By the Committee on Banking and Insurance

311-413B-99

A bill to be entitled

An act relating to the Division of Workers' Compensation; amending s. 440.02, F.S.; redefining the term "employee" to conform to the transfer of enforcement powers and duties to the Department of Insurance; amending s. 440.021, F.S.; exempting from chapter 120, F.S., the collection of penalties by the Department of Insurance pursuant to chapter 440, F.S.; amending s. 440.05, F.S.; transferring exemption reporting requirements from the Division of Workers' Compensation to the Department of Insurance; amending s. 440.10, F.S.; authorizing the Department of Insurance to assess civil penalties against employers for failure to secure workers' compensation coverage; amending s. 440.103, F.S.; revising the requirements for obtaining a building permit; conforming to the transfer of enforcement of workers' compensation compliance to the Department of Insurance; amending s. 440.106, F.S.; requiring the Department of Insurance, rather than the Division of Workers' Compensation, to report certain violations by contractors to the appropriate state licensing board; amending s. 440.107, F.S.; transferring powers to enforce employer compliance with coverage requirements from the Division of Workers' Compensation to the Department of Insurance; amending s. 440.108, F.S.; providing that investigatory records of the Department of

Insurance relating to workers' compensation employer compliance are confidential and exempt form the public records law to the same extent that such records of the division are confidential and exempt; amending s. 440.125, F.S.; providing that medical records of injured employees provided to the Agency for Health Care Administration are confidential and exempt from the public records law to the same extent as medical records provided to the Division of Workers' Compensation; amending s. 440.13, F.S.; transferring from the Division of Workers' Compensation to the Agency for Health Care Administration powers and duties relating to certification of health care providers for workers' compensation, requests for independent medical examinations, receiving reports of medical treatment to injured workers, assessing penalties against carriers for disallowing payments to health care providers, auditing health care providers and carriers, and related medical-related responsibilities for workers' compensation; providing for rules; creating a Workers' Compensation Regulatory Reporting Advisory Council; amending s. 440.15, F.S.; authorizing the division to contract with a third party for the administration and payment of the supplemental benefits to injured workers; amending s. 440.1925, F.S.; transferring powers and duties relating to the resolution of medical disputes from the

division to the Agency for Health Care Administration; amending s. 440.25, F.S.; transferring powers and duties from the division to the Agency for Health Care Administration; amending s. 440.38, F.S.; authorizing the division to contract with the Florida Self-Insurers Guaranty Association, Incorporated, for the administration and audit of individual self-insurers; amending s. 440.385, F.S.; revising the powers and duties of the Florida Self-Insurers Guaranty Association, Incorporated; amending s. 440.44, F.S.; conforming provisions related to personnel appointed by the division; amending s. 440.4416, F.S.; requiring the Workers' Compensation Oversight Board to make recommendations for revising reporting requirements; amending s. 440.50, F.S.; providing for deposit of civil penalties imposed pursuant to chapter 440, F.S.; amending s. 440.51, F.S.; transferring powers and duties relating to self-insurers from the Department of Insurance to the division; amending s. 440.525, F.S.; revising examination requirements and authorizing the division to contract with an independent examiner for the examination of carriers and individual self-insurers; amending s. 440.59, F.S.; revising reporting requirements for the division and the Department of Labor and Employment Security; transferring powers,

duties, records, personnel, property, and funding for the examination of individual self-insurers from the Department of Insurance to the division; transferring powers, duties, records, personnel, property, and funding for enforcement of employer compliance with coverage requirements, proof of coverage, and exemption requirements from the division to the Department of Insurance; transferring powers, duties, records, personnel, property, and funding related to medical services and supplies for workers' compensation, medical dispute resolution, and medical data reporting requirements from the division to the Agency for Health Care Administration; eliminating positions within the Division of Workers' Compensation, contingent upon the division entering into certain contracts; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) of subsection (14) of section 440.02, Florida Statutes, 1998 Supplement, is amended to read:

440.02 Definitions.--When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(14)

(c) "Employee" includes a sole proprietor or a partner who devotes full time to the proprietorship or partnership and, except as provided in this paragraph, elects to be

included in the definition of employee by filing notice thereof as provided in s. 440.05. Partners or sole proprietors actively engaged in the construction industry are considered employees unless they elect to be excluded from the definition of employee by filing written notice of the election with the Department of Insurance ~~division~~ as provided in s. 440.05. However, no more than three partners in a partnership that is actively engaged in the construction industry may elect to be excluded. A sole proprietor or partner who is actively engaged in the construction industry and who elects to be exempt from this chapter by filing a written notice of the election with the Department of Insurance ~~division~~ as provided in s. 440.05 is not an employee. For purposes of this chapter, an independent contractor is an employee unless he or she meets all of the conditions set forth in subparagraph (d)1.

Section 2. Section 440.021, Florida Statutes, is amended to read:

440.021 Exemption of workers' compensation from chapter 120.--Workers' compensation adjudications by judges of compensation claims are exempt from chapter 120, and no judge of compensation claims shall be considered an agency or a part thereof. Communications of the result of investigations by the division pursuant to s. 440.185(4) are exempt from chapter 120. In all instances in which the division or the Department of Insurance institutes action to collect a penalty or interest that is ~~which may be~~ due pursuant to this chapter, the penalty or interest shall be assessed without hearing, and the party against which such penalty or interest is assessed shall be given written notice of such assessment and shall have the right to protest within 20 days of such notice. Upon receipt of a timely notice of protest and after such

investigation as may be necessary, the division or the Department of Insurance shall, if it agrees with such protest, notify the protesting party that the assessment has been revoked. If the division or the Department of Insurance does not agree with the protest, it shall refer the matter to the judge of compensation claims for determination pursuant to s. 440.25(3) and (4). Such action of the division or the Department of Insurance is exempt from the provisions of chapter 120.

Section 3. Section 440.05, Florida Statutes, 1998 Supplement, is amended to read:

440.05 Election of exemption; revocation of election; notice; certification.--

(1) Each corporate officer who elects not to accept the provisions of this chapter or who, after electing such exemption, revokes that exemption shall mail to the Department of Insurance ~~division~~ in Tallahassee notice to such effect in accordance with a form to be prescribed by the Department of Insurance ~~division~~.

(2) Each sole proprietor or partner who elects to be included in the definition of "employee" or who, after such election, revokes that election must mail to the Department of Insurance ~~division~~ in Tallahassee notice to such effect, in accordance with a form to be prescribed by the Department of Insurance ~~division~~.

(3) Each sole proprietor, partner, or officer of a corporation who is actively engaged in the construction industry and who elects an exemption from this chapter or who, after electing such exemption, revokes that exemption, must mail a written notice to such effect to the Department of Insurance ~~division~~ on a form prescribed by the Department of

Insurance ~~division~~. The notice of election to be exempt from the provisions of this chapter must be notarized and under oath. The notice of election to be exempt which is submitted to the Department of Insurance ~~division~~ by the sole proprietor, partner, or officer of a corporation must list the name, federal tax identification number, social security number, all certified or registered licenses issued pursuant to chapter 489 held by the person seeking the exemption, a copy of relevant documentation as to employment status filed with the Internal Revenue Service as specified by the Department of Insurance ~~division~~, a copy of the relevant occupational license in the primary jurisdiction of the business, and, for corporate officers and partners, the registration number of the corporation or partnership filed with the Division of Corporations of the Department of State. The notice of election to be exempt must identify each sole proprietorship, partnership, or corporation that employs the person electing the exemption and must list the social security number or federal tax identification number of each such employer and the additional documentation required by this section. In addition, the notice of election to be exempt must provide that the sole proprietor, partner, or officer electing an exemption is not entitled to benefits under this chapter, must provide that the election does not exceed exemption limits for officers and partnerships provided in s. 440.02, and must certify that any employees of the sole proprietor, partner, or officer electing an exemption are covered by workers' compensation insurance. Upon receipt of the notice of the election to be exempt, receipt of all application fees, and a determination by the Department of Insurance ~~division~~ that the notice meets the requirements of

this subsection, the Department of Insurance ~~division~~ shall issue a certification of the election to the sole proprietor, partner, or officer, unless the Department of Insurance ~~division~~ determines that the information contained in the notice is invalid. The Department of Insurance ~~division~~ shall revoke a certificate of election to be exempt from coverage upon a determination by the Department of Insurance ~~division~~ that the person does not meet the requirements for exemption or that the information contained in the notice of election to be exempt is invalid. The certificate of election must list the names of the sole proprietorship, partnership, or corporation listed in the request for exemption. A new certificate of election must be obtained each time the person is employed by a new sole proprietorship, partnership, or corporation that is not listed on the certificate of election. A copy of the certificate of election must be sent to each workers' compensation carrier identified in the request for exemption. Upon filing a notice of revocation of election, a sole proprietor, partner, or officer who is a subcontractor must notify her or his contractor. Upon revocation of a certificate of election of exemption by the Department of Insurance ~~division~~, the Department of Insurance ~~division~~ shall notify the workers' compensation carriers identified in the request for exemption.

