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LEGISLATIVE ACTION

Senate . House

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Floor: 1/RS/2R .

05/05/2017 11:31 AM .

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Senator Bradley moved the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (40) 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:

(40) "Specificity" means information on the petition for benefits sufficient to put the employer or carrier on notice of

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the exact statutory classification and outstanding time period for each requested benefit, the specific amount of each requested benefit, the calculation used for computing the requested benefit, ~~of benefits being requested~~ and ~~includes~~ a detailed explanation of any benefits received that should be increased, decreased, changed, or otherwise modified. If the petition is for medical benefits, the information must ~~shall~~ include specific details as to why such benefits are being requested, why such benefits are medically necessary, and why current treatment, if any, is not sufficient. Any petition requesting alternate or other medical care, including, but not limited to, petitions requesting psychiatric or psychological treatment, must specifically identify the physician, as defined in s. 440.13(1), who is recommending such treatment. A copy of a report from such physician making the recommendation for alternate or other medical care must ~~shall~~ also be attached to the petition. A judge of compensation claims may ~~shall~~ not order such treatment if a physician is not recommending such treatment.

Section 2. Subsection (3) of section 440.093, Florida Statutes, is amended to read:

440.093 Mental and nervous injuries.—

(3) Subject to the payment of permanent benefits under s. 440.15, in no event shall temporary benefits for a compensable mental or nervous injury be paid for more than 6 months after the date of maximum medical improvement for the injured employee's physical injury or injuries, which shall be included in the maximum number of ~~period of 104~~ weeks as provided in s. 440.15(2) and (4). Mental or nervous injuries are compensable

only in accordance with the terms of this section.

Section 3. Paragraph (c) of subsection (3) of section 440.105, Florida Statutes, is amended to read:

440.105 Prohibited activities; reports; penalties; limitations.—

(3) Whoever violates any provision of this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) Except for an attorney who is retained by or for an injured worker and who receives a fee or other consideration from or on behalf of such worker, it is unlawful for any ~~attorney or other~~ person, in his or her individual capacity or in his or her capacity as a public or private employee, or for any firm, corporation, partnership, or association to receive any fee or other consideration or any gratuity from a person on account of services rendered for a person in connection with any proceedings arising under this chapter, unless such fee, consideration, or gratuity is approved by a judge of compensation claims or by the Deputy Chief Judge of Compensation Claims.

Section 4. Paragraphs (d) and (i) of subsection (3) and paragraph (a) of subsection (12) of section 440.13, Florida Statutes, are amended to read:

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

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(d) A carrier ~~must respond~~, by telephone or in writing, must authorize, deny, or inform the provider of material deficiencies that prevent authorization or denial in response to


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a request for authorization from an authorized health care provider by the close of the third business day after receipt of the request. A carrier who fails to respond to a written request for authorization for referral for medical treatment by the close of the third business day after receipt of the request consents to the medical necessity for such treatment. All such requests must be made to the carrier. Notice to the employer ~~carrier~~ does not include notice to the carrier ~~employer~~.

(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, unless the carrier has failed to authorize, deny, or inform the provider of material deficiencies that prevent authorization or denial ~~respond~~ within 10 days after ~~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, 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.

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

(a)1. A three-member panel is created, consisting of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The Governor shall appoint a new member to the panel within 120 days after a vacancy occurs. If the Governor fails to fill such vacancy, the Chief Financial Officer shall appoint a new member to the panel within 120 days after the expiration of the Governor's opportunity to fill the vacancy, subject to confirmation by the Senate. If the Chief Financial Officer fails to fill such vacancy, authority to appoint such member reverts to the Governor.

2. The panel shall annually adopt ~~determine~~ statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1,


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1994, to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in observation status, which shall not exceed 23 hours. All compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges, except as otherwise provided by this subsection. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.

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. For prescription medication purchased under the requirements of this subsection, a dispensing practitioner shall not possess such medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days of the dispensing


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practitioner taking possession of that medication.

Section 5. Paragraph (a) of subsection (2), paragraph (d) of subsection (3), paragraphs (a) and (e) of subsection (4), and subsection (6) of section 440.15, Florida Statutes, are amended, and subsection (13) is added to that section, 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.—

(a) Subject to subparagraph (3)(d)3. and subsections ~~subsection~~ (7) and (13), in case of disability total in character but temporary in quality, 66 2/3 or 66.67 percent of the average weekly wages shall be paid to the employee during the continuance thereof, ~~not to exceed 104 weeks~~ except as provided in this subsection and~~,~~ s. 440.12(1)~~, and s. 440.14(3)~~. Once the employee reaches the maximum number of weeks allowed, or the employee reaches overall ~~the date of~~ maximum medical improvement, whichever occurs earlier, temporary disability benefits shall cease and the injured worker's permanent impairment shall be determined. If the employee reaches the maximum number of weeks allowed, but has not reached overall maximum medical improvement, benefits shall be provided pursuant to subparagraph (3)(d)3.

