the public the ability of persons to bring suit under the provisions of the FFCA and the potential for the persons bringing a civil action under the FFCA to obtain a monetary award.
AG's Medicaid Fraud Control Powers

Non-Physician Providers. In carrying out the duties and responsibilities under this section, the AG may enter the premises of any health care provider, excluding a physician (but see FS 409.9205(2) broadly granting authority to MFCU to execute search and arrest warrants), participating in the Medicaid program to examine all accounts and records that may, in any manner, be relevant in determining the existence of fraud in the Medicaid program, to investigate alleged abuse or neglect of patients, or to investigate alleged misappropriation of patients' private funds.;

Physician Providers. A participating physician is required to make available any accounts or records that may, in any manner, be relevant in determining the existence of fraud in the Medicaid program, alleged abuse or neglect of patients, or alleged misappropriation of patients' private funds. The accounts or records of a non-Medicaid patient may not be reviewed by, or turned over to, the AG without the patient's written consent.

Subpoena Power. Subpoena witnesses or materials, including medical records relating to Medicaid recipients, within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

Inferences

Claim Submission = Knowledge of False Statement. Proof that a claim was submitted to AHCA or AHCA’s fiscal agent which contained a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to an inference that the person whose signature appears as the provider's authorizing signature on the claim form, or whose signature appears on an AHCA electronic claim submission agreement submitted for claims made to the fiscal agent by electronic means, had knowledge of the false statement or false representation.

False Certification. Proof of submission to AHCA or AHCA’s fiscal agent of a document containing items of income and expense, which document is used or may be used by AHCA or AHCA’s fiscal agent to determine a general or specific rate of payment, and which document contains a false statement or a false representation of a material fact, by commission or omission, unless satisfactorily explained, gives rise to the inference that the person who signed the certification of the document had knowledge of the false statement or representation.

Penalties

A person who violates this provision and receives or endeavors to receive anything of value of:
(1) $10,000 or less, commits a felony of the third degree;
(2) More than $10,000, but less than $50,000, commits a felony of the second degree; or
(3) $50,000 or more, commits a felony of the first degree.
**Damages Multiplied by Five.** In addition, a person convicted of a violation of this provision must pay a fine in an amount equal to five times the pecuniary gain unlawfully received or the loss incurred by the Medicaid program or managed care organization, whichever is greater.

**Case Law**

*State of Florida v. Harden*, 938 So. 2d 480 (Fla. 2006) (See discussion above)

*Morris v. State*, 622 So. 2d 67 (Fla. 4th DCA 1993)

**Facts:** Appellant, William A. Morris, III, M.D. was charged with Medicaid fraud, for billing for services not rendered. At trial Morris moved to suppress evidence seized in a search of his premises by employees of the Florida Auditor General's Office in violation of FS 409.920(10)(a). After an adverse ruling, Morris pled nolo contendere to the charges, but reserved the right to appeal the ruling on the motion to suppress. In carrying out the duties and responsibilities under [the Medicaid Fraud Statute], the Attorney General may enter the premises of any health care provider, *excluding a physician*....”

**Holding:** Trial court erred by failing to suppress the evidence. Reversed and remanded with direction to suppress.

**Medicaid Managed Care**

On June 14, 2013 the Centers for Medicare and Medicaid Services approved a transition of the Florida Medicaid program to a statewide risk-based Medicaid Managed Care model (SMMC). Under SMMC, Medicaid enrollees will receive their health care and long term care services via a limited number of third-party health plans (Plans).

There are two components to SMMC, the Long-Term Care (LTC) program and the Managed Medical Assistance (MMA) program. As a condition of participation, each Plan is required to comply with federal and state laws and regulations, and must incorporate certain contract and program requirements. One such requirement is that the Plan develop mechanisms to detect both under- and over-utilization of services. In addition, the Plan must be able to generate files in prescribed formats for upload to AHCA for Medicaid program integrity and compliance purposes. See Agency for Health Care Administration, Florida Medicaid, Revised Comprehensive Quality Strategy—2013-2014 Update (April 4, 2014). Each plan is required to report any confirmed or suspected instances of provider or recipient fraud to the Office of Medicaid Program Integrity within fifteen calendar days.

**FS Section 409.9201—Medicaid Fraud Generally**

It is unlawful to knowingly make or cause to be made, or attempt or conspire to make, any false statement or representation to any person for the purpose of obtaining goods or services from the Medicaid program.
**Legend Drugs**

Any person who knowingly (1) sells, attempts or conspires to sell, or causes any other person to sell or attempt or conspire to sell a legend drug paid for by the Medicaid program; or (2) purchases, or attempts or conspires to purchase, a legend drug paid for by the Medicaid program and intended for use by another person, commits a felony.

