Bill No. CS for CS for SB 370

Amendment No. ___ Barcode 104940

CHAMBER ACTION

Senate House

Senator Saunders moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Paragraph (g) of subsection (3) of section 20.43, Florida Statutes, is amended to read:

20.43 Department of Health.--There is created a Department of Health.

(3) The following divisions of the Department of Health are established:

(g) Division of Medical Quality Assurance, which is responsible for the following boards and professions established within the division:

1. The Board of Acupuncture, created under chapter 457.

2. The Board of Medicine, created under chapter 458.

3. The Board of Osteopathic Medicine, created under chapter 459.

4. The Board of Chiropractic Medicine, created under

chapter 460.

5. The Board of Podiatric Medicine, created under chapter 461.

6. Naturopathy, as provided under chapter 462.

7. The Board of Optometry, created under chapter 463.

8. The Board of Nursing, created under part I of chapter 464.

9. Nursing assistants, as provided under part II of chapter 464.

10. The Board of Pharmacy, created under chapter 465.

11. The Board of Dentistry, created under chapter 466.

12. Midwifery, as provided under chapter 467.

13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

14. The Board of Nursing Home Administrators, created under part II of chapter 468.

15. The Board of Occupational Therapy, created under part III of chapter 468.

16. The Board of Respiratory Care ~~therapy~~, as created ~~provided~~ under part V of chapter 468.

17. Dietetics and nutrition practice, as provided under part X of chapter 468.

18. The Board of Athletic Training, created under part XIII of chapter 468.

19. The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.

20. Electrolysis, as provided under chapter 478.

21. The Board of Massage Therapy, created under chapter 480.

22. The Board of Clinical Laboratory Personnel, created under part III of chapter 483.

23. Medical physicists, as provided under part IV of chapter 483.

24. The Board of Opticianry, created under part I of chapter 484.

25. The Board of Hearing Aid Specialists, created under part II of chapter 484.

26. The Board of Physical Therapy Practice, created under chapter 486.

27. The Board of Psychology, created under chapter 490.

28. School psychologists, as provided under chapter 490.

29. The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

The department may contract with the Agency for Health Care Administration who shall provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils, or boards, as appropriate.

Section 2. Section 456.047, Florida Statutes, is repealed.

Section 3. All revenues associated with section 456.047, Florida Statutes, and collected by the Department of Health on or before July 1, 2002, shall remain in the Medical Quality Assurance Trust Fund, and no refunds shall be given.

Section 4. Paragraph (d) of subsection (4) of section 456.039, Florida Statutes, is amended to read:

456.039 Designated health care professionals; information required for licensure.--

(4)

(d) Any applicant for initial licensure or renewal of licensure as a health care practitioner who submits to the Department of Health a set of fingerprints or information required for the criminal history check required under this section shall not be required to provide a subsequent set of fingerprints or other duplicate information required for a criminal history check to the Agency for Health Care Administration, the Department of Juvenile Justice, or the Department of Children and Family Services for employment or licensure with such agency or department if the applicant has undergone a criminal history check as a condition of initial licensure or licensure renewal as a health care practitioner with the Department of Health or any of its regulatory boards, notwithstanding any other provision of law to the contrary. In lieu of such duplicate submission, the Agency for Health Care Administration, the Department of Juvenile Justice, and the Department of Children and Family Services shall obtain criminal history information for employment or licensure of health care practitioners by such agency and departments from the Department of Health ~~Health's health care practitioner credentialing system~~.

Section 5. Paragraph (d) of subsection (4) of section 456.0391, Florida Statutes, is amended to read:

456.0391 Advanced registered nurse practitioners; information required for certification.--

(4)

(d) Any applicant for initial certification or renewal of certification as an advanced registered nurse practitioner who submits to the Department of Health a set of fingerprints and information required for the criminal history check

required under this section shall not be required to provide a subsequent set of fingerprints or other duplicate information required for a criminal history check to the Agency for Health Care Administration, the Department of Juvenile Justice, or the Department of Children and Family Services for employment or licensure with such agency or department, if the applicant has undergone a criminal history check as a condition of initial certification or renewal of certification as an advanced registered nurse practitioner with the Department of Health, notwithstanding any other provision of law to the contrary. In lieu of such duplicate submission, the Agency for Health Care Administration, the Department of Juvenile Justice, and the Department of Children and Family Services shall obtain criminal history information for employment or licensure of persons certified under s. 464.012 by such agency or department from the Department of Health ~~Health's health care practitioner credentialing system~~.

Section 6. Paragraphs (e), (v), (aa), and (bb) of subsection (1) of section 456.072, Florida Statutes, are amended to read:

456.072 Grounds for discipline; penalties; enforcement.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(e) Failing to comply with the educational course requirements for conditions caused by nuclear, biological, and chemical terrorism or for human immunodeficiency virus and acquired immune deficiency syndrome. As used in this paragraph, the term "terrorism" has the same meaning as in s. 775.30.

(v) Failing to comply with the requirements for profiling ~~and credentialing~~, including, but not limited to, failing to provide initial information, failing to timely provide updated information, or making misleading, untrue, deceptive, or fraudulent representations on a profile~~,~~ ~~credentialing,~~ or initial or renewal licensure application.

(aa) Performing ~~or attempting to perform~~ health care services on the wrong patient, a wrong-site procedure, a wrong procedure, or an unauthorized procedure or a procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition. For the purposes of this paragraph, performing ~~or attempting to perform~~ health care services includes the preparation of the patient.

(bb) Leaving a foreign body in a patient, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or other diagnostic procedures, unless leaving the foreign body is medically indicated and documented in the patient record. For the purposes of this paragraph, it shall be legally presumed that retention of a foreign body is not in the best interest of the patient and is not within the standard of care of the profession, unless medically indicated and documented in the patient record ~~regardless of the intent of the professional~~.

Section 7. Subsection (2) of section 456.077, Florida Statutes, is amended to read:

456.077 Authority to issue citations.--

(2) The board, or the department if there is no board, shall adopt rules designating violations for which a citation may be issued. Such rules shall designate as citation violations those violations for which there is no substantial threat to the public health, safety, and welfare. Violations

for which a citation may be issued shall include violations of continuing education requirements; failure to timely pay required fees and fines; failure to comply with the requirements of ss. 381.026 and 381.0261 regarding the dissemination of information regarding patient rights; failure to comply with advertising requirements; failure to timely update practitioner profile ~~and credentialing~~ files; failure to display signs, licenses, and permits; failure to have required reference books available; and all other violations that do not pose a direct and serious threat to the health and safety of the patient.

Section 8. Subsection (3) of section 458.309, Florida Statutes, is amended to read:

458.309 Authority to make rules.--

(3) All physicians who perform level 2 procedures lasting more than 5 minutes and all level 3 surgical procedures in an office setting must register the office with the department unless that office is licensed as a facility pursuant to chapter 395. Each office that is required under this subsection to be registered must be ~~The department shall inspect the physician's office annually unless the office is~~ accredited by a nationally recognized accrediting agency approved by the Board of Medicine by rule or an accrediting organization ~~subsequently~~ approved by the Board of Medicine by rule. Each office registered but not accredited as required by this subsection must achieve full and unconditional accreditation no later than July 1, 2003, and must maintain unconditional accreditation as long as procedures described in this subsection which require the office to be registered and accredited are performed. Accreditation reports shall be submitted to the department. The actual costs for registration

and ~~inspection or~~ accreditation shall be paid by the person seeking to register and operate the office setting in which office surgery is performed. The board may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

Section 9. Subsection (2) of section 459.005, Florida Statutes, is amended to read:

459.005 Rulemaking authority.--

(2) All osteopathic physicians who perform level 2 procedures lasting more than 5 minutes and all level 3 surgical procedures in an office setting must register the office with the department unless that office is licensed as a facility pursuant to chapter 395. Each office that is required under this subsection to be registered must be ~~The department shall inspect the physician's office annually unless the office is~~ accredited by a nationally recognized accrediting agency approved by the Board of Medicine or the Board of Osteopathic Medicine by rule or an accrediting organization ~~subsequently~~ approved by the Board of Medicine or the Board of Osteopathic Medicine by rule. Each office registered but not accredited as required by this subsection must achieve full and unconditional accreditation no later than July 1, 2003, and must maintain unconditional accreditation as long as procedures described in this subsection which require the office to be registered and accredited are performed. Accreditation reports shall be submitted to the department. The actual costs for registration ~~and inspection~~ or accreditation shall be paid by the person seeking to register and operate the office setting in which office surgery is performed. The Board of Osteopathic Medicine may adopt rules pursuant to ss. 120.536(1) and 120.54

to implement this subsection.

Section 10. Subsection (11) is added to section 456.004, Florida Statutes, to read:

456.004 Department; powers and duties.--The department, for the professions under its jurisdiction, shall:

(11) Require objective performance measures for all bureaus, units, boards, contracted entities, and board executive directors which reflect the expected quality and quantity of services.

Section 11. Subsection (1) of section 456.009, Florida Statutes, is amended to read:

456.009 Legal and investigative services.--

(1) The department shall provide board counsel for boards within the department by contracting with the Department of Legal Affairs, by retaining private counsel pursuant to s. 287.059, or by providing department staff counsel. The primary responsibility of board counsel shall be to represent the interests of the citizens of the state. A board shall provide for the periodic review and evaluation of the services provided by its board counsel. Fees and costs of such counsel shall be paid from a trust fund used by the department to implement this chapter, subject to the provisions of s. 456.025. All contracts for independent counsel shall provide for periodic review and evaluation by the board and the department of services provided. All legal and investigative services shall be reviewed by the department annually to determine if such services are meeting the performance measures specified in law and in the contract. All contracts for legal and investigative services must include objective performance measures that reflect the expected quality and quantity of the contracted services.

Section 12. Subsection (6) is added to section 456.011, Florida Statutes, to read:

456.011 Boards; organization; meetings; compensation and travel expenses.--

(6) Meetings of board committees, including probable cause panels, shall be conducted electronically unless held concurrently with, or on the day immediately before or after, a regularly scheduled in-person board meeting. However, if a particular committee meeting is expected to last more than 5 hours and cannot be held before or after the in-person board meeting, the chair of the committee may request special permission from the director of the Division of Medical Quality Assurance to hold an in-person committee meeting in Tallahassee.

Section 13. Subsection (11) is added to section 456.026, Florida Statutes, to read:

456.026 Annual report concerning finances, administrative complaints, disciplinary actions, and recommendations.--The department is directed to prepare and submit a report to the President of the Senate and the Speaker of the House of Representatives by November 1 of each year. In addition to finances and any other information the Legislature may require, the report shall include statistics and relevant information, profession by profession, detailing:

(11) The performance measures for all bureaus, units, boards, and contracted entities required by the department to reflect the expected quality and quantity of services, and a description of any effort to improve the performance of such services.

Section 14. Section 458.3093, Florida Statutes, is created to read:

458.3093 Licensure credentials verification.--All applicants for initial physician licensure pursuant to this chapter must submit their credentials to the Federation of State Medical Boards. Effective January 1, 2003, the board and the department shall only consider applications for initial physician licensure pursuant to this chapter which have been verified by the Federation of State Medical Boards Credentials Verification Service or an equivalent program approved by the board.

Section 15. Section 459.0053, Florida Statutes, is created to read:

459.0053 Licensure credentials verification.--All applicants for initial osteopathic physician licensure pursuant to this chapter must submit their credentials to the Federation of State Medical Boards. Effective January 1, 2003, the board and the department shall only consider applications for initial osteopathic physician licensure pursuant to this chapter which have been verified by the Federation of State Medical Boards Credentials Verification Service, the American Osteopathic Association, or an equivalent program approved by the board.

Section 16. Paragraph (t) of subsection (1) and subsection (6) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and

treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of$50,000~~$25,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 456.049, or upon the receipt from a claimant of a presuit notice against a physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that a physician has had three or more claims with indemnities exceeding$50,000~~$25,000~~ each within the previous 5-year period, the department shall investigate the

occurrences upon which the claims were based and determine whether ~~if~~ action by the department against the physician is warranted.

Section 17. Paragraph (x) of subsection (1) and subsection (6) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(x) Gross or repeated malpractice or the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $50,000~~$25,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the osteopathic physician. As used in this paragraph, "gross malpractice" or "the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that an osteopathic physician be

incompetent to practice osteopathic medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances," or any combination thereof, and any publication by the board shall so specify.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against an osteopathic physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 456.049, or upon the receipt from a claimant of a presuit notice against an osteopathic physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that an osteopathic physician has had three or more claims with indemnities exceeding$50,000~~$25,000~~ each within the previous 5-year period, the department shall investigate the occurrences upon which the claims were based and determine whether ~~if~~ action by the department against the osteopathic physician is warranted.

Section 18. Subsection (1) of section 627.912, Florida Statutes, is amended to read:

627.912 Professional liability claims and actions; reports by insurers.--

(1) Each self-insurer authorized under s. 627.357 and each insurer or joint underwriting association providing

professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, to an ambulatory surgical center as defined in s. 395.002, or to a member of The Florida Bar shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

(a) A final judgment in any amount.

(b) A settlement in any amount.

Reports shall be filed with the Department of Insurance.~~and,~~ If the insured party is licensed under chapter 458, chapter 459, or chapter 461, ~~or chapter 466,~~with the Department of Health, and the final judgment or settlement was in an amount exceeding $50,000, the report shall also be filed with the Department of Health. If the insured is licensed under chapter 466 and the final judgment or settlement was in an amount exceeding $25,000, the report shall also be filed with the Department of Health. Reports must be filed no later than 30 days following the occurrence of any event listed in this subsection ~~paragraph (a) or paragraph (b)~~. The Department of Health shall review each report and determine whether any of

the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. The Department of Health, as part of the annual report required by s. 456.026, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the Department of Health or the appropriate regulatory board.

