By Senator Villalobos

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1 A bill to be entitled
2 An act relating to workers' compensation; amending s.
3 440.13, F.S.; requiring an insurance carrier to give an
4 employee more than one opportunity to change physicians
5 for medical treatment; redefining the term "independent
6 medical examination" to exclude evaluations by an expert
7 medical advisor; providing for all parties involved in a
8 workers' compensation case to have access to medical
9 information provided by an authorized health care
10 provider; revising the list of persons who may request
11 medical information concerning an injured employee;
12 requiring such release of medical information by an
13 authorized health care provider; revising requirements for
14 obtaining an independent medical examination; providing
15 that the medical opinion of a medical advisor appointed by
16 the judge of compensation claims or the Department of
17 Financial Services is not admissible in proceedings before
18 the judges of compensation claims; deleting the use of
19 expert medical advisors by the judges of compensation
20 claims; amending s. 440.15, F.S.; deleting a provision
21 limiting impairment income benefits for impairment ratings
22 for physical impairments; revising the method by which
23 permanent impairment benefits are paid; providing
24 requirements for entitlement to supplemental benefits;
25 requiring a carrier to pay supplemental benefits under
26 certain conditions; providing the method of calculating
27 supplemental benefits; authorizing the department to
28 define terms, forms, and procedures governing the method
29 of paying supplemental benefits for accidents occurring

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30 within specified periods; providing an expiration date for
31 an employee's eligibility for certain benefits; providing
32 that temporary disability and medical benefits are not
33 subject to apportionment; authorizing an employee to
34 receive benefits for the total compensable permanent
35 impairment when his or her injury is aggravated or
36 accelerated by, or merged with, a preexisting condition;
37 revising the term "merger"; amending s. 440.25, F.S.,
38 relating to procedures for mediation and hearings;
39 conforming provisions to changes made by the act; amending
40 s. 440.32, F.S.; requiring that the cost of a frivolous
41 proceeding in compensation claims be assessed against the
42 party or the attorney; deleting a provision requiring that
43 a copy of the order assessing a penalty be forwarded to a
44 grievance committee; amending s. 440.34, F.S.; providing
45 circumstances under which the attorney's fees due to the
46 claimant's attorney shall equal the attorney's fees paid
47 to the employer's or carrier's attorney; amending s.
48 440.491, F.S.; providing that the time period for benefits
49 provided to an injured employee for additional education
50 or training is in addition to the time allowed for the
51 receipt of temporary disability benefits; amending s.
52 468.525, F.S.; requiring an employee leasing company to
53 provide written notice of obtaining workers' compensation
54 coverage to each of its employees; amending s. 468.529,
55 F.S.; requiring an employee leasing company to notify
56 certain persons and agencies regarding the initiation of a
57 contract with a client company in a format acceptable to
58 the Department of Financial Services; providing that a

59 contract or policy of insurance issued by a carrier may
60 not expire or be cancelled until a specified period after
61 a notice of cancellation has been sent to the employees,
62 the department, and the employee leasing company;
63 authorizing the Department of Business and Professional
64 Regulation to prescribe the content of the notice of
65 cancellation and the time, place, and manner in which the
66 notice is served; providing an effective date.
67
68 Be It Enacted by the Legislature of the State of Florida:
69
70 Section 1. Paragraph (j) of subsection (1), paragraph (f)
71 of subsection (2), paragraph (c) of subsection (4), paragraphs
72 (a) and (e) of subsection (5), paragraph (b) of subsection (8),
73 and subsections (9) through (17) of section 440.13, Florida
74 Statutes, are amended to read:
75 440.13 Medical services and supplies; penalty for
76 violations; limitations.--
77 (1) DEFINITIONS.--As used in this section, the term:
78 (j) "Independent medical examination" means an objective
79 evaluation of the injured employee's medical condition,
80 including, but not limited to, impairment or work status,
81 performed by a physician ~~or an expert medical advisor~~ at the
82 request of a party, a judge of compensation claims, or the agency
83 to assist in the resolution of a dispute arising under this
84 chapter.
85 (2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.--
86 (f) Upon the written request of the employee, the carrier
87 shall give the employee the opportunity <u>to</u> ~~for one~~ change

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88 physicians ~~of physician during the course of treatment for any~~
89 ~~one accident~~. Upon the granting of a change of physician, the
90 originally authorized physician in the same specialty as the
91 changed physician shall become deauthorized upon written
92 notification by the employer or carrier. The employee may select
93 the change of physician and may select any physician licensed to
94 practice in this state who is a certified health care provider
95 unless the medical care is being provided through a managed care
96 arrangement. If the medical care is being provided through a
97 managed care arrangement, the employee may select any physician
98 in the managed care network as the change of physician. The
99 carrier shall authorize the ~~an~~ alternative physician ~~who shall~~
100 ~~not be professionally affiliated with the previous physician~~
101 within 5 days after receipt of the request. If the carrier fails
102 to timely authorize the alternative physician ~~provide a change of~~
103 ~~physician~~ as requested by the employee, the employee may select
104 the physician and such physician shall be deemed ~~considered~~
105 authorized and remain authorized if the treatment being sought
106 ~~provided~~ is compensable and medically necessary.
107
108 Failure of the carrier to timely comply with this subsection
109 shall be a violation of this chapter and the carrier shall be
110 subject to penalties as provided for in s. 440.525.
111 (4) NOTICE OF TREATMENT TO CARRIER; FILING WITH
112 DEPARTMENT.--
113 (c) It is the policy for the administration of the workers'
114 compensation system that there shall be reasonable access to
115 medical information from an authorized health care provider to ~~by~~
116 all parties to facilitate the self-executing features of the law.

