A bill to be entitled

An act relating to workers' compensation system administration; amending s. 284.44, F.S.; revising duties of state agencies covered by the state risk management program with respect to funding costs for employees entitled to workers' compensation benefits; revising a definition; revising terminology; amending s. 440.02, F.S.; revising a definition for purposes of workers' compensation; amending s. 440.05, F.S.; revising requirements relating to submitting notice of election of exemption; amending s. 440.102, F.S.; conforming a cross-reference; amending s. 440.107, F.S.; revising effectiveness of stop-work orders and penalty assessment orders; amending s. 440.11, F.S.; revising immunity from liability standards for employers and employees using a help supply services company; amending s. 440.13, F.S.; deleting and revising definitions; revising health care provider requirements and responsibilities; deleting rulemaking authority and responsibilities of the Department of Financial Services; revising provider reimbursement dispute procedures; revising penalties for certain violations or overutilization of treatment; deleting certain Office of Insurance Regulation audit requirements; deleting provisions providing for removal of physicians from lists of those authorized to render medical care under certain conditions; amending s. 440.15, F.S.; revising limitations on

compensation for temporary total disability; amending s. 440.185, F.S.; revising and deleting penalties for noncompliance relating to duty of employer upon receipt of notice of injury or death; amending s. 440.20, F.S.; transferring certain responsibilities of the office to the department; deleting certain responsibilities of the department; amending s. 440.211, F.S.; deleting a requirement that a provision that is mutually agreed upon in any collective bargaining agreement be filed with the department; amending s. 440.385, F.S.; correcting cross-references; amending s. 440.491, F.S.; revising certain carrier reporting requirements; revising duties of the department upon referral of an injured employee; providing effective dates.

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

Section 1. Effective October 1, 2013, section 284.44, Florida Statutes, is amended to read:

284.44 Medical care and ~~salary~~ indemnification costs of state agencies.—

(1) It is the intent of the Legislature, through the implementation of this section, to provide state agencies with an increased incentive to become actively involved in the prevention and management of workers' compensation claims involving state employees.

(2) State agencies covered by the state risk management

program established under this part shall be responsible for funding an amount equal to 1.5 percent of all medical care and ~~initial salary~~ indemnification costs, for employees who are entitled to workers' compensation benefits pursuant to chapter 440, from funds appropriated to pay salaries and benefits.

(3) For the purposes of this section, "medical care and ~~salary~~ indemnification costs" means the payments made to employees for their medical care for work-related injuries or as indemnification for costs resulting from work-related injuries ~~temporary total disability benefits~~. ~~After an employee has been eligible for disability benefits for 10 weeks, salary indemnification costs shall be funded from the State Risk Management Trust Fund in accordance with the provisions of this part for those agencies insured by the fund.~~

(4) For the purpose of administering this section, the Division of Risk Management of the Department of Financial Services shall continue to pay all claims~~,~~ but shall be periodically reimbursed from funds of state agencies for medical care and ~~initial salary~~ indemnification costs for which they are responsible. The amount of reimbursement due from each agency shall be calculated quarterly and billed to the agency. The amount due shall be 1.5 percent of all medical care and indemnification costs paid for agency workers' compensation claims during the quarterly billing period.

(5) If a state agency demonstrates to the Executive Office of the Governor and the chairs of the legislative appropriations committees that no funds are available to pay medical care and ~~initial salary~~ indemnification costs for a specific quarterly

billing period ~~claim~~ pursuant to this section without adversely impacting its ability to perform statutory responsibilities, the Executive Office of the Governor may direct the Division of Risk Management to fund all medical care and ~~salary~~ indemnification costs for that specific quarterly billing period ~~claim~~ from the State Risk Management Trust Fund and waive the state agency reimbursement requirement.

(6) The Division of Risk Management shall prepare quarterly reports to the Executive Office of the Governor and the chairs of the legislative appropriations committees indicating for each state agency the total amount of medical care and ~~salary~~ indemnification benefits paid to claimants and the total amount of reimbursements from state agencies to the State Risk Management Trust Fund for ~~initial~~ costs for the previous quarter. These reports shall also include information for each state agency indicating ~~the number of cases and amounts of initial salary indemnification costs for~~ which reimbursement requirements were waived by the Executive Office of the Governor pursuant to this section.