(4) The notice of election to be exempt from the provisions of this chapter must contain a notice that clearly states in substance the following: "Any person who, knowingly and with intent to injure, defraud, or deceive the Department of Insurance ~~division~~ or any employer or employee, insurance company, or purposes program, files a notice of election to be exempt containing any false or misleading information is

guilty of a felony of the third degree." Each person filing a notice of election to be exempt shall personally sign the notice and attest that he or she has reviewed, understands, and acknowledges the foregoing notice.

(5) A notice given under subsection (1), subsection (2), or subsection (3) shall become effective when issued by the Department of Insurance ~~division~~ or 30 days after an application for an exemption is received by the Department of Insurance ~~division~~, whichever occurs first. However, if an accident or occupational disease occurs less than 30 days after the effective date of the insurance policy under which the payment of compensation is secured or the date the employer qualified as a self-insurer, such notice is effective as of 12:01 a.m. of the day following the date it is mailed to the Department of Insurance ~~division~~ in Tallahassee.

(6) A construction industry certificate of election to be exempt that ~~which~~ is issued in accordance with this section shall be valid for 2 years after the effective date stated thereon. Both the effective date and the expiration date must be listed on the face of the certificate by the Department of Insurance ~~division~~. The construction industry certificate must expire at midnight, 2 years from its issue date, as noted on the face of the exemption certificate. Any person who has received from the division a construction industry certificate of election to be exempt which is in effect on December 31, 1998, shall file with the Department of Insurance a new notice of election to be exempt by the last day in his or her birth month following December 1, 1998. A construction industry certificate of election to be exempt may be revoked before its expiration by the sole proprietor, partner, or officer for whom it was issued or by the Department of Insurance ~~division~~

for the reasons stated in this section. At least 60 days before ~~prior to~~ the expiration date of a construction industry certificate of exemption issued after December 1, 1998, the Department of Insurance ~~division~~ shall send notice of the expiration date and an application for renewal to the certificateholder at the address on the certificate.

(7) Any contractor responsible for compensation under s. 440.10 may register in writing with the workers' compensation carrier for any subcontractor and shall thereafter be entitled to receive written notice from the carrier of any cancellation or nonrenewal of the policy.

(8)(a) The Department of Insurance ~~division~~ may assess a fee, not to exceed $50, with each request for a nonconstruction election under this section.

(b) The Department of Insurance ~~division~~ must assess a fee of $50 with each request for a construction industry certificate of election to be exempt or renewal of election to be exempt under this section.

(c) The funds collected by the Department of Insurance ~~division~~ shall be deposited into the Insurance Commissioner's Regulatory Trust Fund and shall be used to administer this section, to audit the businesses that pay the fee for compliance with any requirements of this chapter, and to enforce compliance with the provisions of this chapter.

(9) The Department of Insurance ~~division~~ may by rule prescribe forms and procedures for filing an election of exemption, revocation of election to be exempt, and notice of election of coverage for all employers and require specified forms to be submitted by all employers in filing for the election of exemption. The Department of Insurance ~~division~~

may by rule prescribe forms and procedures for issuing a certificate of the election of exemption.

Section 4. Paragraphs (f) and (g) of subsection (1) of section 440.10, Florida Statutes, 1998 Supplement, are amended to read:

440.10 Liability for compensation.--

(1)

(f) If an employer willfully fails to secure compensation as required by this chapter, the Department of Insurance ~~division~~ may assess against the employer a penalty not to exceed $5,000 for each employee of that employer who is classified by the employer as an independent contractor but who is found by the Department of Insurance ~~division~~ to not meet the criteria for an independent contractor that are set forth in s. 440.02.

(g) For purposes of this section, a person is conclusively presumed to be an independent contractor if:

1. The independent contractor provides the general contractor with an affidavit stating that he or she meets all the requirements of s. 440.02(14)(d); and

2. The independent contractor provides the general contractor with a valid certificate of workers' compensation insurance or a valid certificate of exemption issued by the Department of Insurance ~~division~~.

A sole proprietor, partner, or officer of a corporation who elects exemption from this chapter by filing a certificate of election under s. 440.05 may not recover benefits or compensation under this chapter. An independent contractor who provides the general contractor with both an affidavit stating that he or she meets the requirements of s.

440.02(14)(d) and a certificate of exemption is not an employee under s. 440.02(14)(c) and may not recover benefits under this chapter. For purposes of determining the appropriate premium for workers' compensation coverage, carriers may not consider any person who meets the requirements of this paragraph to be an employee.

Section 5. Section 440.103, Florida Statutes, 1998 Supplement, is amended to read:

440.103 Building permits; identification of minimum premium policy.--Except as otherwise provided in this chapter, every employer shall, as a condition to receiving a building permit, show proof that it has secured compensation for its employees under this chapter as provided in ss. 440.10 and 440.38. Such proof of compensation must be evidenced by a certificate of coverage issued by the carrier, a valid exemption certificate approved by the Department of Insurance ~~division~~, or a copy of the employer's authority to self-insure and shall be presented each time the employer applies for a building permit. As provided in s. 627.413(5), each certificate of coverage must show, on its face, whether or not coverage is secured under the minimum premium provisions of rules adopted by rating organizations licensed by the Department of Insurance. The words "minimum premium policy" or equivalent language shall be typed, printed, stamped, or legibly handwritten.

Section 6. Subsection (4) of section 440.106, Florida Statutes, 1998 Supplement, is amended to read:

440.106 Civil remedies; administrative penalties.--

(4) The Department of Insurance ~~division~~ shall report any contractor determined in violation of requirements of this

chapter to the appropriate state licensing board for disciplinary action.

Section 7. Section 440.107, Florida Statutes, 1998 Supplement, is amended to read:

440.107 Department of Insurance ~~Division~~ powers to enforce employer compliance with coverage requirements.--

(1) The Legislature finds that the failure of an employer to comply with the workers' compensation coverage requirements under this chapter poses an immediate danger to public health, safety, and welfare. The Legislature authorizes the Department of Insurance ~~division~~ to secure employer compliance with the workers' compensation coverage requirements and authorizes the Department of Insurance ~~division~~ to conduct investigations for the purpose of ensuring employer compliance.

(2) The Department of Insurance ~~division~~ and its authorized representatives may enter and inspect any place of business at any reasonable time for the limited purpose of investigating compliance with workers' compensation coverage requirements under this chapter. Each employer shall keep true and accurate business records that contain such information as the Department of Insurance ~~division~~ prescribes by rule. The business records must contain information necessary for the Department of Insurance ~~division~~ to determine compliance with workers' compensation coverage requirements and must be maintained within this state by the business, in such a manner as to be accessible within a reasonable time upon request by the Department of Insurance ~~division~~. The business records must be open to inspection and be available for copying by the Department of Insurance ~~division~~ at any reasonable time and place and as often as necessary. The Department of Insurance

~~division~~ may require from any employer any sworn or unsworn reports, pertaining to persons employed by that employer, deemed necessary for the effective administration of the workers' compensation coverage requirements.

(3) In discharging its duties, the Department of Insurance ~~division~~ may administer oaths and affirmations, certify to official acts, issue subpoenas to compel the attendance of witnesses and the production of books, papers, correspondence, memoranda, and other records deemed necessary by the Department of Insurance ~~division~~ as evidence in order to ensure proper compliance with the coverage provisions of this chapter.

(4) If a person has refused to obey a subpoena to appear before the Department of Insurance ~~division~~ or its authorized representative and produce evidence requested by the Department of Insurance ~~division~~ or to give testimony about the matter that is under investigation, a court has jurisdiction to issue an order requiring compliance with the subpoena if the court has jurisdiction in the geographical area where the inquiry is being carried on or in the area where the person who has refused the subpoena is found, resides, or transacts business. Failure to obey such a court order may be punished by the court as contempt.

(5) Whenever the Department of Insurance ~~division~~ determines that an employer who is required to secure the payment to his or her employees of the compensation provided for by this chapter has failed to do so, such failure shall be deemed an immediate serious danger to public health, safety, or welfare sufficient to justify service by the Department of Insurance ~~division~~ of a stop-work order on the employer, requiring the cessation of all business operations at the

place of employment or job site. The order shall take effect upon the date of service upon the employer, unless the employer provides evidence satisfactory to the division of having secured any necessary insurance or self-insurance and pays a civil penalty to the Department of Insurance ~~division~~, to be deposited by the Department of Insurance ~~division~~ into the Insurance Commissioner's Regulatory ~~Workers' Compensation Administration~~ Trust Fund, in the amount of $100 per day for each day the employer was not in compliance with this chapter.

(6) The Department of Insurance ~~division~~ may file a complaint in the circuit court in and for Leon County to enjoin any employer, who has failed to secure compensation as required by this chapter, from employing individuals and from conducting business until the employer presents evidence satisfactory to the Department of Insurance ~~division~~ of having secured payment for compensation and pays a civil penalty to the Department of Insurance ~~division~~, to be deposited by the Department of Insurance ~~division~~ into the Insurance Commissioner's Regulatory ~~Workers' Compensation Administration~~ Trust Fund, in the amount of $100 per day for each day the employer was not in compliance with this chapter.