(3) PERMANENT IMPAIRMENT BENEFITS.—

(d) After the employee has been certified by a doctor as having reached maximum medical improvement or 6 weeks before the expiration of temporary benefits, whichever occurs earlier, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating, using the impairment schedule

referred to in paragraph (b). If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation must be submitted to the treating doctor, the employee, and the carrier within 10 days after the evaluation. The treating doctor must indicate to the carrier agreement or disagreement with the other doctor's certification and evaluation.

1. The certifying doctor shall issue a written report to the employee and the carrier certifying that maximum medical improvement has been reached, stating the impairment rating to the body as a whole, and providing any other information required by the department by rule. The carrier shall establish an overall maximum medical improvement date and permanent impairment rating, based upon all such reports.

2. Within 14 days after the carrier's knowledge of each maximum medical improvement date and impairment rating to the body as a whole upon which the carrier is paying benefits, the carrier shall report such maximum medical improvement date and, when determined, the overall maximum medical improvement date and associated impairment rating to the department in a format as set forth in department rule. If the employee has not been certified as having reached overall maximum medical improvement before the expiration of 254 ~~98~~ weeks after the date temporary disability benefits begin to accrue, the carrier shall notify the treating doctor of the requirements of this section.

3. If an employee receiving benefits under subsection (2) has not reached overall maximum medical improvement before receiving the maximum number of weeks of temporary disability benefits, the maximum number of weeks are extended for up to an


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additional 26 weeks. If the employee has not reached overall maximum medical improvement after receiving the additional weeks allowed under this subparagraph, a judge of compensation claims, upon petition, must determine the employee's current eligibility for benefits under this subsection and subsection (1).

4. If an employee receiving benefits under subsection (4) has not reached overall maximum medical improvement before receiving the maximum number of weeks of temporary disability benefits, the employee shall receive benefits under this subsection in accordance with the greatest single impairment rating assigned to the employee. Impairment benefits received under this subparagraph must be credited against indemnity benefits subsequently due to the employee.

(4) TEMPORARY PARTIAL DISABILITY.—

(a) Subject to subparagraph (3)(d)3. and subsections ~~subsection~~ (7) and (13), in case of temporary partial disability, compensation shall be equal to 80 percent of the difference between 80 percent of the employee's average weekly wage and the salary, wages, and other remuneration the employee is able to earn postinjury, as compared weekly; however, weekly temporary partial disability benefits may not exceed an amount equal to 66 2/3 or 66.67 percent of the employee's average weekly wage at the time of accident. In order to simplify the comparison of the preinjury average weekly wage with the salary, wages, and other remuneration the employee is able to earn postinjury, the department may by rule provide for payment of the initial installment of temporary partial disability benefits to be paid as a partial week so that payment for remaining weeks of temporary partial disability can coincide as closely as

possible with the postinjury employer's work week. The amount determined to be the salary, wages, and other remuneration the employee is able to earn shall in no case be less than the sum actually being earned by the employee, including earnings from sheltered employment. Benefits shall be payable under this subsection only if overall maximum medical improvement has not been reached and the medical conditions resulting from the accident create restrictions on the injured employee's ability to return to work.

(e) Subject to subparagraph (3)(d)3. and subsections (7) and (13), such benefits shall be paid during the continuance of such disability~~, not to exceed a period of 104 weeks,~~ as provided by this subsection and subsection (2). ~~Once the injured employee reaches the maximum number of weeks, temporary disability benefits cease and the injured worker's permanent impairment must be determined.~~ If the employee is terminated from postinjury employment based on the employee's misconduct, temporary partial disability benefits are not payable as provided for in this section. The department shall by rule specify forms and procedures governing the method and time for payment of temporary disability benefits for dates of accidents before January 1, 1994, and for dates of accidents on or after January 1, 1994.

(6) EMPLOYEE REFUSES EMPLOYMENT.—If an injured employee refuses employment suitable to the capacity thereof, offered to or procured therefor, such employee shall not be entitled to any compensation at any time during the continuance of such refusal unless at any time in the opinion of the judge of compensation claims such refusal is justifiable. ~~Time periods for the payment~~

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~~of benefits in accordance with this section shall be counted in determining the limitation of benefits as provided for in paragraphs (2)(a), (3)(c), and (4)(b).~~

(13) MAXIMUM BENEFITS ALLOWED.—An employee may not receive more than 260 weeks of temporary total disability benefits pursuant to subsection (2), temporary partial disability benefits pursuant to subsection (4), or temporary total disability benefits pursuant to s. 440.491, or a combination thereof, except as provided in subparagraph (3)(d)3.