(7) If a state agency fails to pay casualty ~~increase~~ premiums or medical care and ~~salary~~ indemnification reimbursements within 30 days after being billed, the Division of Risk Management shall advise the Chief Financial Officer. After verifying the accuracy of the billing, the Chief Financial Officer shall transfer the appropriate amount from any available funds of the delinquent state agency to the State Risk Management Trust Fund.

Section 2. Subsection (8) of section 440.02, Florida

Statutes, 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:

(8) "Construction industry" means for-profit activities involving any building, clearing, filling, excavation, or substantial improvement in the size or use of any structure or the appearance of any land. However, "construction" does not mean a homeowner's act of construction or the result of a construction upon his or her own premises, provided such premises are not intended to be sold, resold, or leased by the owner within 1 year after the commencement of construction. The division may, by rule, establish ~~standard industrial classification~~ codes and definitions thereof that ~~which~~ meet the criteria of the term "construction industry" as set forth in this section.

Section 3. Subsection (3) of section 440.05, Florida Statutes, is amended to read:

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

(3) Each officer of a corporation who is engaged in the construction industry and who elects an exemption from this chapter or who, after electing such exemption, revokes that exemption~~,~~ must submit a notice to such effect to the department on a form prescribed by the department. The notice of election to be exempt must be ~~which is~~ electronically submitted to the department by the officer of a corporation who is allowed to claim an exemption as provided by this chapter and must list the

name, federal tax identification number, date of birth, ~~Florida~~ driver license number or Florida identification card number, and all certified or registered licenses issued pursuant to chapter 489 held by the person seeking the exemption, the registration number of the corporation filed with the Division of Corporations of the Department of State, and the percentage of ownership evidencing the required ownership under this chapter. The notice of election to be exempt must identify each 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 officer electing an exemption is not entitled to benefits under this chapter, must provide that the election does not exceed exemption limits for officers provided in s. 440.02, and must certify that any employees of the corporation whose officer elects 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 that the notice meets the requirements of this subsection, the department shall issue a certification of the election to the officer, unless the department determines that the information contained in the notice is invalid. The department shall revoke a certificate of election to be exempt from coverage upon a determination by the department 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 name of the corporation listed in the request for exemption. A new certificate of election must be obtained each time the person is employed by a new or different 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, an officer who is a subcontractor or an officer of a corporate subcontractor must notify her or his contractor. Upon revocation of a certificate of election of exemption by the department, the department shall notify the workers' compensation carriers identified in the request for exemption.

Section 4. Paragraph (p) of subsection (5) of section 440.102, Florida Statutes, is amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(5) PROCEDURES AND EMPLOYEE PROTECTION.—All specimen collection and testing for drugs under this section shall be performed in accordance with the following procedures:

(p) All authorized remedial treatment, care, and attendance provided by a health care provider to an injured employee before medical and indemnity benefits are denied under this section must be paid for by the carrier or self-insurer. However, the carrier or self-insurer must have given reasonable notice to all affected health care providers that payment for treatment, care, and attendance provided to the employee after a

future date certain will be denied. A health care provider, as defined in s. 440.13(1)(g) ~~440.13(1)(h)~~, that refuses, without good cause, to continue treatment, care, and attendance before the provider receives notice of benefit denial commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 5. Paragraph (b) of subsection (7) of section 440.107, Florida Statutes, is amended to read:

440.107 Department powers to enforce employer compliance with coverage requirements.—

(7)

(b) Stop-work orders and penalty assessment orders issued under this section against a corporation, limited liability company, partnership, or sole proprietorship shall be in effect against any successor corporation or business entity that has one or more of the same principals or officers as the corporation, limited liability company, or partnership against which the stop-work order was issued and are engaged in the same or equivalent trade or activity.

Section 6. Subsection (2) of section 440.11, Florida Statutes, is amended to read:

440.11 Exclusiveness of liability.—

(2) The immunity from liability described in subsection (1) shall extend to an employer and to each employee of the employer which uses ~~utilizes~~ the services of the employees of a help supply services company, as set forth in North American Industrial Classification System Codes 561320 and 561330 ~~Standard Industry Code Industry Number 7363~~, when such

employees, whether management or staff, are acting in furtherance of the employer's business. An employee so engaged by the employer shall be considered a borrowed employee of the employer~~,~~ and, for the purposes of this section, shall be treated as any other employee of the employer. The employer shall be liable for and shall secure the payment of compensation to all such borrowed employees as required in s. 440.10, except when such payment has been secured by the help supply services company.