Section 19. Subsection (1) of section 456.025, Florida Statutes, is amended to read:

456.025 Fees; receipts; disposition.--

(1) It is the intent of the Legislature that all costs of regulating health care professions and practitioners shall be borne solely by licensees and licensure applicants. It is also the intent of the Legislature that fees should be reasonable and not serve as a barrier to licensure. Moreover, it is the intent of the Legislature that the department operate as efficiently as possible and regularly report to the Legislature additional methods to streamline operational costs. Therefore, the boards in consultation with the department, or the department if there is no board, shall, by rule, set renewal fees which:

(a) Shall be based on revenue projections prepared using generally accepted accounting procedures;

(b) Shall be adequate to cover all expenses relating to that board identified in the department's long-range policy plan, as required by s. 456.005;

(c) Shall be reasonable, fair, and not serve as a barrier to licensure;

(d) Shall be based on potential earnings from working under the scope of the license;

(e) Shall be similar to fees imposed on similar licensure types; and

~~(f) Shall not be more than 10 percent greater than the fee imposed for the previous biennium;~~

~~(g) Shall not be more than 10 percent greater than the actual cost to regulate that profession for the previous biennium; and~~

(f)~~(h)~~ Shall be subject to challenge pursuant to chapter 120.

Section 20. Section 456.0165, Florida Statutes, is created to read:

456.0165 Examination location.--A college, university, or vocational school in this state may serve as the host school for a health care practitioner licensure examination. However, the college, university, or vocational school may not charge the department for rent, space, reusable equipment, utilities, or janitorial services. The college, university, or vocational school may charge the department only the actual cost of nonreusable supplies provided by the school at the request of the department.

Section 21. Effective July 1, 2003, paragraph (g) of subsection (3) and paragraph (c) of subsection (6) of section 468.302, Florida Statutes, are amended to read:

468.302 Use of radiation; identification of certified persons; limitations; exceptions.--

(3)

(g) A person holding a certificate as a nuclear medicine technologist may only:

1. Conduct in vivo and in vitro measurements of radioactivity and administer radiopharmaceuticals to human beings for diagnostic and therapeutic purposes.

2. Administer X radiation from a combination nuclear medicine-computed tomography device if that radiation is administered as an integral part of a nuclear medicine procedure that uses an automated computed tomography protocol and the person has received device-specific training on the combination device.

However, the authority of a nuclear medicine technologist under this paragraph excludes radioimmunoassay and other clinical laboratory testing regulated pursuant to chapter 483.

(6) Requirement for certification does not apply to:

(c) A person who is a registered nurse licensed under part I of chapter 464, a respiratory therapist licensed under part V of chapter 468, or a cardiovascular technologist or cardiopulmonary technologist with active certification as a registered cardiovascular invasive specialist from a nationally recognized credentialing organization, or future equivalent should such credentialing be subsequently modified, each of whom is trained and skilled in invasive cardiovascular ~~cardiopulmonary~~ technology, including the radiologic technology duties associated with such procedures,and who provides invasive cardiovascular ~~cardiopulmonary~~ technology services at the direction, and under the direct supervision, of a licensed practitioner. A person requesting this exemption must have successfully completed a didactic and clinical training program in the following areas before performing radiologic technology duties under the direct supervision of a licensed practitioner:

1. Principles of X-ray production and equipment operation.

2. Biological effects of radiation.

3. Radiation exposure and monitoring.

4. Radiation safety and protection.

5. Evaluation of radiographic equipment and accessories.

6. Radiographic exposure and technique factors.

7. Film processing.

8. Image quality assurance.

9. Patient positioning.

10. Administration and complications of contrast media.

11. Specific fluoroscopic and digital X-ray imaging procedures related to invasive cardiovascular technology.

Section 22. Section 468.352, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 468.352, F.S., for present text.)

468.352 Definitions.--As used in this part the term:

(1) "Board" means the Board of Respiratory Care.

(2) "Certified respiratory therapist" means any person licensed pursuant to this part who is certified by the National Board for Respiratory Care or its successor; who is employed to deliver respiratory care services, under the order of a physician licensed pursuant to chapter 458 or chapter 459, in accordance with protocols established by a hospital or other health care provider or the board; and who functions in situations of unsupervised patient contact requiring individual judgment.

(3) "Critical care" means care given to a patient in any setting involving a life-threatening emergency.

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

(5) "Direct supervision" means practicing under the

direction of a licensed, registered, or certified respiratory therapist who is physically on the premises and readily available, as defined by the board.

(6) "Physician supervision" means supervision and control by a physician licensed under chapter 458 or chapter 459 who assumes the legal liability for the services rendered by the personnel employed in his or her office. Except in the case of an emergency, physician supervision requires the easy availability of the physician within the office or the physical presence of the physician for consultation and direction of the actions of the persons who deliver respiratory care services.

(7) "Practice of respiratory care" or "respiratory therapy" means the allied health specialty associated with the cardiopulmonary system that is practiced under the orders of a physician licensed under chapter 458 or chapter 459 and in accordance with protocols, policies, and procedures established by a hospital or other health care provider or the board, including the assessment, diagnostic evaluation, treatment, management, control, rehabilitation, education, and care of patients.

(8) "Registered respiratory therapist" means any person licensed under this part who is registered by the National Board for Respiratory Care or its successor, and who is employed to deliver respiratory care services under the order of a physician licensed under chapter 458 or chapter 459, in accordance with protocols established by a hospital or other health care provider or the board, and who functions in situations of unsupervised patient contact requiring individual judgment.

(9) "Respiratory care practitioner" means any person

licensed under this part who is employed to deliver respiratory care services, under direct supervision, pursuant to the order of a physician licensed under chapter 458 or chapter 459.

(10) "Respiratory care services" includes:

(a) Evaluation and disease management.

(b) Diagnostic and therapeutic use of respiratory equipment, devices, or medical gas.

(c) Administration of drugs, as duly ordered or prescribed by a physician licensed under chapter 458 or chapter 459 and in accordance with protocols, policies, and procedures established by a hospital or other health care provider or the board.

(d) Initiation, management, and maintenance of equipment to assist and support ventilation and respiration.

(e) Diagnostic procedures, research, and therapeutic treatment and procedures, including measurement of ventilatory volumes, pressures, and flows; specimen collection and analysis of blood for gas transport and acid/base determinations; pulmonary-function testing; and other related physiological monitoring of cardiopulmonary systems.

(f) Cardiopulmonary rehabilitation.

(g) Cardiopulmonary resuscitation, advanced cardiac life support, neonatal resuscitation, and pediatric advanced life support, or equivalent functions.

(h) Insertion and maintenance of artificial airways and intravascular catheters.

(i) Performing sleep-disorder studies.

(j) Education of patients, families, the public, or other health care providers, including disease process and management programs and smoking prevention and cessation

programs.

(k) Initiation and management of hyperbaric oxygen.

Section 23. Section 468.355, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 468.355, F.S., for present text.)

468.355 Licensure requirements.--To be eligible for licensure by the board, an applicant must be certified as a "Certified Respiratory Therapist" or be registered as a "Registered Respiratory Therapist" by the National Board for Respiratory Care, or its successor.

Section 24. Section 468.368, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 468.368, F.S., for present text.)

468.368 Exemptions.--This part may not be construed to prevent or restrict the practice, service, or activities of:

(1) Any person licensed in this state by any other law from engaging in the profession or occupation for which he or she is licensed.

(2) Any legally qualified person in the state or another state or territory who is employed by the United States Government or any agency thereof while such person is discharging his or her official duties.

(3) A friend or family member who is providing respiratory care services to an ill person and who does not represent himself or herself to be a respiratory care practitioner or respiratory therapist.

(4) An individual providing respiratory care services in an emergency who does not represent himself or herself as a respiratory care practitioner or respiratory therapist.

(5) Any individual employed to deliver, assemble, set up, or test equipment for use in a home, upon the order of a physician licensed pursuant to chapter 458 or chapter 459. This subsection does not, however, authorize the practice of respiratory care without a license.

(6) Any individual credentialed by the Board of Registered Polysomnographic Technologists as a registered polysomnographic technologist, as related to the diagnosis and evaluation of treatment for sleep disorders.

(7) Any individual certified or registered as a pulmonary function technologist who is credentialed by the National Board for Respiratory Care for performing cardiopulmonary diagnostic studies.

(8) Any student who is enrolled in an accredited respiratory care program approved by the board, while performing respiratory care as an integral part of a required course.

(9) The delivery of incidental respiratory care to noninstitutionalized persons by surrogate family members who do not represent themselves as registered or certified respiratory care therapists.

(10) Any individual credentialed by the Underseas Hyperbaric Society in hyperbaric medicine or its equivalent as determined by the board, while performing related duties. This subsection does not, however, authorize the practice of respiratory care without a license.

Section 25. Sections 468.356 and 468.357, Florida Statutes, are repealed.

Section 26. Sections 381.0602, 381.6021, 381.6022, 381.6023, 381.6024, and 381.6026, Florida Statutes, are renumbered as sections 765.53, 765.541, 765.542, 765.544,

765.545, and 765.547, Florida Statutes, respectively.

Section 27. Section 381.60225, Florida Statutes, is renumbered as section 765.543, Florida Statutes, and is amended to read:

765.543 ~~381.60225~~ Background screening.--

(1) Each applicant for certification must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the Agency for Health Care Administration shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual responsible for the daily operation of the organization, agency, or entity, and financial officer, or other similarly titled individual who is responsible for the financial operation of the organization, agency, or entity, including billings for services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435, as well as the requirements of s. 435.03(3).

(b) The Agency for Health Care Administration may require background screening of any other individual who is an applicant if the Agency for Health Care Administration has probable cause to believe that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional certification may be granted to the

organization, agency, or entity when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435, but a response has not yet been issued. A standard certification may be granted to the organization, agency, or entity upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense

prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) The agency may not certify any organization, agency, or entity if any applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke certification of any organization, agency, or entity if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in

paragraph (e).

(i) An application for renewal of certification must contain the information required under paragraphs (e) and (f).

(2) An organ procurement organization, tissue bank, or eye bank certified by the Agency for Health Care Administration in accordance with ss. 381.6021 and 765.542 ~~381.6022~~ is not subject to the requirements of this section if the entity has no direct patient care responsibilities and does not bill patients or insurers directly for services under the Medicare or Medicaid programs, or for privately insured services.

Section 28. Section 381.6025, Florida Statutes, is renumbered as section 765.546, Florida Statutes, and amended to read:

765.546 ~~381.6025~~ Physician supervision of cadaveric organ and tissue procurement coordinators.--Organ procurement organizations, tissue banks, and eye banks may employ coordinators, who are registered nurses, physician's assistants, or other medically trained personnel who meet the relevant standards for organ procurement organizations, tissue banks, or eye banks as adopted by the Agency for Health Care Administration under s. 765.541 ~~381.6021~~, to assist in the medical management of organ donors or in the surgical procurement of cadaveric organs, tissues, or eyes for transplantation or research. A coordinator who assists in the medical management of organ donors or in the surgical procurement of cadaveric organs, tissues, or eyes for transplantation or research must do so under the direction and supervision of a licensed physician medical director pursuant to rules and guidelines to be adopted by the Agency for Health Care Administration. With the exception of organ procurement

surgery, this supervision may be indirect supervision. For purposes of this section, the term "indirect supervision" means that the medical director is responsible for the medical actions of the coordinator, that the coordinator is operating under protocols expressly approved by the medical director, and that the medical director or his or her physician designee is always available, in person or by telephone, to provide medical direction, consultation, and advice in cases of organ, tissue, and eye donation and procurement. Although indirect supervision is authorized under this section, direct physician supervision is to be encouraged when appropriate.

Section 29. Subsection (2) of section 395.2050, Florida Statutes, is amended to read:

395.2050 Routine inquiry for organ and tissue donation; certification for procurement activities.--

(2) Every hospital licensed under this chapter that is engaged in the procurement of organs, tissues, or eyes shall comply with the certification requirements of ss. 765.541-765.547 ~~381.6021-381.6026~~.

Section 30. Paragraph (e) of subsection (2) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.--

(2) BENCHMARK BENEFITS.--In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.820, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

(e) Organ transplantation services.--Covered services include pretransplant, transplant, and postdischarge services and treatment of complications after transplantation for

transplants deemed necessary and appropriate within the guidelines set by the Organ Transplant Advisory Council under s. 765.53 ~~381.0602~~ or the Bone Marrow Transplant Advisory Panel under s. 627.4236.

Section 31. Subsection (2) of section 765.5216, Florida Statutes, is amended to read:

765.5216 Organ and tissue donor education panel.--

(2) There is created within the Agency for Health Care Administration a statewide organ and tissue donor education panel, consisting of 12 members, to represent the interests of the public with regard to increasing the number of organ and tissue donors within the state. The panel and the Organ and Tissue Procurement and Transplantation Advisory Board established in s. 765.544 ~~381.6023~~ shall jointly develop, subject to the approval of the Agency for Health Care Administration, education initiatives pursuant to s. 732.9215, which the agency shall implement. The membership must be balanced with respect to gender, ethnicity, and other demographic characteristics so that the appointees reflect the diversity of the population of this state. The panel members must include:

(a) A representative from the Agency for Health Care Administration, who shall serve as chairperson of the panel.