Section 6. Subsections (2), (4), (5), and (7) of section 440.192, Florida Statutes, are amended to read:

440.192 Procedure for resolving benefit disputes.—

(2) Upon receipt, the Office of the Judges of Compensation Claims shall review each petition and shall dismiss each petition or any portion of such a petition that does not on its face meet the requirements of this section and the definition of specificity under s. 440.02 and specifically identify or itemize the following:

(a) The name, address, and telephone number~~, and social security number~~ of the employee.

(b) The name, address, and telephone number of the employer.

(c) A detailed description of the injury and cause of the injury, including the county in this state or, if outside this state, the state ~~location~~ of the occurrence and the date or dates of the accident.

(d) A detailed description of the employee's job, work responsibilities, and work the employee was performing when the injury occurred.

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(e) The specific time period for which compensation and the specific classification of compensation were not timely provided.

(f) The specific date of maximum medical improvement, character of disability, and specific statement of all benefits or compensation that the employee is seeking. A claim for permanent benefits must include the specific date of maximum medical improvement and the specific date that such permanent benefits are claimed to begin.

(g) All specific travel costs to which the employee believes she or he is entitled, including dates of travel and purpose of travel, means of transportation, and mileage and including the date the request for mileage was filed with the carrier and a copy of the request filed with the carrier.

(h) A specific listing of all medical charges alleged unpaid, including the name and address of the medical provider, the amounts due, and the specific dates of treatment.

(i) The type or nature of treatment care or attendance sought and the justification for such treatment. If the employee is under the care of a physician for an injury identified under paragraph (c), a copy of the physician’s request, authorization, or recommendation for treatment, care, or attendance must accompany the petition.

(j) The specific amount of compensation claimed and the methodology used to calculate the average weekly wage, if the average weekly wage calculated by the employer or carrier is disputed; otherwise, the average weekly wage and corresponding compensation calculated by the employer or carrier are presumed to be accurate.


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(k) ~~(j)~~ Specific explanation of any other disputed issue that a judge of compensation claims will be called to rule upon.

(l) Evidence of a good faith effort to resolve the dispute pursuant to subsection (4).

The dismissal of any petition or portion of such a petition under this subsection ~~section~~ is without prejudice and does not require a hearing.

(4) Before filing a petition, the claimant, or, if the claimant is represented by counsel, the claimant's attorney, must make a good faith effort to resolve the dispute. The petition must include evidence and a certification by the claimant or, if the claimant is represented by counsel, the claimant's attorney, stating that the claimant, or attorney if the claimant is represented by counsel, has made a good faith effort to resolve the dispute and that the claimant or attorney was unable to resolve the dispute with the carrier or employer, if self-insured. If the petition is not dismissed under subsection (2), the judge of compensation claims must review the evidence required under this subsection and determine, using independent discretion, whether the claimant or claimant's attorney made a good faith effort to resolve the dispute. Upon determining that the claimant or claimant's attorney did not make a good faith effort to resolve the dispute, the judge of compensation claims must dismiss the petition and may impose sanctions to ensure compliance with this section. Such sanctions may include an order to pay to the carrier or employer the reasonable expenses incurred because of the filing of the petition, including attorney fees, not to exceed $200 per hour,

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based on the number of necessary hours related to the determination that the claimant or, if the claimant is represented by counsel, the claimant's attorney has not made a good faith effort to resolve the dispute.

(5)(a) All motions to dismiss must state with particularity the basis for the motion. The judge of compensation claims shall enter an order upon such motions without hearing, unless good cause for hearing is shown. Dismissal of any petition or portion of a petition under this subsection is without prejudice.

(b) Upon motion that a petition or portion of a petition be dismissed for lack of specificity, the judge of compensation claims shall enter an order on the motion, unless stipulated in writing by the parties, within 10 days after the motion is filed, or, if good cause for hearing is shown, within 20 days after hearing on the motion. When any petition or portion of a petition is dismissed for lack of specificity under this subsection, the claimant must be allowed 20 days after the date of the order of dismissal in which to file an amended petition. Any grounds for dismissal for lack of specificity under this section which are not asserted within 30 days after receipt of the petition for benefits are thereby waived.

(7) Notwithstanding ~~the provisions of~~ s. 440.34, a judge of compensation claims may not award attorney ~~attorney's~~ fees payable by the employer or carrier for services expended or costs incurred before ~~prior to~~ the filing of a petition ~~that does not meet the requirements of this section~~.

Section 7. Paragraphs (c) and (j) of subsection (4) of section 440.25, Florida Statutes, are amended to read:

440.25 Procedures for mediation and hearings.—

(4)

(c) The judge of compensation claims shall give the interested parties at least 14 days' advance notice of the final hearing, served upon the interested parties by mail or by electronic means approved by the Deputy Chief Judge. At least 5 days before the final hearing, the claimant's attorney must file with the judge of compensation claims and serve on all interested parties a personal attestation detailing his or her hours to date, which specifically allocates the hours by each benefit claimed, and accounting for hours relating to multiple benefits in a manner that apportions such hours by percentage, in whole numbers, to each benefit.