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117 An employee who reports an injury or illness alleged to be work-
118 related waives any physician-patient privilege with respect to
119 any condition or complaint reasonably related to the condition
120 for which the employee claims compensation. Notwithstanding the
121 limitations in s. 456.057 and subject to the limitations in s.
122 381.004, upon the request of the employer, the carrier, ~~an~~
123 ~~authorized qualified rehabilitation provider,~~ or the attorney for
124 the employer or carrier, the medical records, reports, and
125 information of an injured employee relevant to the particular
126 injury or illness for which compensation is sought must be
127 furnished to those persons and the medical condition of the
128 injured employee must be discussed with those persons, if the
129 records and the discussions are restricted to conditions relating
130 to the workplace injury. Release of medical information by the
131 authorized health care provider or other physician does not
132 require the authorization of the injured employee. If medical
133 records, reports, and information of an injured employee are
134 sought from health care providers who are not subject to the
135 jurisdiction of the state, the injured employee shall sign an
136 authorization allowing for the employer or carrier to obtain the
137 medical records, reports, or information. Any such discussions or
138 release of information may be held before or after the filing of
139 a claim or petition for benefits without the knowledge, consent,
140 or presence of any other party or his or her agent or
141 representative. An authorized ~~A~~ health care provider who
142 willfully refuses to provide medical records or to discuss the
143 medical condition of the injured employee, after a reasonable
144 request is made for such information pursuant to this subsection,
145 shall be subject by the department to one or more of the

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146 penalties set forth in paragraph (8)(b). The department may adopt
147 rules to carry out this subsection.
148 (5) INDEPENDENT MEDICAL EXAMINATIONS.--
149 (a) In any dispute concerning overutilization, medical
150 benefits, compensability, or disability under this chapter, the
151 carrier or the employee may select an independent medical
152 examiner. If the parties agree, the examiner may be a health care
153 provider treating or providing other care to the employee. An
154 independent medical examiner may not render an opinion outside
155 his or her area of expertise, as demonstrated by licensure and
156 applicable practice parameters. The employer and employee shall
157 be entitled to ~~only~~ one independent medical examination <u>payable</u>
158 <u>by the employer or carrier</u> ~~per accident and not one independent~~
159 ~~medical examination per medical specialty. The party requesting~~
160 ~~and selecting the independent medical examination shall be~~
161 ~~responsible for all expenses associated with said examination,~~
162 ~~including, but not limited to, medically necessary diagnostic~~
163 ~~testing performed and physician or medical care provider fees for~~
164 ~~the evaluation~~. The party selecting the independent medical
165 examination shall identify the choice of the independent medical
166 examiner to all other parties within 15 days after the date the
167 independent medical examination is to take place. Failure to
168 timely provide such notification shall preclude the requesting
169 party from submitting the findings of such independent medical
170 examiner in a proceeding before a judge of compensation claims.
171 The independent medical examiner may not provide followup care if
172 such recommendation for care is found to be medically necessary.
173 ~~If the employee prevails in a medical dispute as determined in an~~
174 ~~order by a judge of compensation claims or if benefits are paid~~

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175 ~~or treatment provided after the employee has obtained an~~
176 ~~independent medical examination based upon the examiner's~~
177 ~~findings, the costs of such examination shall be paid by the~~
178 ~~employer or carrier.~~
179 (e) <u>A</u> ~~No~~ medical opinion other than the opinion of ~~a~~
180 ~~medical advisor appointed by the judge of compensation claims or~~
181 ~~the department,~~ an independent medical examiner~~,~~ or an authorized
182 treating provider is <u>not</u> admissible in proceedings before the
183 judges of compensation claims.
184 (8) PATTERN OR PRACTICE OF OVERUTILIZATION.--
185 (b) If the agency determines that a health care provider
186 has engaged in a pattern or practice of overutilization or a
187 violation of this chapter or rules adopted by the agency,
188 including a pattern or practice of providing treatment in excess
189 of the practice parameters or protocols of treatment, it may
190 impose one or more of the following penalties:
191 1. An order of the agency barring the provider from payment
192 under this chapter;
193 2. Deauthorization of care under review;
194 3. Denial of payment for care rendered in the future;
195 4. Decertification of ~~a health care provider certified as~~
196 ~~an expert medical advisor under subsection (9) or of~~ a
197 rehabilitation provider certified under s. 440.49;
198 5. An administrative fine assessed by the agency in an
199 amount not to exceed $5,000 per instance of overutilization or
200 violation; and
201 6. Notification of and review by the appropriate licensing
202 authority pursuant to s. 440.106(3).
203 ~~(9) EXPERT MEDICAL ADVISORS.--~~

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204 ~~(a) The agency shall certify expert medical advisors in~~
205 ~~each specialty to assist the agency and the judges of~~
206 ~~compensation claims within the advisor's area of expertise as~~
207 ~~provided in this section. The agency shall, in a manner~~
208 ~~prescribed by rule, in certifying, recertifying, or decertifying~~
209 ~~an expert medical advisor, consider the qualifications, training,~~
210 ~~impartiality, and commitment of the health care provider to the~~
211 ~~provision of quality medical care at a reasonable cost. As a~~
212 ~~prerequisite for certification or recertification, the agency~~
213 ~~shall require, at a minimum, that an expert medical advisor have~~
214 ~~specialized workers' compensation training or experience under~~
215 ~~the workers' compensation system of this state and board~~
216 ~~certification or board eligibility.~~
217 ~~(b) The agency shall contract with one or more entities~~
218 ~~that employ, contract with, or otherwise secure expert medical~~
219 ~~advisors to provide peer review or expert medical consultation,~~
220 ~~opinions, and testimony to the agency or to a judge of~~
221 ~~compensation claims in connection with resolving disputes~~
222 ~~relating to reimbursement, differing opinions of health care~~
223 ~~providers, and health care and physician services rendered under~~
224 ~~this chapter, including utilization issues. The agency shall by~~
225 ~~rule establish the qualifications of expert medical advisors,~~
226 ~~including training and experience in the workers' compensation~~
227 ~~system in the state and the expert medical advisor's knowledge of~~
228 ~~and commitment to the standards of care, practice parameters, and~~
229 ~~protocols established pursuant to this chapter. Expert medical~~
230 ~~advisors contracting with the agency shall, as a term of such~~
231 ~~contract, agree to provide consultation or services in accordance~~
232 ~~with the timetables set forth in this chapter and to abide by~~