(7) In addition to any penalty, stop-work order, or injunction, the Department of Insurance ~~division~~ may assess against any employer~~,~~ who has failed to secure the payment of compensation as required by this chapter~~,~~ a penalty in the amount of:

(a) Twice the amount the employer would have paid during periods it illegally failed to secure payment of compensation in the preceding 3-year period based on the employer's payroll during the preceding 3-year period; or

(b) One thousand dollars, whichever is greater.

Any penalty assessed under this subsection is due within 30 days after the date on which the employer is notified, except that, if the Department of Insurance ~~division~~ has posted a stop-work order or obtained injunctive relief against the employer, payment is due, in addition to those conditions set forth in this section, as a condition to relief from a stop-work order or an injunction. Interest shall accrue on amounts not paid when due at the rate of 1 percent per month.

(8) The Department of Insurance ~~division~~ may bring an action in circuit court to recover penalties assessed under this section, including any interest owed to the Department of Insurance ~~division~~ pursuant to this section. In any action brought by the Department of Insurance ~~division~~ pursuant to this section in which it prevails, the circuit court shall award costs, including the reasonable costs of investigation and a reasonable attorney's fee.

(9) Any judgment obtained by the Department of Insurance ~~division~~ and any penalty due pursuant to the service of a stop-work order or otherwise due under this section shall, until collected, constitute a lien upon the entire interest of the employer, legal or equitable, in any property, real or personal, tangible or intangible; however, such lien is subordinate to claims for unpaid wages and any prior recorded liens, and a lien created by this section is not valid against any person who, subsequent to such lien and in good faith and for value, purchases real or personal property from such employer or becomes the mortgagee on real or personal property of such employer, or against a subsequent attaching creditor, unless, with respect to real estate of the employer, a notice of the lien is recorded in the public

records of the county where the real estate is located, and with respect to personal property of the employer, the notice is recorded with the Secretary of State.

(10) Any law enforcement agency in the state may, at the request of the Department of Insurance ~~division~~, render any assistance necessary to carry out the provisions of this section, including, but not limited to, preventing any employee or other person from remaining at a place of employment or job site after a stop-work order or injunction has taken effect.

(11) Actions by the Department of Insurance ~~division~~ under this section must be contested as provided in chapter 120. All civil penalties assessed by the Department of Insurance ~~division~~ must be paid into the Insurance Commissioner's Regulatory ~~Workers' Compensation Administration~~ Trust Fund. The Department of Insurance ~~division~~ shall return any sums previously paid, upon conclusion of an action, if the Department of Insurance ~~division~~ fails to prevail and if so directed by an order of court or an administrative hearing officer. The requirements of this subsection may be met by posting a bond in an amount equal to twice the penalty and in a form approved by the Department of Insurance ~~division~~.

Section 8. Subsection (1) of section 440.108, Florida Statutes, 1998 Supplement, is amended to read:

440.108 Investigatory records relating to workers' compensation employer compliance; confidentiality.--

(1) All investigatory records of the Department of Insurance or the Division of Workers' Compensation made or received pursuant to s. 440.107 and any records necessary to complete an investigation are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State

Constitution until the investigation is completed or ceases to be active. For purposes of this section, an investigation is considered "active" while such investigation is being conducted by the Department of Insurance or the division with a reasonable, good faith belief that it may lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the agency is proceeding with reasonable dispatch and there is a good faith belief that action may be initiated by the agency or other administrative or law enforcement agency. After an investigation is completed or ceases to be active, records relating to the investigation remain confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution if disclosure would:

(a) Jeopardize the integrity of another active investigation;

(b) Reveal a trade secret, as defined in s. 688.002;

(c) Reveal business or personal financial information;

(d) Reveal the identity of a confidential source;

(e) Defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual; or

(f) Reveal investigative techniques or procedures.

Section 9. Section 440.125, Florida Statutes, is amended to read:

440.125 Medical records and reports; identifying information in employee medical bills; confidentiality.--

(1) Any medical records and medical reports of an injured employee and any information identifying an injured employee in medical bills which are provided to the Agency for Health Care Administration or the Division of Workers'

Compensation of the Department of Labor and Employment Security pursuant to s. 440.13 are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution, except as otherwise provided by this chapter.

(2) The Legislature finds that it is a public necessity that an injured employee's medical records and medical reports and information identifying the employee in medical bills held by the Agency for Health Care Administration or the Division of Workers' Compensation pursuant to s. 440.13 be confidential and exempt from the public records law. Public access to such information is an invasion of the injured employee's right to privacy in that personal, sensitive information would be revealed, and public knowledge of such information could lead to discrimination against the employee by coworkers and others. Additionally, there is little utility in providing public access to such information in that the effectiveness and efficiency of the workers' compensation program can be otherwise adequately monitored and evaluated.

Section 10. Section 440.13, Florida Statutes, 1998 Supplement, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.--

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

(a) "Alternate medical care" means a change in treatment or health care provider.

(b) "Attendant care" means care rendered by trained professional attendants which is beyond the scope of household duties. Family members may provide nonprofessional attendant care, but may not be compensated under this chapter for care

that falls within the scope of household duties and other services normally and gratuitously provided by family members. "Family member" means a spouse, father, mother, brother, sister, child, grandchild, father-in-law, mother-in-law, aunt, or uncle.

(c) "Carrier" means, for purposes of this section, insurance carrier, self-insurance fund or individually self-insured employer, or assessable mutual insurer.

(d) "Catastrophic injury" means an injury as defined in s. 440.02.

(e) "Certified health care provider" means a health care provider who has been certified by the Agency for Health Care Administration ~~division~~ or who has entered an agreement with a licensed managed care organization to provide treatment to injured workers under this section. Certification of such health care provider must include documentation that the health care provider has read and is familiar with the portions of the statute, impairment guides, and rules which govern the provision of remedial treatment, care, and attendance.

(f) "Compensable" means a determination by a carrier or judge of compensation claims that a condition suffered by an employee results from an injury arising out of and in the course of employment.

(g) "Emergency services and care" means emergency services and care as defined in s. 395.002.

(h) "Health care facility" means any hospital licensed under chapter 395 and any health care institution licensed under chapter 400.

(i) "Health care provider" means a physician or any recognized practitioner who provides skilled services pursuant

to a prescription or under the supervision or direction of a physician and who has been certified by the division as a health care provider. The term "health care provider" includes a health care facility.

(j) "Independent medical examiner" means a physician selected by either an employee or a carrier to render one or more independent medical examinations in connection with a dispute arising under this chapter.

(k) "Independent medical examination" means an objective evaluation of the injured employee's medical condition, including, but not limited to, impairment or work status, performed by a physician or an expert medical advisor at the request of a party, a judge of compensation claims, or the Agency for Health Care Administration ~~division~~ to assist in the resolution of a dispute arising under this chapter.

(l) "Instance of overutilization" means a specific inappropriate service or level of service provided to an injured employee.

(m) "Medically necessary" means any medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature, except in those instances in which prior approval of the Agency for Health Care Administration has been obtained. The Agency for Health Care Administration shall adopt rules providing for such approval on a case-by-case basis when the

service or supply is shown to have significant benefits to the recovery and well-being of the patient.

(n) "Medicine" means a drug prescribed by an authorized health care provider and includes only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes or states that the brand-name drug as defined in s. 465.025 is medically necessary, or is a drug appearing on the schedule of drugs created pursuant to s. 465.025(6), or is available at a cost lower than its generic equivalent.

(o) "Palliative care" means noncurative medical services that mitigate the conditions, effects, or pain of an injury.

(p) "Pattern or practice of overutilization" means repetition of instances of overutilization within a specific medical case or multiple cases by a single health care provider.

(q) "Peer review" means an evaluation by two or more physicians licensed under the same authority and with the same or similar specialty as the physician under review, of the appropriateness, quality, and cost of health care and health services provided to a patient, based on medically accepted standards.

(r) "Physician" or "doctor" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, each of whom must be certified by the division as a health care provider.

(s) "Reimbursement dispute" means any disagreement between a health care provider or health care facility and carrier concerning payment for medical treatment.

(t) "Utilization control" means a systematic process of implementing measures that assure overall management and cost containment of services delivered.

(u) "Utilization review" means the evaluation of the appropriateness of both the level and the quality of health care and health services provided to a patient, including, but not limited to, evaluation of the appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. Such evaluation must be accomplished by means of a system that identifies the utilization of medical services based on medically accepted standards as established by medical consultants with qualifications similar to those providing the care under review, and that refers patterns and practices of overutilization to the division.