**Penalties**

The degree of the felony depends on the value of the goods or services involved:

- If the value of the goods or services is less than $20,000, the person commits a felony of the third degree punishable by up to a $5,000 fine, up to five years’ imprisonment, or both;
- If the value of the goods or services is $20,000 or more but less than $100,000, the person commits a felony of the second degree, punishable by up to a $10,000 fine, up to 15 years’ imprisonment, or both; or
- If the value of the goods or services involved is $100,000 or more, the person commits a felony of the first degree, punishable by up to a $10,000 fine, up to 30 years’ imprisonment, or both.

**FS Section 817.234—Insurance Fraud**

**Insurance Fraud**

A person commits insurance fraud if that person, with the intent to injure, defraud, or deceive any insurer:

1. **False Claim in Connection with Insurance Payment or Benefit.** Prepares, makes, presents, or causes to be presented any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or a health maintenance organization (HMO) subscriber or provider contract, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;
2. **False Claim in Connection with Insurance Issuance or Rating.** Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any employee or agent thereof, any false, incomplete, or misleading information or written or oral statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a HMO subscriber or provider contract; or knowingly conceals information concerning any fact material to such application; or
3. **Health Care Clinic Fraud.** Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer, a claim for payment or other benefit under a personal injury protection (PIP) insurance policy if the person knows that the payee knowingly submitted a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with the Florida HCCA. With respect to PIP claims, it is important to note that the PIP statute, FS 627.736(4)(h), modifies the exclusions under the HCCA, and imposes additional requirements on certain entities based on
their ownership to also become licensed as a health care clinic in order to be paid under the PIP statute.

**Motor Vehicle and Casualty Insurance Fraud**

*Physicians and Practitioners.* Any medical physician, osteopathic physician, chiropractic physician, or other practitioner licensed under the laws of this state who knowingly and willfully assists, conspires with, or urges any insured party to fraudulently violate any of the provisions of this section or FS Chapter 627 Part XI (Motor Vehicle and Casualty Insurance Contracts), or any person who, due to such assistance, conspiracy, or urging by said physician, osteopathic physician, chiropractic physician, or practitioner, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud.

*Actions Against Attorneys.* Any attorney who knowingly and willfully assists, conspires with, or urges any claimant to fraudulently violate any of the provisions of this section or FS Chapter 627 Part XI, or any person who, due to such assistance, conspiracy, or urging on such attorney's part, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud.

*Actions Against Hospitals.* Any person or governmental unit licensed under FS Chapter 395 (Hospitals) to maintain or operate a hospital, and any administrator or employee of any such hospital, who knowingly and willfully allows the use of the facilities of said hospital by an insured party in a scheme or conspiracy to fraudulently violate any of the provisions of this section or FS Chapter 627 Part XI, commits insurance fraud. Any adjudication of guilt for a violation of this subsection, or the use of business practices demonstrating a pattern indicating that the spirit of the law set forth in this section or FS Chapter 627 Part XI is not being followed, constitutes grounds for suspension or revocation of the license to operate the hospital or the imposition of an administrative penalty of up to $5,000 by the licensing agency, as set forth in Chapter 395.

*Altering Mental and Physical Exams.* An insurer, or any person acting at the direction of or on behalf of an insurer, may not change an opinion in a mental or physical report prepared under the Florida Motor Vehicle No-Fault Law (No-Fault Law) or direct the physician preparing the report to change such opinion; however, this provision does not preclude the insurer from calling to the attention of the physician errors of fact in the report based on information in the claim file. A violation is a felony of the third degree.

*Automobile Accident Solicitation.* It is unlawful for any person intending to defraud any other person to solicit or cause to be solicited any business from a person involved in a motor vehicle accident for the purpose of making, adjusting, or settling motor vehicle tort claims or claims for PIP benefits. A violation is a felony of the second degree, requiring a minimum term of two years’ imprisonment.
No Solicitations Within 60 days. A person may not solicit or cause to be solicited any business from a person involved in a motor vehicle accident by any means of communication other than advertising directed to the public for the purpose of making motor vehicle tort claims or claims for PIP benefits, within 60 days after the occurrence of the motor vehicle accident. Any person who violates this paragraph commits a felony of the third degree.