(b) A representative from a Florida licensed organ procurement organization.

(c) A representative from a Florida licensed tissue bank.

(d) A representative from a Florida licensed eye bank.

(e) A representative from a Florida licensed hospital.

(f) A representative from the Division of Driver Licenses of the Department of Highway Safety and Motor

Vehicles, who possesses experience and knowledge in dealing with the public.

(g) A representative from the family of an organ, tissue, or eye donor.

(h) A representative who has been the recipient of a transplanted organ, tissue, or eye, or is a family member of a recipient.

(i) A representative who is a minority person as defined in s. 381.81.

(j) A representative from a professional association or public relations or advertising organization.

(k) A representative from a community service club or organization.

(l) A representative from the Department of Education.

Section 32. Subsection (5) of section 765.522, Florida Statutes, is amended to read:

765.522 Duty of certain hospital administrators; liability of hospital administrators, organ procurement organizations, eye banks, and tissue banks.--

(5) There shall be no civil or criminal liability against any organ procurement organization, eye bank, or tissue bank certified under s. 765.542 ~~381.6022~~, or against any hospital or hospital administrator or designee, when complying with the provisions of this part and the rules of the Agency for Health Care Administration or when, in the exercise of reasonable care, a request for organ donation is inappropriate and the gift is not made according to this part and the rules of the Agency for Health Care Administration.

Section 33. Present subsections (11) through (33) of section 395.002, Florida Statutes, are renumbered as subsections (12) through (34), respectively, and a new

subsection (11) is added to that section, to read:

395.002 Definitions.--As used in this chapter:

(11) "Medically unnecessary procedure" means a surgical or other invasive procedure that no reasonable physician, in light of the patient's history and available diagnostic information, would deem to be indicated in order to treat, cure, or palliate the patient's condition or disease.

Section 34. Subsection (5) is added to section 395.0161, Florida Statutes, to read:

395.0161 Licensure inspection.--

(5)(a) The agency shall adopt rules governing the conduct of inspections or investigations it initiates in response to:

1. Reports filed pursuant to s. 395.0197.

2. Complaints alleging violations of state or federal emergency access laws.

3. Complaints made by the public alleging violations of law by licensed facilities or personnel.

(b) The rules must set forth the procedures to be used in the investigations or inspections in order to protect the due process rights of licensed facilities and personnel and to minimize, to the greatest reasonable extent possible, the disruption of facility operations and the cost to facilities resulting from those investigations.

Section 35. Subsections (2), (14), and (16) of section 395.0197, Florida Statutes, are amended to read:

395.0197 Internal risk management program.--

(2) The internal risk management program is the responsibility of the governing board of the health care facility. Each licensed facility shall use the services of ~~hire~~ a risk manager, licensed under s. 395.10974, who is

responsible for implementation and oversight of such facility's internal risk management program as required by this section. ~~A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.~~

(14) The agency shall have access, as set forth in rules adopted under s. 395.0161(5), to all licensed facility records necessary to carry out the provisions of this section. The records obtained by the agency under subsection (6), subsection (8), or subsection (10) are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall records obtained pursuant to s. 456.071 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, s. 766.101 controls.

(16) The agency shall review, as part of its licensure inspection process, the internal risk management program at each licensed facility regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program

is appropriately reporting incidents under this section. Only a risk manager, licensed under s. 395.10974 and employed by the Agency for Health Care Administration has the authority to conduct inspections necessary to determine whether a program meets the requirements of this section. A determination must be based on the care, skill, and judgment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar licensed risk managers. By July 1, 2004, the Agency for Health Care Administration shall employ a minimum of three licensed risk managers in each district to conduct inspections as provided in this subsection.

Section 36. Paragraph (b) of subsection (1) of section 456.0375, Florida Statutes, is amended to read:

456.0375 Registration of certain clinics; requirements; discipline; exemptions.--

(1)

(b) For purposes of this section, the term "clinic" does not include and the registration requirements herein do not apply to:

1. Entities licensed or registered by the state pursuant to chapter 390, chapter 394, chapter 395, chapter 397, chapter 400, chapter 463, chapter 465, chapter 466, chapter 478, chapter 480, or chapter 484.

2. Entities exempt from federal taxation under 26 U.S.C. s. 501(c)(3) and community college and university clinics.

3. Sole proprietorships, group practices, partnerships, or corporations that provide health care services by licensed health care practitioners pursuant to chapters 457, 458, 459, 460, 461, 462, 463, 466, 467, 484,

486, 490, 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, which are wholly owned by licensed health care practitioners or the licensed health care practitioner and the spouse, parent, or child of a licensed health care practitioner, so long as one of the owners who is a licensed health care practitioner is supervising the services performed therein and is legally responsible for the entity's compliance with all federal and state laws. However, no health care practitioner may supervise the delivery of health care services beyond the scope of the practitioner's license. This section does not prohibit a health care practitioner from providing administrative or managerial supervision for personnel purposes.

Section 37. Paragraph (b) of subsection (2) of section 465.019, Florida Statutes, is amended to read:

465.019 Institutional pharmacies; permits.--

(2) The following classes of institutional pharmacies are established:

(b) "Class II institutional pharmacies" are those institutional pharmacies which employ the services of a registered pharmacist or pharmacists who, in practicing institutional pharmacy, shall provide dispensing and consulting services on the premises to patients of that institution and to patients receiving care in a hospice licensed under part VI of chapter 400 which is located on the premises of that institution, for use on the premises of that institution. However, an institutional pharmacy located in an area or county included in an emergency order or proclamation of a state of emergency declared by the Governor may provide dispensing and consulting services to individuals who are not patients of the institution. However, a single dose of a

medicinal drug may be obtained and administered to a patient on a valid physician's drug order under the supervision of a physician or charge nurse, consistent with good institutional practice procedures. The obtaining and administering of such single dose of a medicinal drug shall be pursuant to drug-handling procedures established by a consultant pharmacist. Medicinal drugs may be dispensed in a Class II institutional pharmacy, but only in accordance with the provisions of this section.

Section 38. Subsection (7) is added to section 631.57, Florida Statutes, to read:

631.57 Powers and duties of the association.--

(7) Notwithstanding any other provision of law, the net direct written premiums of medical malpractice insurance are not subject to assessment under this section to cover claims and administrative costs for the type of insurance defined in s. 624.604.

Section 39. Paragraph (a) of subsection (1) of section 766.101, Florida Statutes, is amended to read:

766.101 Medical review committee, immunity from liability.--

(1) As used in this section:

(a) The term "medical review committee" or "committee" means:

1.a. A committee of a hospital or ambulatory surgical center licensed under chapter 395 or a health maintenance organization certificated under part I of chapter 641,

b. A committee of a physician-hospital organization, a provider-sponsored organization, or an integrated delivery system,

c. A committee of a state or local professional

society of health care providers,

d. A committee of a medical staff of a licensed hospital or nursing home, provided the medical staff operates pursuant to written bylaws that have been approved by the governing board of the hospital or nursing home,

e. A committee of the Department of Corrections or the Correctional Medical Authority as created under s. 945.602, or employees, agents, or consultants of either the department or the authority or both,

f. A committee of a professional service corporation formed under chapter 621 or a corporation organized under chapter 607 or chapter 617, which is formed and operated for the practice of medicine as defined in s. 458.305(3), and which has at least 25 health care providers who routinely provide health care services directly to patients,

g. A committee of a mental health treatment facility licensed under chapter 394 or a community mental health center as defined in s. 394.907, provided the quality assurance program operates pursuant to the guidelines which have been approved by the governing board of the agency,

h. A committee of a substance abuse treatment and education prevention program licensed under chapter 397 provided the quality assurance program operates pursuant to the guidelines which have been approved by the governing board of the agency,

i. A peer review or utilization review committee organized under chapter 440,

j. A committee of the Department of Health, a county health department, healthy start coalition, or certified rural health network, when reviewing quality of care, or employees of these entities when reviewing mortality records, ~~or~~

k. A continuous quality improvement committee of a pharmacy licensed pursuant to chapter 465,

l. A committee established by a university board of trustees, or

m. A committee comprised of faculty, residents, students, and administrators of an accredited college of medicine, nursing, or other health care discipline,

which committee is formed to evaluate and improve the quality of health care rendered by providers of health service or to determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health services in the area; or

2. A committee of an insurer, self-insurer, or joint underwriting association of medical malpractice insurance, or other persons conducting review under s. 766.106.

Section 40. The Office of Legislative Services shall contract for a business case study of the feasibility of outsourcing the administrative, investigative, legal, and prosecutorial functions and other tasks and services that are necessary to carry out the regulatory responsibilities of the Board of Dentistry employing its own executive director and other staff and obtaining authority over collections and expenditures of funds paid by professions regulated by the board into the Medical Quality Assurance Trust Fund. This feasibility study must include a business plan and an assessment of the direct and indirect costs associated with outsourcing these functions. The sum of $50,000 is appropriated from the Board of Dentistry account within the

Medical Quality Assurance Trust Fund to the Office of Legislative Services for the purpose of contracting for the study. The Office of Legislative Services shall submit the completed study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

Section 41. Subsection (5) of section 393.064, Florida Statutes, is amended to read:

393.064 Prevention.--

(5) The Department of Health ~~Children and Family Services~~ shall have the authority, within available resources, to contract for the supervision and management of the Raymond C. Philips Research and Education Unit, and such contract shall include specific program objectives.

Section 42. Section 408.7057, Florida Statutes, is amended to read:

408.7057 Statewide provider and health plan ~~managed care organization~~ claim dispute resolution program.--

(1) As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b)~~(a)~~ "Health plan ~~Managed care organization~~" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, ~~or~~ an exclusive provider organization certified under s. 627.6472, or a major medical expense health insurance policy, as defined in s. 627.643(2)(e), offered by a group or an individual health insurer licensed pursuant to chapter 624, including a preferred provider organization under s. 627.6471.

(c)~~(b)~~ "Resolution organization" means a qualified

independent third-party claim-dispute-resolution entity selected by and contracted with the Agency for Health Care Administration.

(2)(a) The agency ~~for Health Care Administration~~ shall establish a program by January 1, 2001, to provide assistance to contracted and noncontracted providers and health plans ~~managed care organizations~~ for resolution of claim disputes that are not resolved by the provider and the health plan ~~managed care organization~~. The agency shall contract with a resolution organization to timely review and consider claim disputes submitted by providers and health plans ~~managed care organizations~~ and recommend to the agency an appropriate resolution of those disputes. The agency shall establish by rule jurisdictional amounts and methods of aggregation for claim disputes that may be considered by the resolution organization.

(b) The resolution organization shall review claim disputes filed by contracted and noncontracted providers and health plans ~~managed care organizations~~ unless the disputed claim:

1. Is related to interest payment;

2. Does not meet the jurisdictional amounts or the methods of aggregation established by agency rule, as provided in paragraph (a);

3. Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process;

4. Is related to a health plan that is not regulated by the state;

5. Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

6. Is the basis for an action pending in state or federal court; or

7. Is subject to a binding claim-dispute-resolution process provided by contract entered into prior to October 1, 2000, between the provider and the managed care organization.

(c) Contracts entered into or renewed on or after October 1, 2000, may require exhaustion of an internal dispute-resolution process as a prerequisite to the submission of a claim by a provider or a health plan ~~maintenance organization~~ to the resolution organization ~~when the dispute-resolution program becomes effective~~.

(d) A contracted or noncontracted provider or health plan ~~maintenance organization~~ may not file a claim dispute with the resolution organization more than 12 months after a final determination has been made on a claim by a health plan or provider ~~maintenance organization~~.

(e) The resolution organization shall require the health plan or provider submitting the claim dispute to submit any supporting documentation to the resolution organization within 15 days after receipt by the health plan or provider of a request from the resolution organization for documentation in support of the claim dispute. The resolution organization may extend the time if appropriate. Failure to submit the supporting documentation within such time period shall result in the dismissal of the submitted claim dispute.

(f) The resolution organization shall require the respondent in the claim dispute to submit all documentation in support of its position within 15 days after receiving a request from the resolution organization for supporting documentation. The resolution organization may extend the time if appropriate. Failure to submit the supporting documentation

within such time period shall result in a default against the health plan or provider. In the event of such a default, the resolution organization shall issue its written recommendation to the agency that a default be entered against the defaulting entity. The written recommendation shall include a recommendation to the agency that the defaulting entity shall pay the entity submitting the claim dispute the full amount of the claim dispute, plus all accrued interest, and shall be considered a nonprevailing party for the purposes of this section.

(g)1. If on an ongoing basis during the preceding 12 months, the agency has reason to believe that a pattern of noncompliance with s. 627.6131 and s. 641.3155 exists on the part of a particular health plan or provider, the agency shall evaluate the information contained in these cases to determine whether the information evidences a pattern and report its findings, together with substantiating evidence, to the appropriate licensure or certification entity for the health plan or provider.

2. In addition, the agency shall prepare an annual report to the Governor and the Legislature by February 1 of each year, enumerating: claims dismissed; defaults issued; and failures to comply with agency final orders issued under this section.

(3) The agency shall adopt rules to establish a process to be used by the resolution organization in considering claim disputes submitted by a provider or health plan ~~managed care organization~~ which must include the issuance by the resolution organization of a written recommendation, supported by findings of fact, to the agency within 60 days after the requested information is received by the resolution

organization within the timeframes specified by the resolution organization. In no event shall the review time exceed 90 days following receipt of the initial claim dispute submission by the resolution organization ~~receipt of the claim dispute submission~~.