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.--

(a) Subject to the limitations specified elsewhere in this chapter, the employer shall furnish to the employee such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, including medicines, medical supplies, durable medical equipment, orthoses, prostheses, and other medically necessary apparatus. Remedial treatment, care, and attendance, including work-hardening programs or pain-management programs accredited by the Commission on Accreditation of Rehabilitation Facilities or Joint Commission on the Accreditation of Health Organizations or pain-management programs affiliated with medical schools,

shall be considered as covered treatment only when such care is given based on a referral by a physician as defined in this chapter. Each facility shall maintain outcome data, including work status at discharges, total program charges, total number of visits, and length of stay. ~~The department shall utilize such data and report to the President of the Senate and the Speaker of the House of Representatives regarding the efficacy and cost-effectiveness of such program, no later than October 1, 1994.~~Medically necessary treatment, care, and attendance does not include chiropractic services in excess of 18 treatments or rendered 8 weeks beyond the date of the initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employee is catastrophically injured.

(b) The employer shall provide appropriate professional or nonprofessional attendant care performed only at the direction and control of a physician when such care is medically necessary. The value of nonprofessional attendant care provided by a family member must be determined as follows:

1. If the family member is not employed, the per-hour value equals the federal minimum hourly wage.

2. If the family member is employed and elects to leave that employment to provide attendant or custodial care, the per-hour value of that care equals the per-hour value of the family member's former employment, not to exceed the per-hour value of such care available in the community at large. A family member or a combination of family members providing nonprofessional attendant care under this paragraph may not be compensated for more than a total of 12 hours per day.

(c) If the employer fails to provide treatment or care required by this section after request by the injured employee, the employee may obtain such treatment at the expense of the employer, if the treatment is compensable and medically necessary. There must be a specific request for the treatment, and the employer or carrier must be given a reasonable time period within which to provide the treatment or care. However, the employee is not entitled to recover any amount personally expended for the treatment or service unless he or she has requested the employer to furnish that treatment or service and the employer has failed, refused, or neglected to do so within a reasonable time or unless the nature of the injury requires such treatment, nursing, and services and the employer or his or her superintendent or foreman, having knowledge of the injury, has neglected to provide the treatment or service.

(d) The carrier has the right to transfer the care of an injured employee from the attending health care provider if an independent medical examination determines that the employee is not making appropriate progress in recuperation.

(e) Except in emergency situations and for treatment rendered by a managed care arrangement, after any initial examination and diagnosis by a physician providing remedial treatment, care, and attendance, and before a proposed course of medical treatment begins, each insurer shall review, in accordance with the requirements of this chapter, the proposed course of treatment, to determine whether such treatment would be recognized as reasonably prudent. The review must be in accordance with all applicable workers' compensation practice parameters. The insurer must accept any such proposed course of treatment unless the insurer notifies the physician of its

specific objections to the proposed course of treatment by the close of the tenth business day after notification by the physician, or a supervised designee of the physician, of the proposed course of treatment.

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.--

(a) As a condition to eligibility for payment under this chapter, a health care provider who renders services must be a certified health care provider and must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care. The Agency for Health Care Administration ~~division~~ shall adopt rules to implement the certification of health care providers. As a one-time prerequisite to obtaining certification, the Agency for Health Care Administration ~~division~~ shall require each physician to demonstrate proof of completion of a minimum 5-hour course that covers the subject areas of cost containment, utilization control, ergonomics, and the practice parameters adopted by the division governing the physician's field of practice. The Agency for Health Care Administration ~~division~~ shall coordinate with ~~the Agency for Health Care Administration,~~the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Chiropractic Association, the Florida Podiatric Medical Association, the Florida Optometric Association, the Florida Dental Association, and other health professional organizations and their respective boards as deemed necessary by the Agency for Health Care Administration in complying with this subsection. No later than October 1, 2000 ~~1994~~, the Agency for Health Care Administration ~~division~~ shall adopt rules regarding the criteria and procedures for approval of courses and the filing of proof of completion by the physicians.

(b) A health care provider who renders emergency care must notify the carrier by the close of the third business day after it has rendered such care. If the emergency care results in admission of the employee to a health care facility, the health care provider must notify the carrier by telephone within 24 hours after initial treatment. Emergency care is not compensable under this chapter unless the injury requiring emergency care arose as a result of a work-related accident. Pursuant to chapter 395, all licensed physicians and health care providers in this state shall be required to make their services available for emergency treatment of any employee eligible for workers' compensation benefits. To refuse to make such treatment available is cause for revocation of a license.

(c) A health care provider may not refer the employee to another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the carrier, except when emergency care is rendered. Any referral must be to a health care provider that has been certified by the Agency for Health Care Administration ~~division~~, unless the referral is for emergency treatment.

(d) A carrier must respond, by telephone or in writing, to a request for authorization by the close of the third business day after receipt of the request. A carrier who fails to respond to a written request for authorization for referral for medical treatment by the close of the third business day after receipt of the request consents to the medical necessity for such treatment. All such requests must be made to the carrier. Notice to the carrier does not include notice to the employer.

(e) Carriers shall adopt procedures for receiving, reviewing, documenting, and responding to requests for

authorization. Such procedures shall be for a health care provider certified under this section.

(f) By accepting payment under this chapter for treatment rendered to an injured employee, a health care provider consents to the jurisdiction of the Agency for Health Care Administration ~~division~~ as set forth in subsection (11) and to the submission of all records and other information concerning such treatment to the Agency for Health Care Administration ~~division~~ in connection with a reimbursement dispute, audit, or review as provided by this section. The health care provider must further agree to comply with any decision of the Agency for Health Care Administration ~~division~~ rendered under this section.

(g) The employee is not liable for payment for medical treatment or services provided pursuant to this section except as otherwise provided in this section.

(h) The provisions of s. 455.654 are applicable to referrals among health care providers, as defined in subsection (1), treating injured workers.

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other specialty services that the Agency for Health Care Administration ~~division~~ identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, or unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall not refuse to authorize such consultation or procedure unless the health care provider or facility is not

authorized or certified or unless an expert medical advisor has determined that the consultation or procedure is not medically necessary or otherwise compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to identify and disallow overutilization or billing errors.

(j) Notwithstanding anything in this chapter to the contrary, a sick or injured employee shall be entitled, at all times, to free, full, and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines required under this chapter. It is expressly forbidden for the Agency for Health Care Administration ~~division~~, an employer, or a carrier, or any agent or representative of the agency ~~division~~, an employer, or a carrier to select the pharmacy or pharmacist which the sick or injured employee must use; condition coverage or payment on the basis of the pharmacy or pharmacist utilized; or to otherwise interfere in the selection by the sick or injured employee of a pharmacy or pharmacist.

(4) NOTICE OF TREATMENT TO CARRIER; FILING WITH AGENCY FOR HEALTH CARE ADMINISTRATION ~~DIVISION~~.--

(a) Any health care provider providing necessary remedial treatment, care, or attendance to any injured worker shall submit treatment reports to the carrier in a format prescribed by the Agency for Health Care Administration ~~division~~. A claim for medical or surgical treatment is not valid or enforceable against such employer or employee, unless, by the close of the third business day following the

first treatment, the physician providing the treatment furnishes to the employer or carrier a preliminary notice of the injury and treatment on forms prescribed by the Agency for Health Care Administration ~~division~~ and, within 15 days thereafter, furnishes to the employer or carrier a complete report, and subsequent thereto furnishes progress reports, if requested by the employer or insurance carrier, at intervals of not less than 3 weeks apart or at less frequent intervals if requested on forms prescribed by the Agency for Health Care Administration ~~division~~.

(b) Each medical report or bill obtained or received by the employer, the carrier, or the injured employee, or the attorney for the employer, carrier, or injured employee, with respect to the remedial treatment or care of the injured employee, including any report of an examination, diagnosis, or disability evaluation, must be filed with the Agency for Health Care Administration ~~Division of Workers' Compensation~~ pursuant to rules adopted by the agency ~~division~~. The health care provider shall also furnish to the injured employee or to his or her attorney, on demand, a copy of his or her office chart, records, and reports, and may charge the injured employee an amount authorized by the Agency for Health Care Administration ~~division~~ for the copies. Each such health care provider shall provide to the Agency for Health Care Administration ~~division~~ any additional information about the remedial treatment, care, and attendance that the Agency for Health Care Administration ~~division~~ reasonably requests.

(c) It is the policy for the administration of the workers' compensation system that there be reasonable access to medical information by all parties to facilitate the self-executing features of the law. Notwithstanding the

limitations in s. 455.667 and subject to the limitations in s. 381.004, upon the request of the employer, the carrier, or the attorney for either of them, the medical records of an injured employee must be furnished to those persons and the medical condition of the injured employee must be discussed with those persons, if the records and the discussions are restricted to conditions relating to the workplace injury. Any such discussions may be held before or after the filing of a claim without the knowledge, consent, or presence of any other party or his or her agent or representative. A health care provider who willfully refuses to provide medical records or to discuss the medical condition of the injured employee, after a reasonable request is made for such information pursuant to this subsection, shall be subject by the Agency for Health Care Administration ~~division~~ to one or more of the penalties set forth in paragraph (8)(b).