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233 ~~rules adopted by the agency, including, but not limited to, rules~~
234 ~~pertaining to procedures for review of the services rendered by~~
235 ~~health care providers and preparation of reports and testimony or~~
236 ~~recommendations for submission to the agency or the judge of~~
237 ~~compensation claims.~~
238 ~~(c) If there is disagreement in the opinions of the health~~
239 ~~care providers, if two health care providers disagree on medical~~
240 ~~evidence supporting the employee's complaints or the need for~~
241 ~~additional medical treatment, or if two health care providers~~
242 ~~disagree that the employee is able to return to work, the agency~~
243 ~~may, and the judge of compensation claims shall, upon his or her~~
244 ~~own motion or within 15 days after receipt of a written request~~
245 ~~by either the injured employee, the employer, or the carrier,~~
246 ~~order the injured employee to be evaluated by an expert medical~~
247 ~~advisor. The opinion of the expert medical advisor is presumed to~~
248 ~~be correct unless there is clear and convincing evidence to the~~
249 ~~contrary as determined by the judge of compensation claims. The~~
250 ~~expert medical advisor appointed to conduct the evaluation shall~~
251 ~~have free and complete access to the medical records of the~~
252 ~~employee. An employee who fails to report to and cooperate with~~
253 ~~such evaluation forfeits entitlement to compensation during the~~
254 ~~period of failure to report or cooperate.~~
255 ~~(d) The expert medical advisor must complete his or her~~
256 ~~evaluation and issue his or her report to the agency or to the~~
257 ~~judge of compensation claims within 15 days after receipt of all~~
258 ~~medical records. The expert medical advisor must furnish a copy~~
259 ~~of the report to the carrier and to the employee.~~
260 ~~(e) An expert medical advisor is not liable under any~~
261 ~~theory of recovery for evaluations performed under this section~~

262 ~~without a showing of fraud or malice. The protections of s.~~
263 ~~766.101 apply to any officer, employee, or agent of the agency~~
264 ~~and to any officer, employee, or agent of any entity with which~~
265 ~~the agency has contracted under this subsection.~~
266 ~~(f) If the agency or a judge of compensation claims orders~~
267 ~~the services of a certified expert medical advisor to resolve a~~
268 ~~dispute under this section, the party requesting such examination~~
269 ~~must compensate the advisor for his or her time in accordance~~
270 ~~with a schedule adopted by the agency. If the employee prevails~~
271 ~~in a dispute as determined in an order by a judge of compensation~~
272 ~~claims based upon the expert medical advisor's findings, the~~
273 ~~employer or carrier shall pay for the costs of such expert~~
274 ~~medical advisor. If a judge of compensation claims, upon his or~~
275 ~~her motion, finds that an expert medical advisor is needed to~~
276 ~~resolve the dispute, the carrier must compensate the advisor for~~
277 ~~his or her time in accordance with a schedule adopted by the~~
278 ~~agency. The agency may assess a penalty not to exceed $500~~
279 ~~against any carrier that fails to timely compensate an advisor in~~
280 ~~accordance with this section.~~
281 (9) ~~(10)~~ WITNESS FEES.--Any health care provider who gives a
282 deposition shall be allowed a witness fee. The amount charged by
283 the witness may not exceed $200 per hour. An expert witness who
284 has never provided direct professional services to a party but
285 has merely reviewed medical records and provided an expert
286 opinion or has provided only direct professional services that
287 were unrelated to the workers' compensation case may not be
288 allowed a witness fee in excess of $200 per day.
289 (10) ~~(11)~~ AUDITS.--

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290 (a) The Agency for Health Care Administration may
291 investigate health care providers to determine whether providers
292 are complying with this chapter and with rules adopted by the
293 agency, whether the providers are engaging in overutilization,
294 whether providers are engaging in improper billing practices, and
295 whether providers are adhering to practice parameters and
296 protocols established in accordance with this chapter. If the
297 agency finds that a health care provider has improperly billed,
298 overutilized, or failed to comply with agency rules or the
299 requirements of this chapter, including, but not limited to,
300 practice parameters and protocols established in accordance with
301 this chapter, it must notify the provider of its findings and may
302 determine that the health care provider may not receive payment
303 from the carrier or may impose penalties as set forth in
304 subsection (8) or other sections of this chapter. If the health
305 care provider has received payment from a carrier for services
306 that were improperly billed, that constitute overutilization, or
307 that were outside practice parameters or protocols established in
308 accordance with this chapter, it must return those payments to
309 the carrier. The agency may assess a penalty not to exceed $500
310 for each overpayment that is not refunded within 30 days after
311 notification of overpayment by the agency or carrier.
312 (b) The department shall monitor carriers as provided in
313 this chapter and the Office of Insurance Regulation shall audit
314 insurers and group self-insurance funds as provided in s.
315 624.3161, to determine if medical bills are paid in accordance
316 with this section and rules of the department and Financial
317 Services Commission, respectively. Any employer, if self-insured,
318 or carrier found by the department or Office of Insurance

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319 Regulation not to be within 90 percent compliance as to the
320 payment of medical bills after July 1, 1994, must be assessed a
321 fine not to exceed 1 percent of the prior year's assessment
322 levied against such entity under s. 440.51 for every quarter in
323 which the entity fails to attain 90-percent compliance. The
324 department shall fine or otherwise discipline an employer or
325 carrier, pursuant to this chapter or rules adopted by the
326 department, and the Office of Insurance Regulation shall fine or
327 otherwise discipline an insurer or group self-insurance fund
328 pursuant to the insurance code or rules adopted by the Financial
329 Services Commission, for each late payment of compensation that
330 is below the minimum 95-percent performance standard. Any carrier
331 that is found to be not in compliance in subsequent consecutive
332 quarters must implement a medical-bill review program approved by
333 the department or office, and an insurer or group self-insurance
334 fund is subject to disciplinary action by the Office of Insurance
335 Regulation.
336 (c) The agency has exclusive jurisdiction to decide any
337 matters concerning reimbursement, to resolve any overutilization
338 dispute under subsection (7), and to decide any question
339 concerning overutilization under subsection (8), which question
340 or dispute arises after January 1, 1994.
341 (d) The following agency actions do not constitute agency
342 action subject to review under ss. 120.569 and 120.57 and do not
343 constitute actions subject to s. 120.56: referral by the entity
344 responsible for utilization review; a decision by the agency to
345 refer a matter to a peer review committee; establishment by a
346 health care provider or entity of procedures by which a peer
347 review committee reviews the rendering of health care services;