(4) Within 30 days after receipt of the recommendation of the resolution organization, the agency shall adopt the recommendation as a final order.

(5) The agency shall notify within 7 days the appropriate licensure or certification entity whenever there is a violation of a final order issued by the agency pursuant to this section.

(6)~~(5)~~ The entity that does not prevail in the agency's order must pay a review cost to the review organization, as determined by agency rule. Such rule must provide for an apportionment of the review fee in any case in which both parties prevail in part. If the nonprevailing party fails to pay the ordered review cost within 35 days after the agency's order, the nonpaying party is subject to a penalty of not more than $500 per day until the penalty is paid.

(7)~~(6)~~ The agency ~~for Health Care Administration~~ may adopt rules to administer this section.

Section 43. Subsection (1) of section 626.88, Florida Statutes, is amended to read:

626.88 Definitions of "administrator" and "insurer".--

(1) For the purposes of this part, an "administrator" is any person who directly or indirectly solicits or effects coverage of, collects charges or premiums from, or adjusts or settles claims on residents of this state in connection with authorized commercial self-insurance funds or with insured or self-insured programs which provide life or health insurance

coverage or coverage of any other expenses described in s. 624.33(1) or any person who, through a health care risk contract as defined in s. 641.234 with an insurer or health maintenance organization, provides billing and collection services to health insurers and health maintenance organizations on behalf of health care providers, other than any of the following persons:

(a) An employer on behalf of such employer's employees or the employees of one or more subsidiary or affiliated corporations of such employer.

(b) A union on behalf of its members.

(c) An insurance company which is either authorized to transact insurance in this state or is acting as an insurer with respect to a policy lawfully issued and delivered by such company in and pursuant to the laws of a state in which the insurer was authorized to transact an insurance business.

(d) A health care services plan, health maintenance organization, professional service plan corporation, or person in the business of providing continuing care, possessing a valid certificate of authority issued by the department, and the sales representatives thereof, if the activities of such entity are limited to the activities permitted under the certificate of authority.

(e) An insurance agent licensed in this state whose activities are limited exclusively to the sale of insurance.

(f) An adjuster licensed in this state whose activities are limited to the adjustment of claims.

(g) A creditor on behalf of such creditor's debtors with respect to insurance covering a debt between the creditor and its debtors.

(h) A trust and its trustees, agents, and employees

acting pursuant to such trust established in conformity with 29 U.S.C. s. 186.

(i) A trust exempt from taxation under s. 501(a) of the Internal Revenue Code, a trust satisfying the requirements of ss. 624.438 and 624.439, or any governmental trust as defined in s. 624.33(3), and the trustees and employees acting pursuant to such trust, or a custodian and its agents and employees, including individuals representing the trustees in overseeing the activities of a service company or administrator, acting pursuant to a custodial account which meets the requirements of s. 401(f) of the Internal Revenue Code.

(j) A financial institution which is subject to supervision or examination by federal or state authorities or a mortgage lender licensed under chapter 494 who collects and remits premiums to licensed insurance agents or authorized insurers concurrently or in connection with mortgage loan payments.

(k) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized such collection if such company does not adjust or settle claims.

(l) A person who adjusts or settles claims in the normal course of such person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life or health insurance coverage.

(m) A person approved by the Division of Workers' Compensation of the Department of Labor and Employment Security who administers only self-insured workers' compensation plans.

(n) A service company or service agent and its

employees, authorized in accordance with ss. 626.895-626.899, serving only a single employer plan, multiple-employer welfare arrangements, or a combination thereof.

(o) Any provider or group practice, as defined in s. 456.053, providing services under the scope of the license of the provider or the member of the group practice.

(p) Any hospital providing billing, claims, and collection services solely on its own and its physicians' behalf and providing services under the scope of its license.

A person who provides billing and collection services to health insurers and health maintenance organizations on behalf of health care providers shall comply with the provisions of ss. 627.6131, 641.3155, and 641.51(4).

Section 44. Section 627.6131, Florida Statutes, is created to read:

627.6131 Payment of claims.--

(1) The contract shall include the following provision:

"Time of Payment of Claims: After receiving written proof of loss, the insurer will pay monthly all benefits then due for ...(type of benefit).... Benefits for any other loss covered by this policy will be paid as soon as the insurer receives proper written proof."

(2) As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the insurer's designated location that consists of the HCFA 1500 data set, or its successor, that has

all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, "claim" means a paper or electronic billing instrument submitted to the insurer's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

(3) All claims for payment, whether electronic or nonelectronic:

(a) Are considered received on the date the claim is received by the insurer at its designated claims receipt location.

(b) Must be mailed or electronically transferred to an insurer within 6 months after completion of the service and the provider is furnished with the correct name and address of the patient's health insurer. Submission of a provider's claim is considered made on the date it is electronically transferred or mailed.

(c) Must not duplicate a claim previously submitted unless it is determined that the original claim was not received or is otherwise lost.

(4) For all electronically submitted claims, a health insurer shall:

(a) Within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim.

(b) Within 20 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or

contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(c)1. Notification of the health insurer's determination of a contested claim must be accompanied by an itemized list of additional information or documents the insurer can reasonably determine are necessary to process the claim.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Failure of a provider to submit by mail or electronically the additional information or documentation requested within 35 days after receipt of the notification may result in denial of the claim.

3. A health insurer may not make more than one request for documents under this paragraph in connection with a claim, unless the provider fails to submit all of the requested documents to process the claim or if documents submitted by the provider raise new additional issues not included in the original written itemization, in which case the health insurer may provide the provider with one additional opportunity to submit the additional documents needed to process the claim. In no case may the health insurer request duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payments shall be used to the greatest extent possible by the health insurer and the provider.

(e) A claim must be paid or denied within 90 days after receipt of the claim. Failure to pay or deny a claim within 120 days after receipt of the claim creates an uncontestable obligation to pay the claim.

(5) For all nonelectronically submitted claims, a health insurer shall:

(a) Effective November 1, 2003, provide acknowledgment of receipt of the claim within 15 days after receipt of the claim to the provider or provide a provider within 15 days after receipt with electronic access to the status of a submitted claim.

(b) Within 40 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(c)1. Notification of the health insurer's determination of a contested claim must be accompanied by an itemized list of additional information or documents the insurer can reasonably determine are necessary to process the claim.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Failure of a provider to submit by mail or electronically the additional information or documentation requested within 35 days after receipt of the notification may result in denial of the claim.

3. A health insurer may not make more than one request for documents under this paragraph in connection with a claim unless the provider fails to submit all of the requested documents to process the claim or if documents submitted by the provider raise new additional issues not included in the original written itemization, in which case the health insurer may provide the provider with one additional opportunity to submit the additional documents needed to process the claim.

In no case may the health insurer request duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payments shall be used to the greatest extent possible by the health insurer and the provider.

(e) A claim must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny a claim within 140 days after receipt of the claim creates an uncontestable obligation to pay the claim.

(6) If a health insurer determines that it has made an overpayment to a provider for services rendered to an insured, the health insurer must make a claim for such overpayment to the provider's designated location. A health insurer that makes a claim for overpayment to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial or payment adjustment. The insurer must identify the claim or claims, or overpayment claim portion thereof, for which a claim for overpayment is submitted.

(a) If an overpayment determination is the result of retroactive review or audit of coverage decisions or payment levels not related to fraud, a health insurer shall adhere to the following procedures:

1. All claims for overpayment must be submitted to a provider within 30 months after the health insurer's payment of the claim. A provider must pay, deny, or contest the health insurer's claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay

the claim.

2. A provider that denies or contests a health insurer's claim for overpayment or any portion of a claim shall notify the health insurer, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, must include a request for additional information. If the health insurer submits additional information, the health insurer must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information. The notice is considered made on the date the notice is mailed or electronically transferred by the provider.

3. Failure of a health insurer to respond to a provider's contesting of claim or request for additional information regarding the claim within 35 days after receipt of such notice may result in denial of the claim.

4. The health insurer may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health insurer's overpayment claim as required by this paragraph.

5. Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest at the rate of 12 percent per year. Interest on an overdue payment for a claim for an overpayment begins to accrue when the claim should have been paid, denied, or

contested.

(b) A claim for overpayment shall not be permitted beyond 30 months after the health insurer's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(7) Payment of a claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest of 12 percent per year. Interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should have been paid, denied, or contested. The interest is payable with the payment of the claim.

(8) For all contracts entered into or renewed on or after October 1, 2002, a health insurer's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity must be finalized within 60 days after the receipt of the provider's request for review or appeal.

(9) A provider or any representative of a provider, regardless of whether the provider is under contract with the health insurer, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency an insured for payment of covered services for which the health insurer contested or denied the provider's claim. This prohibition applies during the pendency of any claim for payment made by the provider to the health insurer for payment of the services or internal dispute resolution process to determine whether the health insurer is liable for the services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date

of the completion of the health insurer's internal dispute resolution process, not to exceed 60 days.

(10) The provisions of this section may not be waived, voided, or nullified by contract.

(11) A health insurer may not retroactively deny a claim because of insured ineligibility more than 1 year after the date of payment of the claim.

(12) A health insurer shall pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted hospital to an insured if such services are determined by the health insurer to be medically necessary and covered services under the health insurer's contract with the contract holder.

(13) Upon written notification by an insured, an insurer shall investigate any claim of improper billing by a physician, hospital, or other health care provider. The insurer shall determine if the insured was properly billed for only those procedures and services that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the insured, the insurer shall pay to the insured 20 percent of the amount of the reduction up to $500.

(14) A permissible error ratio of 5 percent is established for insurer's claims payment violations of s. 627.6131(4)(a), (b), (c), and (e) and (5)(a), (b), (c), and (e). If the error ratio of a particular insurer does not exceed the permissible error ratio of 5 percent for an audit period, no fine shall be assessed for the noted claims

violations for the audit period. The error ratio shall be determined by dividing the number of claims with violations found on a statistically valid sample of claims for the audit period by the total number of claims in the sample. If the error ratio exceeds the permissible error ratio of 5 percent, a fine may be assessed according to s. 624.4211 for those claims payment violations which exceed the error ratio. Notwithstanding the provisions of this section, the department may fine a health insurer for claims payment violations of s. 627.6131(4)(e) and (5)(e) which create an uncontestable obligation to pay the claim. The department shall not fine insurers for violations which the department determines were due to circumstances beyond the insurer's control.

(15) This section is applicable only to a major medical expense health insurance policy as defined in s. 627.643(2)(e) offered by a group or an individual health insurer licensed pursuant to chapter 624, including a preferred provider policy under s. 627.6471 and an exclusive provider organization under s. 627.6472 or a group or individual insurance contract that only provides direct payments to dentists for enumerated dental services.

(16) Notwithstanding s. 627.6131(4)(b), where an electronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health insurer the pharmacy benefits manager shall, within 30 days of receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(17) Notwithstanding s. 627.6131(5)(a), effective

November 1, 2003, where a nonelectronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health insurer the pharmacy benefits manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

Section 45. Paragraph (a) of subsection (2) of section 627.6425, Florida Statutes, is amended to read:

627.6425 Renewability of individual coverage.--

(2) An insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(a) The individual has failed to pay premiums, ~~or~~ contributions, or a required copayment payable to the insurer in accordance with the terms of the health insurance coverage or the insurer has not received timely premium payments. When the copayment is payable to the insurer and exceeds $300 the insurer shall allow the insured up to ninety days from the date of the procedure to pay the required copayment. The insurer shall print in 10 point type on the Declaration of Benefits page notification that the insured could be terminated for failure to make any required copayment to the insurer.

Section 46. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

627.651 Group contracts and plans of self-insurance must meet group requirements.--

(4) This section does not apply to any plan which is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of

1974, Pub. L. No. 93-406, or to a multiple-employer welfare arrangement as defined in s. 624.437(1), except that a multiple-employer welfare arrangement shall comply with ss. 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8)~~(6)~~. This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not comply with this part.

Section 47. Section 627.662, Florida Statutes, is amended to read:

627.662 Other provisions applicable.--The following provisions apply to group health insurance, blanket health insurance, and franchise health insurance:

(1) Section 627.569, relating to use of dividends, refunds, rate reductions, commissions, and service fees.

(2) Section 627.602(1)(f) and (2), relating to identification numbers and statement of deductible provisions.

(3) Section 627.635, relating to excess insurance.

(4) Section 627.638, relating to direct payment for hospital or medical services.

(5) Section 627.640, relating to filing and classification of rates.

(6) Section 627.613, relating to timely payment of claims, or s. 627.6131, relating to payment of claims.

(7)~~(6)~~ Section 627.645(1), relating to denial of claims.

(8)~~(7)~~ Section 627.613, relating to time of payment of claims.

(9)~~(8)~~ Section 627.6471, relating to preferred provider organizations.

(10)~~(9)~~ Section 627.6472, relating to exclusive

provider organizations.

(11)~~(10)~~ Section 627.6473, relating to combined preferred provider and exclusive provider policies.

(12)~~(11)~~ Section 627.6474, relating to provider contracts.

Section 48. Subsection (2) of section 627.638, Florida Statutes, is amended to read:

627.638 Direct payment for hospital, medical services.--

(2) Whenever, in any health insurance claim form, an insured specifically authorizes payment of benefits directly to any recognized hospital or physician, the insurer shall make such payment to the designated provider of such services, unless otherwise provided in the insurance contract. However, if:

(a) The benefit is determined to be covered under the terms of the policy;

(b) The claim is limited to treatment of mental health or substance abuse, including drug and alcohol abuse; and

(c) The insured authorizes the insurer, in writing, as part of the claim to make direct payment of benefits to a recognized hospital, physician, or other licensed provider,

payments shall be made directly to the recognized hospital, physician, or other licensed provider, notwithstanding any contrary provisions in the insurance contract.