(5) INDEPENDENT MEDICAL EXAMINATIONS.--

(a) In any dispute concerning overutilization, medical benefits, compensability, or disability under this chapter, the carrier or the employee may select an independent medical examiner. The examiner may be a health care provider treating or providing other care to the employee. An independent medical examiner may not render an opinion outside his or her area of expertise, as demonstrated by licensure and applicable practice parameters.

(b) Each party is bound by his or her selection of an independent medical examiner and is entitled to an alternate examiner only if:

1. The examiner is not qualified to render an opinion upon an aspect of the employee's illness or injury which is material to the claim or petition for benefits;

2. The examiner ceases to practice in the specialty relevant to the employee's condition;

3. The examiner is unavailable due to injury, death, or relocation outside a reasonably accessible geographic area; or

4. The parties agree to an alternate examiner.

Any party may request, or a judge of compensation claims may require, designation of an Agency for Health Care Administration ~~a division~~ medical advisor as an independent medical examiner. The opinion of the advisors acting as examiners shall not be afforded the presumption set forth in paragraph (9)(c).

(c) The carrier may, at its election, contact the claimant directly to schedule a reasonable time for an independent medical examination. The carrier must confirm the scheduling agreement in writing within 5 days and notify claimant's counsel, if any, at least 7 days before the date upon which the independent medical examination is scheduled to occur. An attorney representing a claimant is not authorized to schedule independent medical evaluations under this subsection.

(d) If the employee fails to appear for the independent medical examination without good cause and fails to advise the physician at least 24 hours before the scheduled date for the examination that he or she cannot appear, the employee is barred from recovering compensation for any period during which he or she has refused to submit to such examination. Further, the employee shall reimburse the carrier 50 percent of the physician's cancellation or no-show fee unless the carrier that schedules the examination fails to

timely provide to the employee a written confirmation of the date of the examination pursuant to paragraph (c) which includes an explanation of why he or she failed to appear. The employee may appeal to a judge of compensation claims for reimbursement when the carrier withholds payment in excess of the authority granted by this section.

(e) No medical opinion other than the opinion of a medical advisor appointed by the judge of compensation claims or the Agency for Health Care Administration ~~division~~, an independent medical examiner, or an authorized treating provider is admissible in proceedings before the judges of compensation claims.

(f) Attorney's fees incurred by an injured employee in connection with delay of or opposition to an independent medical examination, including, but not limited to, motions for protective orders, are not recoverable under this chapter.

(6) UTILIZATION REVIEW.--Carriers shall review all bills, invoices, and other claims for payment submitted by health care providers in order to identify overutilization and billing errors, and may hire peer review consultants or conduct independent medical evaluations. Such consultants, including peer review organizations, are immune from liability in the execution of their functions under this subsection to the extent provided in s. 766.101. If a carrier finds that overutilization of medical services or a billing error has occurred, it must disallow or adjust payment for such services or error without order of a judge of compensation claims or the Agency for Health Care Administration ~~division~~, if the carrier, in making its determination, has complied with this section and rules adopted by the Agency for Health Care Administration ~~division~~.

(7) UTILIZATION AND REIMBURSEMENT DISPUTES.--

(a) Any health care provider, carrier, or employer who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 30 days after receipt of notice of disallowance or adjustment of payment, petition the Agency for Health Care Administration ~~division~~ to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a petitioner to submit such documentation to the Agency for Health Care Administration ~~division~~ results in dismissal of the petition.

(b) The carrier must submit to the Agency for Health Care Administration ~~division~~ within 10 days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to submit the requested documentation to the Agency for Health Care Administration ~~division~~ within 10 days constitutes a waiver of all objections to the petition.

(c) Within 60 days after receipt of all documentation, the Agency for Health Care Administration ~~division~~ must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The Agency for Health Care Administration ~~division~~ must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, in rendering its determination.

(d) If the Agency for Health Care Administration ~~division~~ finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the

health care provider, facility, insurer, or employer within 30 days, subject to the penalties provided in this subsection.

(e) The Agency for Health Care Administration ~~division~~ shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a petitioner and expanding the timetable for rendering a determination upon a consolidated petition.

(f) Any carrier that engages in a pattern or practice of arbitrarily or unreasonably disallowing or reducing payments to health care providers may be subject to one or more of the following penalties imposed by the Agency for Health Care Administration ~~division~~:

1. Repayment of the appropriate amount to the health care provider.

2. An administrative fine assessed by the Agency for Health Care Administration ~~division~~ in an amount not to exceed $5,000 per instance of improperly disallowing or reducing payments.

3. Award of the health care provider's costs, including a reasonable attorney's fee, for prosecuting the petition.

(8) PATTERN OR PRACTICE OF OVERUTILIZATION.--

(a) Carriers must report to the Agency for Health Care Administration ~~division~~ all instances of overutilization including, but not limited to, all instances in which the carrier disallows or adjusts payment. The Agency for Health Care Administration ~~division~~ shall determine whether a pattern or practice of overutilization exists.

(b) If the Agency for Health Care Administration ~~division~~ determines that a health care provider has engaged in a pattern or practice of overutilization or a violation of

this chapter or rules adopted by the Agency for Health Care Administration ~~division~~, it may impose one or more of the following penalties:

1. An order of the Agency for Health Care Administration ~~division~~ barring the provider from payment under this chapter;

2. Deauthorization of care under review;

3. Denial of payment for care rendered in the future;

4. Decertification of a health care provider certified as an expert medical advisor under subsection (9) or of a rehabilitation provider certified under s. 440.49;

5. An administrative fine assessed by the Agency for Health Care Administration ~~division~~ in an amount not to exceed $5,000 per instance of overutilization or violation; and

6. Notification of and review by the appropriate licensing authority pursuant to s. 440.106(3).

(9) EXPERT MEDICAL ADVISORS.--

(a) The Agency for Health Care Administration ~~division~~ shall certify expert medical advisors in each specialty to assist the Agency for Health Care Administration ~~division~~ and the judges of compensation claims within the advisor's area of expertise as provided in this section. The Agency for Health Care Administration ~~division~~ shall, in a manner prescribed by rule, in certifying, recertifying, or decertifying an expert medical advisor, consider the qualifications, training, impartiality, and commitment of the health care provider to the provision of quality medical care at a reasonable cost. As a prerequisite for certification or recertification, the Agency for Health Care Administration ~~division~~ shall require, at a minimum, that an expert medical advisor have specialized workers' compensation training or experience under the

workers' compensation system of this state and board certification or board eligibility.

(b) The Agency for Health Care Administration ~~division~~ shall contract with or employ expert medical advisors to provide peer review or medical consultation to the Agency for Health Care Administration ~~division~~ or to a judge of compensation claims in connection with resolving disputes relating to reimbursement, differing opinions of health care providers, and health care and physician services rendered under this chapter. Expert medical advisors contracting with the Agency for Health Care Administration ~~division~~ shall, as a term of such contract, agree to provide consultation or services in accordance with the timetables set forth in this chapter and to abide by rules adopted by the Agency for Health Care Administration ~~division~~, including, but not limited to, rules pertaining to procedures for review of the services rendered by health care providers and preparation of reports and recommendations for submission to the Agency for Health Care Administration ~~division~~.

(c) If there is disagreement in the opinions of the health care providers, if two health care providers disagree on medical evidence supporting the employee's complaints or the need for additional medical treatment, or if two health care providers disagree that the employee is able to return to work, the Agency for Health Care Administration ~~division~~ may, and the judge of compensation claims shall, upon his or her own motion or within 15 days after receipt of a written request by either the injured employee, the employer, or the carrier, order the injured employee to be evaluated by an expert medical advisor. The opinion of the expert medical advisor is presumed to be correct unless there is clear and

convincing evidence to the contrary as determined by the judge of compensation claims. The expert medical advisor appointed to conduct the evaluation shall have free and complete access to the medical records of the employee. An employee who fails to report to and cooperate with such evaluation forfeits entitlement to compensation during the period of failure to report or cooperate.

(d) The expert medical advisor must complete his or her evaluation and issue his or her report to the Agency for Health Care Administration ~~division~~ or to the judge of compensation claims within 45 days after receipt of all medical records. The expert medical advisor must furnish a copy of the report to the carrier and to the employee.

(e) An expert medical advisor is not liable under any theory of recovery for evaluations performed under this section without a showing of fraud or malice. The protections of s. 766.101 apply to any officer, employee, or agent of the Agency for Health Care Administration ~~division~~ and to any officer, employee, or agent of any entity with which the Agency for Health Care Administration ~~division~~ has contracted under this subsection.

(f) If the Agency for Health Care Administration ~~division~~ or a judge of compensation claims determines that the services of a certified expert medical advisor are required to resolve a dispute under this section, the carrier must compensate the advisor for his or her time in accordance with a schedule adopted by the Agency for Health Care Administration ~~division~~. The Agency for Health Care Administration ~~division~~ may assess a penalty not to exceed $500 against any carrier that fails to timely compensate an advisor in accordance with this section.