(j) A judge of compensation claims may not award interest on unpaid medical bills and the amount of such bills may not be used to calculate the amount of interest awarded. Regardless of the date benefits were initially requested, attorney ~~attorney's~~ fees do not attach under this subsection until 45 ~~30~~ days after the date the carrier ~~or self-insured employer~~ receives the petition.

Section 8. Section 440.34, Florida Statutes, is amended to read

440.34 Attorney ~~Attorney's~~ fees; costs.—

(1) A judge of compensation claims may award attorney fees payable to the claimant pursuant to this section to be paid by the employer or carrier. An employer or carrier may not pay a fee, gratuity, or other consideration ~~may not be paid~~ for a claimant in connection with any proceedings arising under this chapter, unless approved by the judge of compensation claims or court having jurisdiction over such proceedings. Attorney fees


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awarded ~~Any attorney's fee approved~~ by a judge of compensation claims for benefits secured on behalf of a claimant must equal to 20 percent of the first $5,000 of the amount of the benefits secured, 15 percent of the next $5,000 of the amount of the benefits secured, 10 percent of the remaining amount of the benefits secured to be provided during the first 10 years after the date the claim is filed, and 5 percent of the benefits secured after 10 years. A ~~The judge of compensation claims shall not approve a compensation order, a joint stipulation for lump-sum settlement, a stipulation or agreement between a claimant and his or her attorney, or any other agreement related to benefits under this chapter which provides for an attorney's fee in excess of the amount permitted by this section. The judge of compensation claims is not required to approve any~~ retainer agreement between the claimant and his or her attorney is not subject to approval by a judge of compensation claims but must be filed with the Office of the Judges of Compensation Claims. Notwithstanding s. 440.22, attorney fees are a lien upon compensation payable to the claimant. A retainer agreement may not place any portion of the employee's compensation into an escrow account until benefits are secured. ~~The retainer agreement as to fees and costs may not be for compensation in excess of the amount allowed under this subsection or subsection (7).~~

(2)(a) In awarding a claimant's attorney fees ~~attorney's fee~~, a ~~the~~ judge of compensation claims must ~~shall~~ consider only those benefits secured by the attorney. ~~An~~ Attorney ~~is not entitled to attorney's~~ fees are not due in any of the following circumstances:

1. For representation in any issue that was ripe, due, and owing and that reasonably could have been addressed, but was not addressed, during the pendency of other issues for the same injury;

2. On claimant attorney hours related to a benefit upon which the claimant did not prevail; or

3. On claimant attorney hours that the judge of compensation claims apportions to benefits upon which the claimant did not prevail, pursuant to paragraph (5)(d).

(b) The amount, statutory basis, and type of benefits obtained through legal representation shall be listed on all attorney ~~attorney's~~ fees awarded by a ~~the~~ judge of compensation claims. For purposes of this section, the term "benefits secured" does not include future medical benefits to be provided ~~on any date~~ more than 5 years after the date the petition ~~claim~~ is filed. In the event an offer to settle an issue pending before a judge of compensation claims, including attorney ~~attorney's~~ fees ~~as provided for in this section~~, is communicated in writing to the claimant or the claimant's attorney at least 30 days before ~~prior to~~ the trial date on such issue, for purposes of calculating the amount of attorney ~~attorney's~~ fees to be taxed against the employer or carrier, the term "benefits secured" includes ~~shall be deemed to include~~ only that amount awarded to the claimant above the amount specified in the offer to settle. If multiple issues are pending before a ~~the~~ judge of compensation claims, said offer of settlement must ~~shall~~ address each issue pending and shall state explicitly whether or not the offer on each issue is severable. The written offer must ~~shall~~ also unequivocally state whether or not it includes medical


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witness fees and expenses and all other costs associated with the claim.

(3) If a ~~any~~ party prevails ~~should prevail~~ in ~~any~~ proceedings before a judge of compensation claims or court, there shall be taxed against the nonprevailing party the reasonable costs of such proceedings, not to include attorney ~~attorney's~~ fees. A claimant is responsible for the payment of her or his own attorney ~~attorney's~~ fees, except that a claimant is entitled to recover attorney fees ~~an attorney's fee~~ in an amount equal to the amount provided for in subsection (1), subsection (5), or subsection (6) ~~(7)~~ from a carrier or employer:

(a) Against whom she or he successfully asserts a petition for medical benefits only, if the claimant has not filed or is not entitled to file at such time a claim for disability, permanent impairment, ~~wage-loss,~~ or death benefits, arising out of the same accident;

(b) In a ~~any~~ case in which the employer or carrier files a response to petition denying benefits with the Office of the Judges of Compensation Claims and the injured person has employed an attorney in the successful prosecution of the petition;

(c) In a proceeding in which a carrier or employer denies that an accident occurred for which compensation benefits are payable, and the claimant prevails on the issue of compensability; or

(d) In cases in which ~~where~~ the claimant successfully prevails in proceedings filed under s. 440.24 or s. 440.28.

