Florida Division of Workers' Compensation




2011 Annual Report

CHIEF FINANCIAL OFFICER
JEFF ATWATER
FLORIDA DEPARTMENT OF FINANCIAL SERVICES

CHIEF FINANCIAL OFFICER
JEFF ATWATER
STATE OF FLORIDA

September 15, 2011

Dear Governor Scott, President Haridopolos, and Speaker Cannon:

It is my honor and privilege to present the 2011 Division of Workers' Compensation Annual Report, as required by Section 440.59, Florida Statutes.

This year our continued focus on leveraging our technology and system applications allowed us to more efficiently fulfill our regulatory duties, manage internal management processes and their controls, measure our accomplishments, and improve performance. These electronic systems and resultant data allow us to better evaluate our business processes in order to continuously improve the efficiency and effectiveness for all workers' compensation stakeholders. Our electronic claims data systems and Centralized Performance System provide real-time feedback to data submitters. The results of our submitter real-time feedback process are used by the Division to develop new customer education and support which allows our customers and stakeholders to increase their performance as well.

This year, the Division added online payment options for employer payment flexibility and better fiscal efficiency. These continuous evaluation and improvement cycles also contribute to us being able to provide the highest level of customer service. The Division proudly accepted eight Davis Productivity Awards this past year.

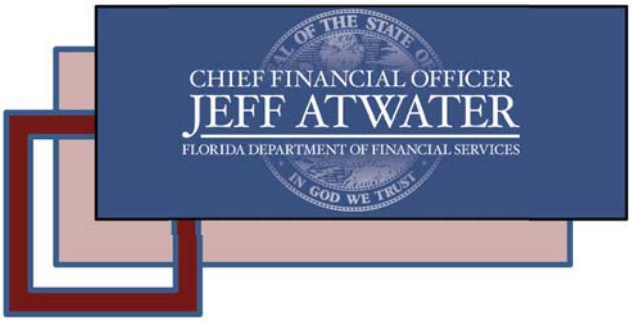
All of our initiatives are driven by our focus on the Division's mission to incorporate initiatives that actively ensure the self-execution of the Workers' Compensation System through educating and informing all stakeholders in the system of their rights and responsibilities, leveraging data to deliver exceptional value to our customers and stakeholders, and holding parties accountable for meeting their obligations.

As the Division continues to meet its regulatory responsibilities in the most cost effective and efficient means possible, we will also strive to improve Florida's Workers' Compensation System for the benefit of all of its stakeholders.

We welcome any suggestions and comments with regard to this report and the performance of the Division.

Sincerely,

Tanner Holloman
Director



Division of Workers' Compensation 2011 Annual Report*

Department of Financial Services Mission Statement:

To safeguard the integrity of the transactions entrusted to the Department of Financial Services and to ensure that every program within the Department delivers value to the citizens of Florida by continually improving the efficiency and cost effectiveness of internal management processes and regularly validating the value equation with our customers.

Division of Workers' Compensation Mission Statement:

To actively ensure the self-execution of the workers' compensation system through educating and informing all stakeholders of their rights and responsibilities, leveraging data to deliver exceptional value to our customers and stakeholders, and holding parties accountable for meeting their obligations.

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*Please note: All data contained in the graphics herein were extracted from Division of Workers' Compensation resources as of 6/30/11, unless otherwise noted.

BUREAU OF EMPLOYEE ASSISTANCE AND OMBUDSMAN OFFICE

The Bureau of Employee Assistance and Ombudsman Office (EAO) was established pursuant to s. 440.191, F.S., to assist injured workers, employers, carriers, health care providers, and managed care arrangements in fulfilling their responsibilities under the Workers' Compensation Law. EAO is a resource for all stakeholders in the Workers' Compensation System and uses the Division's website, brochures, toll-free telephone lines, email, and group presentations to educate and communicate its role of education and advocacy. To effectively fulfill its mission, EAO utilizes a team structure. This approach allows each team to focus on a specific area of EAO's statutory responsibilities.

In addition to the other stakeholders assisted, EAO assists injured workers by:

- Educating and disseminating workers' compensation information;
- Proactively contacting injured workers to discuss their rights and responsibilities and advise them of services available through EAO;
- Resolving disputes between injured workers and carriers to avoid undue expense, costly litigation, or delay in the provision of benefits.

Customer Service Team

The Customer Service Team assists and educates employers with questions regarding workers' compensation coverage, exemptions from coverage requirements, and drug-free workplace and safety programs. This fiscal year, the team handled 94,231 calls for assistance from employers. The Customer Service Team also responds to email inquiries from employers sent to the Division at: Workers.CompService@myfloridacfo.com. **Graphic 1.1** illustrates the quarterly call volume handled by the Customer Service Team.
In addition, the Team also receives calls about employer non-compliance. When compliance violations are reported, those inquiries are submitted to the Bureau of Compliance via the Non-Compliance Referral Database for review and handling. The Team also provides assistance by responding to inquiries about provider certification, Expert Medical Advisors, and stakeholder responsibilities. The Customer Service Team is responsible for responding to emails concerning health care provider issues sent to the Division at: Workers.CompMedService@myfloridacfo.com.

1.1 Customer Service Call Volume FY 10-11

	# of Handled Calls
1st Qtr	24,812
2nd Qtr	20,948
3rd Qtr	24,757
4th Qtr	23,714

First Report of Injury Team

Utilizing Division data, the First Report of Injury Team identifies injured workers who have lost more than seven days of work due to job related injuries. Within two business days of the Division's receipt of First Reports of Injury or Illness, the Team contacts injured workers to provide educational information about the Workers' Compensation System, advise injured workers of their statutory responsibilities, and inform them of EAO's services. During FY 2010-2011, the First Report of Injury Team contacted 32,140 injured workers by telephone, contacted 3,158 employers/carriers when the team was unable to reach injured workers to inquire about the status of injured workers' claims and to advise them of EAO's services, and mailed letters to 41,885 injured workers to advise them of EAO's services and offer assistance.

During the initial contact with injured workers, the Team asks specific questions about the handling of their claims to determine if they are experiencing any problems for which EAO staff can provide assistance. If there are issues to be resolved about medical or indemnity benefits, the Team refers injured workers to the Ombudsman Team, which then contacts various parties to intervene on the injured workers' behalf to resolve the issues. After contacting injured workers, the Team mails follow-up information to injured workers about the services EAO provides, EAO's toll free telephone number, and an overview of the information available on the Division's website. The Team requests information to determine if each injured worker's claim is progressing positively, if the injured worker is satisfied with the medical treatment being provided, if the carrier has provided the injured worker with information, and whether or not the injured worker has returned to work or been in contact with his/her employer. The data obtained

can then be aggregated based on the responses for all injured workers or can be separated by insurer, so each insurer can compare its injured workers' response results to those of the overall industry.

Graphic 1.2 illustrates the Team success rate in contacting injured workers over time. The increased contact success rate is attributed to EAO establishing a team dedicated to this function.

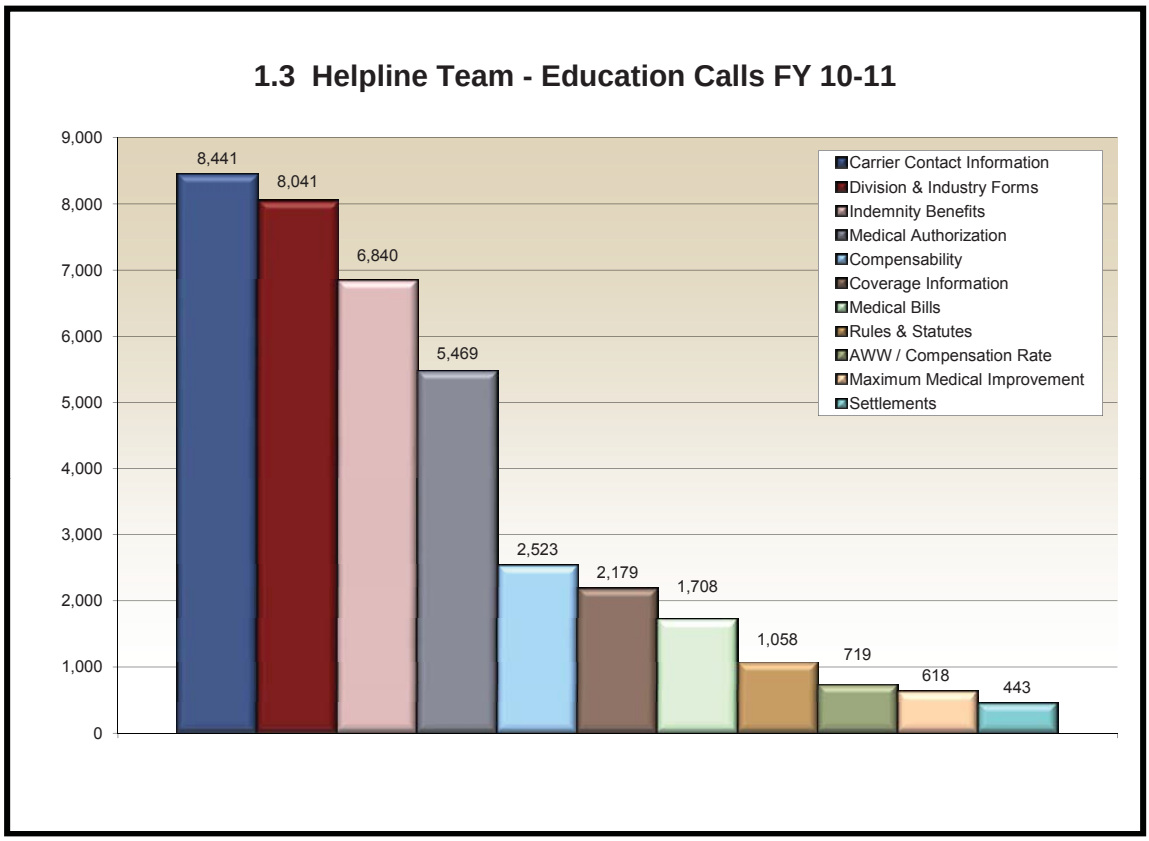
1.2 Injured Worker Contacts		
	# Contacted	% Contacted
07-08	26,140	58%
08-09	25,271	63%
09-10	28,768	69%
10-11	32,140	71%

Denials Team

The Denials Team reviews and analyzes all denied claims filed with the Division to validate denial codes. This data is used to monitor the denial trends of the industry and examine carrier practice outliers for denials. When suspected coding errors are identified in denials, the specialists contact the carriers to validate the information. A substantial amount of time is devoted to educating insurers on proper coding procedures. Denial Team efforts resulted in 79 denials being rescinded during FY 2010-2011. During this fiscal year, the Denials Team reviewed 22,687 total denials (in which both indemnity and medical benefits were denied) and 7,614 partial denials (in which indemnity or medical benefits were denied). The Team also participated in 18 on-site carrier audits to review carrier denials to provide the Bureau of Monitoring and Audit information about the denial practices of the carrier being audited.

Injured Worker Helpline Team

The Injured Worker Helpline Team educates people who call the Division's toll free telephone line about the requirements of Florida's Workers' Compensation Law. The Team receives calls from all types of system stakeholders: injured workers, employers, carriers, medical providers, attorneys, and the general public. In addition, the Team provides assistance to injured workers who are experiencing a problem in obtaining medical or indemnity benefits. The Team identifies disputed issues, researches injured workers' concerns, and contacts employers, carriers, medical providers, attorneys, or other appropriate parties to facilitate resolution. Disputes requiring extensive investigation are referred to the Ombudsman Team for handling. During FY 2010-2011, the Injured Worker Helpline Team provided workers' compensation educational information and



assistance to 61,752 callers, including 8,894 Spanish speaking callers. The Team resolved 65% of the 804 disputes received. This Team also provides assistance to walk-in customers with questions or concerns about their workers' compensation claims.

When callers' inquiries are beyond the scope of the Division's jurisdiction, the Team refers callers to the appropriate external agency. The Team frequently receives calls about unemployment compensation, job retraining, and social security benefits, and refers these callers to the Agency for Workforce Innovation, Department of Education's Division of Vocational Rehabilitation, and to the Social Security Administration, respectively.

Graphic 1.3 depicts the volume of educational inquiries by topic handled by the Injured Worker Helpline Team.

Ombudsman Team

The Ombudsman Team assists injured workers in resolving complex and contentious disputes by conducting fact-finding reviews, analyzing claim files, researching case law, promoting open communication between parties, and helping them understand their statutory responsibilities. This Team also provides early intervention services to injured workers with catastrophic or severe injuries. The Ombudsman Team assists walk-in customers in eight offices around the State resolving disputes and providing workers' compensation information applicable to each injured worker's claim, including guidance on the Petition for Benefits process. The Team also assists injured workers referred from the Governor's Office, legislators, and other elected officials. System participants with questions can also contact the Team at: wceao@myfloridacfo.com.

EAO contacts injured workers within two days of receipt of the First Report of Injury or Illness and if injured workers have concerns about the progress of their claim, they are referred to the Ombudsman Team for assistance.

Graphic 1.4 illustrates the results of these follow-up contacts by an Ombudsman and demonstrates that while injured workers' concerns are primarily related to medical treatment, they have other concerns as illustrated. During FY 2010-2011, the Ombudsman Team resolved 91% of the issues identified during the follow-up call.

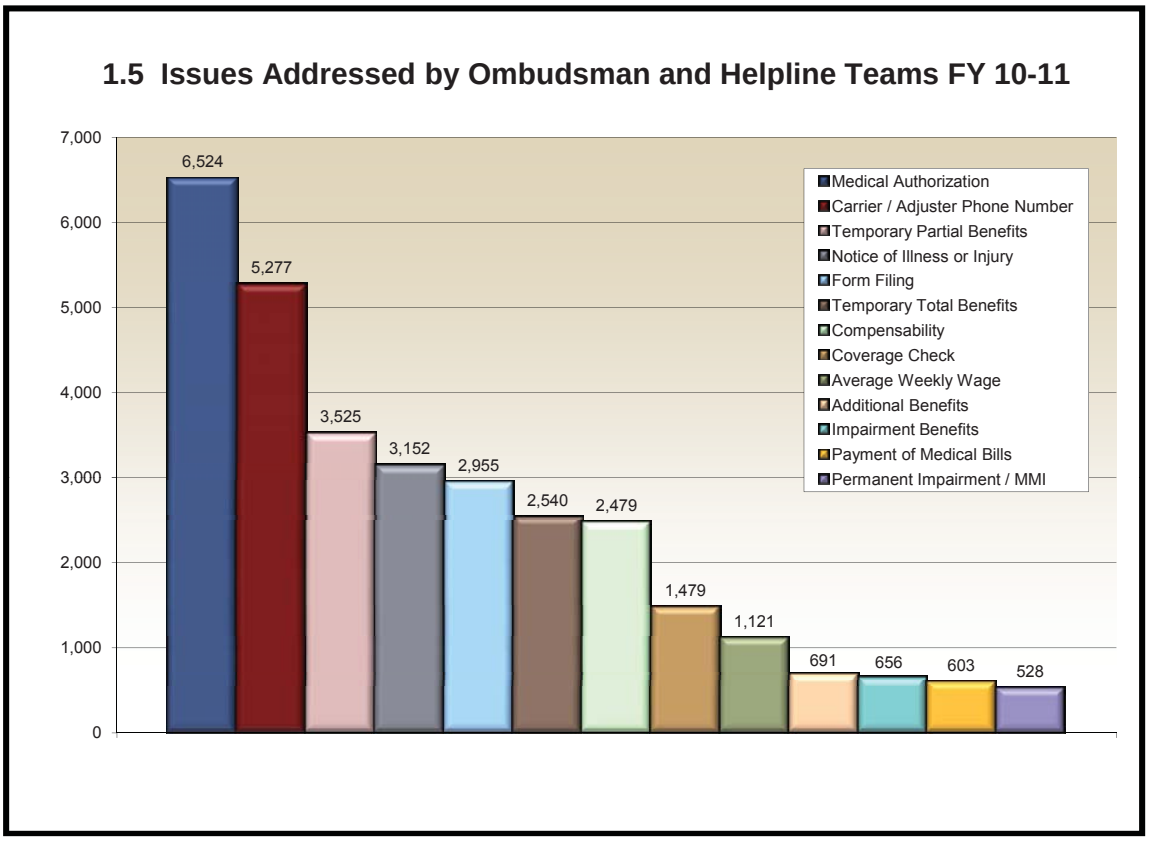
1.4 Ombudsman Intervention FY 10-11

Issue	Resolved	Unresolved	% Resolved
AWW	11	1	92%
Med. Auth	298	16	95%
Voc. Rehab	2	0	100%
Indemnity - TPD	25	9	73%
Indemnity - TTD	16	1	94%
Compensability	4	1	80%
P & I	10	1	91%
Medical Mileage	8	1	89%
Medical Bills	8	0	100%
Other	17	8	68%
Totals:	399	38	91%

During FY 2010-2011, the Ombudsman Team:

- Resolved 87% of the 1,665 disputes received;
- Resolved 97% of the 291 medical bill disputes received, compared to 75% resolution in FY 2007-2008, 88% resolution in FY 2008-2009, and 93% resolution in FY 2009-2010. The previously unpaid medical bills resolved totaled $393,314;
- Prevented 4,252 potential disputes by educating injured workers and providing them with in-depth case specific information;
- Responded to 1,692 email inquiries from injured workers, employers, insurers, and health care providers about issues related to provisions in the Workers' Compensation Law and related administrative rules;
- In cooperation with the Injured Worker Helpline Team, secured $679,082 in indemnity benefits for 289 injured workers and obtained 918 authorizations for medical treatment; and
- Assisted 339 walk-in customers with questions and concerns about their workers' compensation claims and 150 injured workers with the Petition for Benefits process.

Graphic 1.5 illustrates the array of issues addressed by the Ombudsman and Injured Worker Helpline Teams.



EAO SUCCESS STORIES

A 35-year old pilot, who had sustained a work-related spine injury in March 2010, called EAO's Helpline because he was not able to fill his prescription. The Specialist determined the wrong date of accident was on the prescription card the injured worker received from the carrier and worked with the carrier to resolve the issue. Two months later, the Specialist received an urgent call from the same injured worker regarding authorization for a psychological evaluation and subsequent treatment by a gastrointestinal specialist, which the Specialist also resolved with the insurer.

In January 2011, the injured worker accessed the newly created Benefits Calculator on the Division's website to check his compensation rate and contacted the Specialist for more assistance. The Specialist thought the amount paid was in error and asked the adjuster to review the file to determine if the calculations were correct. As a result of EAO's intervention, the injured worker received $1,673 in past due benefits, penalties, and interest.

A 43-year old truck driver with an elbow injury contacted the EAO Helpline because he believed that he was due temporary partial disability benefits. He stated that he had received initial medical treatment, and the physician had referred him to an orthopedist, but he had not heard from the insurer about the referral, and he had left several messages. The Ombudsman attempted to contact the adjuster several times. Since the Ombudsman did not receive a response from the adjuster, the Ombudsman obtained a copy of the Florida Workers' Compensation Uniform Medical Treatment/Status Report Form from the initial treating physician. The Form confirmed what the injured worker had advised. The adjuster eventually contacted the Ombudsman and concurred that benefits in the amount of $3,088 were due and scheduled an appointment for the injured worker with an orthopedist.

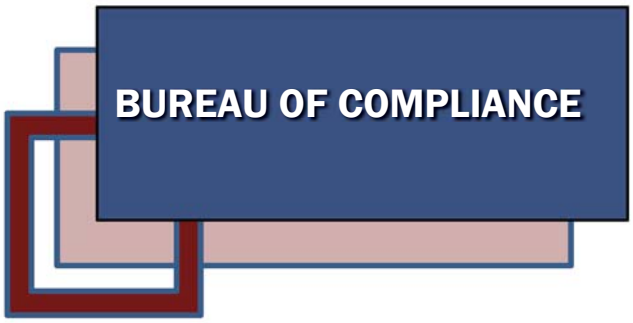
A 79-year old millwright, who sustained an injury to his low back on December 1, 1990 that resulted in him being permanently and totally disabled, contacted EAO's Helpline in November 2010. The injured worker requested assistance in obtaining medical authorization for pain management. While discussing the injured worker's concerns, the EAO Specialist also discovered that he was not receiving permanent total supplemental benefits. The Specialist determined that the injured worker should have been receiving permanent total supplemental benefits from 1997 to the present and continuing.

The Specialist contacted the carrier and notified the adjuster that permanent total supplemental benefits appeared to be due. After two months of intervention by the Specialist, the adjuster agreed to pay back benefits, penalties, and interest in the amount of $314,496.

In February 2011, a 41-year old laborer sustained a low back injury while lifting boxes at work. The injured worker contacted EAO's Helpline because he had missed more than 21 days from work and had not received any indemnity benefits.