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348 and the review proceedings, report, and recommendation of the
349 peer review committee.
350 (11) ~~(12)~~ CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM
351 REIMBURSEMENT ALLOWANCES.--
352 (a) A three-member panel is created, consisting of the
353 Chief Financial Officer, or the Chief Financial Officer's
354 designee, and two members to be appointed by the Governor,
355 subject to confirmation by the Senate, one member who, on account
356 of present or previous vocation, employment, or affiliation,
357 shall be classified as a representative of employers, the other
358 member who, on account of previous vocation, employment, or
359 affiliation, shall be classified as a representative of
360 employees. The panel shall determine statewide schedules of
361 maximum reimbursement allowances for medically necessary
362 treatment, care, and attendance provided by physicians,
363 hospitals, ambulatory surgical centers, work-hardening programs,
364 pain programs, and durable medical equipment. The maximum
365 reimbursement allowances for inpatient hospital care shall be
366 based on a schedule of per diem rates, to be approved by the
367 three-member panel no later than March 1, 1994, to be used in
368 conjunction with a precertification manual as determined by the
369 department, including maximum hours in which an outpatient may
370 remain in observation status, which shall not exceed 23 hours.
371 All compensable charges for hospital outpatient care shall be
372 reimbursed at 75 percent of usual and customary charges, except
373 as otherwise provided by this subsection. Annually, the three-
374 member panel shall adopt schedules of maximum reimbursement
375 allowances for physicians, hospital inpatient care, hospital
376 outpatient care, ambulatory surgical centers, work-hardening

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377 programs, and pain programs. An individual physician, hospital,
378 ambulatory surgical center, pain program, or work-hardening
379 program shall be reimbursed either the agreed-upon contract price
380 or the maximum reimbursement allowance in the appropriate
381 schedule.
382 (b) It is the intent of the Legislature to increase the
383 schedule of maximum reimbursement allowances for selected
384 physicians effective January 1, 2004, and to pay for the
385 increases through reductions in payments to hospitals. Revisions
386 developed pursuant to this subsection are limited to the
387 following:
388 1. Payments for outpatient physical, occupational, and
389 speech therapy provided by hospitals shall be reduced to the
390 schedule of maximum reimbursement allowances for these services
391 which applies to nonhospital providers.
392 2. Payments for scheduled outpatient nonemergency
393 radiological and clinical laboratory services that are not
394 provided in conjunction with a surgical procedure shall be
395 reduced to the schedule of maximum reimbursement allowances for
396 these services which applies to nonhospital providers.
397 3. Outpatient reimbursement for scheduled surgeries shall
398 be reduced from 75 percent of charges to 60 percent of charges.
399 4. Maximum reimbursement for a physician licensed under
400 chapter 458 or chapter 459 shall be increased to 110 percent of
401 the reimbursement allowed by Medicare, using appropriate codes
402 and modifiers or the medical reimbursement level adopted by the
403 three-member panel as of January 1, 2003, whichever is greater.
404 5. Maximum reimbursement for surgical procedures shall be
405 increased to 140 percent of the reimbursement allowed by Medicare

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406 or the medical reimbursement level adopted by the three-member
407 panel as of January 1, 2003, whichever is greater.
408 (c) As to reimbursement for a prescription medication, the
409 reimbursement amount for a prescription shall be the average
410 wholesale price plus $4.18 for the dispensing fee, except where
411 the carrier has contracted for a lower amount. Fees for
412 pharmaceuticals and pharmaceutical services shall be reimbursable
413 at the applicable fee schedule amount. Where the employer or
414 carrier has contracted for such services and the employee elects
415 to obtain them through a provider not a party to the contract,
416 the carrier shall reimburse at the schedule, negotiated, or
417 contract price, whichever is lower. No such contract shall rely
418 on a provider that is not reasonably accessible to the employee.
419 (d) Reimbursement for all fees and other charges for such
420 treatment, care, and attendance, including treatment, care, and
421 attendance provided by any hospital or other health care
422 provider, ambulatory surgical center, work-hardening program, or
423 pain program, must not exceed the amounts provided by the uniform
424 schedule of maximum reimbursement allowances as determined by the
425 panel or as otherwise provided in this section. This subsection
426 also applies to independent medical examinations performed by
427 health care providers under this chapter. In determining the
428 uniform schedule, the panel shall first approve the data which it
429 finds representative of prevailing charges in the state for
430 similar treatment, care, and attendance of injured persons. Each
431 health care provider, health care facility, ambulatory surgical
432 center, work-hardening program, or pain program receiving
433 workers' compensation payments shall maintain records verifying

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434 their usual charges. In establishing the uniform schedule of
435 maximum reimbursement allowances, the panel must consider:
436 1. The levels of reimbursement for similar treatment, care,
437 and attendance made by other health care programs or third-party
438 providers;
439 2. The impact upon cost to employers for providing a level
440 of reimbursement for treatment, care, and attendance which will
441 ensure the availability of treatment, care, and attendance
442 required by injured workers;
443 3. The financial impact of the reimbursement allowances
444 upon health care providers and health care facilities, including
445 trauma centers as defined in s. 395.4001, and its effect upon
446 their ability to make available to injured workers such medically
447 necessary remedial treatment, care, and attendance. The uniform
448 schedule of maximum reimbursement allowances must be reasonable,
449 must promote health care cost containment and efficiency with
450 respect to the workers' compensation health care delivery system,
451 and must be sufficient to ensure availability of such medically
452 necessary remedial treatment, care, and attendance to injured
453 workers; and
454 4. The most recent average maximum allowable rate of
455 increase for hospitals determined by the Health Care Board under
456 chapter 408.
457 (e) In addition to establishing the uniform schedule of
458 maximum reimbursement allowances, the panel shall:
459 1. Take testimony, receive records, and collect data to
460 evaluate the adequacy of the workers' compensation fee schedule,
461 nationally recognized fee schedules and alternative methods of