Regardless of the date benefits were initially requested, attorney ~~attorney's~~ fees do ~~shall~~ not attach under this subsection until 45 ~~30~~ days after the date the carrier or employer~~, if self-insured,~~ receives the petition.

~~(4) In such cases in which the claimant is responsible for the payment of her or his own attorney's fees, such fees are a lien upon compensation payable to the claimant, notwithstanding s. 440.22.~~

(4)~~(5)~~ If ~~any~~ proceedings are had for review of any claim, award, or compensation order before any court, the court may, in its discretion, award the injured employee or dependent attorney fees ~~an attorney's fee~~ to be paid by the employer or carrier~~, in its discretion, which shall be paid~~ as the court may direct.

(5)(a) As used in this subsection, the term:

1. "Attorney hours" means the number of hours necessary for the claimant's attorney to obtain the benefits secured, as determined by a judge of compensation claims. The term only includes hours expended by the claimant's attorney reasonably related to claimed benefits upon which the claimant prevailed.

2. "Customary fee" means the average hourly rate that an attorney for a claimant customarily charges in the same locality for similar legal services under this chapter, as determined by a judge of compensation claims.

3. "Departure fee" means the amount of attorney fees calculated by a judge of compensation claims in place of the fee allowed under subsection (1) when attorney fees are due under this section.

(b) A departure fee under this subsection is in place of, not in addition to, the amount allowed under subsection (1) or

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subsection (6).

(c) Upon a petition for a departure fee, a judge of compensation claims may depart from the attorney fees amount set forth in subsection (1) upon a finding that the attorney fees provided for in that subsection are less than 60 percent or greater than 125 percent of the customary fee when the amount allowed under subsection (1) is converted to an hourly rate by dividing that amount by the attorney hours necessary to obtain the benefits secured.

(d)1. When resolving a petition for a departure fee under this subsection, a judge of compensation claims must determine the number of attorney hours by making detailed findings that specifically allocate and account for the attorney hours to each benefit claimed by the claimant's attorney that, in the independent discretion of the judge of compensation claims, reasonably relate to:

a. Benefits upon which the claimant prevailed;

b. Benefits upon which the claimant did not prevail; and

c. Multiple benefits, regarding which the judge of compensation claims shall exercise independent discretion and apportion such hours by percentage, in whole numbers, to each benefit claimed.

2. A judge of compensation claims must reduce the number of attorney hours if the judge of compensation claims independently determines that the number of attorney hours is excessive.

(e) A judge of compensation claims may determine the customary fee and is not limited to an average hourly rate or number of attorney hours pled by a party. In determining the customary fee, the judge of compensation claims may rely on

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evidence or take notice of credible data, including attorney fee data on file with the Office of the Judges of Compensation Claims or The Florida Bar. The judge of compensation claims may not exceed the amount or hours pled by the claimant's attorney.

(f) If a departure is permitted pursuant to paragraph (c), a judge of compensation claims must consider the following factors when departing from the amount set forth in subsection (1):

1. The time and labor reasonably required, the novelty and difficulty of the questions involved, and the skill required to properly perform the legal services as established by evidence or as independently determined by the judge of compensation claims.

2. The customary fee.

3. The experience, reputation, and ability of the attorney or attorneys providing services.

4. The time limits imposed by the circumstances.

5. The contingency or certainty of a claimant's attorney fee, taking into account any retainer agreement filed under this section.

6. The volume of hours expended by the claimant's attorney which were devoted to issues upon which the claimant prevailed, and the volume of hours expended devoted to issues upon which the claimant did not prevail.

7. Whether the total fee available under this section in relation to the amount involved in the controversy is excessive.

8. Whether the total fee available under this section in relation to the amount of benefits secured is excessive.

9. Whether the departure fee sought by the claimant's


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attorney is excessive.

10. Whether the departure fee sought by the claimant's attorney shocks the conscience as excessive.

(g) A judge of compensation claims shall determine the hourly rate used to compute the departure fee awarded under this subsection, in $1 increments, based upon consideration of the factors in paragraph (f). A judge of compensation claims may exercise independent judgment in setting the hourly rate and is not limited to an hourly rate pled by a party. However, the hourly rate may not exceed $200 per hour.

(h) The departure fee must be the attorney hours determined under paragraph (d) multiplied by the hourly rate determined under paragraph (g). The claimant is responsible for attorney fees pursuant to his or her retainer agreement which exceed the departure fee.