The EAO Specialist determined that the carrier had denied benefits because the injured worker had received medical treatment from an unauthorized physician. After further investigation, the Specialist determined that the injured worker's employer had not informed him where to go to obtain medical treatment, so the injured worker had gone to a physician on his own. Due to EAO's intervention, the claims adjuster obtained medical records from the unauthorized treating physician that confirmed that the injured worker had been placed on a "no work" status as of the date of the accident.

Subsequently, the carrier sent the injured worker to an authorized physician, who determined that the injured worker was then able to return to work, three weeks after his injury. As a result of EAO's intervention, the carrier rescinded the denial of indemnity benefits and the injured worker received $720 in indemnity benefits for the three weeks he was out of work.



The Bureau of Compliance (Compliance) is responsible for ensuring that employers comply with their statutory obligations to obtain workers' compensation insurance coverage for their employees. Compliance's enforcement actions ensure that employers adhere to workers' compensation coverage requirements and that all employees covered under Chapter 440, F.S., have insurance coverage for work-related injuries so they can receive all statutorily required benefits if they do sustain a work-related injury. Requiring that employers actually have workers' compensation coverage levels the playing field for all employers who are bidding jobs and adds premium dollars to the system that were previously evaded due to noncompliance. The Bureau accomplishes its mission through investigations, enforcement actions, processing exemption applications, and education of employers.

Proof of Coverage and Construction Policy Tracking Databases

The Division has numerous databases that provide access to information for all stakeholders in the Workers' Compensation System. The Bureau recognizes the importance of providing stakeholders with as much information as possible to assist them in fulfilling their rights and responsibilities under the Workers' Compensation Law. The Proof of Coverage Database and the Construction Policy Tracking Database provide stakeholders and consumers with valuable tools to verify employer compliance. The databases provide information regarding workers' compensation coverage as well as exemptions from workers' compensation. Data regarding workers' compensation insurance policies, endorsements, reinstatements, cancellations, non-renewals, and certificates of exemption can be publicly accessed via the database.

Online Payment Activities

Section 440.107(7)(a), F.S., permits employers to submit periodic penalty payments pursuant to a payment agreement schedule. This year, the Division entered into 670 Periodic Payment Agreements (PPA), which represent 31% of the employers that were issued Stop-Work Orders and assessed a penalty in FY 2010-2011. As a new initiative, the Bureau enhanced the online payment options available to employers. The online payment service, available for employers to pay assessed penalties via online payments from checking or savings accounts, was expanded to include the acceptance of credit cards as a method of payment. This additional payment option provides employers with increased payment flexibility, automated payment scheduling, and enables the Division to deposit payments more expeditiously, realizing significant efficiencies in the fiscal business process.

Employer Education and Outreach

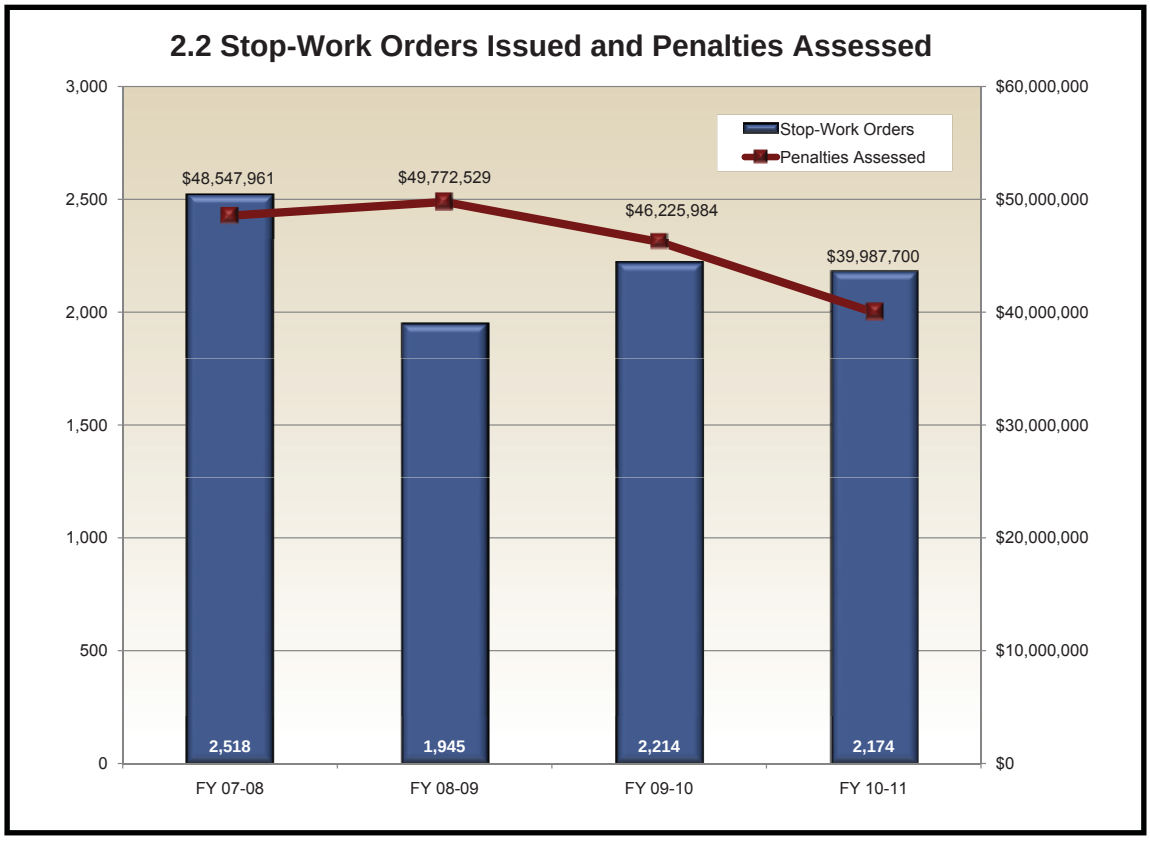
Compliance provides free educational seminars statewide that address workers' compensation and workplace safety issues to educate employers, contractors, and other stakeholders. During FY 2010-2011, the Bureau held 43 seminars with 1,970 attendees. The topics included employers' workers' compensation coverage requirements, exemptions, contractor responsibilities, and enforcement provisions. These courses provided continuing education units for contractors with the Construction Industry Licensing Board and the Electrical Contractors' Licensing Board. In addition to the seminars sponsored by the Division, Compliance representatives also spoke to 23 employer groups and organizations throughout the year.

The following six graphics pertain to Compliance's enforcement and investigative efforts in FY 2010-2011.

Graphic 2.1 shows the total number of investigations conducted during the last four fiscal years. Investigations are physical, on-site inspections of an employer's job-site or business location to determine compliance with workers' compensation coverage requirements. Some investigations originate from referrals and consist of on-site inspections of residential and commercial construction sites. During FY 2010-2011, the Bureau conducted 34,252 investigations, of which 2,044 investigations were conducted in response to referrals alleging employer noncompliance.

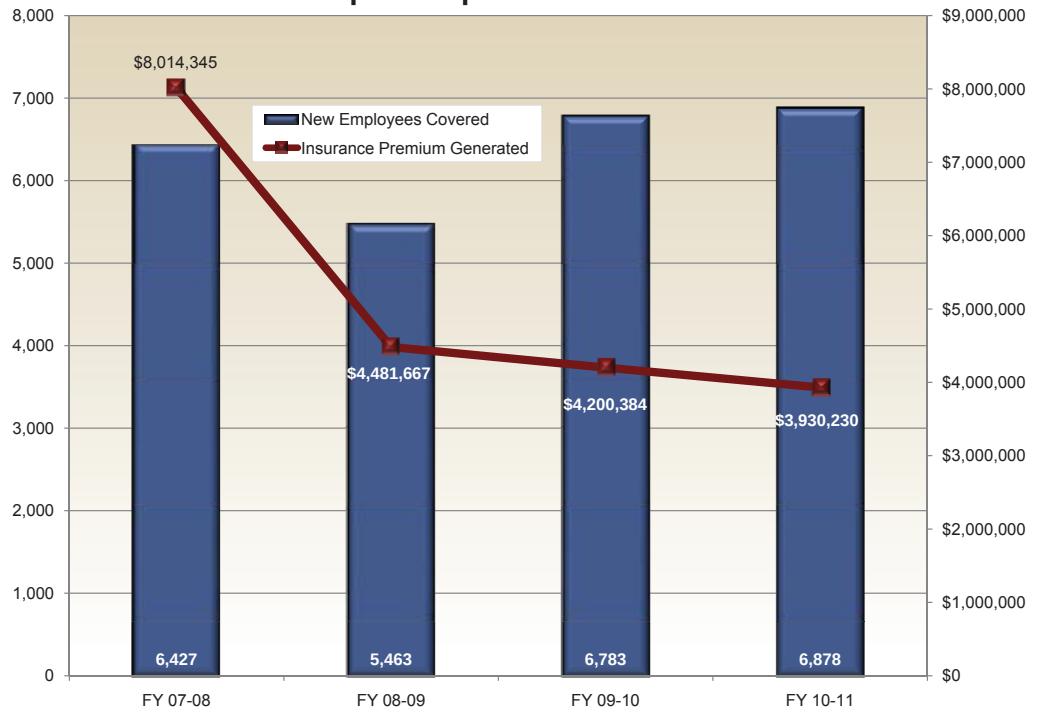
2.1 Investigations Conducted	
07-08	27,674
08-09	29,166
09-10	33,235
10-11	34,252

If an employer fails to comply with workers' compensation coverage requirements, the Division must issue a Stop-Work Order within 72 hours of knowledge of non-compliance. Stop-Work Orders require the employer to cease business operations and the Order remains in effect until the Division issues an Order Releasing the Stop-Work Order. Additionally, employers are assessed penalties based upon the methodology required by the Workers' Compensation Law. Assessed penalties are equal to 1.5 times what the employer would have paid in workers' compensation insurance premiums for all periods of non-compliance during the preceding three-year period or $1,000, whichever is greater. Stop-Work Orders are issued for the following violations: failure to obtain workers' compensation insurance, materially understating or concealing payroll, materially misrepresenting or concealing employee duties to avoid paying the proper premium, materially concealing information pertinent to the calculation of an experience modification factor, and failure to produce business records in a timely manner. **Graphic 2.2** illustrates the number of Stop-Work Orders Issued and the amount of penalties assessed over the past four fiscal years. These enforcement efforts resulted in 6,878 new employees being covered by workers' compensation insurance.



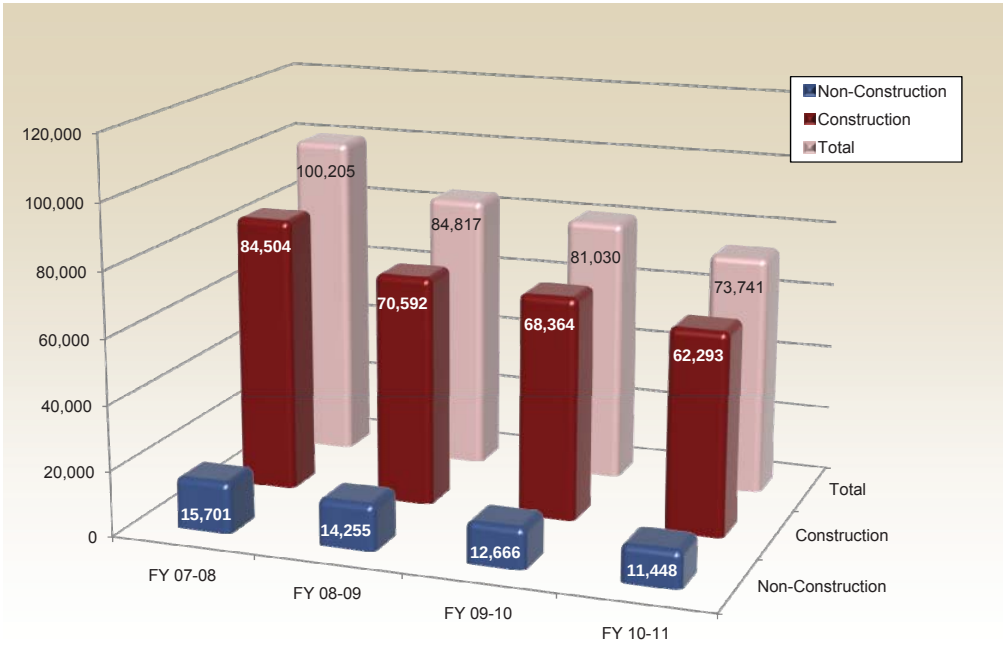
Graphic 2.3 shows the number of employees covered as a direct result of the Bureau's enforcement efforts and issuance of Stop-Work Orders and the monies added to the workers' compensation premium base that had previously been evaded.

2.3 New Employees Covered and Insurance Premium Generated Based Upon Stop-Work Orders Issued

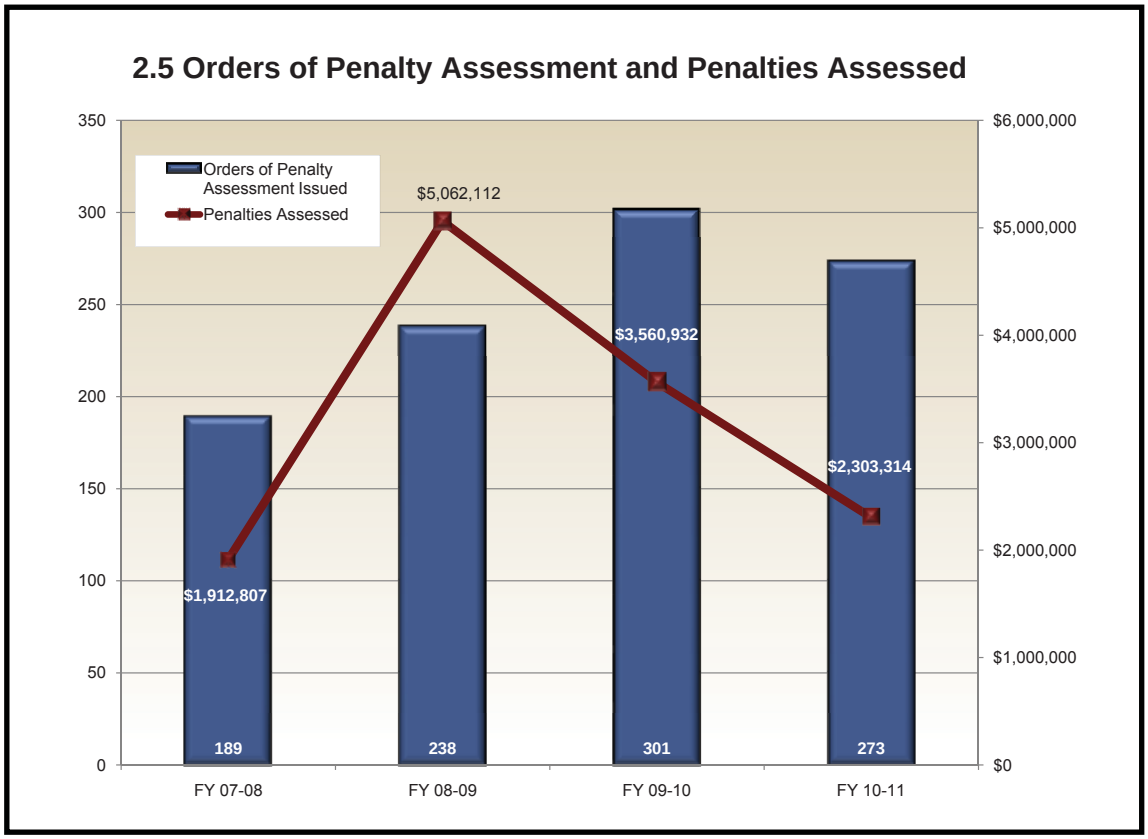


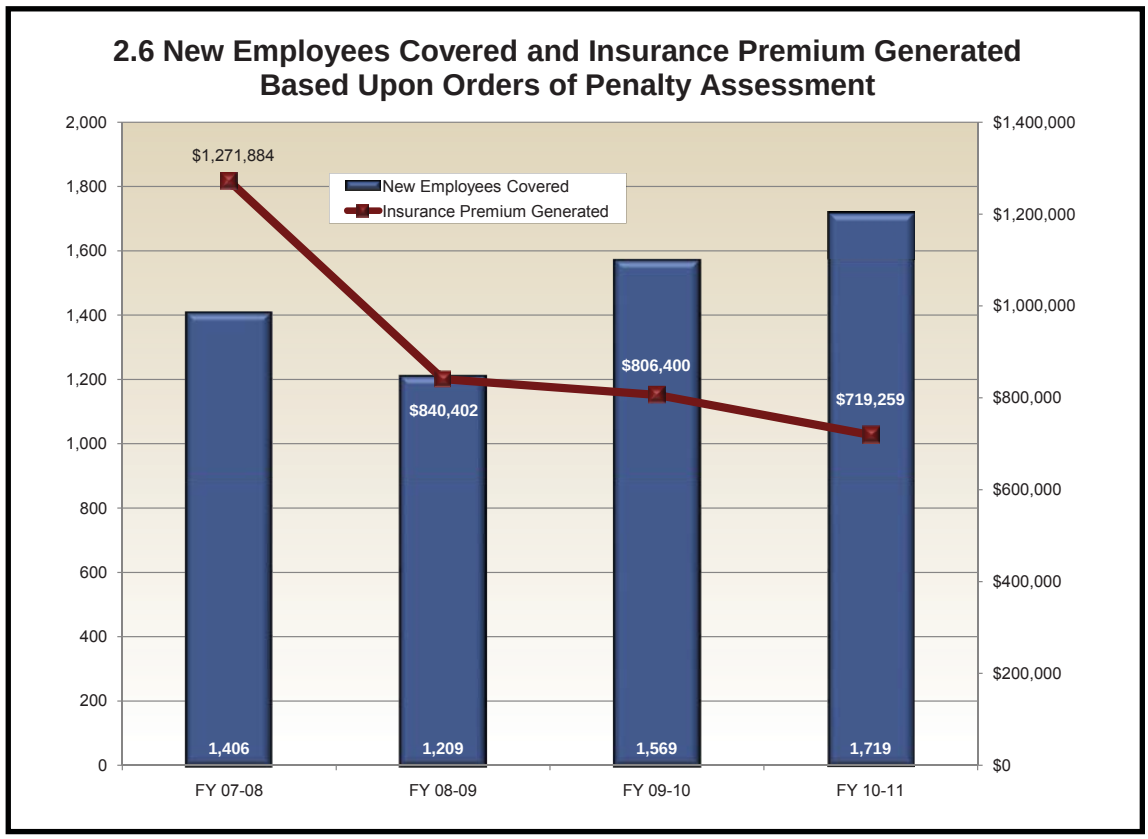
The Bureau processed 62,293 construction industry exemption applications in FY 2010-2011, which is a decrease of 9% over last fiscal year, and 11,448 non-construction industry exemption applications as illustrated in **Graphic 2.4**. As of June 30, 2011, there were 1,123,275 active exemptions.

2.4 Exemption Applications Processed



The next two graphics pertain to Orders of Penalty Assessment for instances when the employer obtained coverage subsequent to the commencement of an investigation, which made the issuance of a Stop-Work Order unnecessary. During FY 2010-2011, 273 employers were issued an Order of Penalty Assessment with assessed penalties totaling $2,303,314. **Graphic 2.5** illustrates the volume of Orders of Penalty Assessment issued and penalties assessed over time. **Graphic 2.6** illustrates the new employees covered as a result of those Orders after the employers purchased workers' compensation insurance.





BUREAU OF COMPLIANCE SUCCESS STORIES

While conducting investigations in Jacksonville, an Investigator observed three men performing carpentry work at a restaurant. The Investigator determined the employer was an active corporation registered and based in Georgia. Further investigation revealed that the employer had been actively engaged in construction activities in both Florida and Georgia for several years. The employer did not have insurance in effect at the time of the Investigator's site visit. The employer previously had a Georgia policy that had been canceled seven months prior to the site visit. The policy did not include statutorily required Florida coverage. A Stop-Work Order was issued and posted at the job site. Approximately 30 days later, another Investigator discovered employees of the same Georgia-based employer performing construction work at another restaurant. The Investigator confirmed that the employer's Stop-Work Order was still in effect. A $12,611 penalty was assessed based on the employer's payroll, with an additional $1,000 penalty assessed for working in violation of the Stop-Work Order. The employer renewed the coverage, added "Florida" coverage to the policy, and added five employees to coverage, which generated $8,381 in premium. The employer paid a 10% down payment on the penalty, which permitted him to enter into a PPA and be conditionally released from the Stop-Work Order.