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462 reimbursement to certified health care providers and health care
463 facilities for inpatient and outpatient treatment and care.
464 2. Survey certified health care providers and health care
465 facilities to determine the availability and accessibility of
466 workers' compensation health care delivery systems for injured
467 workers.
468 3. Survey carriers to determine the estimated impact on
469 carrier costs and workers' compensation premium rates by
470 implementing changes to the carrier reimbursement schedule or
471 implementing alternative reimbursement methods.
472 4. Submit recommendations on or before January 1, 2003, and
473 biennially thereafter, to the President of the Senate and the
474 Speaker of the House of Representatives on methods to improve the
475 workers' compensation health care delivery system.
476
477 The agency and the department, as requested, shall provide data
478 to the panel, including but not limited to, utilization trends in
479 the workers' compensation health care delivery system. The agency
480 shall provide the panel with an annual report regarding the
481 resolution of medical reimbursement disputes and any actions
482 pursuant to s. 440.13(8). The department shall provide
483 administrative support and service to the panel to the extent
484 requested by the panel.
485 (12) ~~(13)~~ REMOVAL OF PHYSICIANS FROM LISTS OF THOSE
486 AUTHORIZED TO RENDER MEDICAL CARE.--The agency shall remove from
487 the list of physicians or facilities authorized to provide
488 remedial treatment, care, and attendance under this chapter the
489 name of any physician or facility found after reasonable
490 investigation to have:

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491 (a) Engaged in professional or other misconduct or
492 incompetency in connection with medical services rendered under
493 this chapter;
494 (b) Exceeded the limits of his or her or its professional
495 competence in rendering medical care under this chapter, or to
496 have made materially false statements regarding his or her or its
497 qualifications in his or her application;
498 (c) Failed to transmit copies of medical reports to the
499 employer or carrier, or failed to submit full and truthful
500 medical reports of all his or her or its findings to the employer
501 or carrier as required under this chapter;
502 (d) Solicited, or employed another to solicit for himself
503 or herself or itself or for another, professional treatment,
504 examination, or care of an injured employee in connection with
505 any claim under this chapter;
506 (e) Refused to appear before, or to answer upon request of,
507 the agency or any duly authorized officer of the state, any legal
508 question, or to produce any relevant book or paper concerning his
509 or her conduct under any authorization granted to him or her
510 under this chapter;
511 (f) Self-referred in violation of this chapter or other
512 laws of this state; or
513 (g) Engaged in a pattern of practice of overutilization or
514 a violation of this chapter or rules adopted by the agency,
515 including failure to adhere to practice parameters and protocols
516 established in accordance with this chapter.
517 (13) ~~(14)~~ PAYMENT OF MEDICAL FEES.--
518 (a) Except for emergency care treatment, fees for medical
519 services are payable only to a health care provider certified and

520 authorized to render remedial treatment, care, or attendance
521 under this chapter. Carriers shall pay, disallow, or deny payment
522 to health care providers in the manner and at times set forth in
523 this chapter. A health care provider may not collect or receive a
524 fee from an injured employee within this state, except as
525 otherwise provided by this chapter. Such providers have recourse
526 against the employer or carrier for payment for services rendered
527 in accordance with this chapter. Payment to health care providers
528 or physicians shall be subject to the medical fee schedule and
529 applicable practice parameters and protocols, regardless of
530 whether the health care provider or claimant is asserting that
531 the payment should be made.
532 (b) Fees charged for remedial treatment, care, and
533 attendance, except for independent medical examinations and
534 consensus independent medical examinations, may not exceed the
535 applicable fee schedules adopted under this chapter and
536 department rule. Notwithstanding any other provision in this
537 chapter, if a physician or health care provider specifically
538 agrees in writing to follow identified procedures aimed at
539 providing quality medical care to injured workers at reasonable
540 costs, deviations from established fee schedules shall be
541 permitted. Written agreements warranting deviations may include,
542 but are not limited to, the timely scheduling of appointments for
543 injured workers, participating in return-to-work programs with
544 injured workers' employers, expediting the reporting of
545 treatments provided to injured workers, and agreeing to
546 continuing education, utilization review, quality assurance,
547 precertification, and case management systems that are designed
548 to provide needed treatment for injured workers.

549 (c) Notwithstanding any other provision of this chapter,
550 following overall maximum medical improvement from an injury
551 compensable under this chapter, the employee is obligated to pay
552 a copayment of $10 per visit for medical services. The copayment
553 shall not apply to emergency care provided to the employee.
554 (14) ~~(15)~~ PRACTICE PARAMETERS.--The practice parameters and
555 protocols mandated under this chapter shall be the practice
556 parameters and protocols adopted by the United States Agency for
557 Healthcare Research and Quality in effect on January 1, 2003.
558 (15) ~~(16)~~ STANDARDS OF CARE.--The following standards of
559 care shall be followed in providing medical care under this
560 chapter:
561 (a) Abnormal anatomical findings alone, in the absence of
562 objective relevant medical findings, shall not be an indicator of
563 injury or illness, a justification for the provision of remedial
564 medical care or the assignment of restrictions, or a foundation
565 for limitations.
566 (b) At all times during evaluation and treatment, the
567 provider shall act on the premise that returning to work is an
568 integral part of the treatment plan. The goal of removing all
569 restrictions and limitations as early as appropriate shall be
570 part of the treatment plan on a continuous basis. The assignment
571 of restrictions and limitations shall be reviewed with each
572 patient exam and upon receipt of new information, such as
573 progress reports from physical therapists and other providers.
574 Consideration shall be given to upgrading or removing the
575 restrictions and limitations with each patient exam, based upon
576 the presence or absence of objective relevant medical findings.