(i) The employer or carrier may contest the departure fee awarded under this subsection within 20 calendar days after the entry of the departure fee award if the number of attorney hours determined by the presiding judge of compensation claims under paragraph (d) exceeds 125 percent of the number of hours the employer's or carrier's attorney attests were devoted to the defense of the benefits secured. Upon the filing of a request by the employer or carrier, the departure fee award must be vacated and reviewed de novo upon the existing record by a judge of compensation claims in a different district as assigned by the Deputy Chief Judge of Compensation Claims. The reviewing judge of compensation claims must issue an order determining the departure fee, making all determinations and findings required under this subsection. The judge of compensation claims must


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issue the order within 30 calendar days after receiving the assignment. This paragraph does not apply to cases settled under s. 440.20(11) or if a stipulation has been filed resolving the claimant's attorney fees.

(6) ~~A judge of compensation claims may not enter an order approving the contents of a retainer agreement that permits placing any portion of the employee's compensation into an escrow account until benefits have been secured.~~

~~(7)~~ If an attorney ~~attorney's~~ fee is owed under paragraph (3)(a), a ~~the~~ judge of compensation claims may approve an alternative attorney ~~attorney's~~ fee not to exceed $1,500 ~~only once per accident~~, based on a maximum hourly rate of $200 ~~$150~~ per hour, if the judge of compensation claims expressly finds that the attorney ~~attorney's~~ fee amount provided for in subsection (1), based on benefits secured, results in an effective hourly rate of less than $200 per hour ~~fails to fairly compensate the attorney~~ for disputed medical-only claims as provided in paragraph (3)(a) ~~and the circumstances of the particular case warrant such action~~. The attorney fees under this subsection are in place of, not in addition to, any attorney fees available under this section.

Section 9. Section 440.345, Florida Statutes, is amended to read:

440.345 Reporting of attorney ~~attorney's~~ fees.—All fees paid to attorneys for services rendered under this chapter shall be reported to the Office of the Judges of Compensation Claims as the Division of Administrative Hearings requires by rule. A carrier must specify in its report the total amount of attorney fees paid for and the total number of attorney hours spent on


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services related to the defense of petitions, and the total amount of attorney fees paid for services unrelated to the defense of petitions.

Section 10. Paragraph (b) of subsection (6) of section 440.491, Florida Statutes, is amended to read:

440.491 Reemployment of injured workers; rehabilitation.—

(6) TRAINING AND EDUCATION.—

(b) When an employee who has attained maximum medical improvement is unable to earn at least 80 percent of the compensation rate and requires training and education to obtain suitable gainful employment, the employer or carrier shall pay the employee additional training and education temporary total compensation benefits while the employee receives such training and education for a period not to exceed 26 weeks, which period may be extended for an additional 26 weeks or less, if such extended period is determined to be necessary and proper by a judge of compensation claims. The benefits provided under this paragraph are ~~shall~~ not ~~be~~ in addition to the maximum number of ~~104~~ weeks as specified in s. 440.15(2). However, a carrier or employer is not precluded from voluntarily paying additional temporary total disability compensation beyond that period. If an employee requires temporary residence at or near a facility or an institution providing training and education which is located more than 50 miles away from the employee's customary residence, the reasonable cost of board, lodging, or travel must be borne by the department from the Workers' Compensation Administration Trust Fund established by s. 440.50. An employee who refuses to accept training and education that is recommended by the vocational evaluator and considered necessary by the

department will forfeit any additional training and education benefits and any additional compensation ~~payment for lost wages~~ under this chapter. The carrier shall notify the injured employee of the availability of training and education benefits as specified in this chapter. The Department of Financial Services shall include information regarding the eligibility for training and education benefits in informational materials specified in ss. 440.207 and 440.40.

Section 11. Section 627.211, Florida Statutes, is amended to read:

627.211 Deviations and departures; workers' compensation and employer's liability insurances.—

(1) Except as provided in subsection (7), every member or subscriber to a rating organization shall, as to workers' compensation or employer's liability insurance, adhere to the filings made on its behalf by such organization; except that any such insurer may make written application to the office for permission to file a uniform percentage decrease or increase to be applied to the premiums produced by the rating system so filed for a kind of insurance, for a class of insurance which is found by the office to be a proper rating unit for the application of such uniform percentage decrease or increase, or for a subdivision of workers' compensation or employer's liability insurance:

(a) Comprised of a group of manual classifications which is treated as a separate unit for ratemaking purposes; or

(b) For which separate expense provisions are included in the filings of the rating organization.


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Such application shall specify the basis for the modification and shall be accompanied by the data upon which the applicant relies. A copy of the application and data shall be sent simultaneously to the rating organization.

(2) Every member or subscriber to a rating organization may, as to workers' compensation and employer's liability insurance, file a plan or plans to use deviations that vary according to factors present in each insured's individual risk. The insurer that files for the deviations provided in this subsection shall file the qualifications for the plans, schedules of rating factors, and the maximum deviation factors which shall be subject to the approval of the office pursuant to s. 627.091. The actual deviation which shall be used for each insured that qualifies under this subsection may not exceed the maximum filed deviation under that plan and shall be based on the merits of each insured's individual risk as determined by using schedules of rating factors which shall be applied uniformly. Insurers shall maintain statistical data in accordance with the schedule of rating factors. Such data shall be available to support the continued use of such varying deviations.