Compliance received a phone tip that a contractor providing housekeeping and maintenance employees to a large resort in the Orlando area was underreporting payroll to its insurer. After an extensive investigation, the business was found to be underreporting its payroll and a Stop-Work Order was served. The payroll was determined to be $5.6 million, not the $700,000 the employer had reported to his insurer. A $233,939 penalty was assessed. The employer came into compliance by entering into a PPA, making a down payment of $24,000, and purchasing coverage for 200 employees, which generated a $65,511 premium.

While conducting coordinated enforcement activities with the Martin County Construction Licensing Office, an Investigator observed two workers applying aluminum strips to the side of a building. The Investigator interviewed the workers to determine their employer. The Investigator contacted the employer and was advised that the business had an employee leasing company (PEO) contract. The Investigator determined that the employer had not reported those two employees to the PEO, so they were not covered by the PEO's policy. The Investigator served a Stop-Work Order and Business Records Request on the employer. A review of the records revealed that the employer had not reported numerous employees to the PEO and also had uninsured sub-contractors. A $56,543 penalty was assessed for the uninsured employees and sub-contractors. The employer came into compliance by adding the two employees to the coverage which generated $4,032 in premium. The employer paid the penalty in full and the Stop-Work Order was released.

While conducting routine investigations in Ft. Myers in 2007, an Investigator observed six men performing landscaping duties at a country club. The employer was present and informed the Investigator that the employees were covered under an employee leasing arrangement (PEO). The Investigator determined that several of the workers present were not covered by the employee leasing arrangement. A Stop-Work Order was issued to the employer for failing to secure coverage for all of its employees and a $147,419 penalty was assessed. The employer added six additional employees to his coverage through the PEO and entered into a PPA. However, after the initial down payment, the employer failed to make any further penalty payments and the Stop-Work Order was reinstated. Subsequently, in 2009, the employer was found working in violation of the reinstated Stop-Work Order and assessed an additional $381,000 penalty. The employer filed a Petition for Hearing. In 2011, the Judge ruled in favor of the Department and ordered the employer to pay the additional $381,000 penalty for working in violation of the reinstated Stop-Work Order.

BUREAU OF MONITORING AND AUDIT

The Bureau of Monitoring and Audit is responsible for carrier and claims-handling entity accountability and enforcement to ensure that they meet their obligations under Chapter 440, F.S., and administrative rules. The Bureau's responsibilities include ensuring that injured workers are paid accurate and timely benefits and that medical bill data and all required claims data are accurately and timely filed with the Division. The Bureau is also responsible for approving self-insurance programs for entities that meet statutory requirements and demonstrate the financial strength to fund their present and future workers' compensation liabilities. The Bureau assesses penalties on carriers and claims-handling entities for failing to meet certain statutory duties.

The Bureau is organized into the following four major sections: Audit, Permanent Total, Self-Insurance, and Penalty Sections.

Audit Section

The Audit Section examines claims-handling practices of insurance companies, self-insurers, self-insurance funds, and claims-handling entities pursuant to ss. 440.20, 440.185, and 440.525, F.S., as well as administrative rules. Audits and investigations conducted by the Audit Section identify patterns and practices of unreasonable delays in claims-handling, untimely and inaccurate payment of benefits to injured workers, untimely and inaccurate filing of required reports, and enforce compliance with compensation orders of Judges of Compensation Claims. Penalties are assessed for failure to meet the required statutory performance standards.

In FY 2010-2011, the Audit Section expanded the review of medical bills to include the required elements of an Explanation of Bill Review (EOBR) pursuant to Rule 69L-7.602(5) of the Florida Administrative Code (F.A.C.). Medical bills are reviewed to determine if they include all information specified in the Rule. Although penalties for noncompliance will not be assessed until after January 1, 2012, the Audit Section provided feedback on the results of these additional reviews as an educational tool during audits.

During FY 2010-2011, 4,340 claim files were audited to identify claims-handling violations. **Graphic 3.1** shows the percent of files audited that included claims-handling violations.

3.1 Claims-Handling Violations	
Inaccurate Indemnity Payments	26%
Untimely Filing of First Reports of Injury or Illness	20%
Untimely Filing of Claim Cost Reports	15%
Untimely Indemnity Payments	14%
Inaccurate FROI Data Reporting	7%
Inaccurate Medical Data Reporting	7%
Untimely Filing of Notices of Denial	7%
Untimely Mailing of Information to Injured Workers	4%

Graphic 3.2 illustrates the most frequent types of pattern and practice violations identified during audits over the last three years.

3.2 Pattern and Practice Violations by Type			
Violation Type	08-09	09-10	10-11
Untimely Filing of Claim Cost Reports	29	36	35
Untimely Filing of Denials	3	11	18
Inaccurate Medical Data Reporting	21	18	17
Inaccurate FROI Data Reporting	8	6	16
Untimely Mailing of Information to Injured Workers	14	11	10
Totals	75	82	96

Graphic 3.3 displays the number of pattern and practice violations identified during audits for which penalties were assessed in the last six fiscal years. The increase over the past three fiscal years reflects the increase in the number of audits performed and the expanded claim components reviewed during audits.

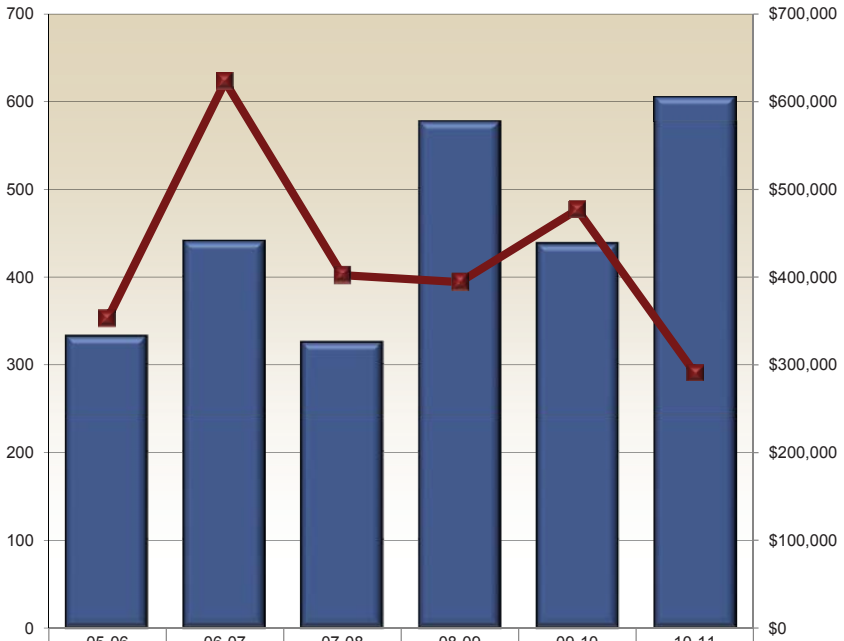
3.3 Pattern and Practice Violations	
05-06	23
06-07	24
07-08	19
08-09	75
09-10	82
10-11	96

During FY 2010-2011, the Audit Section:

- Completed 64 on-site carrier audits and audited 6,614 carrier claim files, during which 96 pattern and practice violations were identified;
- As part of the audits, reviewed 4,340 claim files to determine the accuracy and timeliness of indemnity benefit payments and identified 605 files with underpayments. These underpayments resulted in additional injured worker payments of $290,896 for indemnity benefits, penalties, and interest;
- Determined that 94% of the required informational brochures and employee notification letters were mailed timely to injured workers pursuant to s. 440.185, F.S.;
- Verified the accuracy and/or timeliness of 17,295 claim forms required to be filed with the Division;
- Reviewed 16,966 medical bills and electronic First Reports of Injury or Illness during audits to determine if the Division had received accurate data and the total filings required; and
- As a result of audits conducted during FY 2010-2011, $397,000 in penalties were assessed as follows:
  - $90,400 for untimely indemnity payment performance that fell below the 95% required standard;
  - $66,600 for untimely filing of electronic First Reports of Injury or Illness; and
  - $240,000 for 96 pattern and practice violations.

Graphic 3.4 illustrates the number of files with underpayments identified during audits over time and the total amount of additional monies paid to injured workers as a result.

3.4 Underpaid Indemnity Benefits Identified During Audits



	05-06	06-07	07-08	08-09	09-10	10-11
# of Underpayment Files	332	440	325	576	437	605
Total Underpayments	$352,454	$622,853	$402,252	$394,274	$476,885	$290,896

Permanent Total Section

The Permanent Total (PT) Section is responsible for paying permanent total supplemental benefits to eligible permanently and totally disabled workers who were injured prior to July 1, 1984. Additionally, the PT Section verifies the accuracy and timeliness of permanent total and permanent total supplemental benefits due and paid by carriers, which includes verifying that payments are suspended, reduced, or cancelled based on statutory amendments or case law and that benefit offsets are correctly applied.

The PT Section reviews electronic claim transactions to identify inaccurate benefit payments, notifies carriers of inaccuracies, and requests correction of any under or overpayments of benefits. If an underpayment is identified, the carrier is directed to pay additional benefits to the injured worker. In many cases, the miscalculation may have happened many years ago and not been subsequently corrected. The underpaid benefits, penalties, and interest are often a significant amount of money obtained for the injured worker. Conversely, the miscalculation of benefits can also result in an overpayment of benefits to injured workers. In those cases, the carrier is entitled to recoup the overpayment by as much as a 20% reduction in the injured worker's future payments.

During FY 2010-2011, the PT Section implemented a new initiative as part of the Division's electronic data business processes to identify and follow-up with carriers who had not filed required electronic Claim Cost Report data for PT cases with the Division. The software allows staff to send automated reminders for missing filings so they can concentrate on the accuracy of PT benefit payments. The use of this new process has resulted in fewer late filings. The PT Section reduced delinquent electronic claim cost transactions from 2,034 transactions in FY 2009-2010 to 446 in FY 2010-2011, a decrease of 78%.

In FY 2010-2011, the PT Section reviewed 43,281 electronic claims transactions and obtained $5,895,567 in past due benefits, penalties, and interest for 231 injured workers, which is a 39% increase in the number of claim transactions reviewed and a 105% increase in benefits obtained for injured workers over the prior year. The PT Section also identified and advised carriers about $1,037,982 in benefit overpayments to injured workers. **Graphic 3.5** shows the amount of underpayments by carriers identified through claim file reviews during the last four fiscal years.

3.5 PT Benefit Underpayments	
07-08	$1,136,665
08-09	$1,320,516
09-10	$2,873,482
10-11	$5,895,567

During FY 2010-2011, the PT Section calculated, approved, and processed supplemental benefits for 1,486 claims, totaling $18,028,738. On a continuing basis, the PT Section verifies the eligibility of injured workers' legal entitlement to supplemental benefits by reviewing the following resources:

- A monthly list of in-state deaths from the Department of Health, Bureau of Vital Statistics;
- A monthly list of deaths that occurred out-of-state that is provided by a private vendor;
- Department of Corrections inmate records;
- Judges of Compensation Claims' data;
- Employee Earnings Reports; and
- PT claims data submitted electronically by carriers.

Graphic 3.6 illustrates the permanent total supplemental benefits paid to injured workers by the Division over time and the declining number of injured workers receiving these benefits.

3.6 Division Paid PT Supp Benefits		
	$ Paid	# of Workers
00-01	$23,152,819	2,941
01-02	$25,315,771	2,779
02-03	$22,280,193	2,560
03-04	$21,787,535	2,401
04-05	$21,187,291	2,267
05-06	$20,798,328	2,128
06-07	$20,503,160	2,012
07-08	$20,275,368	1,870
08-09	$20,290,890	1,737
09-10	$18,839,236	1,612
10-11	$18,028,738	1,486

The PT Section provides education and dispute resolution assistance to injured workers and carriers about the proper computation of PT benefits, PT supplemental benefits, and any offsets which may apply. When permanent total benefit discrepancies are identified by staff from the Special Disability Trust Fund, EAO, or the Audit Section, the PT Section collaborates with these units to determine the accuracy of benefits that are due to an injured worker.

Self-Insurance Section

The Self-Insurance Section is responsible for approving and monitoring the self-insurance programs for governmental and non-governmental self-insured entities. To ensure the financial stability of the companies approved to self-insure, the Division contracts with the Florida Self-Insurers Guaranty Association (FSIGA) to review financial statements and monitor self-insurers' ability to pay current and future workers' compensation liabilities. The Self-Insurance Section, in conjunction with FSIGA, evaluates security deposits, grants the self-insurance privilege, and collects, examines, and processes self-insurance payroll, loss data, outstanding liabilities, and financial statements.

The Self-Insurance Section conducted 27 payroll audits and reviewed 59,758 employee payroll records during FY 2010-2011. As a result of these audits, $33,604,166 in underreported payroll was identified and $769,770 in underreported premium was identified and added to the Workers' Compensation System for assessment purposes.

Four new self-insurers were approved in FY 2010-2011. **Graphic 3.7** shows the number of active self-insurers over the last five years.

3.7 Active Self-Insurers	
06-07	415
07-08	404
08-09	398
09-10	418
10-11	410

The experience modification factor indicates the self-insurer's loss experience for the past three years and is a factor in calculating workers' compensation premiums. The Self-Insurance Section promulgated 410 experience modification factors for active self-insurers this fiscal year.

Graphic 3.8 shows the average experience modification of governmental self-insurers, private self-insurers, and insurance companies for the last three years.

3.8 Average Experience Modifications			
	2008	2009	2010
Governmental Self-Insurers	1.08	1.06	1.05
Non-Governmental Self-Insurers	0.91	0.95	0.94
Insurance Companies	0.96	0.98	0.98

Qualified Servicing Entities that request certification to provide claims adjusting, loss control, and rehabilitation services to self-insurers must submit an application and be approved by the Self-Insurance Section. Four new entities were approved and 96 were recertified in FY 2010-2011. **Graphic 3.9** shows the number of approved Qualified Servicing Entities for the past five years.

3.9 Qualified Servicing Entities	
06-07	100
07-08	105
08-09	93
09-10	96
10-11	100

Penalty Section

The Penalty Section is responsible for monitoring and evaluating carrier performance regarding the timely payment and accuracy of initial indemnity benefit payments and timely payment of medical bills. The Section also ensures that First Report of Injury or Illness data and medical bill data are filed timely with the Division. The Penalty Section monitors these measures monthly, utilizing the Centralized Performance System (CPS). The CPS business process electronically provides essential performance information and trends, which enables the Division and its stakeholders to monitor claim performance in a real-time environment. Note that the penalty amounts contained herein may be later updated if penalties are recalculated to reflect different claims dispositions.

There are two components in CPS: a Medical Module and an Indemnity Module. Both modules allow claims-handling entities to monitor their own claims-handling performance and the performance of their third-party administrators and compare that to the industry's performance. The Division uses CPS information to identify those carriers whose performance falls below industry standards and may require additional monitoring, investigation, or examination. Using CPS, carriers and claims-handling entities can respond to their performance information in real-time. The system electronically records and documents communications with regulated entities and also records payment information provided by carriers and other claims-handling entities.

Rule 69L-24, F.A.C., was revised effective January 12, 2010, and changed the way CPS filing penalties are calculated. The maximum penalty assessment for untimely filed medical bill data was reduced from $100 to $50 per bill. Also, once a carrier has been assessed penalties of $10,000 in a calendar month, additional penalties are calculated differently. Each additional untimely DWC-1 filing is penalized at $25.00 each and each additional late medical bill filing is penalized at $5.00 each.

The indemnity module electronically evaluated 53,285 First Reports of Injury or Illness for timely filing and payment of initial indemnity benefits by carriers. If carriers violate the statutory filing requirements regarding a First Report of Injury or Illness, they are assessed an administrative penalty. **Graphic 3.10** shows the volume of reports reviewed, the penalties assessed for late reporting, and the penalties and interest assessed for late payment of initial benefits. The carrier must pay penalties and interest to injured workers who receive late payment of initial indemnity benefits.

3.10 Carrier Penalties

	First Reports Reviewed	Assessed Filing Penalties	Assessed Penalties & Interest
07-08	62,178	$1,676,400	$366,709
08-09	57,821	$2,490,710	$763,238
09-10	52,768	$1,106,455	$616,816
10-11	53,285	$770,375	$870,100

Graphic 3.11 illustrates carriers' performance for timely payment of initial indemnity benefit payment and the performance for timely filing of First Report of Injury and Illness data.

3.11 Performance Percentage

	Timely Benefit Payments	Timely Filing of First Reports
07-08	94.0%	92.1%
08-09	93.7%	86.6%
09-10	95.2%	93.3%
10-11	94.6%	94.8%

Like the carrier, the employer's performance is also evaluated. When an accident occurs, the employer must report the injury or illness to the carrier within seven calendar days of knowledge of the injury or illness to avoid a reporting and/or payment penalty assessment. **Graphic 3.12** shows the penalties assessed against employers for late reporting and the penalties and interest assessed payable to the injured worker for that late reporting.

3.12 Employer Penalties

	Late Reporting Assessment	Assessed Penalties & Interest
07-08	$155,550	$22,635
08-09	$152,000	$27,841
09-10	$135,700	$18,232
10-11	$168,100	$21,702

Medical bills must be paid, disallowed, or denied within 45 calendar days after the bill is received by the carrier and the data must be filed to the Division within 45 calendar days of disposition. Carriers who fail to pay or timely file are subject to administrative fines. **Graphic 3.13** shows the volume of medical data filed with the Division over time, penalties assessed for late payments, and the percent timely paid and filed.

During FY 2010-2011, the medical module electronically evaluated 3,861,864 medical bills for timely disposition and timely filing, which resulted in $390,150 and $819,915 in assessed penalties, respectively.

3.13 Medical Bills

	Late Payment Penalties	Timely Paid	Total Bills Filed	Timely Filed
07-08	$453,550	99%	4,359,092	99%
08-09	$427,925	99%	4,244,800	99%
09-10	$2,129,250	98%	4,070,533	97%
10-11	$390,150	98%	3,861,864	98%

PERMANENT TOTAL SECTION SUCCESS STORIES

The PT Section audited the claim of an 82-year old employee who had injured her back at age 60 while working for a hospital. The PT Section determined that the insurer had erroneously stopped paying permanent total supplemental benefits in 1996. After PT Section staff provided the adjuster with a copy of the court case that demonstrated they had suspended benefits in error, the adjuster immediately concurred that additional benefits were due. As a result of the PT Section's intervention, the insurer paid the injured worker $261,745 in additional benefits, penalties, and interest.

During a claim audit, the PT Section determined that the insurer failed to recalculate a Social Security offset when a 62-year old injured worker's dependent had reached 18 years of age. That oversight resulted in the insurer taking a larger offset from his PT benefits than the one to which they were entitled. When the PT Section intervened, the insurer concurred they failed to recalculate the offset. Since this error occurred years ago, the accumulation of additional benefits due, penalties, and interest resulted in the insurer paying the injured worker $140,351.

During the file audit of a 62-year old worker who had been injured in 1984, the PT Section determined that the injured worker was eligible for, but had not received, PT supplemental benefits. The injured worker had been eligible for PT supplemental benefits since 1997. As a result of the intervention of the PT Section staff, the insurer paid the injured worker $263,490 for 13 years of PT supplemental benefits, penalties, and interest.

An 85-year old injured worker had been injured at age 62 while working as a waste disposal plant operator. One year after his accident, he was accepted as permanently and totally disabled. The insurer then suspended PT supplemental benefits during 2000 due to the adjuster misinterpreting case law. The PT Section staff noticed a discrepancy in what he was being paid while reviewing reports submitted by the insurer, contacted the insurer, and provided the adjuster with the case law applicable to this claim. The adjuster immediately acknowledged the error and advised that the injured worker was due PT supplemental benefits from October 2000 through December 2010. As a result of the PT Section's intervention, the insurer paid the injured worker $276,925 in past due benefits, penalties, and interest.

A 38-year old injured worker had been determined permanently and totally disabled at age 29, when she was injured while working as a surgical nurse. She was referred to the PT Section by EAO because she was concerned she was not receiving the correct amount of indemnity benefits. The PT Section determined that the insurer was paying both PT disability benefits and PT supplemental benefits at the wrong rate. After a protracted investigation, the insurer agreed to pay the injured worker $105,088 in past due benefits, penalties, and interest.

BUREAU OF DATA QUALITY AND COLLECTION

The Bureau of Data Quality and Collection (DQC) receives and manages a large magnitude of data from claims-handling entities and vendors for claims, medical, and Proof of Coverage data, as required by Chapter 440, F.S., and various corresponding rules of the Florida Administrative Code (F.A.C.). These data are submitted primarily in electronic format, although a minimal number of paper forms are still received. As the central data repository for these data, DQC is responsible for receiving, storing, and retrieving information to assist the Division's staff in the completion of their business processes, while ensuring data quality and reliability. Every electronic transaction received is evaluated through extensive program edits to ensure a high degree of accuracy prior to loading the information to the respective Division databases, which facilitates the monitoring of injured worker benefits and health care provider payments. Within hours of receipt, data are organized into formats that provide real-time, accurate feedback to submitters. This near immediate turnaround allows internal claim records and reports to be created to expedite the analysis and determination of whether benefits to injured workers were paid accurately and timely. Various online databases used by external customers are also populated with some of the data processed by DQC.