Section 49. Paragraph (e) of subsection (1) of section 641.185, Florida Statutes, is amended to read:

641.185 Health maintenance organization subscriber protections.--

(1) With respect to the provisions of this part and

part III, the principles expressed in the following statements shall serve as standards to be followed by the Department of Insurance and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(e) A health maintenance organization subscriber should receive timely, concise information regarding the health maintenance organization's reimbursement to providers and services pursuant to ss. 641.31 and 641.31015 and should receive prompt payment from the organization pursuant to s. 641.3155.

Section 50. Subsection (4) is added to section 641.234, Florida Statutes, to read:

641.234 Administrative, provider, and management contracts.--

(4)(a) If a health maintenance organization, through a health care risk contract, transfers to any entity the obligations to pay any provider for any claims arising from services provided to or for the benefit of any subscriber of the organization, the health maintenance organization shall remain responsible for any violations of ss. 641,3155, 641.3156, and 641.51(4). The provisions of ss. 624.418-624.4211 and 641.52 shall apply to any such violations.

(b) As used in this subsection:

1. The term "health care risk contract" means a contract under which an entity receives compensation in exchange for providing to the health maintenance organization a provider network or other services, which may include

administrative services.

2. The term "entity" means a person licensed as an administrator under s. 626.88 and does not include any provider or group practice, as defined in s. 456.053, providing services under the scope of the license of the provider or the members of the group practice. The term does not include a hospital providing billing, claims, and collection services solely on its own and its physicians' behalf and providing services under the scope of its license.

Section 51. Subsection (1) of section 641.30, Florida Statutes, is amended to read:

641.30 Construction and relationship to other laws.--

(1) Every health maintenance organization shall accept the ~~standard health~~ claim form prescribed pursuant to s. 641.3155 ~~627.647~~.

Section 52. Subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing prohibited.--

(4) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is

informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

(a) The provider is informed by the organization that it accepts liability;

(b) A court of competent jurisdiction determines that the organization is liable; ~~or~~

(c) The department or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Statewide Provider and Subscriber Assistance Panel pursuant to s. 408.7056; or

(d) The agency issues a final order that the organization is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to s. 408.7057.

Section 53. Section 641.3155, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 641.3155, F.S., for present text.)

641.3155 Prompt payment of claims.--

(1) As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the HCFA 1500 data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, "claim" means a paper

or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

(2) All claims for payment, whether electronic or nonelectronic:

(a) Are considered received on the date the claim is received by the organization at its designated claims receipt location.

(b) Must be mailed or electronically transferred to an organization within 6 months after completion of the service and the provider is furnished with the correct name and address of the patient's health insurer. Submission of a provider's claim is considered made on the date it is electronically transferred or mailed.

(c) Must not duplicate a claim previously submitted unless it is determined that the original claim was not received or is otherwise lost.

(3) For all electronically submitted claims, a health maintenance organization shall:

(a) Within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgment of the receipt of the claim to the electronic source submitting the claim.

(b) Within 20 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(c)1. Notification of the health maintenance

organization's determination of a contested claim must be accompanied by an itemized list of additional information or documents the insurer can reasonably determine are necessary to process the claim.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Failure of a provider to submit by mail or electronically the additional information or documentation requested within 35 days after receipt of the notification may result in denial of the claim.

3. A health maintenance organization may not make more than one request for documents under this paragraph in connection with a claim, unless the provider fails to submit all of the requested documents to process the claim or if documents submitted by the provider raise new additional issues not included in the original written itemization, in which case the health maintenance organization may provide the provider with one additional opportunity to submit the additional documents needed to process the claim. In no case may the health maintenance organization request duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment shall be used to the greatest extent possible by the health maintenance organization and the provider.

(e) A claim must be paid or denied within 90 days after receipt of the claim. Failure to pay or deny a claim within 120 days after receipt of the claim creates an uncontestable obligation to pay the claim.

(4) For all nonelectronically submitted claims, a health maintenance organization shall:

(a) Effective November 1, 2003, provide acknowledgement of receipt of the claim within 15 days after receipt of the claim to the provider or designee or provide a provider or designee within 15 days after receipt with electronic access to the status of a submitted claim.

(b) Within 40 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the health maintenance organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(c)1. Notification of the health maintenance organization's determination of a contested claim must be accompanied by an itemized list of additional information or documents the organization can reasonably determine are necessary to process the claim.

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Failure of a provider to submit by mail or electronically the additional information or documentation requested within 35 days after receipt of the notification may result in denial of the claim.

3. A health maintenance organization may not make more than one request for documents under this paragraph in connection with a claim unless the provider fails to submit all of the requested documents to process the claim or if documents submitted by the provider raise new additional issues not included in the original written itemization, in which case the health maintenance organization may provide the provider with one additional opportunity to submit the additional documents needed to process the claim. In no case

may the health maintenance organization request duplicate documents.

(d) For purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payments shall be used to the greatest extent possible by the health maintenance organization and the provider.

(e) A claim must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny a claim within 140 days after receipt of the claim creates an uncontestable obligation to pay the claim.

(5) If a health maintenance organization determines that it has made an overpayment to a provider for services rendered to a subscriber, the health maintenance organization must make a claim for such overpayment to the provider's designated location. A health maintenance organization that makes a claim for overpayment to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial or payment adjustment. The health maintenance organization must identify the claim or claims, or overpayment claim portion thereof, for which a claim for overpayment is submitted.

(a) If an overpayment determination is the result of retroactive review or audit of coverage decisions or payment levels not related to fraud, a health maintenance organization shall adhere to the following procedures:

1. All claims for overpayment must be submitted to a provider within 30 months after the health maintenance organization's payment of the claim. A provider must pay, deny, or contest the health maintenance organization's claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied

within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim.

2. A provider that denies or contests a health maintenance organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information. The notice is considered made on the date the notice is mailed or electronically transferred by the provider.

3. Failure of a health maintenance organization to respond to a provider's contestment of claim or request for additional information regarding the claim within 35 days after receipt of such notice may result in denial of the claim.

4. The health maintenance organization may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health maintenance organization's overpayment claim as required by this paragraph.

5. Payment of an overpayment claim is considered made on the date the payment was mailed or electronically

transferred. An overdue payment of a claim bears simple interest at the rate of 12 percent per year. Interest on an overdue payment for a claim for an overpayment payment begins to accrue when the claim should have been paid, denied, or contested.

(b) A claim for overpayment shall not be permitted beyond 30 months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(6) Payment of a claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest of 12 percent per year. Interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should have been paid, denied, or contested. The interest is payable with the payment of the claim.

(7)(a) For all contracts entered into or renewed on or after October 1, 2002, a health maintenance organization's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity must be finalized within 60 days after the receipt of the provider's request for review or appeal.

(b) All claims to a health maintenance organization begun after October 1, 2000, not under active review by a mediator, arbitrator, or third-party dispute entity, shall result in a final decision on the claim by the health maintenance organization by January 2, 2003, for the purpose of the statewide provider and managed care organization claim dispute resolution program pursuant to s. 408.7057.

(8) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber for payment of covered services for which the health maintenance organization contested or denied the provider's claim. This prohibition applies during the pendency of any claim for payment made by the provider to the health maintenance organization for payment of the services or internal dispute resolution process to determine whether the health maintenance organization is liable for the services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of the health maintenance organization's internal dispute resolution process, not to exceed 60 days.

(9) The provisions of this section may not be waived, voided, or nullified by contract.

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility more than 1 year after the date of payment of the claim.

(11) A health maintenance organization shall pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted hospital to a subscriber if such services are determined by the health maintenance organization to be medically necessary and covered services under the health maintenance organization's contract with the contract holder.

(12) Upon written notification by a subscriber, a health maintenance organization shall investigate any claim of improper billing by a physician, hospital, or other health

care provider. The organization shall determine if the subscriber was properly billed for only those procedures and services that the subscriber actually received. If the organization determines that the subscriber has been improperly billed, the organization shall notify the subscriber and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the insured, the insurer shall pay to the insured 20 percent of the amount of the reduction up to $500.

(13) A permissible error ratio of 5 percent is established for health maintenance organizations' claims payment violations of s. 641.3155(3)(a), (b), (c), and (e) and (4)(a), (b), (c), and (e). If the error ratio of a particular insurer does not exceed the permissible error ratio of 5 percent for an audit period, no fine shall be assessed for the noted claims violations for the audit period. The error ratio shall be determined by dividing the number of claims with violations found on a statistically valid sample of claims for the audit period by the total number of claims in the sample. If the error ratio exceeds the permissible error ratio of 5 percent, a fine may be assessed according to s. 624.4211 for those claims payment violations which exceed the error ratio. Notwithstanding the provisions of this section, the department may fine a health maintenance organization for claims payment violations of s. 641.3155(3)(e) and (4)(e) which create an uncontestable obligation to pay the claim. The department shall not fine organizations for violations which the department determines were due to circumstances beyond the organization's control.

(14) This section shall apply to all claims or any

portion of a claim submitted by a health maintenance organization subscriber under a health maintenance organization subscriber contract to the organization for payment.

(15) Notwithstanding s. 641.3155(3)(b), where an electronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health maintenance organization the pharmacy benefits manager shall, within 30 days of receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

(16) Notwithstanding s. 641.3155(4)(a), effective November 1, 2003, where a nonelectronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health maintenance organization the pharmacy benefits manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

Section 54. Subsection (12) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.--

(12) If a contracted primary care physician, licensed under chapter 458 or chapter 459, determines ~~and the organization determine~~ that a subscriber requires examination by a licensed ophthalmologist for medically necessary, contractually covered services, then the organization shall authorize the contracted primary care physician to send the

subscriber to a contracted licensed ophthalmologist.

Section 55. Subsection (3) is added to section 381.003, Florida Statutes, to read:

381.003 Communicable disease and AIDS prevention and control.--

(3) The department shall by rule adopt the blood-borne-pathogen standard set forth in subpart Z of 29 C.F.R. part 1910, as amended by Pub. L. No. 106-430, which shall apply to all public-sector employers. The department shall compile and maintain a list of existing needleless systems and sharps with engineered sharps-injury protection which shall be available to assist employers, including the department and the Department of Corrections, in complying with the applicable requirements of the blood-borne-pathogen standard. The list may be developed from existing sources of information, including, without limitation, the United States Food and Drug Administration, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, and the United States Department of Veterans Affairs.

Section 56. The Agency for Health Care Administration shall conduct a study of health care services provided to the medically fragile or medical-technology-dependent children in the state and conduct a pilot program in Dade County to provide subacute pediatric transitional care to a maximum of 30 children at any one time. The purposes of the study and the pilot program are to determine ways to permit medically fragile or medical-technology-dependent children to successfully make a transition from acute care in a health care institution to live with their families when possible, and to provide cost-effective, subacute transitional care

services.

Section 57. The Agency for Health Care Administration, in cooperation with the Children's Medical Services Program in the Department of Health, shall conduct a study to identify the total number of medically fragile or medical-technology-dependent children, from birth through age 21, in the state. By January 1, 2003, the agency must report to the Legislature regarding the children's ages, the locations where the children are served, the types of services received, itemized costs of the services, and the sources of funding that pay for the services, including the proportional share when more than one funding source pays for a service. The study must include information regarding medically fragile or medical-technology-dependent children residing in hospitals, nursing homes, and medical foster care, and those who live with their parents. The study must describe children served in prescribed pediatric extended-care centers, including their ages and the services they receive. The report must identify the total services provided for each child and the method for paying for those services. The report must also identify the number of such children who could, if appropriate transitional services were available, return home or move to a less-institutional setting.

Section 58. (1) Within 30 days after the effective date of this act, the agency shall establish minimum staffing standards and quality requirements for a subacute pediatric transitional care center to be operated as a 2-year pilot program in Dade County. The pilot program must operate under the license of a hospital licensed under chapter 395, Florida Statutes, or a nursing home licensed under chapter 400, Florida Statutes, and shall use existing beds in the hospital

or nursing home. A child's placement in the subacute pediatric transitional care center may not exceed 90 days. The center shall arrange for an alternative placement at the end of a child's stay and a transitional plan for children expected to remain in the facility for the maximum allowed stay.

(2) Within 60 days after the effective date of this act, the agency must amend the state Medicaid plan and request any federal waivers necessary to implement and fund the pilot program.

(3) The subacute pediatric transitional care center must require level I background screening as provided in chapter 435, Florida Statutes, for all employees or prospective employees of the center who are expected to, or whose responsibilities may require them to, provide personal care or services to children, have access to children's living areas, or have access to children's funds or personal property.

Section 59. (1) The subacute pediatric transitional care center must have an advisory board. Membership on the advisory board must include, but need not be limited to:

(a) A physician and an advanced registered nurse practitioner who is familiar with services for medically fragile or medical-technology-dependent children;

(b) A registered nurse who has experience in the care of medically fragile or medical-technology-dependent children;

(c) A child development specialist who has experience in the care of medically fragile or medical-technology-dependent children and their families;

(d) A social worker who has experience in the care of medically fragile or medical-technology-dependent children and their families; and

(e) A consumer representative who is a parent or guardian of a child placed in the center.