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577 (c) Reasonable necessary medical care of injured employees
578 shall in all situations:
579 1. Utilize a high intensity, short duration treatment
580 approach that focuses on early activation and restoration of
581 function whenever possible.
582 2. Include reassessment of the treatment plans, regimes,
583 therapies, prescriptions, and functional limitations or
584 restrictions prescribed by the provider every 30 days.
585 3. Be focused on treatment of the individual employee's
586 specific clinical dysfunction or status and shall not be based
587 upon nondescript diagnostic labels.
588
589 All treatment shall be inherently scientifically logical, and the
590 evaluation or treatment procedure must match the documented
591 physiologic and clinical problem. Treatment shall match the type,
592 intensity, and duration of service required by the problem
593 identified.
594 (16) ~~(17)~~ Failure to comply with this section shall be
595 considered a violation of this chapter and is subject to
596 penalties as provided for in s. 440.525.
597 Section 2. Paragraph (c) of subsection (3) and subsection
598 (5) of section 440.15, Florida Statutes, are amended, present
599 paragraph (g) of subsection (3) is redesignated as paragraph (h),
600 and a new paragraph (g) is added to that subsection, to read:
601 440.15 Compensation for disability.--Compensation for
602 disability shall be paid to the employee, subject to the limits
603 provided in s. 440.12(2), as follows:
604 (3) PERMANENT IMPAIRMENT BENEFITS.--

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605 (c) All impairment income benefits shall be based on an
606 impairment rating using the impairment schedule referred to in
607 paragraph (b). Impairment income benefits are paid biweekly at
608 the rate of 75 percent of the employee's average weekly temporary
609 total disability benefit not to exceed the maximum weekly benefit
610 under s. 440.12; provided, however, that such benefits shall be
611 reduced by 50 percent for each week in which the employee has
612 earned income equal to or in excess of the employee's average
613 weekly wage. An employee's entitlement to impairment income
614 benefits begins the day after the employee reaches maximum
615 medical improvement or the expiration of temporary benefits,
616 whichever occurs earlier, and continues until the earlier of:
617 1. The expiration of a period computed at the rate of 3
618 weeks for each percentage point of impairment; or
619 2. The death of the employee.
620
621 ~~Impairment income benefits as defined by this subsection are~~
622 ~~payable only for impairment ratings for physical impairments.~~ If
623 ~~objective~~ medical findings can substantiate a permanent
624 psychiatric impairment resulting from the accident, permanent
625 impairment benefits shall be payable for permanent psychiatric
626 impairment in accordance with the Florida Impairment Rating
627 Guide, 1996 Edition ~~are limited for the permanent psychiatric~~
628 ~~impairment to 1-percent permanent impairment~~.
629 (g)1. All supplemental benefits must be paid in accordance
630 with this paragraph. An employee is entitled to supplemental
631 benefits as provided in this paragraph as of the expiration of
632 the impairment period if:
633 a. The employee has an impairment rating from the

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634 compensable injury of 15 percent or more as determined pursuant
635 to this chapter;
636 b. The employee has not returned to work or has returned to
637 work earning less than 80 percent of the employee's average
638 weekly wage as a direct result of the employee's impairment; and
639 c. The employee has in good faith attempted to obtain
640 employment commensurate with the employee's ability to work.
641 2. If an employee is not entitled to supplemental benefits
642 at the time of payment of the final weekly impairment income
643 benefit because the employee is earning at least 80 percent of
644 the employee's average weekly wage, the employee may become
645 entitled to supplemental benefits at any time within 1 year after
646 the impairment income benefit period ends if:
647 a. The employee earns wages that are less than 80 percent
648 of the employee's average weekly wage for a period of at least 90
649 days;
650 b. The employee meets the other requirements of
651 subparagraph 1.; and
652 c. The employee's decrease in earnings is a direct result
653 of the employee's impairment from the compensable injury.
654 3. If an employee earns wages that are at least 80 percent
655 of the employee's average weekly wage for a period of at least 90
656 days during which the employee is receiving supplemental
657 benefits, the employee ceases to be entitled to supplemental
658 benefits for the filing period. Supplemental benefits that have
659 been terminated shall be reinstated when the employee satisfies
660 the conditions enumerated in subparagraph 2. and files the
661 statement required under subparagraph 4. Notwithstanding any
662 other provision, if an employee is not entitled to supplemental

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663 benefits for 12 consecutive months, the employee ceases to be
664 entitled to any additional income benefits for the compensable
665 injury. If the employee is discharged within 12 months after
666 losing entitlement under this paragraph, benefits may be
667 reinstated if the employee was discharged at that time with the
668 intent to deprive the employee of supplemental benefits.
669 4. After the initial determination of supplemental
670 benefits, the employee must file a statement with the carrier
671 stating that the employee has earned less than 80 percent of the
672 employee's average weekly wage as a direct result of the
673 employee's impairment, stating the amount of wages that the
674 employee earned in the filing period, and stating that the
675 employee has in good faith sought employment commensurate with
676 the employee's ability to work. The statement must be filed
677 quarterly on a form and in the manner prescribed by the
678 department. The department may modify the filing period as
679 appropriate to an individual case. Failure to file a statement
680 relieves the carrier of liability for supplemental benefits for
681 the period during which a statement is not filed.
682 5. The carrier shall begin payment of supplemental benefits
683 no later than 7 days after the expiration date of the impairment
684 income benefit period and shall continue to timely pay those
685 benefits. The carrier may request a mediation conference for the
686 purpose of contesting the employee's entitlement to or the amount
687 of supplemental income benefits.
688 6. Supplemental benefits shall be calculated quarterly and
689 paid monthly. For purposes of calculating supplemental benefits,
690 80 percent of the employee's average weekly wage and the average
691 wages the employee has earned per week shall be compared