Proof of Coverage

With the exception of self-insurers, every carrier is required by Rule 69L-56, F.A.C., to electronically file policy information with the Division for the following types of filings: Certificates of Insurance, Notices of Reinstatement, Endorsements, and Cancellations. All workers' compensation Proof of Coverage (POC) data are received via electronic data interchange (EDI). Presently, all carriers comply with the Proof of Coverage filing requirements through a contractual arrangement with one of two authorized vendors that send POC transactions directly to the Division. These data are used to populate multiple online Division databases, including the Proof of Coverage database, which can be used to verify if an employer has current or prior workers' compensation coverage. The Construction Policy Tracking Database is also populated by these data and when requested to do so by contractors, notifies the contractors electronically about changes to the coverage status of the subcontractors they use, including changes to a specified policy, renewals, or revocation of certificates of exemption.

During FY 2010-2011, the Division processed and accepted 715,716 electronic POC filings, which is a 4.9% decrease since FY 2009-2010. **Graphic 4.1** shows Proof of Coverage transactions for the last three fiscal years by type of filing.

4.1 Proof of Coverage Accepted Filings

	08-09	09-10	10-11
New Policies	244,766	248,448	253,998
Reinstatements	87,369	86,885	80,306
Endorsements	221,491	249,438	225,425
Cancellations	161,195	167,873	155,987

Medical EDI Data

The Florida Workers' Compensation Medical Services Billing, Filing, and Reporting Rule, Rule 69L-7.602, F.A.C., was amended effective January 12, 2010. The amended rule includes new electronic reporting requirements, updated unique codes that identify carrier payment/non-payment decisions for each service rendered, and require additional data elements be reported in order to expand the breadth and depth of medical data collected. This rule provided a gradual phase-in period for medical submitters to convert to the new reporting requirements. After extensive testing of system edits by submitters and the Division, all medical submitters successfully converted to the new data reporting by September 2010. The amended rule also required that nursing home facilities, ambulatory surgical centers, and home health agencies begin reporting detailed medical bill service, charge, and payment data to the Division using the national standardized hospital reporting form data. These changes resulted in the added collection of data from thousands of medical bills that were previously unreported and permitted the Division to evaluate each filing for timely reimbursement, as required by Florida Statutes.

Graphic 4.2 illustrates that after the peak number of medical filings were accepted in FY 2006-2007,

the volume of accepted filings declined annually, most likely due to the decrease in the number of lost-time injuries.

4.2 Electronic Medical Bills Accepted	
	Bills Accepted
05-06	4,306,458
06-07	4,319,522
07-08	4,243,354
08-09	4,161,712
09-10	4,017,169
10-11	3,884,818

Any medical filings that are rejected to the submitter due to structural or quality edits must be corrected and resubmitted to the Division. To assist submitters with the management of rejected medical filings and to allow comparison benchmarking among the industry, DQC generates monthly report cards that identify the top five reasons by volume for initial medical bill filing rejection compared to the reasons and volume for all submitters. **Graphic 4.3** illustrates the top five reasons for medical bill rejection over time.

4.3 Top Five Rejection Reasons for Medical Bills				
	07-08	08-09	09-10	10-11
Blank or zero value not allowed	20.93%	21.63%	25.57%	27.75%
Invalid code, ID, or value specified	10.43%	6.19%	6.33%	16.55%
No matching code value found in database	18.81%	17.69%	17.89%	15.31%
License # not found in database	7.06%	n/a	7.63%	10.48%
Inappropriate license number prefix for form type	10.31%	8.11%	13.19%	8.81%

Claims EDI Data Collection

Over the past decade, DQC actively pursued the full implementation of data collection through electronic data interchange (EDI). This effort resulted in the adoption of national standardized electronic formats, which were originally implemented by the Division in 1993. During March 2008, DQC worked collaboratively with the workers' compensation industry to initiate the conversion to the most current version of the national workers' compensation claims electronic format. By the end of FY 2010-2011, the Division had approved all 174 electronic trading partners (carriers and third party administrators approved to transmit electronic data), representing 1,127 carriers, to submit data using the new electronic format.

To assist its customers in understanding the new requirements, and facilitate increased data acceptance rates, DQC conducted training during FY 2010-2011. Three webinar training sessions on the fundamentals of the newest electronic format and Florida-specific filing requirements were presented to 404 claims-handling representatives. In addition, five Webinar training sessions were presented to 439 claims-handling representatives on Electronic Claim Cost Report filing requirements and techniques for resolving errors and overdue reports.

During FY 2010-2011, DQC achieved its highest rate of electronic claims data submissions using these new formats. For the first time, 98.8% of the required filings were received electronically, with 1.2% filed on paper forms (allowed by new submitters not yet approved for electronic submissions and certain submitter systems issues). During this fiscal year, DQC received and processed 526,976 electronic claims filings and 6,319 paper filings.

Graphic 4.4 shows the progression of increased electronic claims filing acceptance in relation to sharply declining paper filings over the last three fiscal years.

4.4 Accepted Claims Forms		
	EDI	Paper
08-09	57.7%	42.3%
09-10	97.8%	2.2%
10-11	98.8%	1.2%

Public Records Requests and Subpoenas

During FY 2010-2011, the Division processed 7,162 public record requests and subpoenas. Florida's Public Records Law and Civil Rules of Procedure require the release of certain information for public inspection upon request. Records maintained by DQC are stored on various media such as microfilm, scanned images, and electronic records. Documents must be identified, located, printed and assembled from these various mediums and then staff must redact any information exempt from inspection under Chapter 119, F.S., and administrative rules. During FY 2010-2011, DQC processed 3,711 subpoenas, which necessitated the retrieval of 249,523 documents. Responses to subpoenas were mailed an average of four business days after receipt. Public records request responses were completed within two business days of receipt (on average) for the 3,451 received, which resulted in the production of 27,084 documents.

Confidentiality of Information

When requested to share data, DQC provides information to several federal and state agencies under strict data sharing arrangements to ensure the recipients agree to and are bound by statutory confidentiality requirements. These agreements allow the agencies to enhance their enforcement capabilities and facilitate financial eligibility determinations, including: the investigation of chemical/poison exposures; state and federal child support programs designed to locate delinquent parents; enforcement of child labor laws; Social Security disability determinations; and the provision of workers' compensation reemployment services. In addition to promoting the transparency of information, the Division also has a statutory responsibility to maintain the confidentiality of specified information. Florida's public records law requires that most workers' compensation accident information be released upon request. However, Chapter 119, F.S., specifies some occupational classes such as law enforcement personnel, firefighters, state attorneys and prosecutors, judges, etc., for which personal information (such as home telephone number and address) and Social Security Number are exempt from public records release. During FY 2010-2011, DQC identified and flagged 4,970 workers' compensation records eligible for this exemption from public records inspection.

Enhanced on-line educational information was made available on the Division's website on how the request process could be expedited and DQC initiated an electronic process to notify requestors when their request has been completed. To date, DQC has protected the exempt information for 28,694 employees.

OFFICE OF MEDICAL SERVICES

The Office of Medical Services (OMS) is responsible for the regulation of medical services in the Workers' Compensation System. Its duties are almost exclusively contained in Section 440.13, F.S. These duties fall into four main areas: developing and adopting the various health care reimbursement manuals; resolving medical reimbursement disputes between providers and payors; certifying Health Care Providers and Expert Medical Advisors; and investigating reports of provider violations. OMS also provides administrative support to the Three-Member Panel. The Three-Member Panel adopts uniform schedules of maximum reimbursement allowances for physicians, hospitals, ambulatory surgical centers (ASC), and other service providers. Upon approval by the Three-Member Panel, OMS works collaboratively with the Bureau of Data Quality and Collection to incorporate the schedules into reimbursement manuals and implement related policies. The Division's Bureau of Monitoring and Audit is responsible for ensuring that carriers meet their obligations under the law, including timely and accurate payment and filing of medical bills. Since the duties of the Bureau and OMS are closely related and require significant interaction and coordination, OMS became part of the Bureau of Monitoring and Audit.

OMS also provides educational assistance and consultation on issues related to medical bill filing and reimbursement. During FY 2010-2011, OMS conducted three Webinar educational seminars for 295 carrier and claims-handling entity participants about the requirements for properly issuing an Explanation of Bill Review (EOBR) in accordance with administrative rule requirements. The EOBRs are used by carriers and claims-handling entities to communicate medical bill reimbursement decisions.

Medical Reimbursement Disputes

OMS is responsible for resolving medical reimbursement disputes between health care providers (HCP) and carriers. Disputes about compensability and medical authorization are addressed by Judges of Compensation Claims. The following five graphics provide an overview of the medical reimbursement dispute resolution process. The term "practitioner" refers to individual providers licensed by the Florida Department of Health to provide medical care.

Graphic 5.1 illustrates the total number of Petitions for Resolution of Reimbursement Dispute submitted to OMS during the last three fiscal years. There was an 82.5% increase in the number of petitions submitted in FY 2010-2011 over the prior year. The primary reason for the increase is the receipt of a large number of petitions related to reimbursement of practitioner-dispensed prescription medication. Despite the increase in the number of petitions submitted, OMS has consistently been able to resolve the petitions well within the 60 days required by statute. In FY 2010-2011, OMS closed petitions within 25 days, on average with the increased workload, compared to an average of 20 days during the prior fiscal year.

5.1 Petitions Submitted by Provider Type

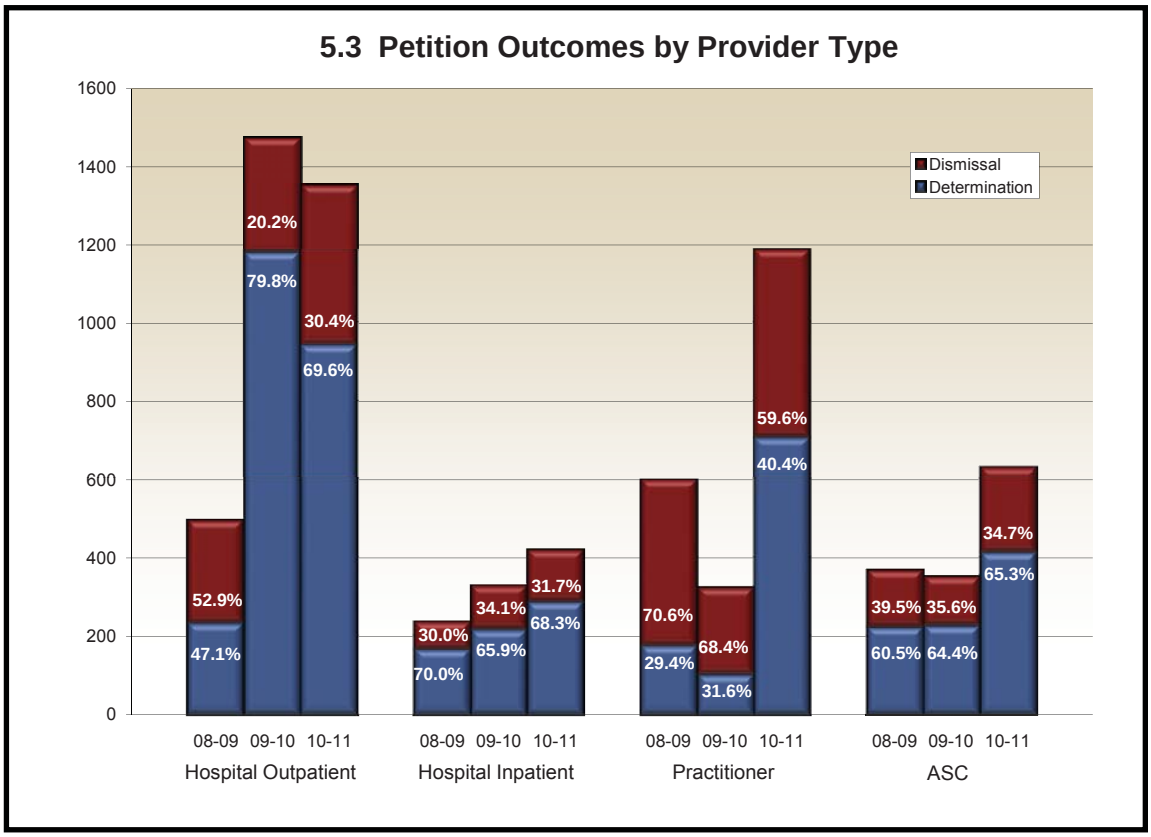
	08-09	09-10	10-11
Practitioner	568	296	1,308
ASC	349	373	655
Hospital Inpatient	244	330	436
Hospital Outpatient	745	1,071	1,378
Total	1,906	2,070	3,777

Graphic 5.2 presents the total number of Petitions for Resolution of Reimbursement Dispute closed during the last three fiscal years by type of outcome.

5.2 Petitions Closed by Type of Closure

	08-09	09-10	10-11
Dismissal	899	753	1,241
Determination	788	1,721	2,345

Graphic 5.3 illustrates the outcome of Petitions for Resolution of Reimbursement Dispute, by provider type, during the last three fiscal years. Hospital Outpatient and Practitioner petitions were the two most frequently filed types, in both the number of filings and dismissals.



Graphic 5.4 illustrates the petitions for which a determination was issued during the last three fiscal years by the reason for the determination. OMS found that the petitioner had been underpaid in more than 93% of all determinations issued. However, in most of those cases, the amount reimbursed to the provider did not equal the billed amount.

Graphic 5.5 illustrates, by reason, the volume of petitions dismissed during the last three fiscal years. The nine reasons listed are the basis for all petitions dismissed during that time. Failure to Cure Deficiency is the primary reason for dismissals, however, there continues to be an increase in the number of petitions withdrawn by the petitioner.

5.4 Determinations Issued by Reason

	08-09	09-10	10-11
Underpayment	715	1,635	2,181
Correct Payment	28	25	41
Overpayment	19	34	28
Other Finding	19	2	5
No Additional Payment Due	9	25	90

5.5 Dismissals Issued by Reason

	08-09	09-10	10-11
Failure to Cure Deficiency	402	236	507
Untimely Filed	234	229	255
Petition Withdrawn	134	199	295
Other Reason	64	15	19
Lack of Jurisdiction	41	45	92
Non-HCP	8	4	30
Managed Care	8	4	9
Not-Ripe for Resolution	6	20	34
Improper Service	2	0	0
Total	899	752	1,241

This fiscal year, OMS issued a Notice of Deficiency to the petitioner for 27.7% of the petitions submitted. For these cases, the petition was ultimately dismissed for one or more reasons 60.2% of the time, which is a 13% increase in this type of dismissal over the prior year. While Failure to Cure Deficiency is the most frequent reason for dismissal of petitions following a deficiency notice, a petition could be dismissed for any of the reasons provided in **Graphic 5.5.**

Health Care Provider and Expert Medical Advisor Certification

OMS certifies health care providers so that they may provide workers' compensation medical services. This permits physicians and other recognized practitioners licensed by the Department of Health to participate in the Workers' Compensation System. As of June 30, 2011, there were 37,216 certified health care providers. OMS also certifies eligible health care providers as Expert Medical Advisors so that they may provide examinations and render expert testimony in OMS investigations and Office of the Judges of Compensation Claims proceedings. As of June 30, 2011, there were 130 certified Expert Medical Advisors.

Provider Investigations

Carriers are required by statute to report overutilization to the Division. OMS is responsible for investigating alleged health care provider violations of Florida's Workers' Compensation Law or administrative rules. However, there is no current administrative rule that governs overutilization reporting or investigation.

To begin that rule development, OMS held a rulemaking hearing to finalize proposed Rule 69L-34, F.A.C., on June 23, 2011. The proposed rule states that a carrier will have satisfied its overutilization reporting obligation by complying with the electronic filing requirements of the Florida Workers' Compensation Medical Services, Billing, Filing, and Reporting Rule (Rule 69L-7.602, F.A.C.). It gives carriers the option to file reports in individual matters via a paper reporting form in addition to the electronic methodology already in place. The new rule is expected to become effective early in FY 2011-2012.

New Initiatives

The American Medical Association publishes the International Classification of Diseases, 9th Revision–Clinical Modification, commonly referred to as the ICD-9-CM, which is the nationally accepted standard for coding disease diagnoses and is used by all types of health care providers and facilities. The next revision, the ICD-10-CM, will become the new national standard effective October 1, 2013. OMS and DQC have worked toward a seamless transition from the ICD-9-CM to the ICD-10-CM.

To accommodate the ICD-10-CM coding differences and facilitate the transition, DQC has implemented an expanded data format for electronic data collection. This change was effective with the implementation of Revision E of the Florida Medical EDI Implementation Guide (MEIG) in July 2010. The revision to the MEIG has prepared the Division and its data submitters for the implementation of ICD-10-CM. To complete this transition, OMS will also need to amend the Florida Workers' Compensation Medical Services, Billing, Filing, and Reporting Rule (Rule 69L-7.602, F.A.C.) and the Florida Workers' Compensation Reimbursement Manual for Hospitals (Rule 69L-7.501, F.A.C.) to incorporate the ICD-10-CM.

OFFICE OF SPECIAL DISABILITY TRUST FUND

The Special Disability Trust Fund (SDTF) was created by the Florida Legislature in 1955 to encourage employers to hire and reemploy individuals with a pre-existing permanent physical disability, by reimbursing the employer for excess costs if the employee experienced a new injury subsequent to being hired and the subsequent work-related injury resulted in a greater permanent impairment. Legislative changes in 1997 resulted in the SDTF being prospectively abolished and statutorily prohibited from accepting any new claims for dates of accident after December 31, 1997. However, in accordance with the statute, carriers continue to be assessed to fund the run-off claims.

Presently, the SDTF has three primary business processes. First, the Fund must review all filed Proofs of Claim to determine if the claim meets eligibility requirements for reimbursement of benefits paid by the carrier and then notifies the carrier whether the claim has been accepted or denied. Second, once a claim is accepted as eligible for reimbursement by the Fund, the carrier must submit documentation of benefits paid on that claim by filing Reimbursement Requests which are audited by the Fund to determine which benefits are eligible for reimbursement payment by the Fund. Third, the Fund must issue accurate reimbursements.

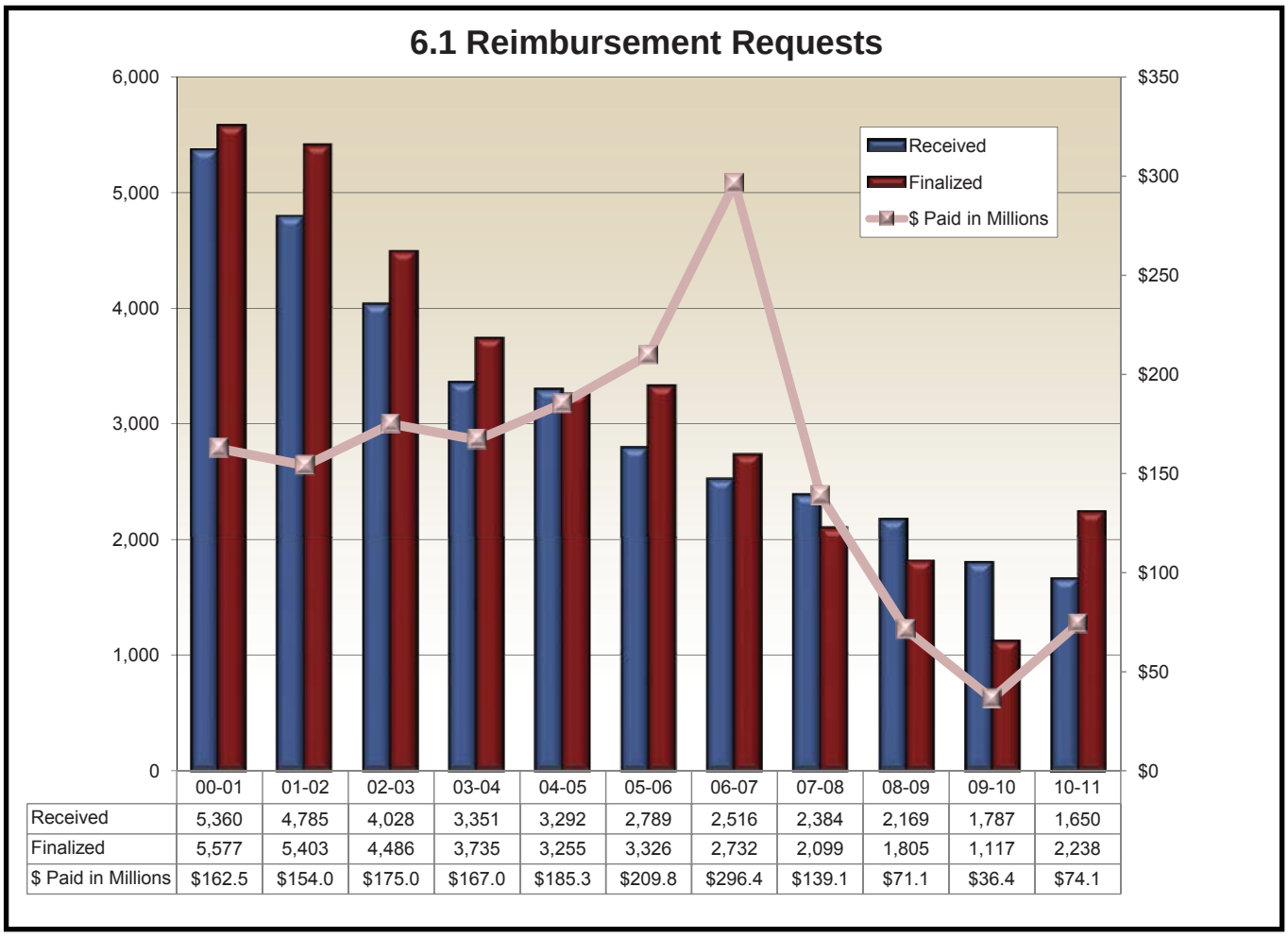
As a direct result of the prospective abolishment of the Fund, there has been a steady decline in the number of Proofs of Claim submitted. Only one new Proof of Claim was received during each of the last two fiscal years. In addition, the number of open claims declined by more than 57% between FY 2000-2001 and FY 2005-2006, when they decreased from 16,286 to 7,073. The number of open claims declined by an additional 23% over the last five fiscal years, with only 5,439 open claims as of 6/30/11. Because the number of new Proofs of Claim filed is so few, the Fund's primary focus has changed to auditing Reimbursement Requests and sending appropriate disbursements to carriers. The payment of Reimbursement Requests is limited to those documented benefits related to accepted claims and is the result of detailed audits conducted and approved by the SDTF.