No Solicitations Ever. A lawyer, health care practitioner as defined in FS 456.001, or owner or medical director of a health care clinic may not, at any time after 60 days have elapsed from the occurrence of a motor vehicle accident, solicit or cause to be solicited any business from a person involved in a motor vehicle accident by means of in-person or telephone contact at the person's residence, for the purpose of making motor vehicle tort claims or claims for PIP benefits required by FS 627.736. A violation is a felony of the third degree. "Health care practitioner" is defined as any person licensed under FS Chapters 457 (Acupuncture), 458 (Medical Doctor), 459 (Osteopathic Doctor), 460 (Chiropractic Doctor), 461 (Podiatrist), 462 (Naturopath), 463 (Optometrist), 464 (Nurse), 465 (Pharmacist), 466 (Dental Professional), 467 (Midwife), 468 (dealing with Speech Pathology, Nursing Home Administrator, Occupational Therapist, Respiratory Therapist, Nutritionist, Athletic Trainer, and Orthotics Provider), 483 (Clinical Lab Personnel, Medical Physicist), 484 (Optician or Hearing Aid Dispenser), 486 (Physical Therapist), 490 (Psychologist), or 491 (Behavioral Health Provider); and

No Payment. Charges for any services rendered by any person who violates this subsection in regard to the person for whom such services were rendered are noncompensable and unenforceable as a matter of law.

Staged Accidents. A person may not organize, plan, or knowingly participate in an intentional motor vehicle crash or a scheme to create documentation of a motor vehicle crash that did not occur for the purpose of making motor vehicle tort claims or claims for PIP benefits as required by FS 627.736. Any person who violates this subsection commits a felony of the second degree. A violation is a felony of the second degree, requiring a minimum term of two years' imprisonment.

Systematic Upcoding
In addition to any other provision of law, systematic upcoding with the intent to obtain reimbursement otherwise not due from an insurer by a physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state, is punishable as follows:

Adverse Licensure Action. AHCA may suspend the authority of an organization to enroll new subscribers or revoke the health care provider certificate of any organization, or order compliance within a time certain.

Fines. In lieu of revocation or suspension of the provider's license, AHCA may levy a fine against the providers as follows:
Nonwillful Violations. With respect to any nonwillful violation, the fine may not exceed $2,500 per violation. Such fines may not exceed an aggregate amount of $25,000 for all nonwillful violations arising out of the same action.

Willful Violations. With respect to any knowing and willful violation of a lawful order or rule of AHCA or a provision of this part, AHCA may impose a fine upon the organization in an amount not to exceed $20,000 for each such violation. Such fines may not exceed an aggregate amount of $250,000 for all knowing and willful violations arising out of the same action.

Systematic Waiver of Copays and Deductibles
It is a material omission and insurance fraud for any service provider, other than a hospital, to engage in a general business practice of billing amounts as the provider’s usual and customary charge, if such provider has agreed with the insured or intends to waive deductibles or copayments, or does not for any other reason intend to collect the total amount of such charge.

With respect to a determination as to whether a service provider has engaged in such general business practice, consideration shall be given to evidence of whether the physician or other provider made a good faith attempt to collect such deductible or copayment. This provision does not apply to physicians or other providers who waive deductibles or copayments or reduce their bills as part of a bodily injury settlement or verdict.

This provision also applies to any insurer or adjusting firm or its agents or representatives who, with intent, injure, defraud, or deceive any claimant with regard to any claim. The claimant shall have the right to recover the damages provided in this provision.

Insurance Company Private Right of Action
Any insurer damaged as a result of a violation of any provision of this section, when there has been a criminal adjudication of guilt, shall have a cause of action to recover compensatory damages, plus all reasonable investigation and litigation expenses, including attorneys’ fees, at the trial and appellate courts.

Penalties
A licensed health care practitioner found guilty of insurance fraud for an act relating to a PIP insurance policy loses the license to practice for five years and may not receive reimbursement for PIP benefits for ten years.
If the value of any property involved in such a violation:
(1) Is less than $20,000, the offender commits a felony of the third degree, punishable by up to a $5,000 fine, up to five years' imprisonment, or both;
(2) Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable by up to a $10,000 fine, up to 15 years' imprisonment, or both; and
(3) Is $100,000 or more, the offender commits a felony of the first degree, punishable by up to a $10,000 fine, up to 30 years’ imprisonment, or both.

In addition to any criminal liability, a person convicted of violating any provision of this section for the purpose of receiving insurance proceeds from a motor vehicle insurance contract is subject to a civil penalty. Except for violations involving staged accidents, the civil penalty shall be:
(1) A fine up to $5,000 for a first offense;
(2) A fine greater than $5,000, but not to exceed $10,000, for a second offense; and
(3) A fine greater than $10,000, but not to exceed $15,000, for a third or subsequent offense.
(4) The civil penalty for staging an automobile accident must be at least $15,000 but may not exceed $50,000.