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692 quarterly. For purposes of this paragraph, if the employee is
693 offered a bona fide position of employment that the employee is
694 capable of performing, given the physical condition of the
695 employee and the geographic accessibility of the position, the
696 employee's weekly wages are considered equivalent to the weekly
697 wages for the position offered to the employee.
698 7. Supplemental benefits are payable at the rate of 80
699 percent of the difference between 80 percent of the employee's
700 average weekly wage determined pursuant to s. 440.14 and the
701 weekly wages the employee has earned during the reporting period,
702 not to exceed the maximum weekly income benefit under s. 440.12.
703 8. The department may by rule define terms that are
704 necessary to administer this section and forms and procedures
705 governing the method of payment of supplemental benefits for
706 dates of accidents before January 1, 1994, and for dates of
707 accidents on or after January 1, 1994.
708 9. The employee's eligibility for temporary benefits,
709 impairment income benefits, and supplemental benefits terminates
710 on the expiration of 401 weeks after the date of injury.
711 (5) SUBSEQUENT INJURY.--
712 (a) The fact that an employee has suffered previous
713 disability, impairment, anomaly, or disease, or received
714 compensation therefor, shall not preclude her or him from
715 benefits, as specified in paragraph (b), for a subsequent
716 aggravation or acceleration of the preexisting condition or
717 preclude benefits for death resulting therefrom, except that no
718 benefits shall be payable if the employee, at the time of
719 entering into the employment of the employer by whom the benefits
720 would otherwise be payable, falsely represents herself or himself

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721 in writing as not having previously been disabled or compensated
722 because of such previous disability, impairment, anomaly, or
723 disease and the employer detrimentally relies on the
724 misrepresentation. Compensation for temporary disability and
725 medical benefits is not subject to apportionment.
726 (b) If a compensable permanent impairment ~~injury,~~
727 ~~disability, or need for medical care, or any portion thereof,~~ is
728 a result of aggravation or acceleration of a preexisting
729 condition, or is the result of merger with a preexisting
730 condition, or is the result of merger with a preexisting
731 impairment, an employee eligible to receive impairment benefits
732 under subsection(3) shall receive such benefits for the total
733 impairment found to result, excluding the degree of impairment
734 existing at the time of the subject accident or injury ~~only the~~
735 ~~disabilities and medical treatment associated with such~~
736 ~~compensable injury shall be payable under this chapter, excluding~~
737 ~~the degree of disability or medical conditions existing at the~~
738 ~~time of the impairment rating or at the time of the accident,~~
739 ~~regardless of whether the preexisting condition was disabling at~~
740 ~~the time of the accident or at the time of the impairment rating~~
741 ~~and without considering whether the preexisting condition would~~
742 ~~be disabling without the compensable accident~~. The degree of
743 permanent impairment ~~or disability~~ attributable to the accident
744 or injury shall be compensated in accordance with this section~~,~~
745 ~~apportioning out the preexisting condition based on the~~
746 ~~anatomical impairment rating attributable to the preexisting~~
747 ~~condition. Medical benefits shall be paid apportioning out the~~
748 ~~percentage of the need for such care attributable to the~~
749 ~~preexisting condition~~. As used in this paragraph, "merger" means

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750 the combining of a preexisting permanent impairment ~~or disability~~
751 with a subsequent compensable permanent impairment ~~or disability~~
752 which, when the effects of both are considered together, result
753 in a permanent impairment ~~or disability~~ rating which is greater
754 than the sum of the two permanent impairment ~~or disability~~
755 ratings when each impairment ~~or disability~~ is considered
756 individually.
757 Section 3. Paragraph (d) of subsection (4) of section
758 440.25, Florida Statutes, is amended to read:
759 440.25 Procedures for mediation and hearings.--
760 (4)
761 (d) The final hearing shall be held within 210 days after
762 receipt of the petition for benefits in the county where the
763 injury occurred, if the injury occurred in this state, unless
764 otherwise agreed to between the parties and authorized by the
765 judge of compensation claims in the county where the injury
766 occurred. However, the claimant may waive the timeframes within
767 this section for good cause shown. If the injury occurred outside
768 the state and is one for which compensation is payable under this
769 chapter, then the final hearing may be held in the county of the
770 employer's residence or place of business, or in any other county
771 of the state that will, in the discretion of the Deputy Chief
772 Judge, be the most convenient for a hearing. The final hearing
773 shall be conducted by a judge of compensation claims, who shall,
774 within 30 days after final hearing or closure of the hearing
775 record, unless otherwise agreed by the parties, enter a final
776 order on the merits of the disputed issues. The judge of
777 compensation claims may enter an abbreviated final order in cases
778 in which compensability is not disputed. Either party may request

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779 separate findings of fact and conclusions of law. At the final
780 hearing, the claimant and employer may each present evidence with
781 respect to the claims presented by the petition for benefits and
782 may be represented by any attorney authorized in writing for such
783 purpose. When there is a conflict in the medical evidence
784 submitted at the hearing, the provisions of s. 440.13 shall
785 apply. A ~~The report or testimony of the expert medical advisor~~
786 ~~shall be admitted into evidence in a proceeding and all costs~~
787 ~~incurred in connection with such examination and testimony may be~~
788 ~~assessed as costs in the proceeding, subject to the provisions of~~
789 ~~s. 440.13. No~~ judge of compensation claims may not make a finding
790 of a degree of permanent impairment that is greater than the
791 greatest permanent impairment rating given the claimant by any
792 examining or treating physician, except upon stipulation of the
793 parties. Any benefit due but not raised at the final hearing
794 which was ripe, due, or owing at the time of the final hearing is
795 waived.
796 Section 4. Subsection (2) of section 440.32, Florida
797 Statutes, is amended to read:
798 440.32 Cost in proceedings brought without reasonable
799 ground.--
800 (2) If the judge of compensation claims or any court having
801 jurisdiction of proceedings in respect to any claims or defense
802 under this section determines that the proceedings were
803 maintained or continued frivolously, the cost of the proceedings,
804 including reasonable attorney's fees, shall be assessed against
805 the offending party or attorney. ~~If a penalty is assessed under~~
806 ~~this subsection, a copy of the order assessing the penalty must~~
807 ~~be forwarded to the appropriate grievance committee acting under~~