(10) WITNESS FEES.--Any health care provider who gives a deposition shall be allowed a witness fee. The amount charged by the witness may not exceed $200 per hour. An expert witness who has never provided direct professional services to a party but has merely reviewed medical records and provided an expert opinion or has provided only direct professional services that were unrelated to the workers' compensation case may not be allowed a witness fee in excess of $200 per day.

(11) AUDITS BY AGENCY FOR HEALTH CARE ADMINISTRATION ~~DIVISION~~; JURISDICTION.--

(a) The Agency for Health Care Administration ~~Division of Workers' Compensation of the Department of Labor and Employment Security~~ may investigate health care providers to determine whether providers are complying with this chapter and with rules adopted by the Agency for Health Care Administration ~~division~~, whether the providers are engaging in overutilization, and whether providers are engaging in improper billing practices. If the Agency for Health Care Administration ~~division~~ finds that a health care provider has improperly billed, overutilized, or failed to comply with ~~division~~ rules of the Agency for Health Care Administration or the requirements of this chapter it must notify the provider of its findings and may determine that the health care provider may not receive payment from the carrier or may impose penalties as set forth in subsection (8) or other sections of this chapter. If the health care provider has received payment from a carrier for services that were improperly billed or for overutilization, it must return those payments to the carrier. The Agency for Health Care Administration ~~division~~ may assess a penalty not to exceed $500 for each overpayment that is not refunded within 30 days

after notification of overpayment by the Agency for Health Care Administration ~~division~~ or carrier.

(b) The Agency for Health Care Administration ~~division~~ shall monitor and audit carriers to determine if medical bills are paid in accordance with this section and Agency for Health Care Administration ~~division~~ rules. Any employer, if self-insured, or carrier found by the Agency for Health Care Administration ~~division~~ not to be within 90 percent compliance as to the payment of medical bills after July 1, 1994, must be assessed a fine not to exceed 1 percent of the prior year's assessment levied against such entity under s. 440.51 for every quarter in which the entity fails to attain 90-percent compliance. The Agency for Health Care Administration ~~division~~ shall fine an employer or carrier, pursuant to rules adopted by the Agency for Health Care Administration ~~division~~, for each late payment of compensation that is below the minimum 90-percent performance standard. Any carrier that is found to be not in compliance in subsequent consecutive quarters must implement a medical-bill review program approved by the Agency for Health Care Administration ~~division~~, and the carrier is subject to disciplinary action by the Department of Insurance.

(c) The Agency for Health Care Administration ~~division~~ has exclusive jurisdiction to decide any matters concerning reimbursement, to resolve any overutilization dispute under subsection (7), and to decide any question concerning overutilization under subsection (8)~~, which question or dispute arises after January 1, 1994~~.

(d) The following Agency for Health Care Administration ~~division~~ actions do not constitute agency action subject to review under ss. 120.569 and 120.57 and do not constitute actions subject to s. 120.56: referral by the

entity responsible for utilization review; a decision by the Agency for Health Care Administration ~~division~~ to refer a matter to a peer review committee; establishment by a health care provider or entity of procedures by which a peer review committee reviews the rendering of health care services; and the review proceedings, report, and recommendation of the peer review committee.

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.--

(a) A three-member panel is created, consisting of the Insurance Commissioner, or the Insurance Commissioner's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification manual as determined by the division. All compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges. Until the three-member panel approves a schedule of per diem rates for inpatient hospital care and it becomes effective, all compensable charges for

hospital inpatient care must be reimbursed at 75 percent of their usual and customary charges. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. However, the maximum percentage of increase in the individual reimbursement allowance may not exceed the percentage of increase in the Consumer Price Index for the previous year. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the usual and customary charge for treatment, care, and attendance, the agreed-upon contract price, or the maximum reimbursement allowance in the appropriate schedule, whichever is less.

(b) As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price times 1.2 plus $4.18 for the dispensing fee, except where the carrier has contracted for a lower amount. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower.

(c) Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, ambulatory surgical center, work-hardening program, or pain program, must not exceed the amounts provided by the uniform schedule of maximum reimbursement allowances as

determined by the panel or as otherwise provided in this section. This subsection also applies to independent medical examinations performed by health care providers under this chapter. Until the three-member panel approves a uniform schedule of maximum reimbursement allowances and it becomes effective, all compensable charges for treatment, care, and attendance provided by physicians, ambulatory surgical centers, work-hardening programs, or pain programs shall be reimbursed at the lowest maximum reimbursement allowance across all 1992 schedules of maximum reimbursement allowances for the services provided regardless of the place of service. In determining the uniform schedule, the panel shall first approve the data which it finds representative of prevailing charges in the state for similar treatment, care, and attendance of injured persons. Each health care provider, health care facility, ambulatory surgical center, work-hardening program, or pain program receiving workers' compensation payments shall maintain records verifying their usual charges. In establishing the uniform schedule of maximum reimbursement allowances, the panel must consider:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers;

2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will ensure the availability of treatment, care, and attendance required by injured workers;

3. The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.401, and its effect upon their ability to make available to injured

workers such medically necessary remedial treatment, care, and attendance. The uniform schedule of maximum reimbursement allowances must be reasonable, must promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers; and

4. The most recent average maximum allowable rate of increase for hospitals determined by the Health Care Board under chapter 408.

(13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE AUTHORIZED TO RENDER MEDICAL CARE.--The Agency for Health Care Administration ~~division~~ shall remove from the list of physicians or facilities authorized to provide remedial treatment, care, and attendance under this chapter the name of any physician or facility found after reasonable investigation to have:

(a) Engaged in professional or other misconduct or incompetency in connection with medical services rendered under this chapter;

(b) Exceeded the limits of his or her or its professional competence in rendering medical care under this chapter, or to have made materially false statements regarding his or her or its qualifications in his or her application;

(c) Failed to transmit copies of medical reports to the employer or carrier, or failed to submit full and truthful medical reports of all his or her or its findings to the employer or carrier as required under this chapter;

(d) Solicited, or employed another to solicit for himself or herself or itself or for another, professional

treatment, examination, or care of an injured employee in connection with any claim under this chapter;

(e) Refused to appear before, or to answer upon request of, the Agency for Health Care Administration ~~division~~ or any duly authorized officer of the state, any legal question, or to produce any relevant book or paper concerning his or her conduct under any authorization granted to him or her under this chapter;

(f) Self-referred in violation of this chapter or other laws of this state; or

(g) Engaged in a pattern of practice of overutilization or a violation of this chapter or rules adopted by the Agency for Health Care Administration ~~division~~.

(14) PAYMENT OF MEDICAL FEES.--

(a) Except for emergency care treatment, fees for medical services are payable only to a health care provider certified and authorized to render remedial treatment, care, or attendance under this chapter. A health care provider may not collect or receive a fee from an injured employee within this state, except as otherwise provided by this chapter. Such providers have recourse against the employer or carrier for payment for services rendered in accordance with this chapter.

(b) Fees charged for remedial treatment, care, and attendance may not exceed the applicable fee schedules adopted under this chapter.

(c) Notwithstanding any other provision of this chapter, following overall maximum medical improvement from an injury compensable under this chapter, the employee is obligated to pay a copayment of $10 per visit for medical services. The copayment shall not apply to emergency care provided to the employee.

(15) PRACTICE PARAMETERS.--

(a) The Agency for Health Care Administration, in conjunction with ~~the division and~~ appropriate health professional associations and health-related organizations shall develop and may adopt by rule scientifically sound practice parameters for medical procedures relevant to workers' compensation claimants. Practice parameters developed under this section must focus on identifying effective remedial treatments and promoting the appropriate utilization of health care resources. Priority must be given to those procedures that involve the greatest utilization of resources either because they are the most costly or because they are the most frequently performed. ~~Practice parameters for treatment of the 10 top procedures associated with workers' compensation injuries including the remedial treatment of lower-back injuries must be developed by December 31, 1994.~~

(b) The guidelines may be initially based on guidelines prepared by nationally recognized health care institutions and professional organizations but should be tailored to meet the workers' compensation goal of returning employees to full employment as quickly as medically possible, taking into consideration outcomes data collected from managed care providers and any other inpatient and outpatient facilities serving workers' compensation claimants.

(c) Procedures must be instituted which provide for the periodic review and revision of practice parameters based on the latest outcomes data, research findings, technological advancements, and clinical experiences, at least once every 3 years.

(d) Practice parameters developed under this section must be used by carriers and the Agency for Health Care

Administration ~~division~~ in evaluating the appropriateness and overutilization of medical services provided to injured employees.

(16)(a) The Workers' Compensation Regulatory Reporting Advisory Council is created within the Agency for Health Care Administration for the purpose of evaluating current reporting provisions of this chapter relating to medical services and supplies, medical benefits and disputes, and workers' compensation managed care arrangements in order to make recommendations to the Governor for providing such information in the most cost-effective and efficient manner. The council shall consist of the representatives of the three carriers with the largest voluntary net premiums written in this state for workers' compensation; three individual self-insurers; and three certified health care providers, appointed by the Governor to serve terms of 4 years each. The Director of the Agency for Health Care Administration or his or her designee and the Director for the Division of Risk Management of the Department of Insurance or his or her designee shall serve as nonvoting members of the council. Each member of the council shall serve until a successor is appointed. The chair and any other officers of the council shall be selected by the council members for a 1-year term and may succeed themselves.