The cost of operating the SDTF, including reimbursements to carriers, is funded through annual assessments on workers' compensation premiums written by insurance companies, as well as the imputed premium calculated by the Division for individual self-insured employers.

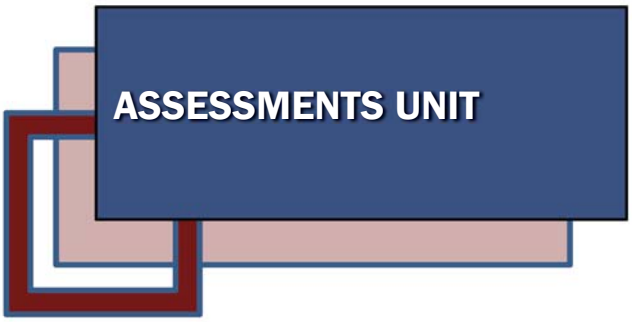
The SDTF has historically relied heavily on paper files and documentation, which resulted in substantial paper files and storage. However, in FY 2009-2010, the SDTF launched an imaging initiative to convert paper documents into electronic images to conserve space, preserve records, and reduce the costs associated with the long-term storage of paper files. Since the implementation of this successful initiative two years ago, the Fund has imaged more than 891,534 pages.

The Fund's next initiative will be to develop an electronic web portal to be used in the submission, review, and approval of Reimbursement Requests. The Fund will be able to leverage some of the electronic data already collected by the Division for use in this process, which will preclude the need for resubmission of some of that data by the carrier. Implementation of such a system will dramatically reduce the paper used, will allow for and encourage more fluid communication between the Fund and its customers, and should reduce the time between submission and final disposition of requests.

Graphic 6.1 illustrates the number of Reimbursement Requests received in comparison to the number finalized since FY 2000-2001, as well as annual disbursements for those Reimbursement Requests.



	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09	09-10	10-11
Received	5,360	4,785	4,028	3,351	3,292	2,789	2,516	2,384	2,169	1,787	1,650
Finalized	5,577	5,403	4,486	3,735	3,255	3,326	2,732	2,099	1,805	1,117	2,238
$ Paid in Millions	$162.5	$154.0	$175.0	$167.0	$185.3	$209.8	$296.4	$139.1	$71.1	$36.4	$74.1



The Workers' Compensation Administration Trust Fund (WCATF)

Annually, the Division is required to estimate the monies and corresponding assessment rate necessary to fund the anticipated expenses for the administration of the Florida's Workers' Compensation System for the upcoming calendar year, taking into account collected penalties, fees, and investment earnings. The expenses of this fund include the administrative costs of the Division and permanent total supplemental benefit payments to eligible injured workers' with dates of accident preceding July 1, 1984. The 2011 Legislature also directed appropriations from the Trust Fund to the following agencies for FY 2011-2012: the First District Court of Appeal, University of South Florida for an occupational safety grant match, Justice Administration Commission for the prosecution of workers' compensation fraud, the Division of Administrative Hearings Office of the Judges of Compensation Claims, the Department of Business and Professional Regulation for the enforcement of farm labor laws, and the Department of Education's Ready to Work Certification Program and Division of Vocational Rehabilitation.

During the nine calendar years from 2001 through 2009, the WCATF assessment rate was decreased from 2.75% in 2001 to a low of 0.25% in 2008, where it remained for two years. Those assessment decreases resulted in a 91% net cumulative reduction during the period, partially due to significant Trust Fund surpluses and increased penalty revenue. These surplus monies were used over time to maintain significantly lower assessment rates than would have otherwise been necessary to fund the expenses described above. Recent economic conditions have impacted employment rates and payroll dollars and resulted in reduced premium dollars. This accelerated the use of the surplus and necessitated an incremental increase to 0.98% for 2011 and 1.75% for 2012.

Graphic 7.1 and **Graphic 7.2** provide another view of the breakout of total revenues and disbursements for the WCATF during FY 2010-2011.

7.1 WCATF Revenues FY 10-11	
WCATF Assessment	$29,997,602
Penalties	$12,289,656
Fees	$3,321,628
Interest Income	$2,473,196
Other	$330,054
Total	$48,412,136

7.2 WCATF Disbursements FY 10-11	
Transfers to Other Agencies	$44,414,838
DWC Salaries, Benefits, & OPS	$20,547,208
PT Supplemental Benefits	$18,000,696
Service Charge to General Revenue	$3,475,219
Other	$3,299,572
Total	$89,737,533

The Special Disability Trust Fund (SDTF)

The SDTF reimburses carriers for eligible expenses incurred when an employee experiences a new injury or illness resulting in a greater impairment. The SDTF was prospectively abolished and thus prohibited from accepting new claims for dates of accidents after December 31, 1997. However, assessments must still be collected to finance the SDTF's unfunded liabilities for accidents that occurred on or prior to December 31, 1997.

The SDTF reimburses carriers for eligible claims and funds the administrative expenses associated with operation of the SDTF. These costs are funded through quarterly assessments on workers' compensation premiums written by insurers and quarterly assessments on the amount of premium calculated by the Assessments Unit (Assessments) for self-insured employers. This Trust Fund is funded primarily through assessments which are supplemented by SDTF's investment income as well as Fund surpluses. Assessments collected approximately $60 million in assessment revenue in FY 2010-2011 from carriers.

Effective July 1, 2010, the SDTF assessment rate was reduced to 1.46% from the statutorily capped rate of 4.52% (which was in effect from 1994 until July 1, 2010). Effective January 1, 2012, the rate will be further reduced to 1.44%.

Graphic 7.3 and **Graphic 7.4** illustrate the breakout of total revenues and disbursements for the SDTF during FY 2010-2011.

7.3 FY 10-11 SDTF Revenues	
SDTF Assessments	$60,471,151
Investment Income & Other	$4,582,763
Total	$65,053,914

7.4 FY 10-11 SDTF Disbursements	
SDTF Disbursements	$73,930,214
Service Charge to General Revenue	$6,811,249
Salaries, Benefits & Other	$1,782,616
Total	$82,524,079

The Assessments Unit (Assessments)

The Division administers the above two trust funds whose funds are required to be kept separate by law. To support each of these trust funds, all carriers must pay statutorily required assessments based on the assessment rate and their applicable Florida workers' compensation premiums. Assessments calculates annual assessment rates for these trust funds by projecting the expected expenditures, revenues, fund balances, statewide future Florida workers' compensation assessable premiums, and by taking into account statewide changes in both the payroll and the employment levels.

Annually, Assessments notifies all carriers of the upcoming year's assessment rate for each trust fund by distributing Informational Bulletins and copies of the Assessment Rate Orders issued by the Chief Financial Officer.

During FY 2010-2011, Assessments invoiced 413 individual self-insurers. The invoiced amounts are calculated by Assessments after determining the actual premium that would have been paid if the self-insured employer had purchased workers' compensation coverage. Assessments also distributed 385 Quarterly Premium Reports to insurers to notify them of their responsibility to report and to pay their assessments. Assessments then collected those payments and confirmed that the approved assessment rate was applied to all insurers' net reported compensation premiums. Assessments also validates and audits carriers' reported premiums with other third-party sources.

During the past year, one of Assessment's priorities was to improve the timeliness and cost effectiveness of the distribution of materials to carriers. Assessments achieved this by electronically distributing reports, invoices, updates, and rate orders instead of using certified mail. In turn, carriers were able to more promptly return their completed materials electronically. Assessments also initiated improved tracking processes that allow the Division to measure the timeliness of payments and initiate follow-up with carriers, the Florida Self-Insurers Guaranty Association, and other internal partners.

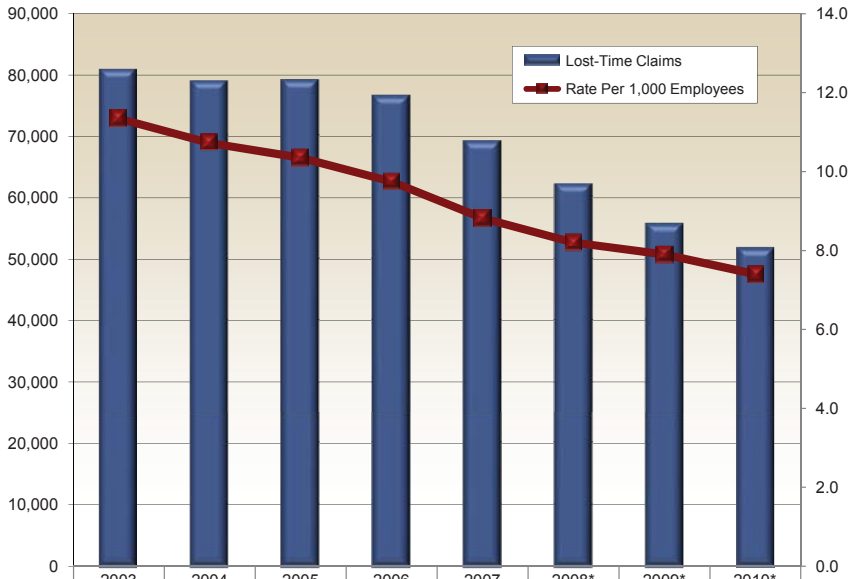
LOST-TIME CLAIMS DATA

Frequency and Rate of Lost-Time Claims

The number of lost-time claims has consistently declined since 2003, as illustrated in **Graphic 8.1**. This downward trend accelerated in 2007, with a decline of 9.6% in the number of claims reported for that year compared to the previous year, which is more than triple the rate of decline for each of the prior three years. **Graphic 8.1** also illustrates the statewide lost-time claim rate per 1,000 employees in Florida, excluding federal government employees.

During 2010, the rate of lost-time claims per 1,000 employees had wide variation by county throughout Florida, ranging from lows of 4.3 and 5.2 in Leon and Seminole Counties respectively, to highs of 17.5 in Okeechobee County and 19.5 in Glades County. The number of statewide lost-time claims per 1,000 employees for 2010 was 7.4. Seventeen counties had lost-time claim rates exceeding 10 cases per 1,000 employees, up from 13 counties in 2009. The statewide lost-time claim rate per 1,000 employees shows a consistent decrease, dropping from 11.3 in 2003 to 8.8 lost-time accidents per 1,000 employees in 2007. Lost-time claims per 1,000 employees for Injury Years 2008 through 2010 are considered preliminary data and will likely increase as some medical only claims convert into lost-time claims.

8.1 Lost-Time Claims and Lost-Time Claim Rate**



	2003	2004	2005	2006	2007	2008*	2009*	2010*
Lost-Time Claims	80,670	78,693	78,835	76,270	68,970	61,972	55,566	51,598
Rate Per 1,000 Employees	11.3	10.7	10.4	9.7	8.8	8.2	7.9	7.4

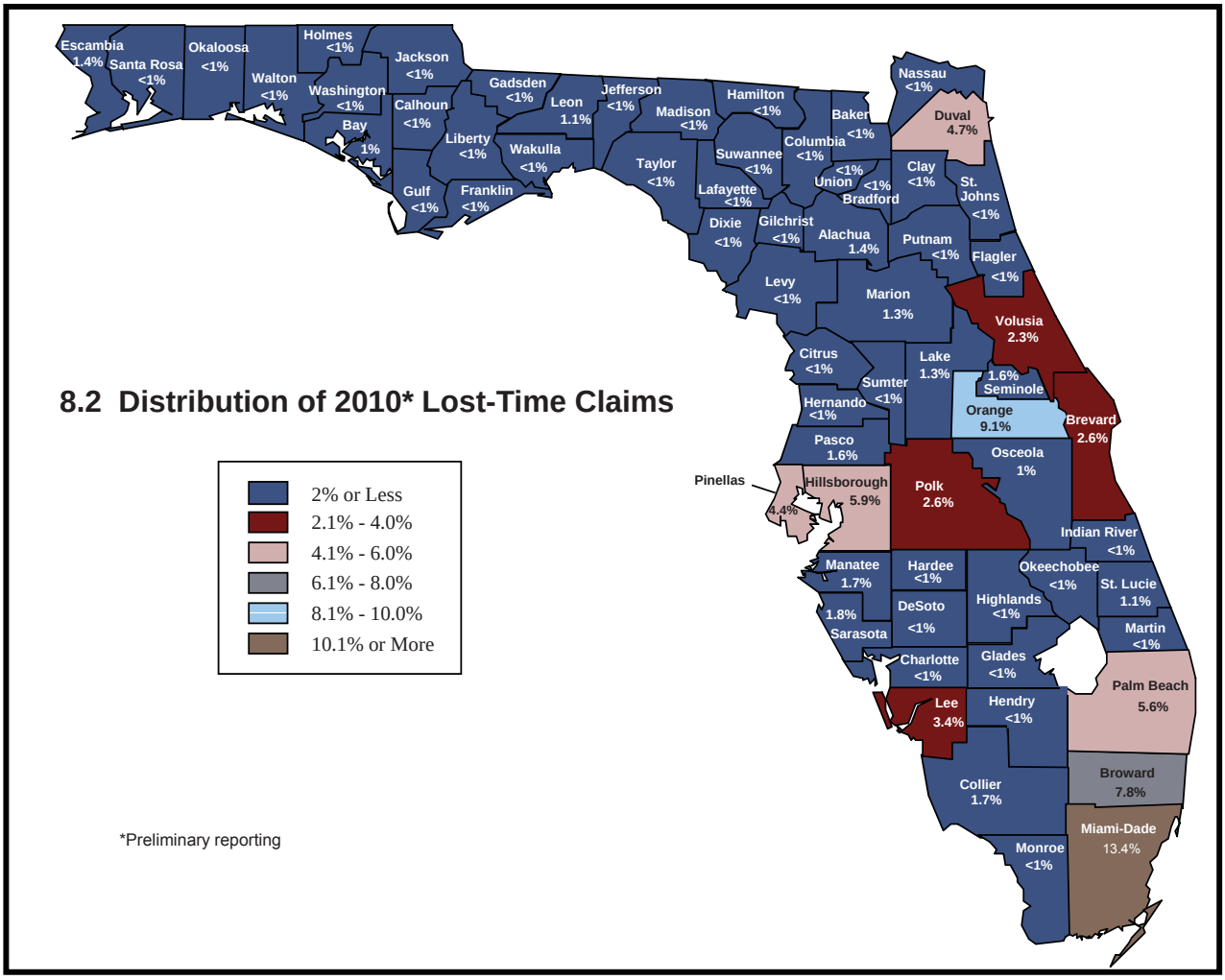
*Preliminary Data

**Lost-time claim frequencies as of 6/30/11, based on the most recent information from insurers about determinations & dispositions.

Source: DWC Integrated Database as of 6/30/11 & the Agency for Workforce Innovation, 2002-2011 Statewide Quarterly Census of Employment and Wages (excluding federal government employment) released July 2011

Geographic Distribution of Lost-Time Cases

Graphic 8.2 shows the distribution of all lost-time claims by county for 2010. Counties with large working populations experience a greater number of lost-time accidents. For example, Miami-Dade County, with the largest workforce in the State, accounted for the largest number of lost-time cases reported (13.4%) for a single county in 2010. Five other highly populated counties (Broward, Duval, Hillsborough, Orange, and Palm Beach) had 33% of all lost-time claims, and the top ten most populated counties had 59.5% of all lost-time claims.

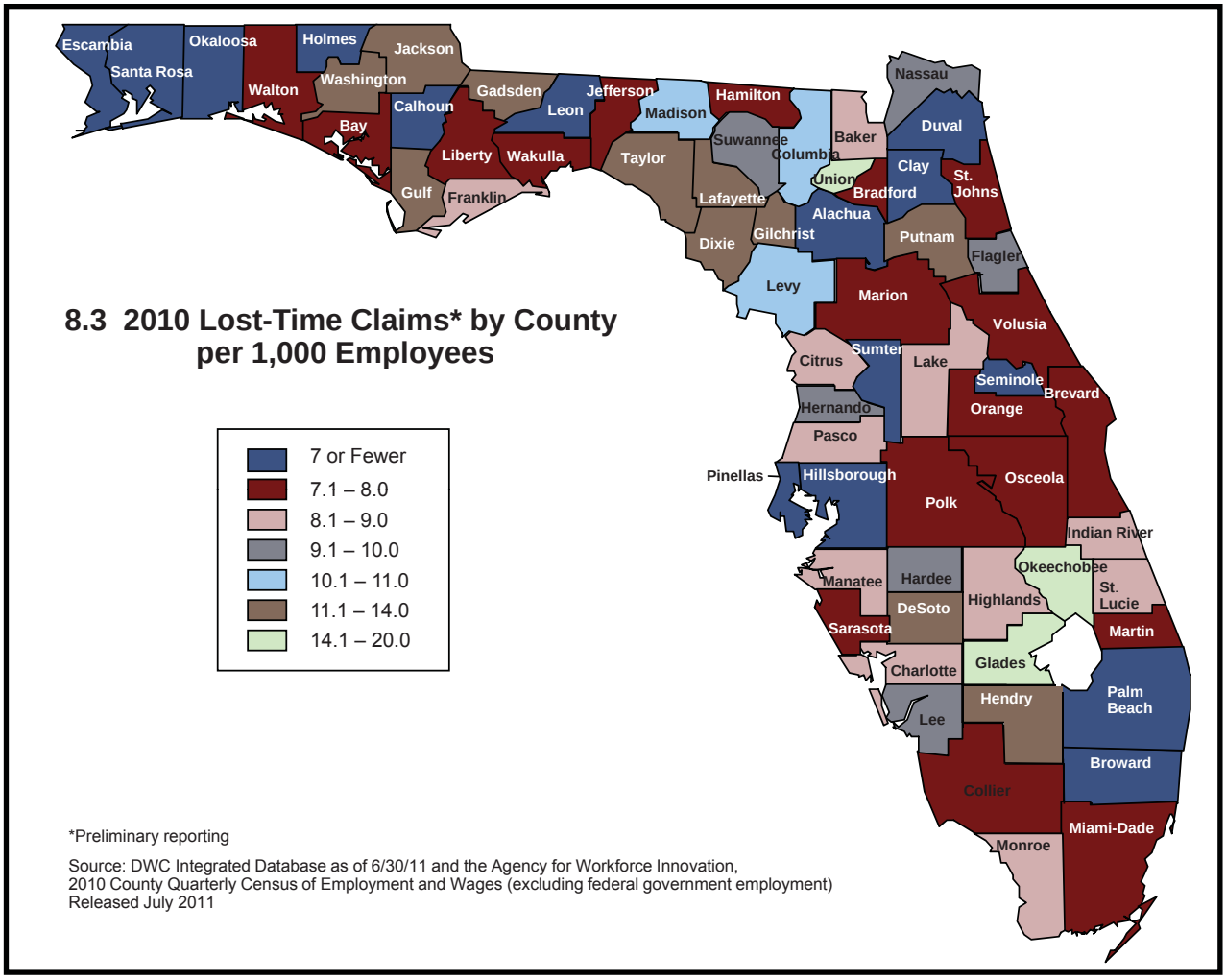


As illustrated in **Graphic 8.3**, the four counties in Florida with large concentrations of employment (Broward, Duval, Hillsborough, and Palm Beach Counties), had lost-time claim rates below the statewide rate of 7.4 per 1,000 employees. Miami-Dade County was slightly higher at 7.5 claims per 1,000 employees. Conversely, counties with smaller workforces sometimes reflect a higher lost-time case rate even though the number of actual lost-time cases is relatively small. Glades, DeSoto, Okeechobee, and Union counties, with comparatively small workforces, had claim rates that ranged from 13.1 to 19.5 claims per 1,000 employees, yet each had less than 1% of all lost-time claims for the entire State.