(2) The advisory board shall:

(a) Review the policy and procedure components of the center to assure conformance with applicable standards developed by the Agency for Health Care Administration; and

(b) Provide consultation with respect to the operational and programmatic components of the center.

Section 60. (1) The subacute pediatric transitional care center must have written policies and procedures governing the admission, transfer, and discharge of children.

(2) The admission of each child to the center must be under the supervision of the center nursing administrator or his or her designee, and must be in accordance with the center's policies and procedures. Each Medicaid admission must be approved as appropriate for placement in the facility by the Children's Medical Services Multidisciplinary Assessment Team of the Department of Health, in conjunction with the Agency for Health Care Administration.

(3) Each child admitted to the center shall be admitted upon prescription of the medical director of the center, licensed pursuant to chapter 458 or chapter 459, and the child shall remain under the care of the medical director and the advanced registered nurse practitioner for the duration of his or her stay in the center.

(4) Each child admitted to the center must meet at least the following criteria:

(a) The child must be medically fragile or medical-technology-dependent.

(b) The child may not, prior to admission, present significant risk of infection to other children or personnel.

The medical and nursing directors shall review, on a case-by-case basis, the condition of any child who is suspected of having an infectious disease to determine whether admission is appropriate.

(c) The child must be medically stabilized and require skilled nursing care or other interventions.

(5) If the child meets the criteria specified in paragraphs (4)(a), (b), and (c), the medical director or nursing director of the center shall implement a preadmission plan that delineates services to be provided and appropriate sources for such services.

(a) If the child is hospitalized at the time of referral, preadmission planning must include the participation of the child's parent or guardian and relevant medical, nursing, social services, and developmental staff to assure that the hospital's discharge plans will be implemented following the child's placement in the center.

(b) A consent form, outlining the purpose of the center, family responsibilities, authorized treatment, appropriate release of liability, and emergency disposition plans, must be signed by the parent or guardian and witnessed before the child is admitted to the center. The parent or guardian shall be provided a copy of the consent form.

Section 61. By January 1, 2003, the Agency for Health Care Administration shall report to the Legislature concerning the progress of the pilot program. By January 1, 2004, the agency shall submit to the Legislature a report on the success of the pilot program.

Section 62. Section 765.510, Florida Statutes, is amended to read:

765.510 Legislative declaration.--Because ~~of the rapid~~

~~medical progress in the fields of tissue and organ preservation, transplantation of tissue, and tissue culture, and because~~ it is in the public interest to aid the medical developments in the ~~these~~ fields of organ and tissue recovery and transplantation, and in order to promote the general welfare, save lives, and reduce sickness, pain, suffering, disabilities, and medical costs of persons with organ and tissue impairment, and to help alleviate the shortage of organs and tissues available for transplantation and research, the Legislature in enacting this part intends to encourage and aid the development of reconstructive medicine and surgery and the development of medical research by facilitating premortem and postmortem authorizations for donations of tissue and organs. It is the purpose of this part to regulate the gift of a body or parts of a body, the gift to be made after the death of a donor.

Section 63. Subsections (1), (2), and (6) of section 765.512, Florida Statutes, are amended to read:

765.512 Persons who may make an anatomical gift.--

(1) Any person who may make a will may give all or part of his or her body for any purpose specified in s. 765.510, the gift to take effect upon death. An anatomical gift made by an adult donor and not revoked by the donor as provided in s. 765.516 is irrevocable ~~and does not require the consent or concurrence of any person~~ after the donor's death. A family member, guardian, representative ad litem, or health care surrogate of a decedent who has made an anatomical gift may not modify the decedent's wishes or deny or prevent the anatomical gift from being made.

(2) If the decedent has executed an agreement concerning an anatomical gift, by ~~including~~ signing an organ

and tissue donor card, by expressing his or her wish to donate in a living will or advance directive, or by signifying his or her intent to donate on his or her driver's license or in some other written form has indicated his or her wish to make an anatomical gift, and in the absence of actual notice of contrary indications by the decedent, the document is evidence of legally sufficient informed consent to donate an anatomical gift and is legally binding. Any surrogate designated by the decedent pursuant to part II of this chapter may give all or any part of the decedent's body for any purpose specified in s. 765.510.

(6) A gift of all or part of a body authorizes:

(a) Any examination necessary to assure medical acceptability of the gift for the purposes intended; and.

(b) The decedent's medical provider, family, or a third party to furnish medical records requested concerning the decedent's medical and social history.

Section 64. Section 765.516, Florida Statutes, is amended to read:

765.516 Amendment of the terms of or the revocation of the gift.--

(1) A donor may amend the terms of or revoke an anatomical gift by:

(a) The execution and delivery to the donee of a signed statement.

(b) An oral statement that is:

~~1. Made to the donor's spouse; or~~

~~2.~~ made in the presence of two persons, other than the donor's spouse, and communicated to the donor's family or attorney or to the donee.

(c) A statement during a terminal illness or injury

addressed to an attending physician, who must communicate the revocation of the gift to the procurement organization that is certified by the state.

(d) A signed document found on or about the donor's person ~~or in the donor's effects~~.

(2) The terms of any gift made by a will may ~~also~~ be amended or the gift may be revoked in the manner provided for the amendment or revocation of wills or as provided in subsection (1).

Section 65. Subsections (1) and (5) of section 765.517, Florida Statutes, are amended to read:

765.517 Rights and duties at death.--

(1) The donee, as specified under the provisions of s. 765.515(2), may accept or reject the gift. If the donee accepts a gift of the entire body or a part of the body to be used for scientific purposes other than a transplant, the donee may authorize embalming and the use of the body in funeral services, subject to the terms of the gift. ~~If the gift is of a part of the body, the donee shall cause the part to be removed without unnecessary mutilation upon the death of the donor and before or after embalming.~~After removal of the part, ~~custody of the remainder of~~ the body shall be made available to ~~vests in~~ the surviving spouse, next of kin, or other persons under obligation to dispose of the body.

(5) A person or entity that ~~who~~ acts or attempts to act in good faith and without negligence in accordance ~~accord~~ with the terms of this part or under the anatomical gift laws of another state or a foreign country is not liable for damages in any civil action or subject to prosecution for his or her acts in any criminal proceeding. Neither an individual who makes an anatomical gift nor the individual's estate is

liable for any injury or damage that results from the making or the use of the anatomical gift.

Section 66. Section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on conditions caused by nuclear, biological, and chemical terrorism and on human immunodeficiency virus and acquired immune deficiency syndrome.--

(1) ~~As of July 1, 1991,~~The Department of Health shall require each person licensed or certified under chapter 401, chapter 467, part IV of chapter 468, or chapter 483, as a condition of biennial relicensure, to complete an educational course approved by the department on conditions caused by nuclear, biological, and chemical terrorism. The course shall consist of education on diagnosis and treatment,~~the~~ modes of transmission, infection control procedures, and clinical management. Such course shall also include information on reporting suspected cases of conditions caused by nuclear, biological, or chemical terrorism to the appropriate health and law enforcement authorities~~, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current Florida law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, and treatment of patients~~. Each such licensee or certificateholder shall submit confirmation of having completed said course, on a form provided by the department, when submitting fees or application for each biennial renewal.

(2) Failure to complete the requirements of this section shall be grounds for disciplinary action contained in the chapters specified in subsection (1). In addition to

discipline by the department, the licensee or certificateholder shall be required to complete the required ~~said~~ course or courses.

(3) The department shall require, as a condition of granting a license under the chapters specified in subsection (1), that an applicant making initial application for licensure complete respective ~~an~~ educational courses ~~course~~ acceptable to the department on conditions caused by nuclear, biological, and chemical terrorism and on human immunodeficiency virus and acquired immune deficiency syndrome. An applicant who has not taken such courses ~~a course~~ at the time of licensure shall, upon an affidavit showing good cause, be allowed 6 months to complete this requirement.

(4) The department shall have the authority to adopt rules to carry out the provisions of this section.

(5) Any professional holding two or more licenses or certificates subject to the provisions of this section shall be permitted to show proof of having taken one department-approved course on conditions caused by nuclear, biological, and chemical terrorism ~~human immunodeficiency virus and acquired immune deficiency syndrome~~, for purposes of relicensure or recertification for the additional licenses.

(6) As used in this section, the term "terrorism" has the same meaning as in s. 775.30.

Section 67. Section 381.0035, Florida Statutes, is amended to read:

381.0035 Educational courses ~~course~~ on human immunodeficiency virus and acquired immune deficiency syndrome and on conditions caused by nuclear, biological, and chemical terrorism; employees and clients of certain health care

facilities.--

(1)(a) The Department of Health shall require all ~~employees and~~ clients of facilities licensed under chapters 393, 394, and 397 ~~and employees of facilities licensed under chapter 395 and parts II, III, IV, and VI of chapter 400~~ to complete, biennially, a continuing educational course on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome with an emphasis on appropriate behavior and attitude change. Such instruction shall include information on current Florida law and its impact on testing, confidentiality of test results, and treatment of patients and any protocols and procedures applicable to human immunodeficiency counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification issues pursuant to ss. 381.004 and 384.25.

(b) The department shall require all employees of facilities licensed under chapters 393, 394, 395, and 397 and parts II, III, IV, and VI of chapter 400 to complete, biennially, a continuing educational course on conditions caused by nuclear, biological, and chemical terrorism. The course shall consist of education on diagnosis and treatment, modes of transmission, infection control procedures, and clinical management. Such course shall also include information on reporting suspected cases of conditions caused by nuclear, biological, or chemical terrorism to the appropriate health and law enforcement authorities.

(2) New employees of facilities licensed under chapters 393, 394, 395, and 397 and parts II, III, IV, and VI of chapter 400 shall be required to complete a course on human

immunodeficiency virus and acquired immune deficiency syndrome, with instruction to include information on current Florida law and its impact on testing, confidentiality of test results, and treatment of patients. New employees of such facilities shall also be required to complete a course on conditions caused by nuclear, biological, and chemical terrorism, with instruction to include information on reporting suspected cases to the appropriate health and law enforcement authorities.

(3) Facilities licensed under chapters 393, 394, 395, and 397~~,~~ and parts II, III, IV, and VI of chapter 400 shall maintain a record of employees and dates of attendance at ~~human immunodeficiency virus and acquired immune deficiency syndrome~~ educational courses on human immunodeficiency virus and acquired immune deficiency syndrome and on conditions caused by nuclear, biological, and chemical terrorism.

(4) The department shall have the authority to review the records of each facility to determine compliance with the requirements of this section. The department may adopt rules to carry out the provisions of this section.

(5) As used in this section, the term "terrorism" has the same meaning as in s. 775.30.

Section 68. Section 401.23, Florida Statutes, is amended to read:

401.23 Definitions.--As used in this part, the term:

(1) "Advanced life support" means the use of skills and techniques described in the most recent U.S. DOT National Standard Paramedic Curriculum by a paramedic under the supervision of a licensee's medical director as required by rules of the department. The term "advanced life support" also includes other techniques which have been approved and are

performed under conditions specified by rules of the department. The term "advanced life support" also includes provision of care by a paramedic under the supervision of a licensee's medical director to one experiencing an emergency medical condition as defined herein.~~"Advanced life support" means treatment of life-threatening medical emergencies through the use of techniques such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, and cardiac defibrillation by a qualified person, pursuant to rules of the department.~~

(2) "Advanced life support service" means any emergency medical transport or nontransport service which uses advanced life support techniques.

(3) "Air ambulance" means any fixed-wing or rotary-wing aircraft used for, or intended to be used for, air transportation of sick or injured persons requiring or likely to require medical attention during transport.

(4) "Air ambulance service" means any publicly or privately owned service, licensed in accordance with the provisions of this part, which operates air ambulances to transport persons requiring or likely to require medical attention during transport.

(5) "Ambulance" or "emergency medical services vehicle" means any privately or publicly owned land or water vehicle that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, land or water transportation of sick or injured persons requiring or likely to require medical attention during transport.

(6) "Ambulance driver" means any person who meets the requirements of s. 401.281.

(7) "Basic life support" means the use of skills and techniques described in the most recent U.S. DOT National Standard EMT-Basic Curriculum by an emergency medical technician or paramedic under the supervision of a licensee's medical director as required by rules of the department. The term "basic life support" also includes other techniques which have been approved and are performed under conditions specified by rules of the department. The term "basic life support" also includes provision of care by a paramedic or emergency medical technician under the supervision of a licensee's medical director to one experiencing an emergency medical condition as defined herein.~~"Basic life support" means treatment of medical emergencies by a qualified person through the use of techniques such as patient assessment, cardiopulmonary resuscitation (CPR), splinting, obstetrical assistance, bandaging, administration of oxygen, application of medical antishock trousers, administration of a subcutaneous injection using a premeasured autoinjector of epinephrine to a person suffering an anaphylactic reaction, and other techniques described in the Emergency Medical Technician Basic Training Course Curriculum of the United States Department of Transportation. The term "basic life support" also includes other techniques which have been approved and are performed under conditions specified by rules of the department.~~

(8) "Basic life support service" means any emergency medical service which uses only basic life support techniques.

(9) "Certification" means any authorization issued pursuant to this part to a person to act as an emergency medical technician or a paramedic.

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

(11) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, psychiatric disturbances, symptoms of substance abuse, or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman, that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(c) With respect to a person exhibiting acute psychiatric disturbance or substance abuse, that the absence of immediate medical attention could reasonably be expected to result in:

1. Serious jeopardy to the health of a patient; or

2. Serious jeopardy to the health of others.

(12)~~(11)~~ "Emergency medical technician" means a person who is certified by the department to perform basic life support pursuant to this part.