(b) The council is assigned to the Agency for Health Care Administration for administrative and fiscal accountability purposes, but the council and its staff shall otherwise function independently of the control and direction of the agency. The agency shall furnish dedicated administrative and secretarial assistance to the council and other assistance to the council as requested.

(c) The council shall hold a minimum of four regular meetings annually, and other meetings may be called by the chair upon giving at least 1 week's notice to all members and the public pursuant to chapter 120. Other meetings may also be held upon the written request of at least four other members of the council, with at least 1 week's notice of such meeting being given to all members and the public by the chair pursuant to chapter 120. Emergency meetings may be held without notice upon the request of all members of the council.

(d) A majority of the membership of the council constitutes a quorum. An action of the council is not considered adopted unless the action is taken pursuant to the affirmative vote of a majority of the members present, but not fewer than four members of the council at a meeting held pursuant to paragraph (c), and the vote is recorded in the minutes of that meeting.

(e) The chair shall cause to be made a complete record of the proceedings of the council. The proceedings of the council shall be open to the public and the records shall be open for public inspection.

(f) The meetings of the council shall be held in the central office of the department in Tallahassee unless the chair determines that special circumstances warrant meeting at another location.

(g) Members of the council are entitled to per diem and travel expenses pursuant to s. 112.061.

Section 11. Effective July 1, 1999, paragraph (f) of subsection (1) of section 440.15, Florida Statutes, 1998 Supplement, is amended to read:

440.15 Compensation for disability.--Compensation for disability shall be paid to the employee, subject to the limits provided in s. 440.12(2), as follows:

(1) PERMANENT TOTAL DISABILITY.--

(f)1. If permanent total disability results from injuries that occurred subsequent to June 30, 1955, and for which the liability of the employer for compensation has not been discharged under s. 440.20(11)~~s. 440.20(12)~~, the injured employee shall receive additional weekly compensation benefits equal to 5 percent of her or his weekly compensation rate, as established pursuant to the law in effect on the date of her or his injury, multiplied by the number of calendar years since the date of injury. The weekly compensation payable and the additional benefits payable under this paragraph, when combined, may not exceed the maximum weekly compensation rate in effect at the time of payment as determined pursuant to s. 440.12(2). Entitlement to these supplemental payments shall cease at age 62 if the employee is eligible for social security benefits under 42 U.S.C. ss. 402 and 423, whether or not the employee has applied for such benefits. The division may contract with an entity to administer the payment of supplemental benefits to employees injured subsequent to June 30, 1955, and before July 1, 1984.These supplemental benefits shall be paid by the division out of the Workers' Compensation Administration Trust Fund when the injury occurred subsequent to June 30, 1955, and before July 1, 1984. These supplemental benefits shall be paid by the employer when the injury occurred on or after July 1, 1984. Supplemental benefits are not payable for any period prior to October 1, 1974.

2.a. The division shall provide by rule for the periodic reporting to the division or an administrator of all

earnings of any nature and social security income by the injured employee entitled to or claiming additional compensation under subparagraph 1. Neither the division nor an administrator, nor the employer or carrier, shall make any payment of those additional benefits provided by subparagraph 1. for any period during which the employee willfully fails or refuses to report upon request by the division or an administrator in the manner prescribed by such rules.

b. The division shall provide by rule for the periodic reporting to the employer or carrier of all earnings of any nature and social security income by the injured employee entitled to or claiming benefits for permanent total disability. The employer or carrier is not required to make any payment of benefits for permanent total disability for any period during which the employee willfully fails or refuses to report upon request by the employer or carrier in the manner prescribed by such rules or if any employee who is receiving permanent total disability benefits refuses to apply for or cooperate with the employer or carrier in applying for social security benefits.

3. When an injured employee receives a full or partial lump-sum advance of the employee's permanent total disability compensation benefits, the employee's benefits under this paragraph shall be computed on the employee's weekly compensation rate as reduced by the lump-sum advance.

Section 12. Subsections (1) and (4) of section 440.1925, Florida Statutes, are amended to read:

440.1925 Procedure for resolving maximum medical improvement or permanent impairment disputes.--

(1) Notwithstanding the limitations on carrier independent medical examinations in s. 440.13, an employee or

carrier who wishes to obtain an opinion other than the opinion of the treating physician or an Agency for Health Care Administration ~~a division~~ advisor on the issue of permanent impairment may obtain one independent medical examination, except that the employee or carrier who selects the treating physician is not entitled to obtain an alternate opinion on the issue of permanent impairment, unless the parties otherwise agree. This section and s. 440.13(2) do not permit an employee or a carrier to obtain an additional medical opinion on the issue of permanent impairment by requesting an alternate treating physician pursuant to s. 440.13.

(4) Only opinions of the employee's treating physician, an Agency for Health Care Administration ~~a division~~ medical advisor, or an independent medical examiner are admissible in proceedings before a judge of compensation claims to resolve maximum medical improvement or impairment disputes.

Section 13. Subsection (7) of section 440.25, Florida Statutes, is amended to read:

440.25 Procedures for mediation and hearings.--

(7) An injured employee claiming or entitled to compensation shall submit to such physical examination by a certified expert medical advisor approved by the Agency for Health Care Administration ~~division~~ or the judge of compensation claims as the Agency for Health Care Administration ~~division~~ or the judge of compensation claims may require. The place or places shall be reasonably convenient for the employee. Such physician or physicians as the employee, employer, or carrier may select and pay for may participate in an examination if the employee, employer, or carrier so requests. Proceedings shall be suspended and no

compensation shall be payable for any period during which the employee may refuse to submit to examination. Any interested party shall have the right in any case of death to require an autopsy, the cost thereof to be borne by the party requesting it; and the judge of compensation claims shall have authority to order and require an autopsy and may, in her or his discretion, withhold her or his findings and award until an autopsy is held.

Section 14. Effective July 1, 1999, subsection (7) is added to section 440.38, Florida Statutes, to read:

440.38 Security for compensation; insurance carriers and self-insurers.--

(7) The division may contract with the Florida Self-Insurers Guaranty Association, Incorporated, for the administration and audit of the individual self-insurers.

Section 15. Effective July 1, 1999, paragraph (c) of subsection (3) of section 440.385, Florida Statutes, is amended to read:

440.385 Florida Self-Insurers Guaranty Association, Incorporated.--

(3) POWERS AND DUTIES.--

(c)1. To the extent necessary to secure funds for the payment of covered claims and also to pay the reasonable costs to administer them, the Department of Labor and Employment Security, upon certification of the board of directors, shall levy assessments based on the annual normal premium each employer would have paid had the employer not been self-insured. Every assessment shall be made as a uniform percentage of the figure applicable to all individual self-insurers, provided that the assessment levied against any self-insurer in any one year shall not exceed 1 percent of the

annual normal premium during the calendar year preceding the date of the assessment. Assessments shall be remitted to and administered by the board of directors in the manner specified by the approved plan. Each employer so assessed shall have at least 30 days' written notice as to the date the assessment is due and payable. The association shall levy assessments against any newly admitted member of the association so that the basis of contribution of any newly admitted member is the same as previously admitted members, provision for which shall be contained in the plan of operation.

2. If, in any one year, funds available from such assessments, together with funds previously raised, are not sufficient to make all the payments or reimbursements then owing, the funds available shall be prorated, and the unpaid portion shall be paid as soon thereafter as sufficient additional funds become available.

3. No state funds of any kind shall be allocated or paid to the association or any of its accounts except those state funds accruing to the association by and through the assignment of rights of an insolvent employer or for the purpose of auditing individual self-insurers.

Section 16. Effective July 1, 1999, subsection (4) of section 440.44, Florida Statutes, is amended to read:

440.44 Workers' compensation; staff organization.--

(4) MERIT SYSTEM PRINCIPLE OF PERSONNEL ADMINISTRATION.--Subject to the other provisions of this chapter, the division is authorized to appoint, and prescribe the duties and powers of, bureau chiefs, attorneys, accountants, qualified rehabilitation providers ~~medical advisers~~, technical assistants, inspectors, claims examiners,

and such other employees as may be necessary in the performance of its duties under this chapter.

Section 17. Effective July 1, 1999, subsection (2) of section 440.4416, Florida Statutes, is amended to read:

440.4416 Workers' Compensation Oversight Board.--

(2) POWERS AND DUTIES; ORGANIZATION.--

(a) The board shall have all the powers necessary and convenient to carry out and effectuate the purposes of this section, including, but not limited to, the power to:

1. Conduct public hearings.

~~2. Report to the Legislature by January 1, 1995, as to the feasibility of a return-to-work program that includes incentives for employers who encourage such a program and disincentives for employers who hinder such a program.~~

2.~~3.~~ Prescribe qualifications for board employees.

3.~~4.~~ Appear on its own behalf before other boards, commissions, or agencies of the state or Federal Government.