(3) In considering an application for the deviation, the office shall give consideration to the applicable principles for ratemaking as set forth in ss. 627.062 and 627.072 and the financial condition of the insurer. In evaluating the financial condition of the insurer, the office may consider: (1) the insurer's audited financial statements and whether the statements provide unqualified opinions or contain significant qualifications or "subject to" provisions; (2) any independent

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or other actuarial certification of loss reserves; (3) whether workers' compensation and employer's liability reserves are above the midpoint or best estimate of the actuary's reserve range estimate; (4) the adequacy of the proposed rate; (5) historical experience demonstrating the profitability of the insurer; (6) the existence of excess or other reinsurance that contains a sufficiently low attachment point and maximums that provide adequate protection to the insurer; and (7) other factors considered relevant to the financial condition of the insurer by the office. The office shall approve the deviation if it finds it to be justified, it would not endanger the financial condition of the insurer, and it would not constitute predatory pricing. The office shall disapprove the deviation if it finds that the resulting premiums would be excessive, inadequate, or unfairly discriminatory, would endanger the financial condition of the insurer, or would result in predatory pricing. The insurer may not use a deviation unless the deviation is specifically approved by the office. An insurer may apply the premiums approved pursuant to s. 627.091 or its uniform deviation approved pursuant to this section to a particular insured according to underwriting guidelines filed with and approved by the office, such approval to be based on ss. 627.062 and 627.072.

(4) Each deviation permitted to be filed shall be effective for a period of 1 year unless terminated, extended, or modified with the approval of the office. If at any time after a deviation has been approved the office finds that the deviation no longer meets the requirements of this code, it shall notify the insurer in what respects it finds that the deviation fails

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to meet such requirements and specify when, within a reasonable period thereafter, the deviation shall be deemed no longer effective. The notice shall not affect any insurance contract or policy made or issued prior to the expiration of the period set forth in the notice.

(5) For purposes of this section, the office, when considering the experience of any insurer, shall consider the experience of any predecessor insurer when the business and the liabilities of the predecessor insurer were assumed by the insurer pursuant to an order of the office which approves the assumption of the business and the liabilities.

(6) The office shall submit an annual report to the President of the Senate and the Speaker of the House of Representatives by January 15 of each year which evaluates competition in the workers' compensation insurance market in this state. The report must contain an analysis of the availability and affordability of workers' compensation coverage and whether the current market structure, conduct, and performance are conducive to competition, based upon economic analysis and tests. The purpose of this report is to aid the Legislature in determining whether changes to the workers' compensation rating laws are warranted. The report must also document that the office has complied with the provisions of s. 627.096 which require the office to investigate and study all workers' compensation insurers in the state and to study the data, statistics, schedules, or other information as it finds necessary to assist in its review of workers' compensation rate filings.

(7) Without approval of the office, a member or subscriber

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to a rating organization may depart from the filings made on its behalf by a rating organization for a period of 12 months by a uniform decrease of up to 5 percent to be applied uniformly to the premiums resulting from the approved rates for the policy period. The member or subscriber must file an informational departure statement with the office within 30 days after initial use of such departure, specifying the percentage of the departure from the approved rates and an explanation of how the departure will be applied. If the departure is to be applied over a subsequent 12-month period, the member or subscriber must file a supplemental informational departure statement pursuant to this subsection at least 30 days before the end of the current period. If the office determines that a departure violates the applicable principles for ratemaking under ss. 627.062 and 627.072, would result in predatory pricing, or imperils the financial condition of the member or subscriber, the office must issue an order specifying its findings and stating the time period within which the departure expires, which must be within a reasonable time period after the order is issued. The order does not affect an insurance contract or policy made or issued before the departure expiration period set forth in the order.

Section 12. (1) The Department of Financial Services, in consultation with the three-member panel, shall contract with an independent consultant to evaluate Florida's current reimbursement methodology for medical services provided by hospitals and ambulatory surgical centers pursuant to s. 440.13, Florida Statutes. The study must evaluate the feasibility of adopting other reimbursement methods, including group health

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outpatient reimbursement rates. The study must include an evaluation of the payments, prices, utilization, and outcomes associated with each of the reimbursement methods. The consultant shall submit a report with findings and recommendations to the Speaker of the House of Representatives and the President of the Senate by November 1, 2017.

(2) Effective July 1, 2017, the sum of $50,000 in nonrecurring funds from the Workers' Compensation Administration Trust Fund is appropriated to the Department of Financial Services for the purpose of funding the study.