Prior Claims

Of the employees injured during the last four years, 85% had not reported a lost-time claim within the five calendar years preceding their reported accident. An additional 12% of injured workers had reported one additional lost-time claim over the same five-year period. Only 3% of injured workers who reported lost-time claims had filed at least two additional claims in the preceding five calendar years. Variation from year to year in the distribution of prior claims has been negligible.

Graphic 8.4 displays the respective shares of lost-time claims over the past eight years, for the three primary types of carriers in the workers' compensation insurance market: insurance companies, self-insured employers, and self-insurance funds. Insurance companies



consistently dominated the distribution, with more than three-quarters of all claims. During this eight-year period, the amount of lost-time claims reported by insurance companies decreased from 77.7% to 74.9%, while the percent reported by self-insured employers increased similarly from 18.4% to 22.2% during this same time period. During 2010, several self-insurance funds converted their business to insurance companies, which resulted in a change in the proportion of claims associated with the different carrier types.

Industry Type

The frequency of lost-time claims for 2010 in the top ten industrial classifications is illustrated in **Graphic 8.5**. These classifications, assigned to industry groups under the North American Industry Classification System (NAICS), were reported for 99.8% of 2010 lost-time claims. The rankings for 2010 mirrored those for 2009, except that Health Care & Social Assistance moved up to third place and Public Administration moved down to fourth place. Retail Trade had more lost-time claims than any other category, followed closely by Administrative, Support, Waste Management,

8.4 Lost-Time Claims by Insurer Type

	Insurance Companies	Self-Insured Employers	Self-Insurance Funds
2003	77.7%	18.4%	3.9%
2004	76.3%	19.2%	4.5%
2005	75.0%	20.2%	4.8%
2006	75.2%	20.0%	4.8%
2007	74.4%	21.1%	4.5%
2008*	76.3%	21.3%	2.4%
2009*	75.1%	22.2%	2.7%
2010*	74.9%	22.2%	2.9%

*Preliminary Data

and Remediation. Only 226 claims separate these two leading categories. The top ten industrial classifications represent 83.7% of all lost-time claims reported for 2010. Because reporting of claims for 2010 is preliminary, frequencies and the ranking order of industrial classifications may change slightly with further reporting.

8.5 Top Ten Industrial Classifications for 2010* Lost-Time Claims

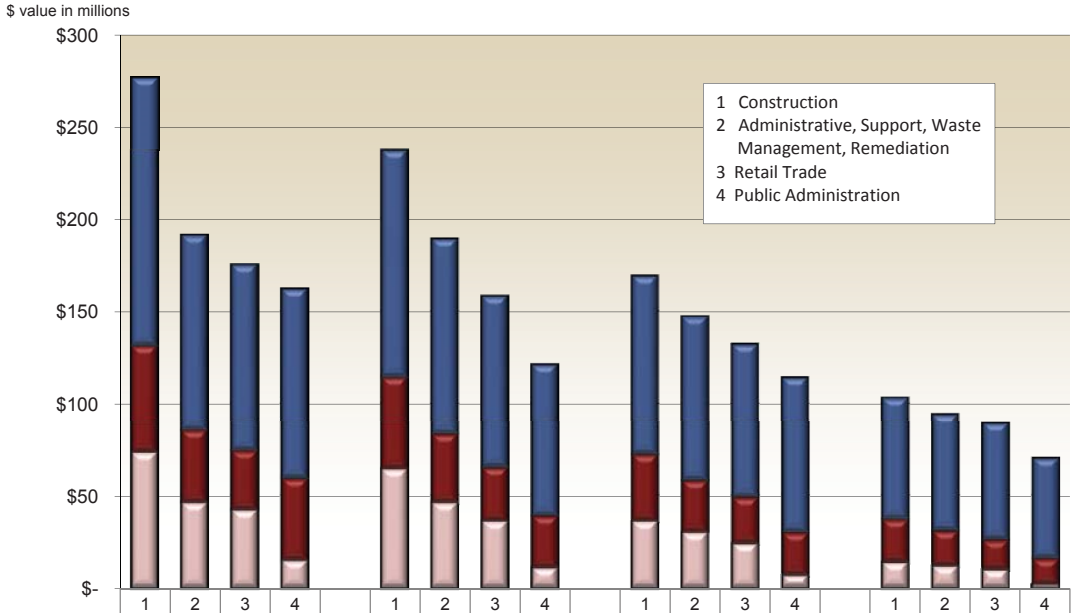
	Number of Claims
Retail Trade	6,356
Administrative, Support, Waste Management, Remediation	6,130
Health Care & Social Assistance	4,980
Public Administration	4,939
Construction	4,833
Accommodation & Food Services	4,273
Manufacturing	3,506
Transportation & Warehousing	3,304
Educational Services	3,185
Wholesale Trade	1,688

*Preliminary Data

Graphic 8.6 displays total benefit payments for the four industrial classifications with the highest benefit payments for medical, indemnity, and settlement benefits. Construction consistently had the most benefit payments of all the industrial classifications for this time period.

For 2010, the ranking order of payment totals for the four leading industrial classifications are: Construction; Administrative, Support, Waste Management, Remediation; Retail Trade; and Public Administration. Each year illustrated represents a different level of data maturity, with only the earliest year, 2007, deemed mature. This offers a perspective for comparing the impact of claim development on benefit payments. For example, the share of medical benefits paid in 2010 represents 64% to 77% of the total benefit payments for that year, depending on the type of industrial classification. By contrast, medical benefits for 2007 range from 53% to 64% because the proportions for indemnity and settlement benefits grow over time as the need for medical services diminishes. Construction consistently has the highest payments associated with settlement benefits and Public Administration has the lowest payments. In all, differences associated with claim development demonstrate the priority of medical services early in the life of a claim and the increasing significance of settlements as claims develop.

8.6 Benefit Payments for the Four Leading Industrial Classifications



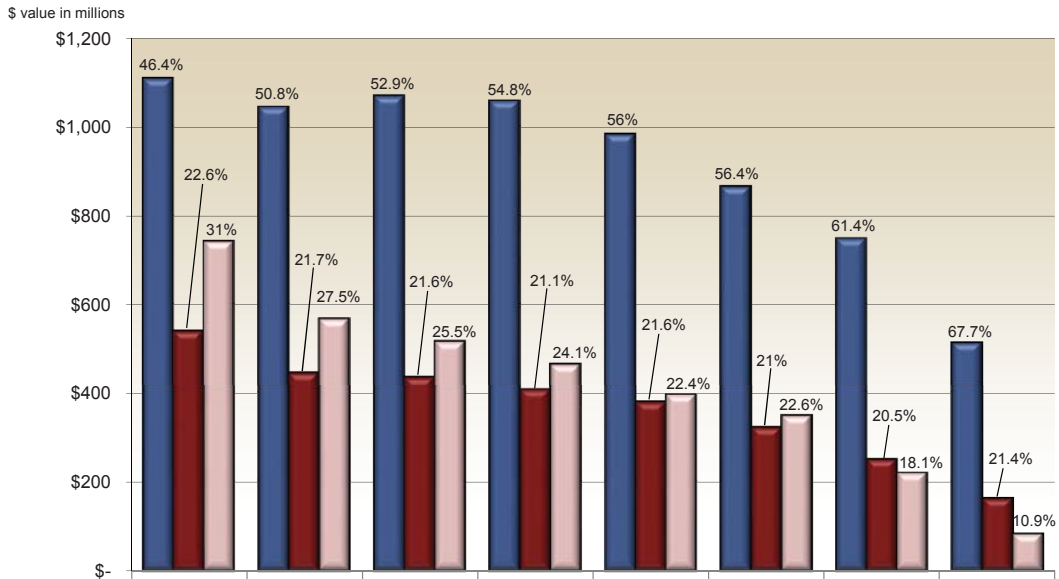
	2007				2008*				2009*				2010*			
Injury Yr	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Medical	$146	$106	$101	$103	$123	$106	$93	$82	$97	$89	$83	$84	$66	$63	$63	$54
Indemnity	$58	$39	$32	$44	$50	$37	$29	$28	$36	$28	$25	$23	$23	$19	$16	$14
Settlement	$73	$46	$42	$15	$64	$46	$36	$11	$36	$30	$24	$7	$14	$12	$10	$2

*Preliminary Data

Benefits Paid

Under Florida's Workers' Compensation Law, workers who sustain a compensable work-related injury are entitled to receive medically necessary medical treatment. If the injury causes loss of more than seven days from work, the injured worker is entitled to payment for a portion of lost wages. Additional benefits may be provided for injuries resulting in permanent impairment and workplace fatalities may qualify for payment of survivor benefits and/or funeral expenses. Treatment for a work-related injury may involve care by physicians or other health care providers; services at hospitals, ambulatory surgical centers, or skilled nursing facilities; prescription drugs, and related items such as prosthetic devices or implants. Medically necessary care is provided as the nature of injury or process of recovery may require. Benefit payments for lost wages or permanent impairments depend on many factors, including the injured worker's prior earnings, the nature and extent of the injury, and the length of time the injured worker is medically unable to work.

8.7 Medical, Indemnity, and Settlement Costs for Lost-Time Claims



	2003	2004	2005	2006	2007	2008*	2009*	2010*
Medical	$1,108.1	$1,042.8	$1,066.9	$1,056.4	$981.3	$863.6	$746.8	$512.3
Indemnity	$539.0	$445.0	$434.7	$406.3	$378.1	$321.2	$249.7	$162.0
Settlements	$740.1	$566.0	$514.8	$463.3	$394.3	$347.2	$219.0	$82.3

*Preliminary Data

Graphic 8.7 illustrates cumulative payments for indemnity, medical, and settlement benefits by Injury Year since 2003. These amounts are unadjusted for inflation. The graphic also shows what proportion each type of benefit is, which provides another view of claim development over time. For example, medical treatment comprises 67.7% of the costs for 2010 claims, but only 46.4% in 2003. However, settlement benefits represent only 10.9% of the costs for 2010 claims, compared to 31% for 2003 claims. Settlement amounts includes both medical and indemnity costs.

Graphic 8.8 breaks out medical costs into four categories: health care providers, dental, and ambulatory surgical center costs; hospital costs; pharmacy costs; and "all other" costs. For injury years with mature data, 2003 through 2007, the proportion of costs associated with health care providers, dental, and ambulatory surgical centers and "all other" providers show very minor variations from year to year. There was a small decline for pharmacy costs, from 9.3% to 6.1% for mature data, and small growth for hospital costs from 34% to 36%.

8.8 Medical Payments for Lost-Time Claims

	Health Care Providers, Dental, Ambulatory Surgical Center	Hospital	Pharmacy	All Other Medical
2003	38.2%	34.0%	9.3%	18.5%
2004	39.6%	33.9%	8.5%	18.0%
2005	39.9%	34.5%	7.5%	18.1%
2006	39.5%	36.1%	6.5%	17.9%
2007	39.2%	36.0%	6.1%	18.7%
2008*	40.8%	35.3%	5.2%	18.7%
2009*	40.0%	37.8%	4.4%	17.8%
2010*	33.9%	46.9%	3.5%	15.7%

*Preliminary Data

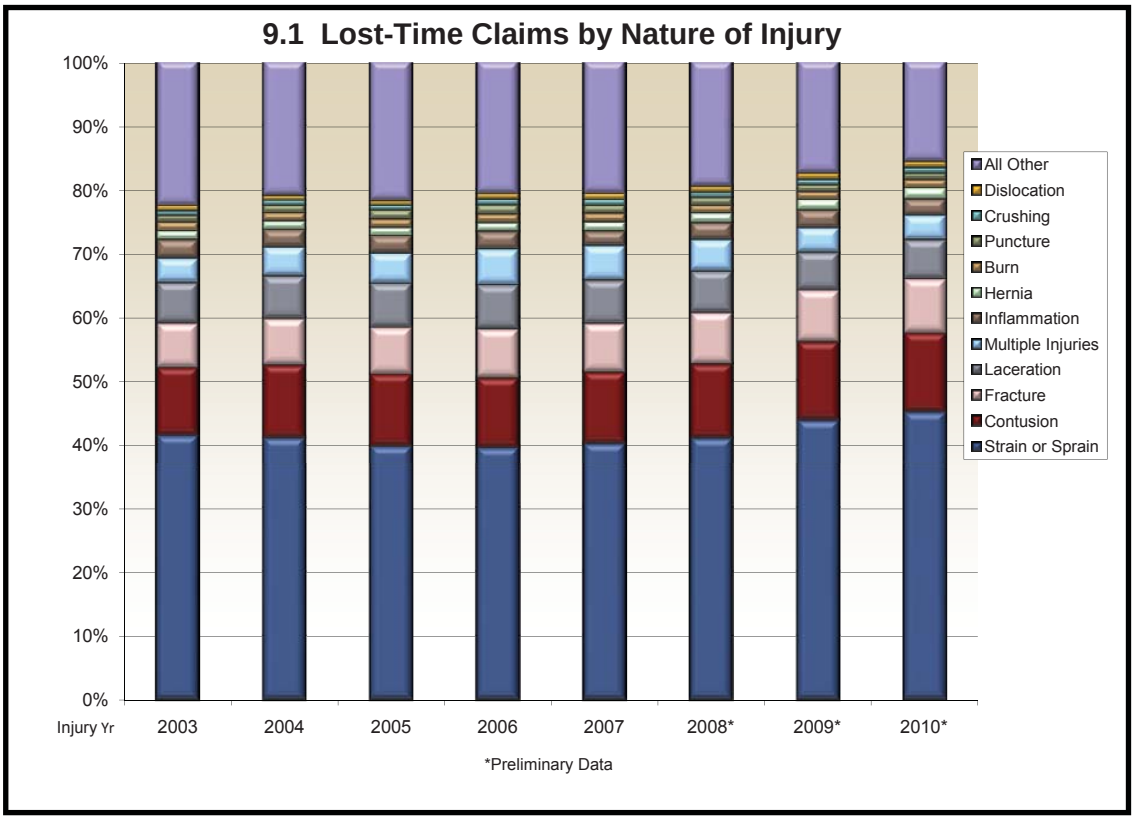
NATURE, CAUSE, AND BODY LOCATION OF WORKPLACE INJURIES

As part of the First Report of Injury or Illness, employers provide information on the nature, cause, and body part of each workplace injury. This chapter summarizes that information to provide current and historical patterns of lost-time injuries.

Because the information in this chapter is reported by employers to their carriers via the First Report of Injury or Illness, it may not correspond to a diagnosis made by a health care professional.

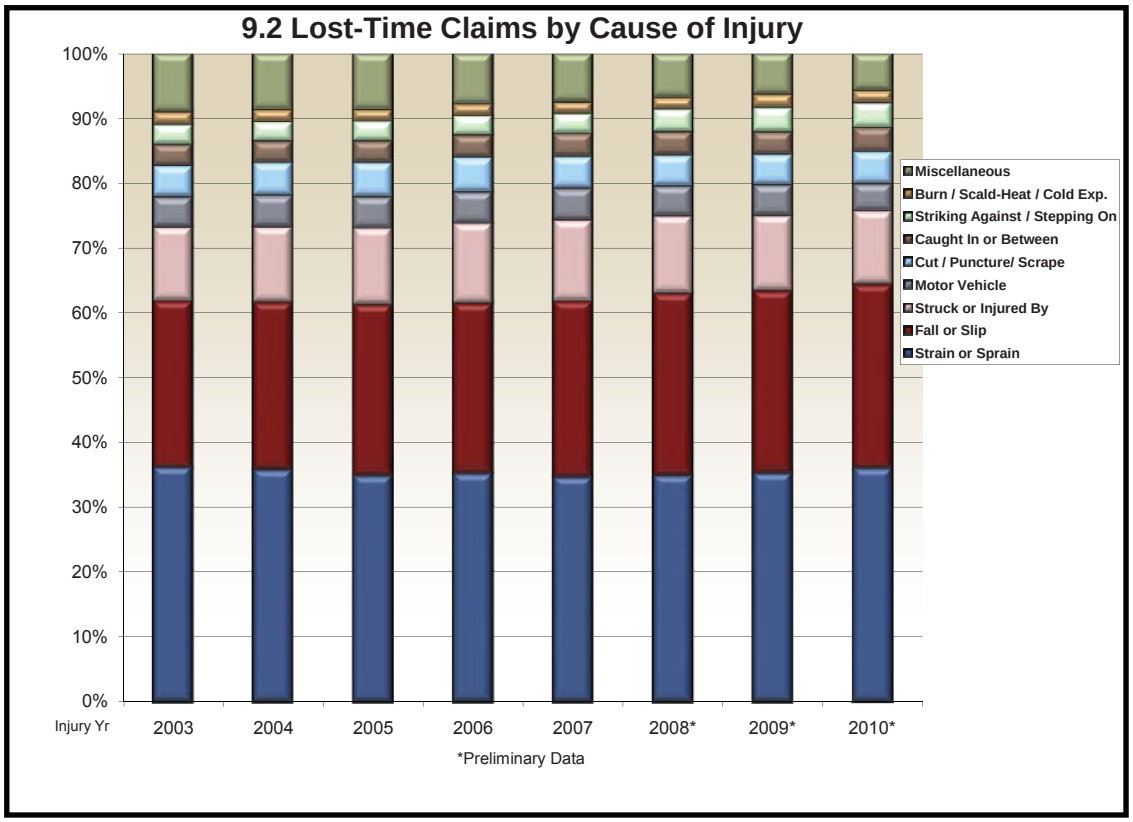
Nature of Injury

Injuries underlying a large proportion of lost-time claims typically fall into four categories. For 2010, Strain or Sprain was the leading injury, comprising 45.1% of all lost-time injuries. Contusion (12.4%), Fracture (8.5%), and Laceration (6.1%) followed. **Graphic 9.1** illustrates that the four leading nature of injury types have not changed over time. The four leading injuries combined increased proportionally during the last four years and comprised 72.1% of the 2010 injuries.



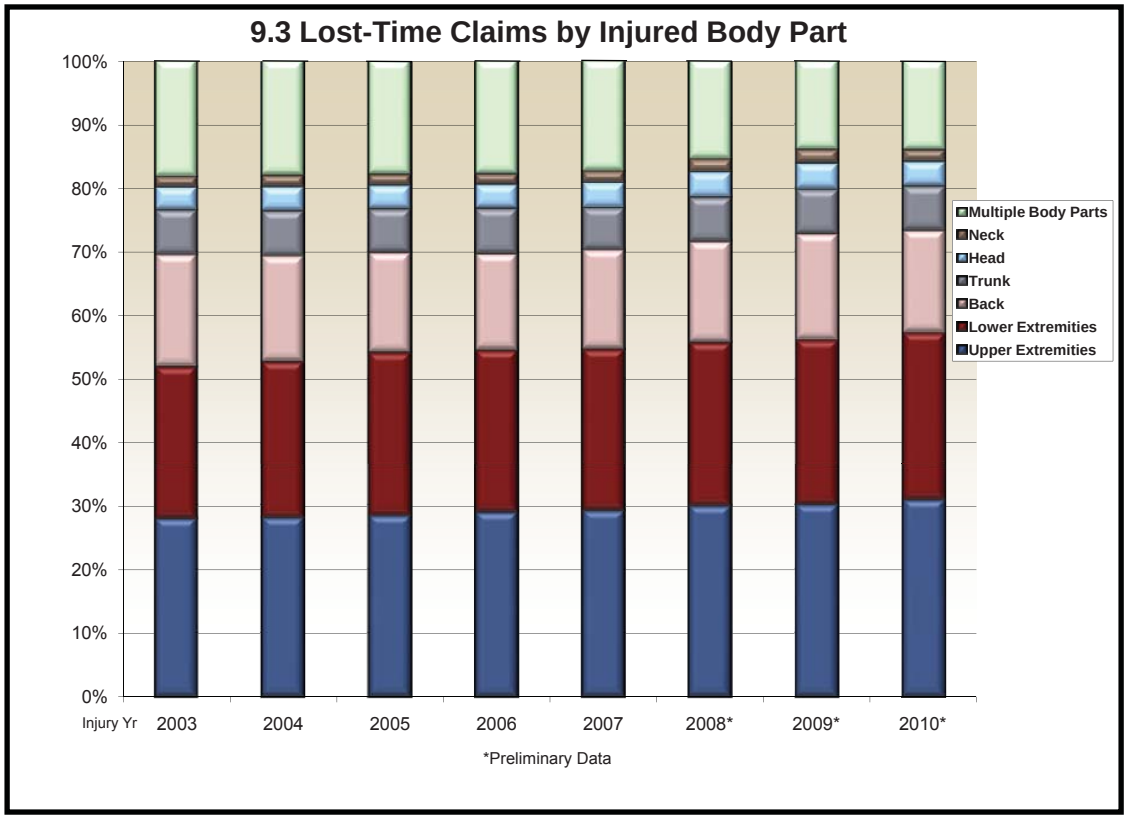
Cause of Injury

The three primary causes of injuries for 2010, which represent 75.7% of all lost-time claims, were Strain or Sprain; Fall or Slip, and Struck or Injured By. The Strain or Sprain category was reported most often, resulting in 35.9% of all injuries. This category of workplace injuries includes causes such as pushing, pulling, reaching, twisting, lifting, throwing, carrying, jumping or repetitive motion which results in a strain or sprain injury. Fall or Slip, the second most frequently reported cause of injury, accounted for an additional 28.5% of lost-time accidents. This includes falls, slips or trips due to liquids on surfaces, falls from ladders, scaffolding, and from elevation variations. The third leading cause of injury was the Struck or Injured By category at 11.3% of lost-time injuries and includes injuries involving encounters with insects or animals, or struck by other people and objects. **Graphic 9.2** shows the reported injury causes over time. There has been little deviation from year to year among the different causes of injury.