**Florida Motor Vehicle No-Fault Law—FS 627.730–627.7405**

The No-Fault Law provides for PIP benefits in the event of an automobile accident. In Florida, all owners of Florida-registered motor vehicles are required to purchase PIP coverage. A great deal of fraudulent activity has occurred in connection with PIP benefits. This area of law changes frequently, and the Florida legislature has enacted a number of restrictions on PIP benefit claims, affecting both health care providers and their patients.

Automobile insurers possess a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud, patient brokering, or kickbacks, in connection with a claim for personal injury protection benefits. Prevailing insurers may recover compensatory, consequential, and punitive damages, as well as attorney's fees and costs.

**6) GENERAL WHISTLEBLOWER PROTECTIONS**

**FS Sections 448.101-105—Prohibited Retaliation and Remedies Statute General**

FS 448.102 prohibits an employer from taking any retaliatory personnel action against an employee because the employee has:
(1) Disclosed, or threatened to disclose, to any appropriate governmental agency, under oath, in writing, an activity, policy, or practice of the employer in violation of a law, rule, or regulation. (However, this subsection does not apply unless the employee has, in writing, brought the activity, policy, or practice to the attention of a supervisor or the employer and has afforded the employer a reasonable opportunity to correct the activity, policy, or practice.);
(2) Provided information to, or testified before, any appropriate governmental agency, person, or entity conducting an investigation, hearing, or inquiry into an alleged violation of a law, rule, or regulation by the employer; or (3) Objected to, or refused to participate in, any activity, policy, or practice of the employer in violation of a law, rule, or regulation.
"Retaliatory personnel action" means the discharge, suspension, or demotion by an employer of an employee or any other adverse employment action taken by an employer against an employee in the terms and conditions of employment.

**Employee's Remedies**
An employee who has been the object of a prohibited retaliatory personnel action may institute a civil action for relief within two years after discovering that the alleged retaliatory personnel action was taken, or within four years after the personnel action was taken, whichever is earlier. Such relief may include: an injunction restraining continued violation; reinstatement of the employee to the same position held before the retaliatory personnel action, or to an equivalent position; reinstatement of full fringe benefits and seniority rights; compensation for lost wages, benefits, and other remuneration; and any other compensatory damages allowable at law. A court may award reasonable attorneys’ fees, court costs, and expenses to the prevailing party.

**Case Law**
The following cases deal with retaliatory personnel action in health care settings:
- **Meyer v. Health Management Associates, Inc.**, 841 F. Supp. 2d 1262 (S.D. Fla. 2012) Complaint by hospital compliance officer whose job duties were substantially changed after reporting Medicare reimbursement issues to superiors.
- **Gillyard v. Delta Health Group, Inc.**, 757 So.2d 601 (Fla. 5th DCA 2000) Nursing home employee.
- **Taylor v. Memorial Health Systems, Inc.**, 770 So. 2d 752 (Fla. 5th DCA 2000) Action by hospital employee regarding suspension after complaining about physician on the hospital's medical staff.

**FS Sections 112.3187–31895—Florida Whistleblower’s Act**
The Florida Whistleblower’s Act prohibits Florida state agencies and their independent contractors from taking retaliatory action against an employee who reports to an appropriate agency violations of law on the part of a public employer or independent contractor that create a substantial and specific danger to the public's health, safety, or welfare. The Whistleblower’s Act also prohibits agencies and their independent contractors from taking retaliatory action against any person who discloses information to an appropriate agency alleging improper use of governmental office, gross waste of funds, or any other abuse or gross neglect of duty on the part of an agency, public officer, or employee.

“Agency” includes any state, regional, county, local, or municipal government entity, whether executive, judicial, or legislative; any official, officer, department, division, bureau, commission, authority, or political subdivision therein; or any public school, community college, or state university. An “independent contractor” means a person, other than an agency, engaged in any business and who enters into a contract, including a provider agreement, with an agency.
7) HELPFUL LINKS

- Florida Statutes, Constitution, and Laws of Florida
- Florida Department of Health
- Florida Senate Website Archive (Legislative History)
- Florida Administrative Code
- Florida Administrative Law Cases
- Florida Board of Medicine Declaratory Statements
- Florida Department of Health Medical Quality Assurance Final Orders
- Florida Agency for Health Care Administration
- Florida Medicaid
- Florida Medicaid Provider Handbooks
- Florida Supreme Court
- Florida District Courts of Appeal
- Florida Attorney General
- Florida Corporations
- The Florida Bar (includes the Florida Rules of Procedure)
- The Florida Bar Health Law Section
- The Florida Medical Association
- The Florida Hospital Association