Section 13. (1) The Office of Insurance Regulation shall contract with an independent consultant to evaluate the competition, availability, and affordability of workers' compensation insurance in Florida, which evaluation must include a review of the current administered pricing rating system, including deviations authorized under s. 627.211(7), to evaluate the advantages and disadvantages of a loss cost system and to evaluate other mechanisms that can be used to increase competition in the marketplace. The consultant shall submit a report of its findings and recommendations to the Governor, the Senate, and the House of Representatives no later than November 1, 2017.

(2) Effective July 1, 2017, the sum of $25,000 in nonrecurring funds from the Workers' Compensation Administration Trust Fund is appropriated to the Office of Insurance Regulation for the purpose of funding the study.

Section 14. This act shall take effect July 1, 2017.

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

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And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to workers' compensation insurance; amending s. 440.02, F.S.; redefining the term "specificity"; amending s. 440.093, F.S.; conforming a provision to changes made by the act; amending s. 440.105, F.S.; revising a prohibition against receiving certain fees, consideration, or gratuities under certain circumstances; amending s. 440.13, F.S.; requiring carriers to authorize, deny, or inform providers of certain material deficiencies preventing authorization or denial in response to certain requests by such providers; revising construction relating to notice to employers and carriers; revising a condition under which claims for specified specialty services are deemed valid and reimbursable; requiring the Governor, or the Chief Financial Officer, in certain circumstances, to appoint a member to fill a vacancy on the three-member panel within specified timeframes; requiring the annual adoption of statewide schedules of maximum reimbursement allowances by the panel; amending s. 440.15, F.S.; revising conditions, limits, requirements, and other provisions relating to temporary total disability benefits and temporary partial disability benefits; amending s. 440.192, F.S.; revising conditions when the Office of the Judges of Compensation Claims must dismiss petitions

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for benefits; revising requirements for such petitions; revising construction relating to dismissals of petitions or portions of such petitions; requiring claimants or claimants' attorneys to make a good faith effort to resolve disputes before filing petitions; requiring petitions to include evidence of such efforts; providing procedures and requirements for judges of compensation claims in reviewing and adjudicating such petitions; authorizing such judges to order sanctions under certain circumstances, including an order to pay attorney fees up to a specified hourly rate; providing that certain dismissed petitions or portions thereof are without prejudice; requiring judges of compensation claims to enter orders on certain motions to dismiss within specified timeframes; revising a condition under which such judges may not award certain attorney fees; amending s. 440.25, F.S.; requiring a claimant's attorney to file and serve, by a specified time before the final hearing, a personal attestation relating to the attorney's hours to date; revising the timeframe under which certain attorney fees attach; amending s. 440.34, F.S.; deleting a provision that prohibits judges of compensation claims from approving certain agreements; revising provisions relating to retainer agreements; deleting a condition specifying when attorney fees are a lien upon compensation payable to the claimant; revising circumstances under which attorney fees are not due to claimants; revising a

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condition under a provision relating to attorney fees on medical-only claims; revising the timeframe under which certain attorney fees attach; defining terms; providing procedures, conditions, and requirements for the determination of customary fees and departure fees by judges of compensation claims; specifying factors that must be considered by judges of compensation claims when departing from certain amounts; providing requirements in determining hourly rates used to compute departure fees; specifying a limit to hourly rates; providing a calculation for the departure fee; providing that claimants are responsible for certain attorney fees that exceed departure fees; authorizing employers or carriers to contest, under certain circumstances, awarded departure fee amounts within a specified timeframe; providing procedures for reviewing and adjudicating a contested departure fee award; providing applicability; deleting a provision prohibiting judges of compensation claims from approving certain retainer agreements; revising the maximum hourly rates for alternative attorney fees awarded under certain circumstances; providing construction; conforming provisions to changes made by the act; conforming cross-references; amending s. 440.345, F.S.; revising requirements for a carrier's reporting of attorney fees to the Office of the Judges of Compensation Claims; amending s. 440.491, F.S.; conforming a provision to changes made by the act; revising a provision that provides for forfeiture of


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certain compensation if an employee refuses to accept certain training and education; amending s. 627.211, F.S.; authorizing rating organization members or subscribers to depart up a specified percentage from certain filings without approval from the Office of Insurance Regulation for a specified timeframe; requiring such members or subscribers to file informational departure statements with the office within a specified timeframe; requiring such members or subscribers, under certain circumstances, to file supplemental informational departure statements within a specified timeframe; requiring the office to issue a specified order if it finds the order violates certain ratemaking principles, would result in predatory pricing, or imperils the financial condition of the member or subscriber; providing construction; requiring the Department of Financial Services, in consultation with the three-member panel, to contract with an independent consultant to conduct a specified study; requiring the consultant to submit a report to the Legislature by a specified date; providing an appropriation; requiring the office to contract with an independent consultant to make certain evaluations; requiring such consultant to submit a report to the Governor and Legislature by a specified date; providing an appropriation; providing an effective date.