Section 7. Paragraphs (e) through (t) of subsection (1) of section 440.13, Florida Statutes, are redesignated as paragraphs (d) through (s), respectively, subsections (14) through (17) are renumbered as subsections (13) through (16), respectively, and present paragraphs (h) and (q) of subsection (1), paragraphs (a), (c), (e), and (i) of subsection (3), subsection (7), paragraph (b) of subsection (8), paragraph (b) of subsection (11), paragraph (e) of subsection (12), and present subsections (13) and (14) of that section are amended to read:

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

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

~~(d) "Certified health care provider" means a health care provider who has been certified by the department 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,~~

~~practice parameters, protocols of treatment, and rules which govern the provision of remedial treatment, care, and attendance.~~

(g) ~~(h)~~ "Health care provider" means a physician or any recognized practitioner licensed to provide ~~who provides~~ skilled services pursuant to a prescription or under the supervision or direction of a physician ~~and who has been certified by the department as a health care provider~~. The term "health care provider" includes a health care facility.

(p) ~~(q)~~ "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 department as a health care provider~~.

(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 department shall adopt rules to implement the certification of health care providers.~~

(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~~

~~department~~, unless the referral is for emergency treatment, and ~~the referral~~ must be made in accordance with practice parameters and protocols of treatment as provided for in this chapter.

(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.~~

(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 department 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 authorize such consultation or procedure unless the health care provider or facility is not authorized ~~or certified~~, unless such treatment is not in accordance with practice parameters and protocols of treatment established in this chapter, or unless a judge of compensation claims has determined that the consultation or procedure is not medically necessary, not in accordance with the practice parameters and protocols of treatment established in this chapter, or otherwise not 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.

(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 45 ~~30~~ days after receipt of notice of disallowance or adjustment of payment, petition the department to resolve the dispute. The health care provider ~~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 health care provider ~~petitioner~~ to submit such documentation to the department results in dismissal of the petition.

(b) The carrier must submit to the department within 30 ~~10~~ days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to timely submit such ~~the requested~~ documentation to the department within 30 ~~10~~ days constitutes a waiver of all objections to the petition.

(c) Within 120 ~~60~~ days after receipt of all documentation, the department must provide to the health care provider ~~petitioner~~, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The department must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, practice parameters, and protocols of treatment, in rendering its determination.

(d) If the department 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 department shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a health care provider ~~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 department:

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

2. An administrative fine assessed by the department 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 ~~attorney's~~ fee, for prosecuting the petition.

(8) PATTERN OR PRACTICE OF OVERUTILIZATION.—

(b) If the department 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 department, including a pattern or practice of providing treatment in excess of the practice parameters or protocols of

treatment, it may impose one or more of the following penalties:

1. An order ~~of the department~~ 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;~~

4.~~5.~~ An administrative fine of ~~assessed by the department in an amount not to exceed~~ $5,000 ~~per instance of overutilization or violation~~; and

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

(11) AUDITS.—

(b) The department shall monitor carriers as provided in this chapter ~~and the Office of Insurance Regulation shall audit insurers and group self-insurance funds as provided in s. 624.3161, to determine if medical bills are paid in accordance with this section and rules of the department and Financial Services Commission, respectively. Any employer, if self-insured, or carrier found by the department or Office of Insurance Regulation 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 department shall fine or otherwise discipline an employer or carrier, pursuant to this chapter or rules adopted~~

~~by the department, and the Office of Insurance Regulation shall fine or otherwise discipline an insurer or group self-insurance fund pursuant to the insurance code or rules adopted by the Financial Services Commission, for each late payment of compensation that is below the minimum 95-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 department or office, and an insurer or group self-insurance fund is subject to disciplinary action by the Office of Insurance Regulation~~.

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

(e) In addition to establishing the uniform schedule of maximum reimbursement allowances, the panel shall:

1. Take testimony, receive records, and collect data to evaluate the adequacy of the workers' compensation fee schedule, nationally recognized fee schedules and alternative methods of reimbursement to ~~certified~~ health care providers and health care facilities for inpatient and outpatient treatment and care.

2. Survey ~~certified~~ health care providers and health care facilities to determine the availability and accessibility of workers' compensation health care delivery systems for injured workers.