(13)~~(12)~~ "Interfacility transfer" means the transportation by ambulance of a patient between two facilities licensed under chapter 393, chapter 395, or chapter 400, pursuant to this part.

(14)~~(13)~~ "Licensee" means any basic life support service, advanced life support service, or air ambulance service licensed pursuant to this part.

(15)~~(14)~~ "Medical direction" means direct supervision

by a physician through two-way voice communication or, when such voice communication is unavailable, through established standing orders, pursuant to rules of the department.

(16)~~(15)~~ "Medical director" means a physician who is employed or contracted by a licensee and who provides medical supervision, including appropriate quality assurance but not including administrative and managerial functions, for daily operations and training pursuant to this part.

(17)~~(16)~~ "Mutual aid agreement" means a written agreement between two or more entities whereby the signing parties agree to lend aid to one another under conditions specified in the agreement and as sanctioned by the governing body of each affected county.

(18)~~(17)~~ "Paramedic" means a person who is certified by the department to perform basic and advanced life support pursuant to this part.

(19)~~(18)~~ "Permit" means any authorization issued pursuant to this part for a vehicle to be operated as a basic life support or advanced life support transport vehicle or an advanced life support nontransport vehicle providing basic or advanced life support.

(20)~~(19)~~ "Physician" means a practitioner who is licensed under the provisions of chapter 458 or chapter 459. For the purpose of providing "medical direction" as defined in subsection (14) for the treatment of patients immediately prior to or during transportation to a United States Department of Veterans Affairs medical facility, "physician" also means a practitioner employed by the United States Department of Veterans Affairs.

(21)~~(20)~~ "Registered nurse" means a practitioner who is licensed to practice professional nursing pursuant to part

I of chapter 464.

(22)~~(21)~~ "Secretary" means the Secretary of Health.

(23)~~(22)~~ "Service location" means any permanent location in or from which a licensee solicits, accepts, or conducts business under this part.

Section 69. Subsection (6) of section 401.27, Florida Statutes, is amended to read:

401.27 Personnel; standards and certification.--

(6)(a) The department shall establish by rule a procedure for biennial renewal certification of emergency medical technicians. Such rules must require a United States Department of Transportation refresher training program of at least 30 hours as approved by the department every 2 years. Completion of the course required by s. 381.0034(1) shall count toward the 30 hours.The refresher program may be offered in multiple presentations spread over the 2-year period. The rules must also provide that the refresher course requirement may be satisfied by passing a challenge examination.

(b) The department shall establish by rule a procedure for biennial renewal certification of paramedics. Such rules must require candidates for renewal to have taken at least 30 hours of continuing education units during the 2-year period. Completion of the course required by s. 381.0034(1) shall count toward the 30 hours.The rules must provide that the continuing education requirement may be satisfied by passing a challenge examination.

Section 70. Section 456.033, Florida Statutes, is amended to read:

456.033 Requirement for instruction for certain licensees on conditions caused by nuclear, biological, and

chemical terrorism and on HIV and AIDS.--

(1) The appropriate board shall require each person licensed or certified under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; part I of chapter 464; chapter 465; chapter 466; part II, part III, part V, or part X of chapter 468; or chapter 486 to complete a continuing educational course, approved by the board, on conditions caused by nuclear, biological, and chemical terrorism ~~human immunodeficiency virus and acquired immune deficiency syndrome~~ as part of biennial relicensure or recertification. The course shall consist of education on diagnosis and treatment,~~the~~ modes of transmission, infection control procedures, and clinical management. Such course shall also include information on reporting suspected cases of conditions caused by nuclear, biological, or chemical terrorism to the appropriate health and law enforcement authorities~~, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current Florida law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, treatment of patients, and any protocols and procedures applicable to human immunodeficiency virus counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification issues pursuant to ss. 381.004 and 384.25~~.

(2) Each such licensee or certificateholder shall submit confirmation of having completed said course, on a form as provided by the board, when submitting fees for each biennial renewal.

(3) The board shall have the authority to approve additional equivalent courses that may be used to satisfy the

requirements in subsection (1). Each licensing board that requires a licensee to complete an educational course pursuant to this section may count the hours required for completion of the course included in the total continuing educational requirements as required by law.

(4) Any person holding two or more licenses subject to the provisions of this section shall be permitted to show proof of having taken one board-approved course on conditions caused by nuclear, biological, and chemical terrorism ~~human immunodeficiency virus and acquired immune deficiency syndrome~~, for purposes of relicensure or recertification for additional licenses.

(5) Failure to comply with the ~~above~~ requirements of this section shall constitute grounds for disciplinary action under each respective licensing chapter and s. 456.072(1)(e). In addition to discipline by the board, the licensee shall be required to complete the required course or courses.

(6) The board shall require as a condition of granting a license under the chapters and parts specified in subsection (1) that an applicant making initial application for licensure complete respective ~~an~~ educational courses ~~course~~ acceptable to the board on conditions caused by nuclear, biological, and chemical terrorism and on human immunodeficiency virus and acquired immune deficiency syndrome. An applicant who has not taken such courses ~~a course~~ at the time of licensure shall, upon an affidavit showing good cause, be allowed 6 months to complete this requirement.

(7) The board shall have the authority to adopt rules to carry out the provisions of this section.

(8) The board shall report to the Legislature by March 1 of each year as to the implementation and compliance with

the requirements of this section.

(9)(a) In lieu of completing a course as required in subsection (1), the licensee may complete a course on ~~in~~ end-of-life care and palliative health care or a course on HIV/AIDS, so long as the licensee completed an approved ~~AIDS/HIV~~ course on conditions caused by nuclear, biological, and chemical terrorism in the immediately preceding biennium.

(b) In lieu of completing a course as required by subsection (1), a person licensed under chapter 466 ~~who has completed an approved AIDS/HIV course in the immediately preceding 2 years~~ may complete a course approved by the Board of Dentistry.

(10) As used in this section, the term "terrorism" has the same meaning as in s. 775.30.

Section 71. Section 456.0345, Florida Statutes, is created to read:

456.0345 Life support training.--Health care practitioners who obtain training in advanced cardiac life support, cardiopulmonary resuscitation, or emergency first aid shall receive an equivalent number of continuing education course credits which may be applied toward licensure renewal requirements.

Section 72. Subsection (4) of section 458.319, Florida Statutes, is amended to read:

458.319 Renewal of license.--

(4) Notwithstanding the provisions of s. 456.033, a physician may complete continuing education on end-of-life care and palliative care in lieu of continuing education in conditions caused by nuclear, biological, and chemical terrorism ~~AIDS/HIV~~, if that physician has completed the ~~AIDS/HIV~~ continuing education in conditions caused by nuclear,

biological, and chemical terrorism in the immediately preceding biennium. As used in this subsection, the term "terrorism" has the same meaning as in s. 775.30.

Section 73. Subsection (5) of section 459.008, Florida Statutes, is amended to read:

459.008 Renewal of licenses and certificates.--

(5) Notwithstanding the provisions of s. 456.033, an osteopathic physician may complete continuing education on end-of-life and palliative care in lieu of continuing education in conditions caused by nuclear, biological, and chemical terrorism ~~AIDS/HIV~~, if that physician has completed the ~~AIDS/HIV~~ continuing education in conditions caused by nuclear, biological, and chemical terrorism in the immediately preceding biennium. As used in this subsection, the term "terrorism" has the same meaning as in s. 775.30.

Section 74. Subsection (6) of section 381.0011, Florida Statutes, is amended to read:

381.0011 Duties and powers of the Department of Health.--It is the duty of the Department of Health to:

(6) Declare, enforce, modify, and abolish quarantine of persons, animals, and premises as the circumstances indicate for controlling communicable diseases or providing protection from unsafe conditions that pose a threat to public health, except as provided in ss. 384.28 and 392.545-392.60.

(a) The department shall adopt rules to specify the conditions and procedures for imposing and releasing a quarantine. The rules must include provisions related to:

1. The closure of premises.

2. The movement of persons or animals exposed to or infected with a communicable disease.

3. The tests or ~~prophylactic~~ treatment, including

vaccination, for communicable disease required prior to employment or admission to the premises or to comply with a quarantine.

4. Testing or destruction of animals with or suspected of having a disease transmissible to humans.

5. Access by the department to quarantined premises.

6. The disinfection of quarantined animals, persons, or premises.

7. Methods of quarantine.

(b) Any health regulation that restricts travel or trade within the state may not be adopted or enforced in this state except by authority of the department.

Section 75. Section 381.00315, Florida Statutes, is amended to read:

381.00315 Public health advisories; public health emergencies.--The State Health Officer is responsible for declaring public health emergencies and issuing public health advisories.

(1) As used in this section, the term:

(a) "Public health advisory" means any warning or report giving information to the public about a potential public health threat. Prior to issuing any public health advisory, the State Health Officer must consult with any state or local agency regarding areas of responsibility which may be affected by such advisory. Upon determining that issuing a public health advisory is necessary to protect the public health and safety, and prior to issuing the advisory, the State Health Officer must notify each county health department within the area which is affected by the advisory of the State Health Officer's intent to issue the advisory. The State Health Officer is authorized to take any action appropriate to

enforce any public health advisory.

(b) "Public health emergency" means any occurrence, or threat thereof, whether natural or man made, which results or may result in substantial injury or harm to the public health from infectious disease, chemical agents, nuclear agents, biological toxins, or situations involving mass casualties or natural disasters. Prior to declaring a public health emergency, the State Health Officer shall, to the extent possible, consult with the Governor and shall notify the Chief of Domestic Security Initiatives as created in s. 943.03. The declaration of a public health emergency shall continue until the State Health Officer finds that the threat or danger has been dealt with to the extent that the emergency conditions no longer exist and he or she terminates the declaration. However, a declaration of a public health emergency may not continue for longer than 60 days unless the Governor concurs in the renewal of the declaration. The State Health Officer, upon declaration of a public health emergency, may take actions that are necessary to protect the public health. Such actions include, but are not limited to:

1. Directing manufacturers of prescription drugs or over-the-counter drugs who are permitted under chapter 499 and wholesalers of prescription drugs located in this state who are permitted under chapter 499 to give priority to the shipping of specified drugs to pharmacies and health care providers within geographic areas that have been identified by the State Health Officer. The State Health Officer must identify the drugs to be shipped. Manufacturers and wholesalers located in the state must respond to the State Health Officer's priority shipping directive before shipping the specified drugs.

2. Notwithstanding chapters 465 and 499 and rules adopted thereunder, directing pharmacists employed by the department to compound bulk prescription drugs and provide these bulk prescription drugs to physicians and nurses of county health departments or any qualified person authorized by the State Health Officer for administration to persons as part of a prophylactic or treatment regimen.

3. Notwithstanding s. 456.036, temporarily reactivating the inactive license of the following health care practitioners, when such practitioners are needed to respond to the public health emergency: physicians licensed under chapter 458 or chapter 459; physician assistants licensed under chapter 458 or chapter 459; licensed practical nurses, registered nurses, and advanced registered nurse practitioners licensed under part I of chapter 464; respiratory therapists licensed under part V of chapter 468; and emergency medical technicians and paramedics certified under part III of chapter 401. Only those health care practitioners specified in this paragraph who possess an unencumbered inactive license and who request that such license be reactivated are eligible for reactivation. An inactive license that is reactivated under this paragraph shall return to inactive status when the public health emergency ends or prior to the end of the public health emergency if the State Health Officer determines that the health care practitioner is no longer needed to provide services during the public health emergency. Such licenses may only be reactivated for a period not to exceed 90 days without meeting the requirements of s. 456.036 or chapter 401, as applicable.

4. Ordering an individual to be examined, tested, vaccinated, treated, or quarantined for communicable diseases

that have significant morbidity or mortality and present a severe danger to public health. Individuals who are unable or unwilling to be examined, tested, vaccinated or treated for reasons of health, religion or conscience may be subjected to quarantine.

a. Examination, testing, vaccination, or treatment may be performed by any qualified person authorized by the State Health Officer.

b. If the individual poses a danger to the public health, the State Health Officer may subject the individual to quarantine. If there is no practical method to quarantine the individual, the State Health Officer may use any means necessary to vaccinate or treat the individual.

Any order of the State Health Officer given to effectuate this paragraph shall be immediately enforceable by a law enforcement officer under s. 381.0012.

(2) Individuals who assist the State Health Officer at his or her request on a volunteer basis during a public health emergency are entitled to the benefits specified in s. 110.504(2), (3), (4), and (5).

Section 76. Paragraphs (a) and (b) of subsection (2) of section 768.13, Florida Statutes, are amended to read:

768.13 Good Samaritan Act; immunity from civil liability.--

(2)(a) Any person, including those licensed to practice medicine, who gratuitously and in good faith renders emergency care or treatment either in direct response to emergency situations related to and arising out of a public health emergency declared pursuant to s. 381.00315, a state of emergency which has been declared pursuant to s. 252.36 or at

the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment, without objection of the injured victim or victims thereof, shall not be held liable for any civil damages as a result of such care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment where the person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.

(b)1. Any hospital licensed under chapter 395, any employee of such hospital working in a clinical area within the facility and providing patient care, and any person licensed to practice medicine who in good faith renders medical care or treatment necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center, or necessitated by a public health emergency declared pursuant to s. 381.00315 shall not be held liable for any civil damages as a result of such medical care or treatment unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of another.