Body Location of Injury

Graphic 9.3 illustrates the distribution of lost-time claims by injured body part over the last eight years. As illustrated, the proportions for both Upper and Lower Extremities injuries both increased by more than two percentage points from 2003 through 2010. Injuries to Multiple Body Parts have correspondingly decreased more than four percentage points during the same time.

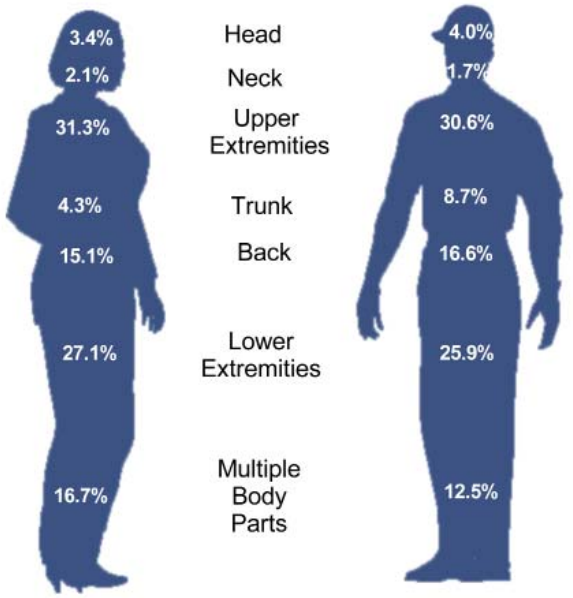


Gender and Age

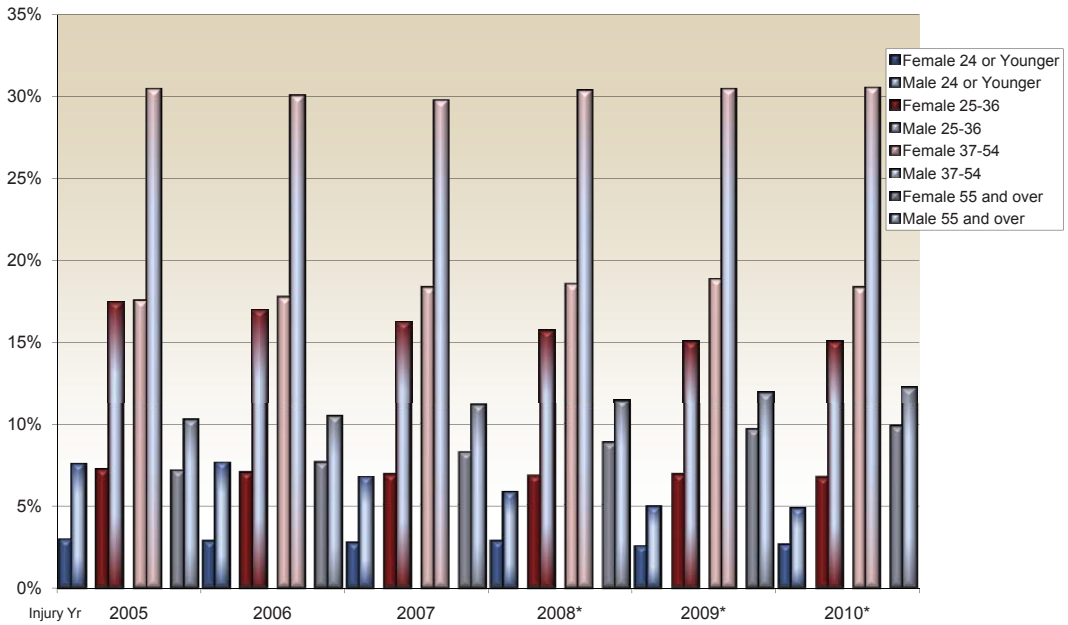
Graphic 9.4 shows the distribution of injured body parts by gender for lost-time injuries in 2010. Several gender-related differences are apparent. Injuries to the trunk region were 8.7% of all lost-time claims for men and 4.3% for women. By contrast, injuries to multiple body parts were 16.7% of lost-time claims for women and 12.5% for men. Overall, lost-time claim counts reflect a nearly two-to-one ratio of men to women with the proportion of women being injured increasing from 34.7% of all lost-time injuries in 2005 to 37.4% of all injuries in 2010.

The distribution of lost-time cases by gender and age group is illustrated in **Graphic 9.5**. During the last six calendar years, males between 37 and 54 have consistently comprised the largest segment of lost-time cases, about 30% for each year. Similarly, females in the same age range were the second largest segment of lost-time cases, at 18% to 19% each year. Injuries for both male and female workers 55 and older have consistently increased with male injuries increasing from 10.2% to 12.2% during the six-year period and female injuries increasing from 7.1% to 9.8% of all injuries during the same time. The largest decrease was for males 24 or younger whose percentage of injuries dropped from 7.5% to 4.8%. It is noted that the median age for all injured workers at the time of accident has increased over time from 41.7 in 2002 to 45.4 in 2010.

9.4 Injury Body Location by Gender for 2010 Lost-Time Claims



9.5 Lost-Time Claims by Age/Gender



MEDICAL DATA

The Bureau of Data Quality and Collection receives nearly four million medical bill records each year via electronic submission, which is the largest volume of data electronically received by the Division. This receipt of data follows a series of events that begins with a workplace injury that requires medical care from a physician, hospital, ambulatory surgical center (ASC), pharmacy, or other health care provider. These providers submit medical bills for payment of rendered services to the applicable carrier using standard medical claim forms (or electronic equivalents). The carrier, or more frequently, a medical bill review vendor that has a contract with the carrier, adjudicates the medical bill.

Review and payment determination may require the involvement of many different parties and require that information submitted on paper be converted into an electronic format. The reimbursement amount for each bill may be based on prices negotiated by the carrier, managed care contracts, or the maximum reimbursement allowance contained in reimbursement manuals adopted by the Three-Member Panel. However, prescription reimbursement is based on prices negotiated by the carrier, managed care contracts, or the statutory formula contained in Chapter 440, F.S. Results of the adjudication, along with information about the medical services provided, are transmitted to the Division via proprietary electronic formats, as required by administrative rule.

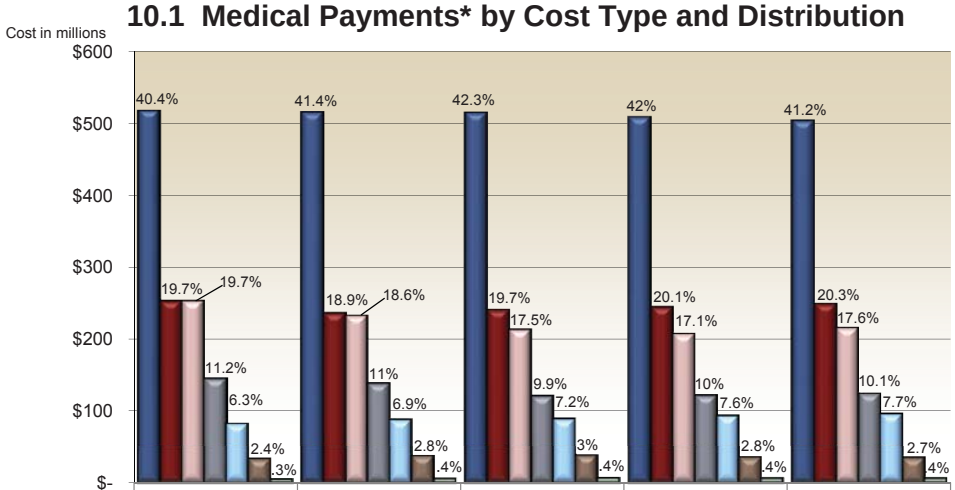
The Division screens incoming medical bills using hundreds of automated structural and quality data edits that reject bills that do not meet Division requirements. Submitters are notified almost instantaneously if submitted bills failed the edits and were rejected. Rejected medical bills are not considered timely filed until corrected, re-submitted, and accepted by the Division. Medical bills that pass the edits are added to the Medical Data Warehouse, which serves as the source of information reported in this chapter.

Information contained in this chapter pertains to both lost-time and medical only claims. Data aggregation is by calendar year of the date of service, rather than injury year. The data for each year in this chapter is restricted to medical bills received and accepted by the Division no later than six months after the end of that year. Payment totals in this report may differ from those previously reported as a result of payment disputes being resolved and data submitted to the Division or adjustments to previously submitted medical bill data.

Graphic 10.1 illustrates payments for seven medical payment cost components and the percent of payments that each component represents for all payments that year. For example, health care provider payments are consistently the largest cost component, with payments reaching more than $500 million each year. Payments to health care providers consistently represent 40% to 42% of the monies paid for the seven cost components displayed in **Graphic 10.1**. These data further illustrate that the ranking order of cost types by payment volume did not change for the years depicted, with only one minor exception. In 2006, hospital inpatient services slightly surpassed hospital outpatient services, $251.7 million compared to $251.6 million. Payments to health care providers exceeded total hospital costs each year, with hospital outpatient and inpatient payments combined ranging from $503.3 million for 2006 to $461.6 million for 2010. Ambulatory surgical center was the only cost type with a consistent annual increase in payments, from $80.6 million to $94.2 million. However, ambulatory surgical centers represent only 6% to 8% of total payments each year.

Graphic 10.2 illustrates the amount of time between the year during which an injury occurs and medical treatment is provided. More than two-thirds of the medical bills are submitted for treatment rendered during the first year. However, 14% to 17% of the treatment occurs more than five years after the year of the accident, which presumably involves the most severe injuries.

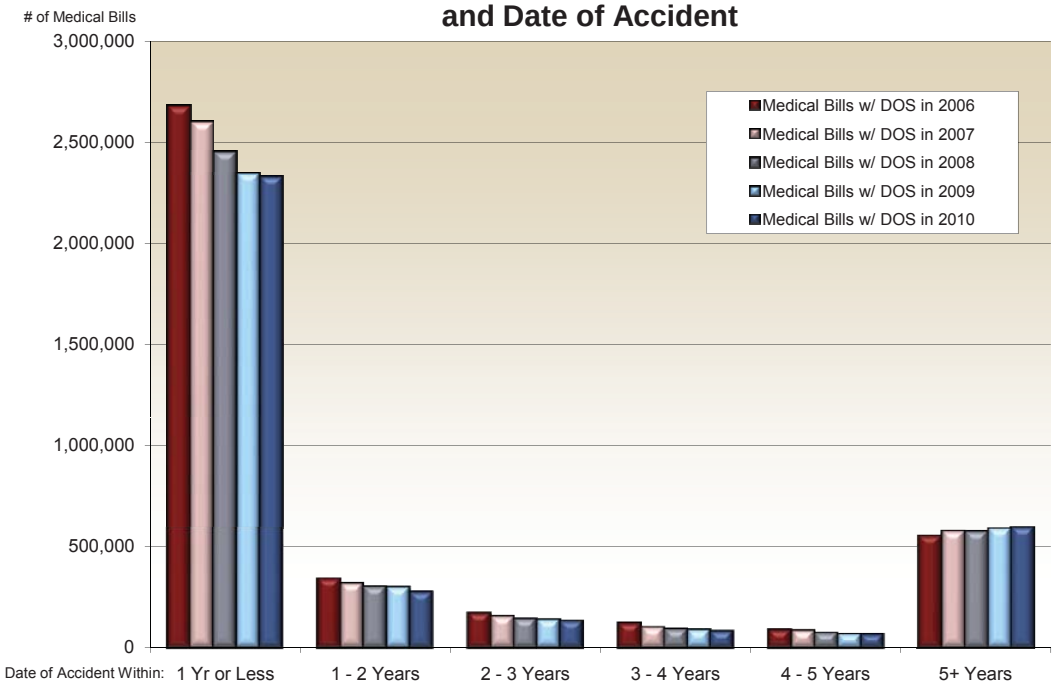
10.1 Medical Payments* by Cost Type and Distribution



	2006	2007	2008	2009	2010
Health Care Provider	$517.4	$514.1	$513.4	$507.6	$502.7
Hospital Outpatient	$251.6	$234.7	$239.2	$242.9	$247.4
Hospital Inpatient	$251.7	$231.0	$211.8	$205.9	$214.2
Pharmacy	$143.7	$137.0	$119.6	$120.6	$123.1
Ambulatory Surgical Center	$80.6	$86.0	$87.1	$92.0	$94.2
Medical Supplies	$31.2	$35.1	$35.9	$33.2	$32.5
Dental	$3.9	$4.6	$5.2	$4.8	$4.9

*Excludes bills received beyond six months of the end of the calendar year of service.

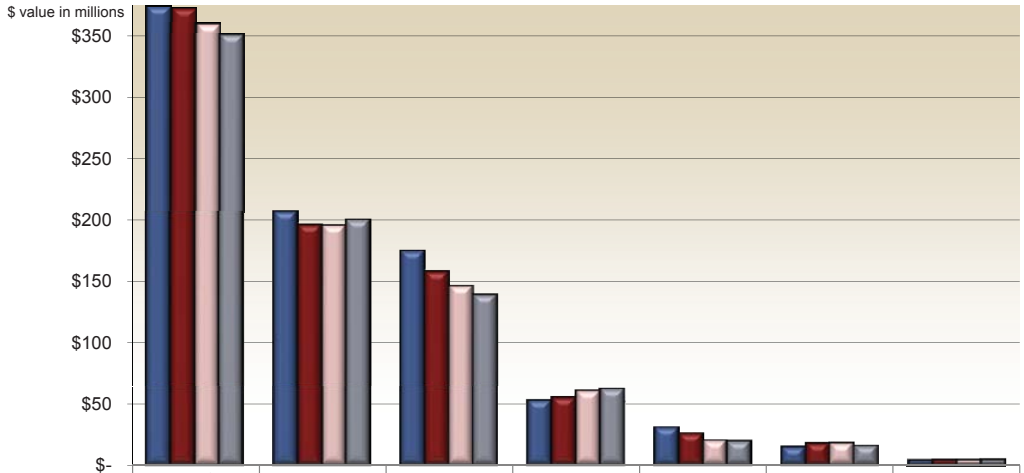
10.2 Correlation Between Medical Bill by Date of Service* and Date of Accident



*Excludes bills received beyond six months of the end of the calendar year of service.

Graphic 10.3 illustrates the type and cost of treatment rendered during the first year following an injury. Total costs for treatment during 2009 for these seven categories was $788.6 million. Health care providers received about 45% of those payments. Payments to ambulatory surgical centers, which proportionately received 6% to 8% of the payments, were the only payments that increased consistently over the four-year period.

10.3 Total Medical Paid* for Services Provided within 12 Months of Injury

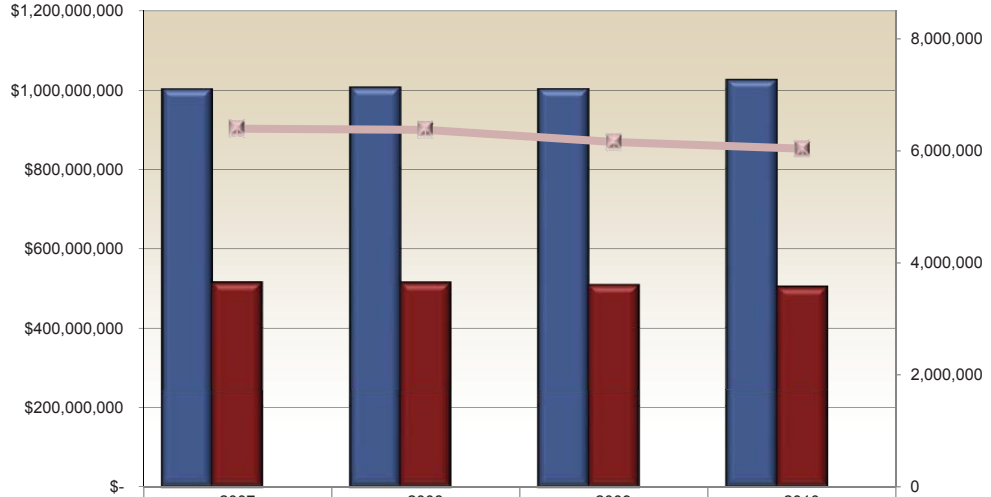


Injury Yr	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental
2006	$373.7	$205.8	$174.0	$51.9	$30.2	$14.4	$3.6
2007	$372.6	$195.1	$157.4	$54.2	$25.3	$17.3	$3.8
2008	$359.8	$194.7	$145.8	$59.7	$19.6	$17.5	$3.8
2009	$351.1	$199.1	$138.7	$61.2	$19.1	$15.4	$4.0

*Excludes bills received beyond six months of the end of the calendar year of service.

Graphic 10.4 illustrates charge and payment data for services billed by health care providers from 2007 through 2010, as well as the average amount charged and paid for each line item on bill data submitted. Over the four-year period, total charges remained around a billion dollars annually and total payments exceeded $500 million each year. Overall, the average amount charged per line item increased 8.5% over the four-year period and the amount paid increased by 3.3%.

10.4 Total Charges and Total Paid for Health Care Provider Services



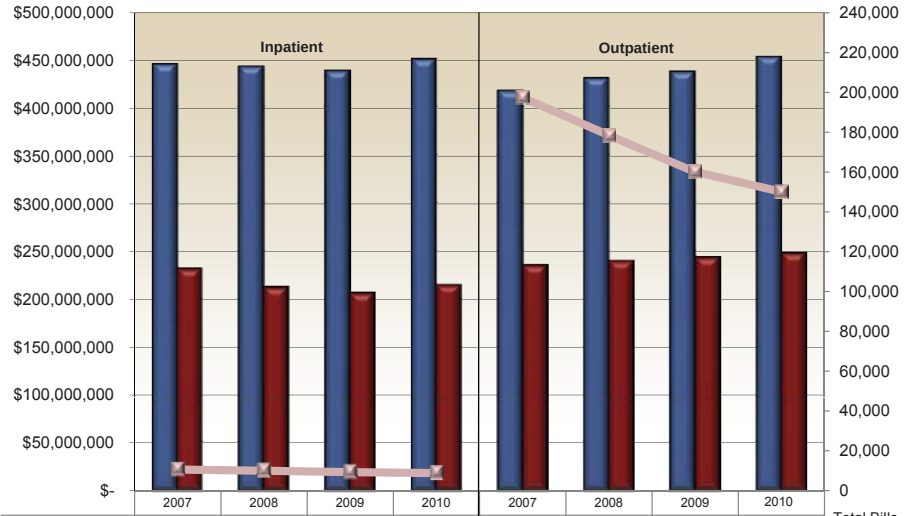
	2007	2008	2009	2010
Charges	$999,621,675.31	$1,003,827,127.85	$1,000,208,145.88	$1,024,384,373.60
Paid	$514,128,187.12	$513,543,093.60	$507,718,821.46	$502,701,664.80
Avg Charge/Per Line Item	$156.31	$157.48	$162.14	$170.00
Avg Paid/Per Line Item	$80.39	$80.55	$82.19	$83.05
Total Line Items	6,395,083	6,374,155	6,159,678	6,040,446

Note: Only bills with payment amount >$0 are included. Prescription drugs & supplies are included when dispensed by a health care provider.