3. Survey carriers to determine the estimated impact on carrier costs and workers' compensation premium rates by implementing changes to the carrier reimbursement schedule or implementing alternative reimbursement methods.

4. Submit recommendations on or before January 1, 2003,

and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel.

~~(13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE AUTHORIZED TO RENDER MEDICAL CARE.—The department 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 department 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 department, including failure to adhere to practice parameters and protocols established in accordance with this chapter.~~

(13)~~(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. Carriers shall pay, disallow, or deny payment to health care providers in the manner and at times set forth in 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. Payment to health care providers or physicians shall be subject to the

medical fee schedule and applicable practice parameters and protocols, regardless of whether the health care provider or claimant is asserting that the payment should be made.

(b) Fees charged for remedial treatment, care, and attendance, except for independent medical examinations and consensus independent medical examinations, may not exceed the applicable fee schedules adopted under this chapter and department rule. Notwithstanding any other provision in this chapter, if a physician or health care provider specifically agrees in writing to follow identified procedures aimed at providing quality medical care to injured workers at reasonable costs, deviations from established fee schedules shall be permitted. Written agreements warranting deviations may include, but are not limited to, the timely scheduling of appointments for injured workers, participating in return-to-work programs with injured workers' employers, expediting the reporting of treatments provided to injured workers, and agreeing to continuing education, utilization review, quality assurance, precertification, and case management systems that are designed to provide needed treatment for injured workers.

(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.

Section 8. Paragraph (b) of subsection (2) of section 440.15, Florida Statutes, 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:

(2) TEMPORARY TOTAL DISABILITY.—

(b) Notwithstanding ~~the provisions of~~ paragraph (a), an employee who has sustained the loss of an arm, leg, hand, or foot, has been rendered a paraplegic, paraparetic, quadriplegic, or quadriparetic, or has lost the sight of both eyes shall be paid temporary total disability of 80 percent of her or his average weekly wage. The increased temporary total disability compensation provided for in this paragraph must not extend beyond 6 months from the date of the accident; however, such benefits shall not be due or payable if the employee is eligible for, entitled to, or collecting permanent total disability benefits. The compensation provided by this paragraph is not subject to the limits provided in s. 440.12(2)~~, but instead is subject to a maximum weekly compensation rate of $700~~. If, at the conclusion of this period of increased temporary total disability compensation, the employee is still temporarily totally disabled, the employee shall continue to receive temporary total disability compensation as set forth in paragraphs (a) and (c). The period of time the employee has received this increased compensation will be counted as part of, and not in addition to, the maximum periods of time for which the employee is entitled to compensation under paragraph (a) but not paragraph (c).

Section 9. Subsection (9) of section 440.185, Florida Statutes, is amended to read:

440.185 Notice of injury or death; reports; penalties for

violations.—

(9) Any employer or carrier who fails or refuses to timely send any form, report, or notice required by this section shall be subject to an administrative fine by the department not to exceed $500 ~~$1,000~~ for each such failure or refusal. ~~If, within 1 calendar year, an employer fails to timely submit to the carrier more than 10 percent of its notices of injury or death, the employer shall be subject to an administrative fine by the department not to exceed $2,000 for each such failure or refusal.~~ However, any employer who fails to notify the carrier of an ~~the~~ injury on the prescribed form or by letter within the 7 days required in subsection (2) shall be liable for the administrative fine, which shall be paid by the employer and not the carrier. Failure by the employer to meet its obligations under subsection (2) shall not relieve the carrier from liability for the administrative fine if it fails to comply with subsections (4) and (5).

Section 10. Paragraph (b) of subsection (8) and paragraphs (a), (b), and (c) of subsection (12) of section 440.20, Florida Statutes, are amended to read:

440.20 Time for payment of compensation and medical bills; penalties for late payment.—

(8)

(b) In order to ensure carrier compliance under this chapter, the department ~~office~~ shall monitor, audit, and investigate the performance of carriers. The department ~~office~~ shall require that all compensation benefits be ~~are~~ timely paid in accordance with this section. The department ~~office~~ shall

impose penalties for late payments of compensation that are below a minimum 95-percent ~~95 percent~~ timely payment performance standard. The carrier shall pay to the Workers' Compensation Administration Trust Fund a penalty of:

1. Fifty dollars per number of installments of compensation below the 95-percent ~~95 percent~~ timely payment performance standard and equal to or greater than a 90-percent ~~90 percent~~ timely payment performance standard.

