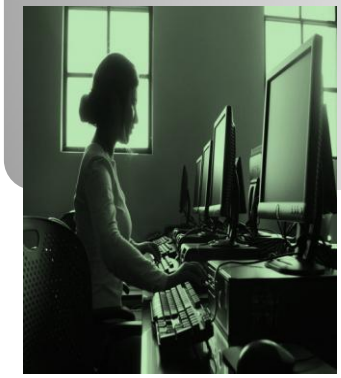
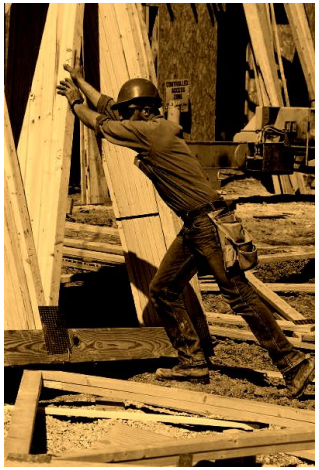
Florida Division of Workers' Compensation 2013 Results and Accomplishments





JEFF ATWATER, CHIEF FINANCIAL OFFICER
FLORIDA DEPARTMENT OF FINANCIAL SERVICES

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.

Director's Message

To Stakeholders of Florida's Workers' Compensation System:

As the Division of Workers' Compensation continues to meet its regulatory responsibilities in the most cost effective and efficient means possible, we also strive to improve Florida's Workers' Compensation System for the benefit of all of stakeholders. In an effort to provide relevant and quality workers' compensation data, the Division's "*Results and Accomplishments Report"* was developed for the second year. This report replaced the former statutorily mandated Annual Report that was repealed during the 2012 Legislative Session.

Highlights from this year's report include: a decrease in the number of reimbursement disputes filed with the Division; creation of the new Bureau of Financial Accountability; the transition of the Reemployment Services program from the Department of Education to the Department of Financial Services, Division of Workers' Compensation; and a significant decrease in assessed penalties for non-willful patterns and practices violations by carriers. You will also learn more about the Division's continued streamlining and modernization efforts as evidenced by:

- Bureau of Compliance – Online exemption application;
- Bureau of Financial Accountability – Creation of online application for carrier reporting and paying assessments;
- Bureau of Employee Assistance & Ombudsman – Creation of Online Reemployment Services Application Portal

As we continue our search for meaningful improvements to Florida's Workers' Compensation System, we welcome any suggestions and comments with regard to this report and the performance of the Division.

Sincerely,

Tanner Holloman

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Note: All data contained in the graphics herein were extracted from the Division of Workers' Compensation resources as of 6/30/13, unless otherwise noted.

Bureau of Financial Accountability

The Bureau of Financial Accountability houses the Division's largest monetary transaction programs and safeguards its assets by developing and implementing a broad range of financial accountability measures. The Bureau's programs work to implement and build upon its internal checks and balances while maintaining effective financial controls that focus on managing the daily functions of cash receipts, revenue and warrant payments. Included in these controls is a series of comprehensive reconciliation processes that balance each cash receipt and cash payment process.

The Bureau of Financial Accountability has the following monetary programs: Assessments Section, Financial Accountability Section, Self-Insurance Section, and Special Disability Trust Fund Section.

The Assessments Section calculates, collects, audits and reconciles quarterly assessment payments by insurance companies, assessable mutual insurance companies, self-insurance funds and individual self-insurers to the Special Disability Trust Fund (SDTF) and the Workers' Compensation Administration Trust Fund (WCATF). The section also calculates the annual assessment rate for both the SDTF and the WCATF.

Bureau of Financial Accountability

The Financial Accountability Section monitors the receipt of all payments related to Notices of Election to be Exempt and employer penalty payments. The Section oversees the process of reinstating Stop-Work Orders to employers who default on payments, referring delinquent accounts to the collection agency, and filing liens against those employers.