4.~~5.~~ Make and execute contracts to the extent that such contracts are consistent with duties and powers set forth in this section and elsewhere in the law of this state.

(b) The board shall adopt bylaws, formulate workers' compensation legislation or amendments, review, advise, and appear before the Legislature in connection with legislation that impacts the workers' compensation system, advise the division on policy, administrative and legislative issues, and appear before other state or federal agencies in connection with matters impacting the workers' compensation system.

(c) The board shall select a chair who shall serve for a period of 2 years and until a successor is elected and qualified. The chair shall be the chief administrative officer

of the board and shall have the authority to plan, direct, coordinate, and execute the powers and duties of the board.

(d) The board shall hold such meetings during the year as it deems necessary, except that the chair, a quorum of the board, or the division may call meetings. The board shall maintain transcripts of each meeting. Such transcripts shall be available to any interested person in accordance with chapter 119.

(e) The board shall approve the bylaws or amendments thereto by unanimous vote. All other board actions or recommendations shall be approved by not less than a majority vote of employee representatives and majority vote of employer representatives, unless the bylaws otherwise provide.

(f) The board shall evaluate the current reporting requirements for carriers and individual self-insurers under the provisions of this chapter and make recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives, on or before January 1 of each year, for revising the reporting requirements to facilitate the reporting of information to the division in the most cost-effective and efficient manner.

Section 18. Subsection (4) of section 440.50, Florida Statutes, 1998 Supplement, is amended to read:

440.50 Workers' Compensation Administration Trust Fund.--

(4)(a) All civil penalties that are imposed by the division, as provided in this chapter, if not voluntarily paid, may be collected by civil suit brought by the division and shall be paid into the Workers' Compensation Administration Trust ~~such~~ Fund.

(b) All civil penalties that are imposed by the Department of Insurance, as provided in this chapter, shall be deposited into the Insurance Commissioner's Regulatory Trust Fund.

(c) All civil penalties that are imposed by the Agency for Health Care Administration, as provided in this chapter, shall be deposited into the Health Care Trust Fund.

Section 19. Subsection (6) of section 440.51, Florida Statutes, is amended to read:

440.51 Expenses of administration.--

(6)(a) The division may require from each carrier, at such time and in accordance with such rules ~~regulations~~ as the division prescribes ~~may prescribe~~, reports in respect to all gross earned premiums and of all payments of compensation made by such carrier during each prior period, and may determine the amounts paid by each carrier and the amounts paid by all carriers during such period.

(b) The division ~~Department of Insurance~~ may require from each self-insurer, at such time and in accordance with such rules ~~regulations~~ as the division ~~Department of Insurance~~ prescribes, reports in respect to wages paid, the amount of premiums such self-insurer would have to pay if insured, and all payments of compensation made by such self-insurer during each prior period, and may determine the amounts paid by each self-insurer and the amounts paid by all self-insurers during such period. For the purposes of this section, the payroll records of each self-insurer shall be open to annual inspection and audit by the division ~~Department of Insurance~~ or its authorized representative, during regular business hours; and if any audit of such records of a self-insurer discloses a deficiency in the amounts reported to the division

~~Department of Insurance~~ or in the amounts paid to the division ~~Department of Insurance~~ by a self-insurer pursuant to this section, the division or its representative ~~Department of Insurance~~ may assess the cost of such audit against the self-insurer.

Section 20. Effective July 1, 1999, section 440.525, Florida Statutes, is amended to read:

440.525 Examination of carriers.--~~Beginning July 1, 1994,~~The division ~~of Workers' Compensation of the Department of Labor and Employment Security~~ may examine each carrier as often as is warranted to ensure that carriers are fulfilling their obligations under the law~~, and shall examine each carrier not less frequently than once every 3 years~~. The examination must ~~cover the preceding 3 fiscal years of the carrier's operations and must~~ commence within 12 months after the end of the most recent fiscal year being covered by the examination. The examination may cover any period of the carrier's operations since the last previous examination. The examination may be conducted by an independent professional examiner under contract with the division, in which case payment shall be made directly to the contracted examiner by the insurer or employer in accordance with rates and terms agreed to by the division and the examiner.

Section 21. Effective July 1, 1999, section 440.59, Florida Statutes, is amended to read:

440.59 Reporting requirements.--

(1) The Department of Labor and Employment Security shall annually prepare a report in the most effective and efficient manner possible of the administration of this chapter for the preceding calendar year, including a detailed statement of the receipts of and expenditures from the fund

established in s. 440.50 and a statement of the causes of the accidents leading to the injuries for which the awards were made, together with such recommendations as the department considers advisable. On or before September 15 of each year, the department shall submit a copy of the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Democratic and Republican Leaders of the Senate and the House of Representatives, and the chairs of the legislative committees having jurisdiction over workers' compensation.

(2) The Division of Workers' Compensation of the Department of Labor and Employment Security shall annually analyze ~~complete on a quarterly basis an analysis of~~ the previous calendar year's ~~quarter's~~ injuries that ~~which~~ resulted in workers' compensation claims. The analysis shall be broken down by risk classification, shall show for each such risk classification the frequency and severity for the various types of injury, and shall include an analysis of the causes of such injuries. Upon request,the division shall distribute to each employer and self-insurer in the state covered by the Workers' Compensation Law the data relevant to its workforce. Upon request,the report shall also be distributed to the insurers authorized to write workers' compensation insurance in the state.

(3) The division shall annually prepare and make available a closed claim report for all claims for which the employee lost more than 7 days from work ~~and shall submit a copy of the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Democratic and Republican Leaders of the Senate and the House of Representatives, and the chairs of the legislative~~

~~committees having jurisdiction over workers' compensation~~ on or before September 15 of each year. The closed claim report shall include, but not be limited to, an analysis of all claims closed during the preceding year as to the date of accident, age of the injured employee, occupation of the injured employee, type of injury, body part affected, type and duration of indemnity benefits paid, permanent impairment rating, medical benefits identified by type of health care provider, and type and cost of any rehabilitation benefits provided.

(4) The division shall prepare and make available an annual report for all claims for which the employee lost more than 7 days from work ~~and shall submit a copy of the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Democratic and Republican Leaders of the Senate and the House of Representatives, and the chairs of the legislative committees having jurisdiction over workers' compensation,~~on or before September 15 of each year. The annual report shall include a status report on all cases involving work-related injuries in the previous 10 years. The annual report shall include, but not be limited to, the number of open and closed cases, the number of cases receiving various types of benefits, the cash and medical benefits paid between the date of injury and the evaluation date, the number of litigated cases, and the amount of attorney's fees paid in each case.

(5) The Chief Judge must prepare an annual report summarizing the disposition of mediation conferences and must submit the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Democratic and Republican Leaders of the Senate and the House

of Representatives, and the chairs of the legislative committees having jurisdiction over workers' compensation, on or before September 15 of each year.

Section 22. All powers, duties, functions, rules, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Department of Insurance related to the examination of individual self-insurers, as established in chapter 440, Florida Statutes, are transferred by a type two transfer, as defined in section 20.06(2), Florida Statutes, from the Department of Insurance to the Division of Workers' Compensation.

Section 23. All powers, duties, functions, rules, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Division of Workers' Compensation related to the enforcement of employer compliance with coverage requirements, proof of coverage, and exemptions, as established in chapter 440, Florida Statutes, are transferred by a type two transfer, as defined in section 20.06(2), Florida Statutes, from the Division of Workers' Compensation to the Department of Insurance.

Section 24. All powers, duties, functions, rules, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Division of Workers' Compensation related to medical services and supplies, dispute resolution, and medical data reporting requirements, as established in chapter 440, Florida Statutes, are transferred by a type two transfer, as defined in section 20.06(2), Florida Statutes, from the Division of Workers' Compensation to the Agency for Health Care Administration.

Section 25. Seven positions within the Division of Workers' Compensation responsible for the regulation of

individual self-insurers are eliminated, contingent upon the division contracting with Florida Self-Insurers Guaranty Association, Incorporated, as authorized under section 440.385, Florida Statutes.

Section 26. Sixteen positions within the Division of Workers' Compensation responsible for examining carriers and individual self-insurers are eliminated, contingent upon the division contracting the audit function to independent examiners, as authorized under section 440.525, Florida Statutes.

Section 27. Five positions within the Division of Workers' Compensation responsible for administering supplemental benefit payments to workers injured subsequent to July 1, 1984, are eliminated, contingent upon the division contracting with a third-party administrator, as authorized under section 440.15, Florida Statutes.

Section 28. Except for this section, which shall take effect upon becoming a law, and except as otherwise provided in this act, this act shall take effect July 1, 2000.

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SENATE SUMMARY

Transfers functions relating to examination of individual workers' compensation self-insurers from the Department of Insurance to the Division of Workers' Compensation. Transfers functions related to enforcement of employer compliance from the Division of Workers' Compensation to the Department of Insurance. Transfers functions related to medical services, supplies, and data and dispute resolution from the Division of Workers' Compensation to the Agency for Health Care Administration.