Graphic 10.5 illustrates the changes over time in the average amount charged and paid per inpatient and outpatient hospital bill, as well as the volume of bills received and payments for those services. The volume of inpatient bills has decreased by 16.5%, aggregate charges for all inpatient bills have decreased by 1.2% over the last four years, and aggregate payments for inpatient bills have decreased by 7.2%. Inpatient bills, on an average per bill basis, have had 21.2% higher charges and were paid, on average, 11.1% more in 2010 than 2007.

The volume of outpatient hospital bills has decreased by 24% over the last four years, aggregate charges for all outpatient bills have increased by 8.6%, and aggregate payments for outpatient hospital bills have increased by 5.4%. Outpatient bills, on an average per bill basis, have had 42.8% higher charges, and on average received 38.7% higher payments than in 2007.

10.5 Total Charges and Total Paid by Hospital Bill Type



	Inpatient				Outpatient			
	2007	2008	2009	2010	2007	2008	2009	2010
Charges	$444,243,873	$441,660,449	$437,218,658	$449,377,622	$416,411,557	$429,649,183	$436,240,713	$452,020,585
Paid	$230,953,032	$211,846,167	$205,869,619	$214,239,891	$234,704,433	$239,210,943	$242,850,845	$247,433,436
Avg Charge/Bill	$42,491	$44,630	$47,544	$51,499	$2,109	$2,408	$2,725	$3,012
Avg Paid/Bill	$22,090	$21,407	$22,387	$24,552	$1,189	$1,341	$1,517	$1,649
Total Bills	10,455	9,896	9,196	8,726	197,421	178,424	160,078	150,071

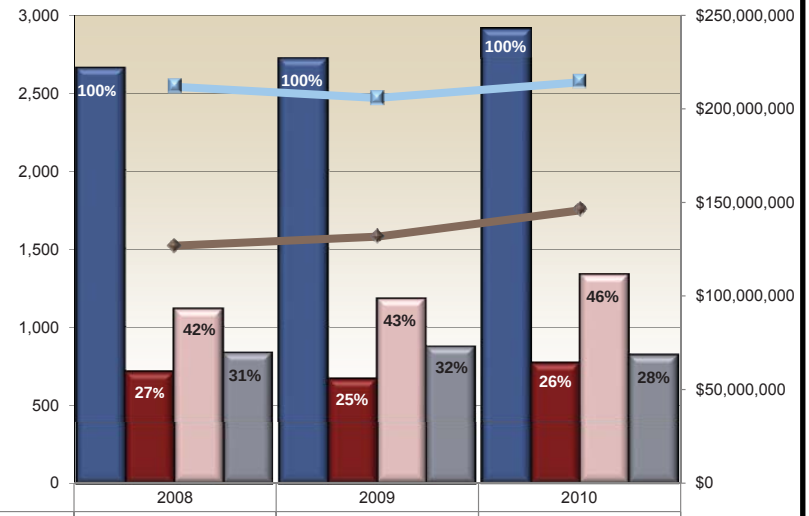
Note: Only bills with payment amount >$0 are included.

The Florida Workers' Compensation Reimbursement Manual for Hospitals, 2006 Edition requires that hospital inpatient services be reimbursed according to a per diem schedule subject to a stop-loss threshold of $51,400, after implant charges are removed from the computation. Hospital bills that still exceed $51,400 are reimbursed at 75% of charges or the agreed-upon negotiated price. Also, implants are reimbursed at 160% of the implant invoice cost. **Graphic 10.6** illustrates the volume of bills without implants, those with implants that exceed $51,400, after exclusion of the cost of implants, and bills that fall below $51,400 after removal of implant charges. For 2008 through 2010, 18% to 24% of all inpatient hospital bills (see **Graphic 10.5**) exceeded the stop-loss amount for bills without implants or after excluding the charges of any implants. These bills comprised 60% to 68% of the aggregate payment for all inpatient bills during those three years. The impact of the stop-loss provision is that over the last three years, 28% to 32% of the bills that would have been paid at 75% of charges were instead paid according to the per diem schedule.

Graphic 10.7 illustrates the impact of maximum reimbursement allowances (MRAs) on ambulatory surgical center (ASC) reimbursements. Insurers may negotiate prices with ASCs, through contracts, or reimburse services according to the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2006 Edition. According to the manual, 27 different procedures have MRAs, and all other procedures are reimbursed at 70% of charges. **Graphic 10.7** illustrates the growth over time in the average percent of charges paid, as well as aggregate payments for line items not covered by an MRA. The number of line items for which an MRA did apply declined from 49.4% to 42.9% of all line items, whereas the number of line items without an MRA increased from 50.6% to 57.1% of all line items.

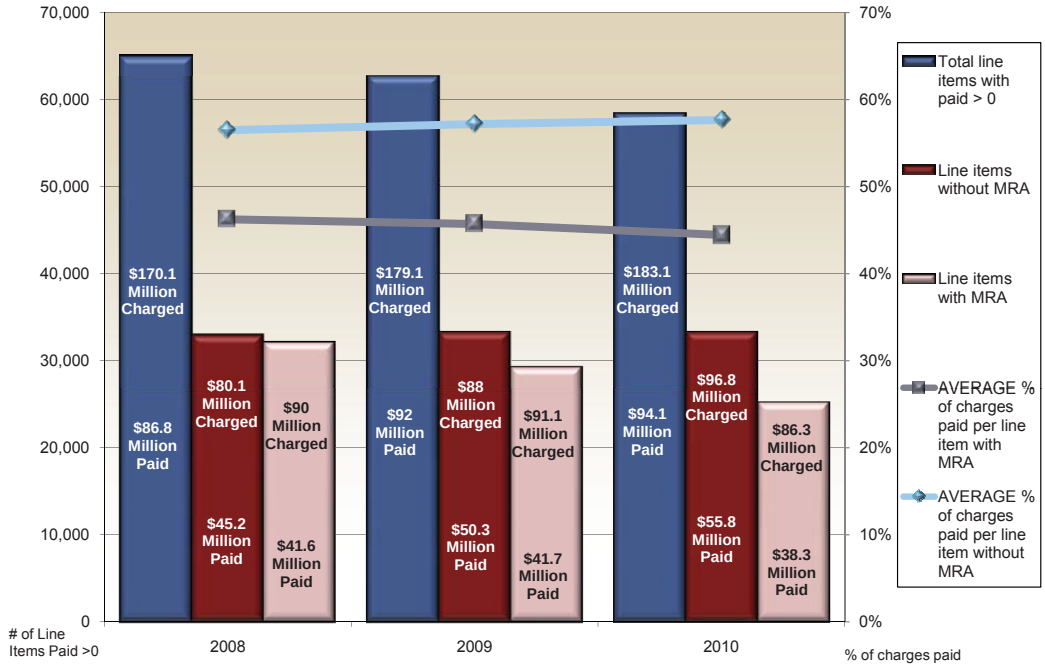
From 2008 to 2010, the average charges for line items without an MRA increased by 19.7% and average payments for those line items increased by 22.1%. For the same time frame, the average charges for line items with an MRA increased by 23.1% and average payments increased by 18.3%.

10.6 Inpatient Hospital Bills that Exceed $51,400 Stop-Loss

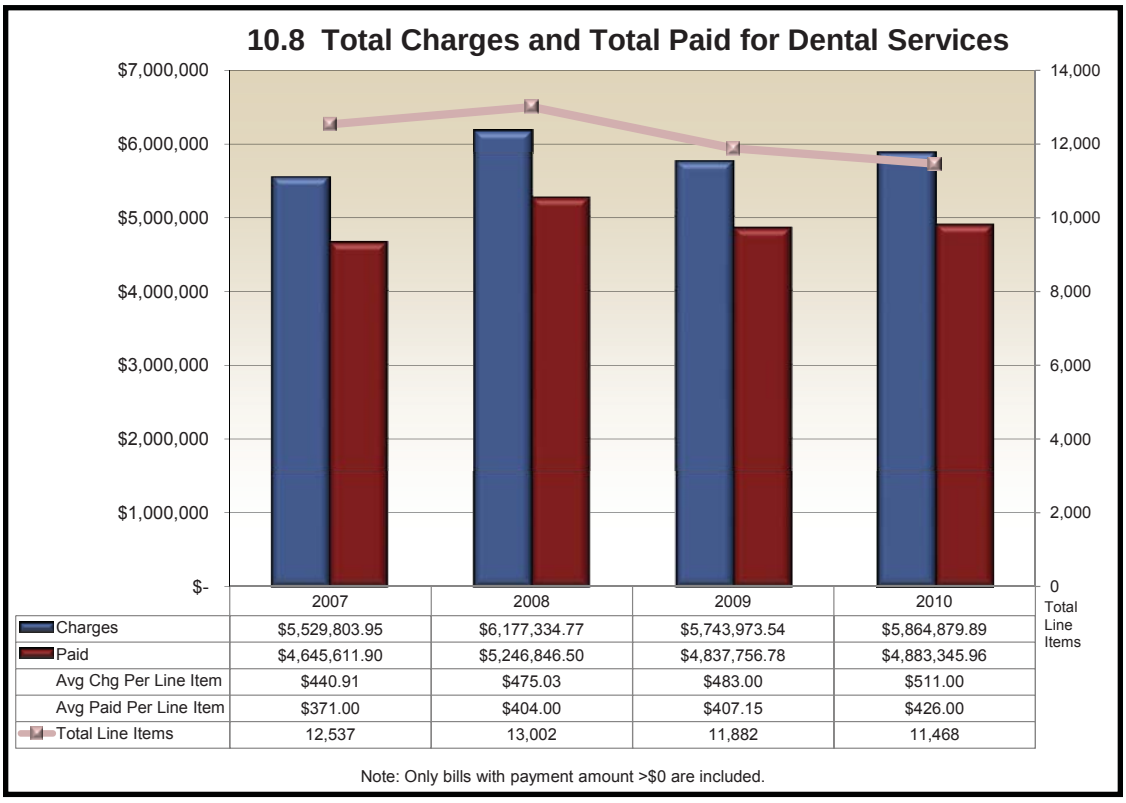


	2008	2009	2010
Total # of Inpatient Hospital Bills Received > Stop-Loss	2,656	2,715	2,917
# of Bills Without Implants > Stop-Loss	711	666	768
# of Bills With Implants > Stop-Loss After Excluding Implant Charges	1,113	1,178	1,332
# of Bills < Stop-Loss After Excluding Implant Charges	832	871	817
Amount Paid for All Inpatient Hospital Bills	$211,846,168	$205,869,619	$214,239,891
Amt Paid All Bills > Stop-Loss With & Without Implants	$126,950,020	$131,766,283	$145,767,445

10.7 Impact of Maximum Reimbursement Allowances on Ambulatory Surgical Center Bills



Graphic 10.8 depicts dental service charge and paid amounts from 2007 through 2010. The number of paid line items declined by 11.8% after 2008 and the amount of aggregate payments declined by 6.9% from 2008 to 2010. The average amount paid per line item has consistently been 83% to 85% of the average amount charged. The average amount of charges increased by 16% per line item over the last four years and the average amount paid increased 14.8% per line item over the same period. Overall, dental services are the smallest cost component among the major medical cost types with the number of line items paid decreasing by 8.5% over the last four years.

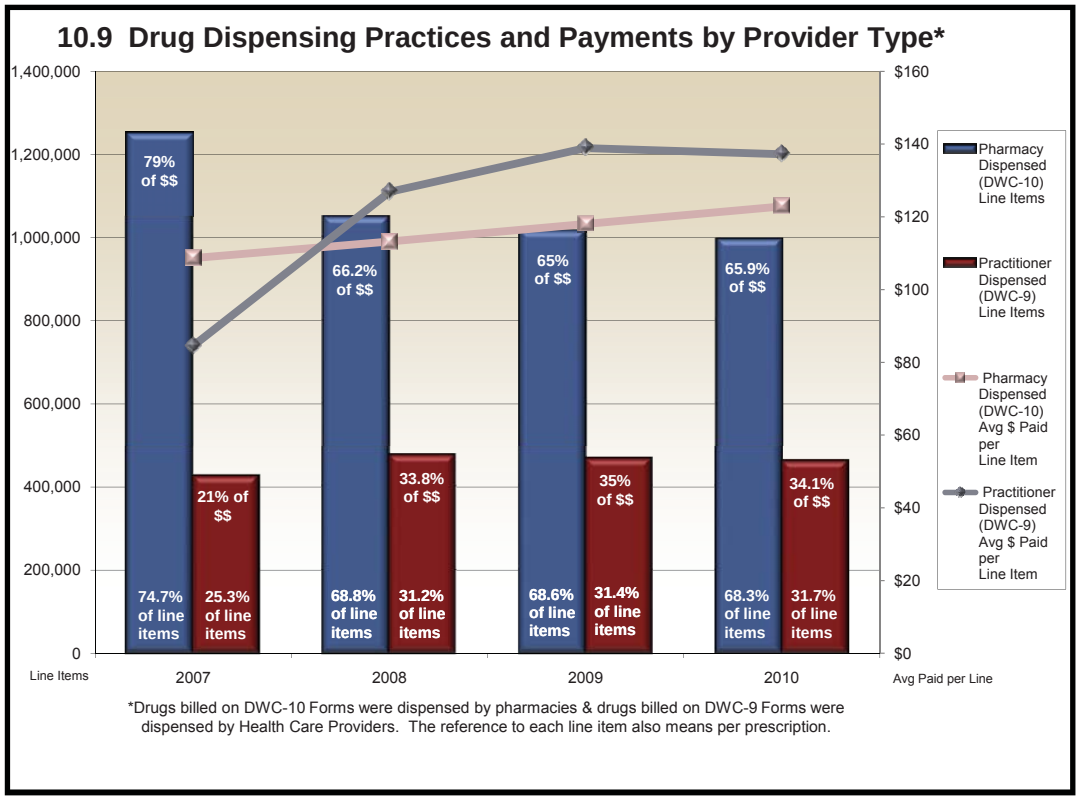


	2007	2008	2009	2010
Charges	$5,529,803.95	$6,177,334.77	$5,743,973.54	$5,864,879.89
Paid	$4,645,611.90	$5,246,846.50	$4,837,756.78	$4,883,345.96
Avg Chg Per Line Item	$440.91	$475.03	$483.00	$511.00
Avg Paid Per Line Item	$371.00	$404.00	$407.15	$426.00
Total Line Items	12,537	13,002	11,882	11,468

Note: Only bills with payment amount >$0 are included.

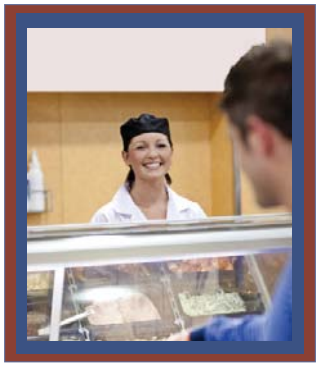
Both dispensing practitioners and pharmacies may bill for prescriptions. Dispensing practitioners bill on the Health Provider Claim Form, while pharmacies use the Statement of Charges for Drugs and Medical Supplies Form. **Graphic 10.9** illustrates the dispensing practices and payments for each of these providers over time. (This analysis excludes any prescriptions dispensed by hospitals and injections by practitioners.) Aggregate pharmacy payments reflected in **Graphic 10.9** went from $136.2 million in 2007 to $122.3 million in 2010. Practitioner payments went from $35.9 million to $63.2 million during the same timeframe.

Pharmacies have dispensed almost 69% of the prescription line items during three of the last four years after experiencing a 16% decline in the number of line items dispensed from 2007 to 2008, which is a 21% decrease over the four-year period. Practitioner dispensed line items increased by 8.6% during the same time. Overall, pharmacies received 79% of aggregate prescription payments in 2007, which declined to 66% of the payments in 2010, while the practitioners' payments grew from 21% of aggregate payments in 2007 to 34% in 2010. The average amount paid per line item increased by 13.1% for pharmacy dispensed prescriptions over the last four years, compared to a 62.1% increase for practitioners over the same timeframe. During 2010, the average amount paid per practitioner dispensed line item was 11.7% higher than pharmacy dispensed items.

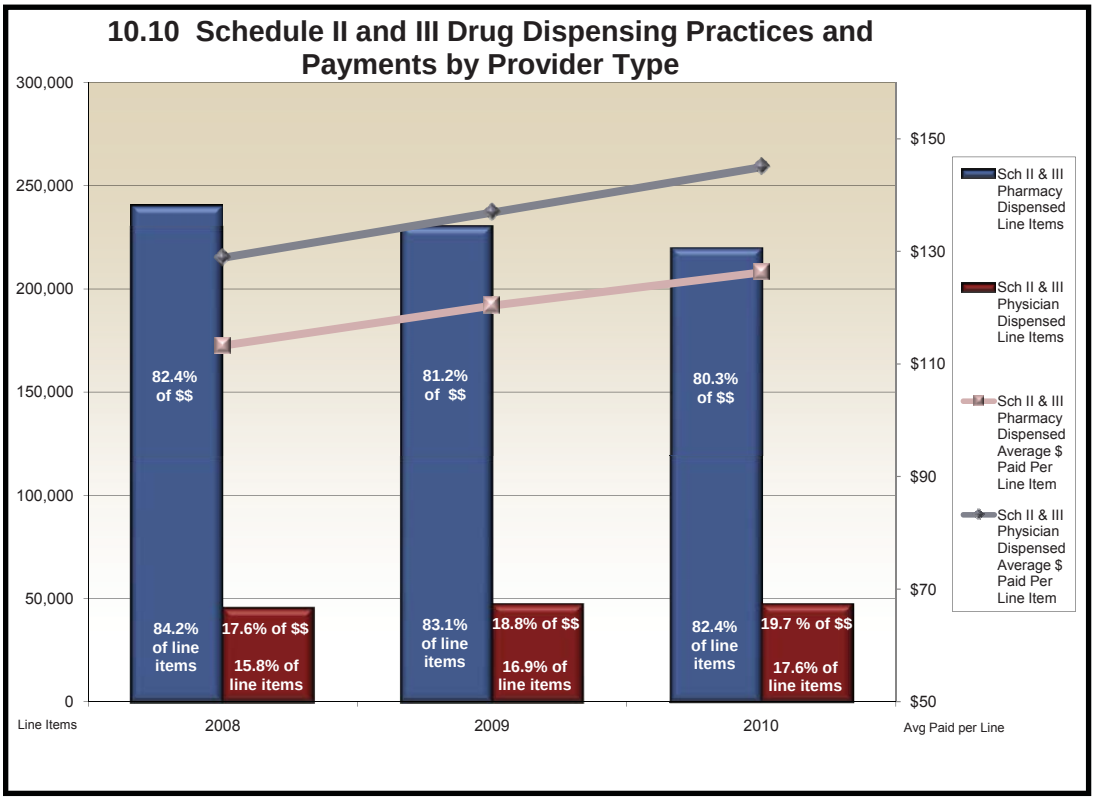


Graphic 10.10 illustrates dispensing practices of and payments to pharmacies and practitioners for Schedule II and III drugs (i.e., controlled substances/narcotics). Pharmacies were paid from $27.2 million to $27.7 million over the last three years for Schedule II and III prescriptions, compared to practitioners who received from $5.8 million to $6.8 million during the same time. Pharmacies have dispensed between 82% and 84% of the Schedule II and III line items over the last three years, compared to practitioners who dispensed 16% to 18% for the same period. Practitioners received 18% to 20% of the aggregate payments, while pharmacies received 80% to 82% of the payments.

Practitioners received, on average, payments that were 17% higher for the Schedule II and III prescriptions they dispensed during the last three years and received, on average, $144.96 per line item in 2010, compared to $126.27 for pharmacies. (This does not take into consideration the drug mix prescribed by pharmacies or practitioners.) Both practitioners and pharmacies were paid an average of 12% more per line item in 2010 than in 2008.



10.10 Schedule II and III Drug Dispensing Practices and Payments by Provider Type



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Compliance Fraud Referral Hotline:
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Employee Assistance Office Hotline:
(800) 342-1741

Customer Service Center:
(850) 413-1601

Contact information for Bureau of Compliance and Bureau of Employee Assistance and Ombudsman District Offices may be found on the Division's website at:
http://www.myfloridacfo.com/wc/dist_offices.html

DIVISION OF WORKERS' COMPENSATION WEBSITE

The Division of Workers' Compensation website home page is located at: http://myfloridacfo.com/wc and provides direct information access for all stakeholders in the Workers' Compensation System. On average, the Division's home page was visited more than 52,609 times per month. The website organizes items of interest by stakeholder group with tabs for Employer, Insurer, Employee and Provider.