808 ~~the jurisdiction of the Supreme Court.~~ Penalties, fees, and costs
809 awarded under this provision may not be recouped from the party.
810 Section 5. Subsection (3) of section 440.34, Florida
811 Statutes, is amended to read:
812 440.34 Attorney's fees; costs.--
813 (3) If any party should prevail in any proceedings before a
814 judge of compensation claims or court, there shall be taxed
815 against the nonprevailing party the reasonable costs of such
816 proceedings, not to include attorney's fees. A claimant shall be
817 responsible for the payment of her or his own attorney's fees,
818 except that a claimant shall be entitled to recover a reasonable
819 attorney's fee from a carrier or employer:
820 (a) Against whom she or he successfully asserts a petition
821 for medical benefits only, if the claimant has not filed or is
822 not entitled to file at such time a claim for disability,
823 permanent impairment, wage-loss, or death benefits, arising out
824 of the same accident;
825 (b) In any case in which the employer or carrier files a
826 response to petition denying benefits with the Office of the
827 Judges of Compensation Claims and the injured person has employed
828 an attorney in the successful prosecution of the petition;
829 (c) In a proceeding in which a carrier or employer denies
830 that an accident occurred for which compensation benefits are
831 payable, and the claimant prevails on the issue of
832 compensability; or
833 (d) In cases where the claimant successfully prevails in
834 proceedings filed under s. 440.24 or s. 440.28.
835

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836 If the guideline fee payable by the employer or carrier pursuant
837 to this subsection is less than the fees paid to the attorney or
838 law firm employed by the employer or carrier to defend against
839 the benefits secured, the fee limitations as set forth in this
840 section do not apply, and the fee due the claimant's attorney
841 shall be equal to the fee paid to the attorney for the employer
842 or carrier or, in the alternative, a reasonable fee as determined
843 by the Judge of Compensation Claims. Regardless of the date
844 benefits were initially requested, attorney's fees may ~~shall~~ not
845 attach under this subsection until 30 days after the date the
846 carrier or employer, if self-insured, receives the petition.
847 Section 6. Paragraph (b) of subsection (6) of section
848 440.491, Florida Statutes, is amended to read:
849 440.491 Reemployment of injured workers; rehabilitation.--
850 (6) TRAINING AND EDUCATION.--
851 (b) When an employee who has attained maximum medical
852 improvement is unable to earn at least 80 percent of the
853 compensation rate and requires training and education to obtain
854 suitable gainful employment, the employer or carrier shall pay
855 the employee additional training and education temporary total
856 compensation benefits while the employee receives such training
857 and education for a period not to exceed 26 weeks, which period
858 may be extended for an additional 26 weeks or less, if such
859 extended period is determined to be necessary and proper by a
860 judge of compensation claims. The benefits provided under this
861 paragraph shall ~~not~~ be in addition to the 104 weeks as specified
862 in s. 440.15(2). However, a carrier or employer is not precluded
863 from voluntarily paying additional temporary total disability
864 compensation beyond that period. If an employee requires

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865 temporary residence at or near a facility or an institution
866 providing training and education which is located more than 50
867 miles away from the employee's customary residence, the
868 reasonable cost of board, lodging, or travel must be borne by the
869 department from the Workers' Compensation Administration Trust
870 Fund established by s. 440.50. An employee who refuses to accept
871 training and education that is recommended by the vocational
872 evaluator and considered necessary by the department will forfeit
873 any additional training and education benefits and any additional
874 payment for lost wages under this chapter. The department shall
875 adopt rules to implement this section, which shall include
876 requirements placed upon the carrier to notify the injured
877 employee of the availability of training and education benefits
878 as specified in this chapter. The department shall also include
879 information regarding the eligibility for training and education
880 benefits in informational materials specified in ss. 440.207 and
881 440.40.
882 Section 7. Paragraph (a) of subsection (3) of section
883 468.525, Florida Statutes, is amended to read:
884 468.525 License requirements.--
885 (3) Each employee leasing company licensed by the
886 department shall have a registered agent for service of process
887 in this state and at least one licensed controlling person. In
888 addition, each licensed employee leasing company shall comply
889 with the following requirements:
890 (a) The employment relationship with workers provided by
891 the employee leasing company to a client company shall be
892 established by written agreement between the leasing company and
893 the client, and written notice of that relationship shall be

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894 given by the employee leasing company to each worker who is
895 assigned to perform services at the client company's worksite.
896 The employee leasing company shall also provide written notice to
897 each worker that the employee leasing company shall obtain
898 workers' compensation coverage for each worker and that such
899 coverage will not expire or be terminated until at least 30 days
900 have elapsed after a notice of cancellation has been sent to the
901 worker.
902 Section 8. Subsection (3) of section 468.529, Florida
903 Statutes, is amended to read:
904 468.529 Licensee's insurance; employment tax; benefit
905 plans.--
906 (3) A licensed employee leasing company shall within 30
907 days after initiation of an employee leasing company contract
908 with a client company ~~or termination~~ notify, in a format
909 acceptable to the Department of Financial Services, its workers'
910 compensation insurance carrier, the Division of Workers'
911 Compensation of the Department of Financial Services, and the
912 state agency providing unemployment tax collection services under
913 contract with the Agency for Workforce Innovation through an
914 interagency agreement pursuant to s. 443.1316 of both the
915 initiation or the termination of the employee leasing company's
916 relationship with the ~~any~~ client company. A contract or policy of
917 insurance issued by a carrier to an employee leasing company may
918 not expire or be cancelled until at least 30 days have elapsed
919 after a notice of cancellation has been sent to the employee, the
920 department, and the employee leasing company. The department may
921 by rule prescribe the content of the notice of cancellation and

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922 specify the time, place, and manner in which the notice of
923 cancellation is to be served.
924 Section 9. This act shall take effect July 1, 2008.

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