2. The immunity provided by this paragraph does not apply to damages as a result of any act or omission of providing medical care or treatment:

a. Which occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity provided by this

paragraph applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery; or

b. Unrelated to the original medical emergency.

3. For purposes of this paragraph, "reckless disregard" as it applies to a given health care provider rendering emergency medical services shall be such conduct which a health care provider knew or should have known, at the time such services were rendered, would be likely to result in injury so as to affect the life or health of another, taking into account the following to the extent they may be present;

a. The extent or serious nature of the circumstances prevailing.

b. The lack of time or ability to obtain appropriate consultation.

c. The lack of a prior patient-physician relationship.

d. The inability to obtain an appropriate medical history of the patient.

e. The time constraints imposed by coexisting emergencies.

4. Every emergency care facility granted immunity under this paragraph shall accept and treat all emergency care patients within the operational capacity of such facility without regard to ability to pay, including patients transferred from another emergency care facility or other health care provider pursuant to Pub. L. No. 99-272, s. 9121. The failure of an emergency care facility to comply with this subparagraph constitutes grounds for the department to initiate disciplinary action against the facility pursuant to chapter 395.

Section 77. Subsection (4) is added to section

401.2715, Florida Statutes, to read:

401.2715 Recertification training of emergency medical technicians and paramedics.--

(4) Any certified emergency medical technician or paramedic may, as a condition of recertification, complete up to 8 hours of training to respond to terrorism, as defined in s. 775.30, and such hours completed may be substituted on a hour-for-hour basis for any other areas of training required for recertification. The department may adopt rules necessary to administer this subsection.

Section 78. Subsection (1) of section 633.35, Florida Statutes, is amended to read:

633.35 Firefighter training and certification.--

(1) The division shall establish a firefighter training program of not less than 360 hours, administered by such agencies and institutions as it approves for the purpose of providing basic employment training for firefighters. Any firefighter may, as a condition of certification, complete up to 8 hours of training to respond to terrorism, as defined in s. 775.30, and such hours completed may be substituted on a hour-for-hour basis for any other areas of training required for certification. The division may adopt rules necessary to administer this subsection.Nothing herein shall require a public employer to pay the cost of such training.

Section 79. Subsection (1) of section 943.135, Florida Statutes, is amended to read:

943.135 Requirements for continued employment.--

(1) The commission shall, by rule, adopt a program that requires all officers, as a condition of continued employment or appointment as officers, to receive periodic commission-approved continuing training or education. Such

continuing training or education shall be required at the rate of 40 hours every 4 years, and up to 8 hours which may consist of training to respond to terrorism as defined in s. 775.30. No officer shall be denied a reasonable opportunity by the employing agency to comply with this section. The employing agency must document that the continuing training or education is job-related and consistent with the needs of the employing agency. The employing agency must maintain and submit, or electronically transmit, the documentation to the commission, in a format approved by the commission. The rule shall also provide:

(a) Assistance to an employing agency in identifying each affected officer, the date of his or her employment or appointment, and his or her most recent date for successful completion of continuing training or education;

(b) A procedure for reactivation of the certification of an officer who is not in compliance with this section; and

(c) A remediation program supervised by the training center director within the geographic area for any officer who is attempting to comply with the provisions of this subsection and in whom learning disabilities are identified. The officer shall be assigned nonofficer duties, without loss of employee benefits, and the program shall not exceed 90 days.

Section 80. Except as otherwise provided in this act, this act shall take effect July 1, 2002.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete everything before the enacting clause

and insert:

A bill to be entitled

An act relating to health regulation; amending s. 20.43, F.S.; updating a reference to provide the name of a regulatory board under the Division of Medical Quality Assurance; repealing s. 456.047, F.S.; terminating the standardized credentialing program for health care practitioners; prohibiting the refund of moneys collected through the credentialing program; amending ss. 456.039, 456.0391, 456.077, F.S.; removing references, to conform; amending s. 456.072, F.S.; revising provisions governing grounds for discipline; amending s. 458.309, F.S.; requiring accreditation of physician offices in which surgery is performed; amending s. 459.005, F.S.; requiring accreditation of osteopathic physician offices in which surgery is performed; amending s. 456.004, F.S., relating to powers and duties of the department; requiring performance measures for certain entities; amending s. 456.009, F.S.; requiring performance measures for certain legal and investigative services and annual review of such services to determine whether such performance measures are being met; amending s. 456.011, F.S.; requiring regulatory board committee meetings, including probable cause panels, to be held electronically unless certain conditions are met; amending s. 456.026, F.S.; requiring

inclusion of performance measures for certain entities in the department's annual report to the Legislature; creating s. 458.3093, F.S.; requiring submission of credentials for initial physician licensure to a national licensure verification service; requiring verification of such credentials by that service or an equivalent program; creating s. 459.0053, F.S.; requiring submission of credentials for initial osteopathic physician licensure to a national licensure verification service; requiring verification of such credentials by that service, a specified association, or an equivalent program; amending ss. 458.331, 459.015, F.S.; revising the definition of the term "repeated malpractice" for purposes of disciplinary action against physicians and osteopaths; increasing the monetary limits of claims against certain health care providers which result in investigation; amending s. 627.912, F.S.; raising the malpractice closed claims reporting requirement amount; amending s. 456.025, F.S.; eliminating certain restrictions on the setting of licensure renewal fees for health care practitioners; creating s. 456.0165, F.S.; restricting the costs that may be charged by educational institutions hosting health care practitioner licensure examinations; amending s. 468.302, F.S.; authorizing certified nuclear medicine technologists to administer X radiation from

certain devices under certain circumstances; exempting certain persons from radiologic technologist certification and providing certain training requirements for such exemption; amending s. 468.352, F.S.; revising and providing definitions applicable to the regulation of respiratory therapy; amending s. 468.355, F.S.; revising provisions relating to respiratory therapy licensure and testing requirements; amending s. 468.368, F.S.; revising exemptions from respiratory therapy licensure requirements; repealing s. 468.356, F.S., relating to the approval of educational programs; repealing s. 468.357, F.S., relating to licensure by examination; renumbering ss. 381.0602, 381.6021, 381.6022, 381.6023, 381.6024, 381.6026, F.S., and renumbering and amending ss. 381.60225, 381.6025, F.S., to move provisions relating to organ and tissue procurement, donation, and transplantation to part V, ch. 765, F.S., relating to anatomical gifts; conforming cross-references; amending ss. 395.2050, 409.815, 765.5216, 765.522, F.S.; conforming cross-references; amending s. 395.002, F.S.; defining the term "medically unnecessary procedure"; amending s. 395.0161, F.S.; requiring the Agency for Health Care Administration to adopt rules governing the conduct of inspections or investigations; amending s. 395.0197, F.S.; revising provisions governing the internal risk management program;

amending s. 456.0375, F.S.; redefining the term "clinic"; amending s. 465.019, F.S.; revising definitions; amending s. 631.57, F.S.; exempting medical professional liability insurance premiums from an assessment; amending s. 766.101, F.S.; redefining the term "medical review committee"; providing an appropriation for a feasibility study; amending s. 393.064, F.S.; transferring to the Department of Health the responsibility for managing the Raymond C. Philips Research and Education Unit; amending s. 408.7057, F.S.; redesignating a program title; revising definitions; including preferred provider organizations and health insurers in the claim dispute resolution program; specifying timeframes for submission of supporting documentation necessary for dispute resolution; providing consequences for failure to comply; providing additional responsibilities for the agency relating to patterns of claim disputes; providing timeframes for review by the resolution organization; directing the agency to notify appropriate licensure and certification entities as part of violation of final orders; amending s. 626.88, F.S.; redefining the term "administrator," with respect to regulation of insurance administrators; creating s. 627.6131, F.S.; specifying payment of claims provisions applicable to certain health insurers; providing a definition; providing requirements

and procedures for paying, denying, or contesting claims; providing criteria and limitations; requiring payment within specified periods; specifying rate of interest charged on overdue payments; providing for electronic and nonelectronic transmission of claims; providing procedures for overpayment recovery; specifying timeframes for adjudication of claims, internally and externally; prohibiting action to collect payment from an insured under certain circumstances; providing applicability; prohibiting contractual modification of provisions of law; specifying circumstances for retroactive claim denial; specifying claim payment requirements; providing for billing review procedures; specifying claim content requirements; establishing a permissible error ratio, specifying its applicability, and providing for fines; providing specified exceptions from notice and acknowledgment requirements for pharmacy benefit manager claims; amending s. 627.6425, F.S., relating to renewability of individual coverage; providing for circumstances relating to nonrenewal or discontinuance of coverage; amending s. 627.651, F.S.; correcting a cross reference, to conform; amending s. 627.662, F.S.; specifying application of certain additional provisions to group, blanket, and franchise health insurance; amending s. 627.638, F.S.; revising requirements relating to direct payment of

benefits to specified providers under certain circumstances; amending s. 641.185, F.S.; specifying that health maintenance organization subscribers should receive prompt payment from the organization; amending s. 641.234, F.S.; specifying responsibility of a health maintenance organization for certain violations under certain circumstances; amending s. 641.30, F.S.; conforming a cross reference; amending s. 641.3154, F.S.; modifying the circumstances under which a provider knows that an organization is liable for service reimbursement; amending s. 641.3155, F.S.; revising payment of claims provisions applicable to certain health maintenance organizations; providing a definition; providing requirements and procedures for paying, denying, or contesting claims; providing criteria and limitations; requiring payment within specified periods; revising rate of interest charged on overdue payments; providing for electronic and nonelectronic transmission of claims; providing procedures for overpayment recovery; specifying timeframes for adjudication of claims, internally and externally; prohibiting action to collect payment from a subscriber under certain circumstances; prohibiting contractual modification of provisions of law; specifying circumstances for retroactive claim denial; specifying claim payment requirements;

providing for billing review procedures; specifying claim content requirements; establishing a permissible error ratio, specifying its applicability, and providing for fines; providing specified exceptions from notice and acknowledgment requirements for pharmacy benefit manager claims; amending s. 641.51, F.S.; revising provisions governing examinations by ophthalmologists; amending s. 381.003, F.S.; requiring the Department of Health to adopt certain standards applicable to all public-sector employers; requiring the compilation and maintenance of certain information by the department for use by employers; requiring the Agency for Health Care Administration to conduct a study of health care services provided to medically fragile or medical-technology-dependent children; requiring the Agency for Health Care Administration to conduct a pilot program for a subacute pediatric transitional care center; requiring background screening of center personnel; requiring the agency to amend the Medicaid state plan and seek federal waivers as necessary; requiring the center to have an advisory board; providing for membership on the advisory board; providing requirements for the admission, transfer, and discharge of a child to the center; requiring the agency to submit certain reports to the Legislature; amending ss. 765.510, 765.512, 765.516, 765.517, F.S.;

amending the declaration of legislative intent; prohibiting modification of a donor's intent; providing that a donor document is legally binding; authorizing specified persons to furnish donors' medical records upon request; revising procedures by which the terms of an anatomical gift may be amended or the gift may be revoked; revising rights and duties with respect to the disposition of a body at death; proscribing legal liability; amending s. 381.0034, F.S.; providing a requirement for instruction of certain health care licensees on conditions caused by nuclear, biological, and chemical terrorism, as a condition of initial licensure, and, in lieu of the requirement for instruction on HIV and AIDS, as a condition of relicensure; amending s. 381.0035, F.S.; providing a requirement for instruction of employees at certain health care facilities on conditions caused by nuclear, biological, and chemical terrorism, upon initial employment, and, in lieu of the requirement of instruction on HIV and AIDS, as biennial continuing education; amending s. 401.23, F.S.; redefining the terms "advanced life support" and "basic life support"; defining the term "emergency medical conditions"; amending s. 401.27, F.S.; providing that the course on conditions caused by nuclear, biological, and chemical terrorism shall count toward the total required hours for biennial recertification of emergency medical

technicians and paramedics; amending s. 456.033, F.S.; providing a requirement for instruction of certain health care practitioners on conditions caused by nuclear, biological, and chemical terrorism, as a condition of initial licensure, and, in lieu of the requirement for instruction on HIV and AIDS, as part of biennial relicensure; creating s. 456.0345, F.S.; providing continuing education credits to health care practitioners for certain life support training; amending ss. 458.319 and 459.008, F.S.; conforming provisions relating to exceptions to continuing education requirements for physicians and osteopathic physicians; amending s. 381.0011, F.S.; revising the rulemaking authority of the Department of Health with respect to its power to impose quarantine, including requiring vaccination; amending s. 381.00315, F.S.; defining the terms "public health advisory" and "public health emergency"; specifying the terms under which a public health emergency is declared; providing for consultation for, notice, and duration of a declaration of a public health emergency; authorizing the State Health Officer to take specified actions upon the declaration of a public health emergency relating to shipping of specified drugs, directing the compounding of bulk prescription drugs, and specifying the use of such drugs; authorizing the State Health Officer to

reactivate the inactive licenses of certain practitioners who request such reactivation; authorizing the State Health Officer to order that an individual be examined, tested, vaccinated, treated, or quarantined for certain communicable diseases under specified circumstances; specifying benefits to be made available to volunteers acting under a public health emergency; amending s. 768.13, F.S.; providing immunity from civil damages under the Good Samaritan Act for actions taken in response to situations during a declared public health emergency; revising the circumstances under which immunity from civil damages is extended to actions taken by persons licensed to practice medicine; amending ss. 401.2715, 633.35, 943.135, F.S.; authorizing the substitution of a specified number of hours of qualifying terrorism response training for a like number of hours of training required for certification; providing effective dates.