The Self-Insurance Section regulates private, individual self-insurers to ensure they have the financial strength required to pay workers' compensation claims. The Self-Insurance Section also regulates governmental individual self-insured employers to ensure timely reporting of Payroll and Loss Data. This Section promulgates experience modifications for all active individually self-insured employers and issues notices of violation for late filing of forms, reports and assessments.

The Special Disability Trust Fund Section reviews all Proofs of Claims filed to determine if the claims meet eligibility requirements for reimbursement of benefits paid by the carriers. It then determines eligibility for reimbursement by the Fund through the audit of submitted requests for issuance of accurate reimbursements. Additionally, the Fund is responsible for the disbursement of Permanent Total Supplemental Benefits to certain injured workers.

Bureau of Financial Accountability

Assessments Section

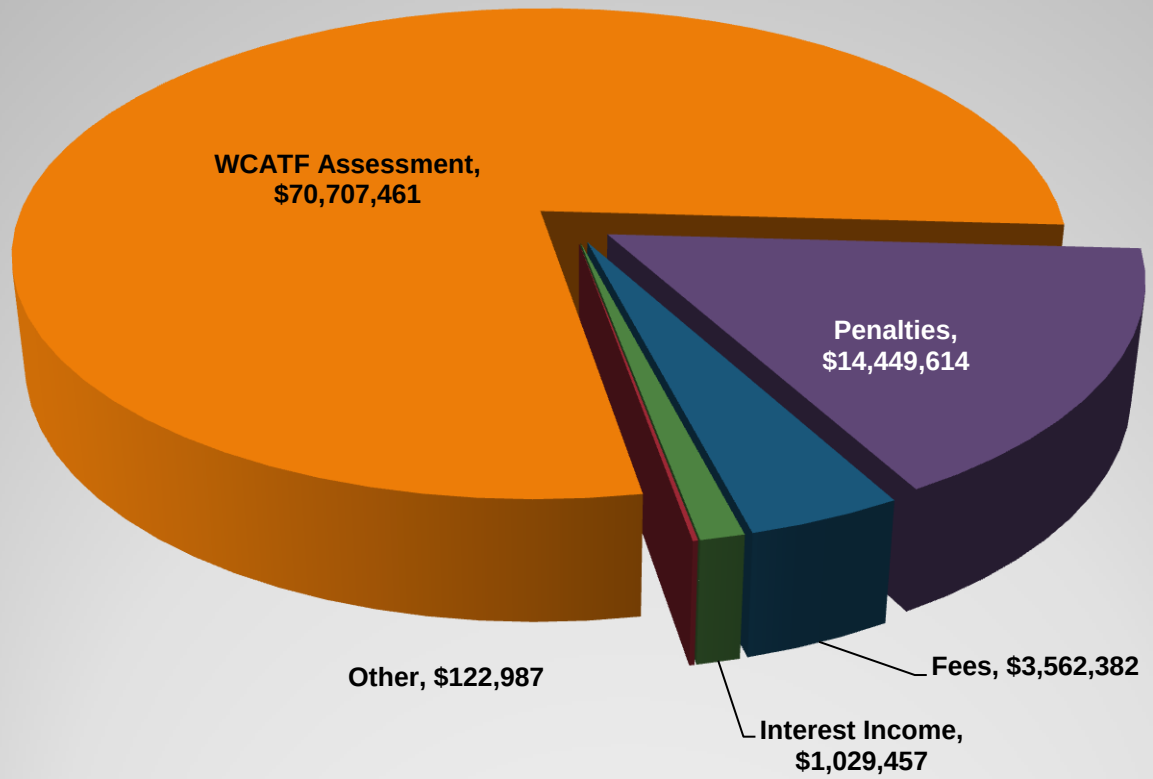
In Fiscal Year 2012-2013, the Assessments Section collected over $70 million in assessments for the Workers' Compensation Administration Trust Fund (WCATF) and over $43 million for the Special Disability Trust Fund (SDTF).

Both trust funds are supported by quarterly assessments. These assessments are based on insurance carriers' Florida workers' compensation net insurance premiums, as required by statute. Each quarter, the Assessments Section notified and provided all carriers with the necessary information to report premiums.