2. One hundred dollars per number of installments of compensation below a 90-percent ~~90 percent~~ timely payment performance standard.

This section does not affect the imposition of any penalties or interest due to the claimant. If a carrier contracts with a servicing agent to fulfill its administrative responsibilities under this chapter, the payment practices of the servicing agent are deemed the payment practices of the carrier for the purpose of assessing penalties against the carrier.

(12)

(a) Liability of an employer for future payments of compensation may not be discharged by advance payment unless prior approval of a judge of compensation claims ~~or the department~~ has been obtained as hereinafter provided. The approval shall not constitute an adjudication of the claimant's percentage of disability.

(b) When the claimant has reached maximum recovery and returned to her or his former or equivalent employment with no substantial reduction in wages, such approval of a reasonable

advance payment of a part of the compensation payable to the claimant may be given informally by letter by a judge of compensation claims ~~or by the department~~.

(c) In the event the claimant has not returned to the same or equivalent employment with no substantial reduction in wages or has suffered a substantial loss of earning capacity or a physical impairment, actual or apparent:

1. An advance payment of compensation not in excess of $2,000 may be approved informally by letter, without hearing, by any judge of compensation claims or the Chief Judge.

2. An advance payment of compensation not in excess of $2,000 may be ordered by any judge of compensation claims after giving the interested parties an opportunity for a hearing thereon pursuant to not less than 10 days' notice by mail, unless such notice is waived, and after giving due consideration to the interests of the person entitled thereto. When the parties have stipulated to an advance payment of compensation not in excess of $2,000, such advance may be approved by an order of a judge of compensation claims, with or without hearing, or informally by letter by any such judge of compensation claims~~, or by the department~~, if such advance is found to be for the best interests of the person entitled thereto.

3. When the parties have stipulated to an advance payment in excess of $2,000, ~~subject to the approval of the department,~~ such payment may be approved by a judge of compensation claims by order if the judge finds that such advance payment is for the best interests of the person entitled thereto and is reasonable

under the circumstances of the particular case. The judge of compensation claims shall make or cause to be made such investigations as she or he considers necessary concerning the stipulation and, in her or his discretion, may have an investigation of the matter made. The stipulation and the report of any investigation shall be deemed a part of the record of the proceedings.

Section 11. Subsection (1) of section 440.211, Florida Statutes, is amended to read:

440.211 Authorization of collective bargaining agreement.—

(1) Subject to the limitation stated in subsection (2), a provision that is mutually agreed upon in any collective bargaining agreement ~~filed with the department~~ between an individually self-insured employer or other employer upon consent of the employer's carrier and a recognized or certified exclusive bargaining representative establishing any of the following shall be valid and binding:

(a) An alternative dispute resolution system to supplement, modify, or replace the provisions of this chapter which may include, but is not limited to, conciliation, mediation, and arbitration. Arbitration held pursuant to this section shall be binding on the parties.

(b) The use of an agreed-upon list of ~~certified~~ health care providers of medical treatment which may be the exclusive source of all medical treatment under this chapter.

(c) The use of a limited list of physicians to conduct independent medical examinations which the parties may agree shall be the exclusive source of independent medical examiners

pursuant to this chapter.

(d) A light-duty, modified-job, or return-to-work program.

(e) A vocational rehabilitation or retraining program.

Section 12. Paragraph (b) of subsection (1) of section 440.385, Florida Statutes, is amended to read:

440.385 Florida Self-Insurers Guaranty Association, Incorporated.—

(1) CREATION OF ASSOCIATION.—

(b) A member may voluntarily withdraw from the association when the member voluntarily terminates the self-insurance privilege and pays all assessments due to the date of such termination. However, the withdrawing member shall continue to be bound by the provisions of this section relating to the period of his or her membership and any claims charged pursuant thereto. The withdrawing member who is a member on or after January 1, 1991, shall also be required to provide to the association upon withdrawal, and at 12-month intervals thereafter, satisfactory proof, including, if requested by the association, a report of known and potential claims certified by a member of the American Academy of Actuaries, that it continues to meet the standards of s. 440.38(1)(b) ~~440.38(1)(b)1.~~ in relation to claims incurred while the withdrawing member exercised the privilege of self-insurance. Such reporting shall continue until the withdrawing member demonstrates to the association that there is no remaining value to claims incurred while the withdrawing member was self-insured. If a withdrawing member fails or refuses to timely provide an actuarial report to the association, the association may obtain an order from a

circuit court requiring the member to produce such a report and ordering any other relief that the court determines appropriate. The association is entitled to recover all reasonable costs and attorney ~~attorney's~~ fees expended in such proceedings. If during this reporting period the withdrawing member fails to meet the standards of s. 440.38(1)(b) ~~440.38(1)(b)1.~~, the withdrawing member who is a member on or after January 1, 1991, shall thereupon, and at 6-month intervals thereafter, provide to the association the certified opinion of an independent actuary who is a member of the American Academy of Actuaries of the actuarial present value of the determined and estimated future compensation payments of the member for claims incurred while the member was a self-insurer, using a discount rate of 4 percent. With each such opinion, the withdrawing member shall deposit with the association security in an amount equal to the value certified by the actuary and of a type that is acceptable for qualifying security deposits under s. 440.38(1)(b). The withdrawing member shall continue to provide such opinions and to provide such security until such time as the latest opinion shows no remaining value of claims. The association has a cause of action against a withdrawing member, and against any successor of a withdrawing member, who fails to timely provide the required opinion or who fails to maintain the required deposit with the association. The association shall be entitled to recover a judgment in the amount of the actuarial present value of the determined and estimated future compensation payments of the withdrawing member for claims incurred during the time that the withdrawing member exercised the privilege of

self-insurance, together with reasonable attorney ~~attorney's~~ fees. The association is also entitled to recover reasonable attorney ~~attorney's~~ fees in any action to compel production of any actuarial report required by this section. For purposes of this section, the successor of a withdrawing member means any person, business entity, or group of persons or business entities, which holds or acquires legal or beneficial title to the majority of the assets or the majority of the shares of the withdrawing member.

Section 13. Paragraph (a) of subsection (3) and paragraph (a) of subsection (6) of section 440.491, Florida Statutes, are amended to read:

440.491 Reemployment of injured workers; rehabilitation.—

(3) REEMPLOYMENT STATUS REVIEWS AND REPORTS.—

(a) When an employee who has suffered an injury compensable under this chapter is unemployed 60 days after the date of injury and is receiving benefits for temporary total disability, temporary partial disability, or wage loss~~,~~ and has not yet been provided medical care coordination and reemployment services voluntarily by the carrier, the carrier must determine whether the employee is likely to return to work and must report its determination to ~~the department and~~ the employee. The report shall include the identification of both the carrier and the employee, ~~and~~ the carrier claim number, and any case number assigned by the Office of the Judges of Compensation Claims. The carrier must thereafter determine the reemployment status of the employee at 90-day intervals as long as the employee remains unemployed, is not receiving medical care coordination or

reemployment services, and is receiving the benefits specified in this subsection.

(6) TRAINING AND EDUCATION.—

(a) Upon referral of an injured employee by the carrier, or upon the request of an injured employee, the department shall conduct a training and education screening to determine whether it should refer the employee for a vocational evaluation ~~and, if appropriate~~, approve training and education, or approve other vocational services for the employee. At the time of such referral, the carrier shall provide the department a copy of any reemployment assessment or reemployment plan provided to the carrier by a rehabilitation provider. The department may not approve formal training and education programs unless it determines, after consideration of the reemployment assessment, that the reemployment plan is likely to result in return to suitable gainful employment. The department may ~~is authorized to~~ expend moneys from the Workers' Compensation Administration Trust Fund, established by s. 440.50, to secure appropriate training and education at a Florida public college or at a career center established under s. 1001.44, or to secure other vocational services when necessary to satisfy the recommendation of a vocational evaluator. As used in this paragraph, "appropriate training and education" includes securing a general education diploma (GED), if necessary. The department shall by rule establish training and education standards pertaining to employee eligibility, course curricula and duration, and associated costs. For purposes of this subsection, training and education services may be secured from additional providers if:

1. The injured employee currently holds an associate degree and requests to earn a bachelor's degree not offered by a Florida public college located within 50 miles from his or her customary residence;

2. The injured employee's enrollment in an education or training program in a Florida public college or career center would be significantly delayed; or

3. The most appropriate training and education program is available only through a provider other than a Florida public college or career center or at a Florida public college or career center located more than 50 miles from the injured employee's customary residence.

Section 14. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2013.