The Assessments Section subsequently collected, audited, and reconciled the quarterly assessments of 366 insurance companies and self-insurance funds. This Section also calculated the imputed premium of 413 individual self-insured companies (premium that the self-insurer would have paid had they not chosen to self-insure). This process utilized the required company payroll, volume discounts, approved credits, and experience modifications in determining the premium for which the assessment was applied.

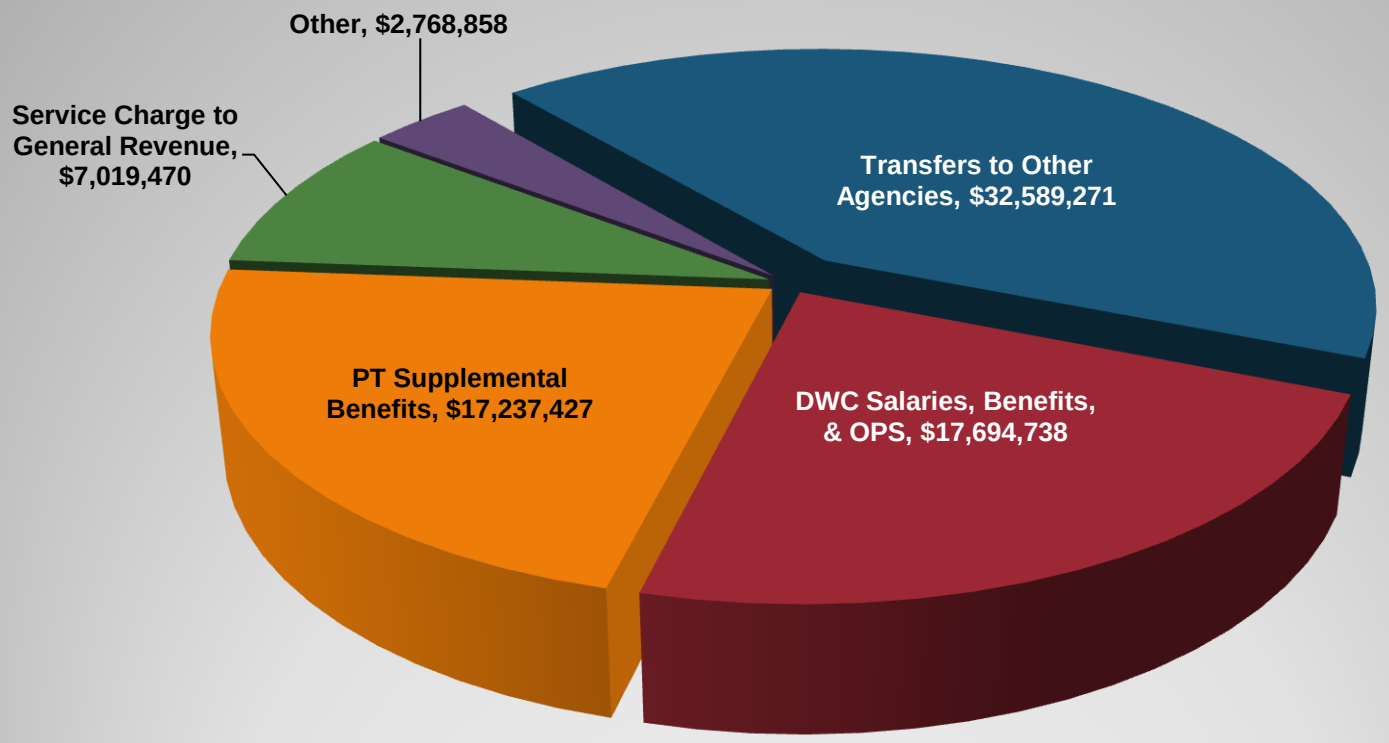
In an effort to improve efficiency and cost effectiveness, the Assessments Section is developing a product that will allow insurance carriers and individual self-insurers to report and pay their assessments online.

Workers' Compensation Administration Trust Fund (WCATF) Revenues for Fiscal Year 2012-2013



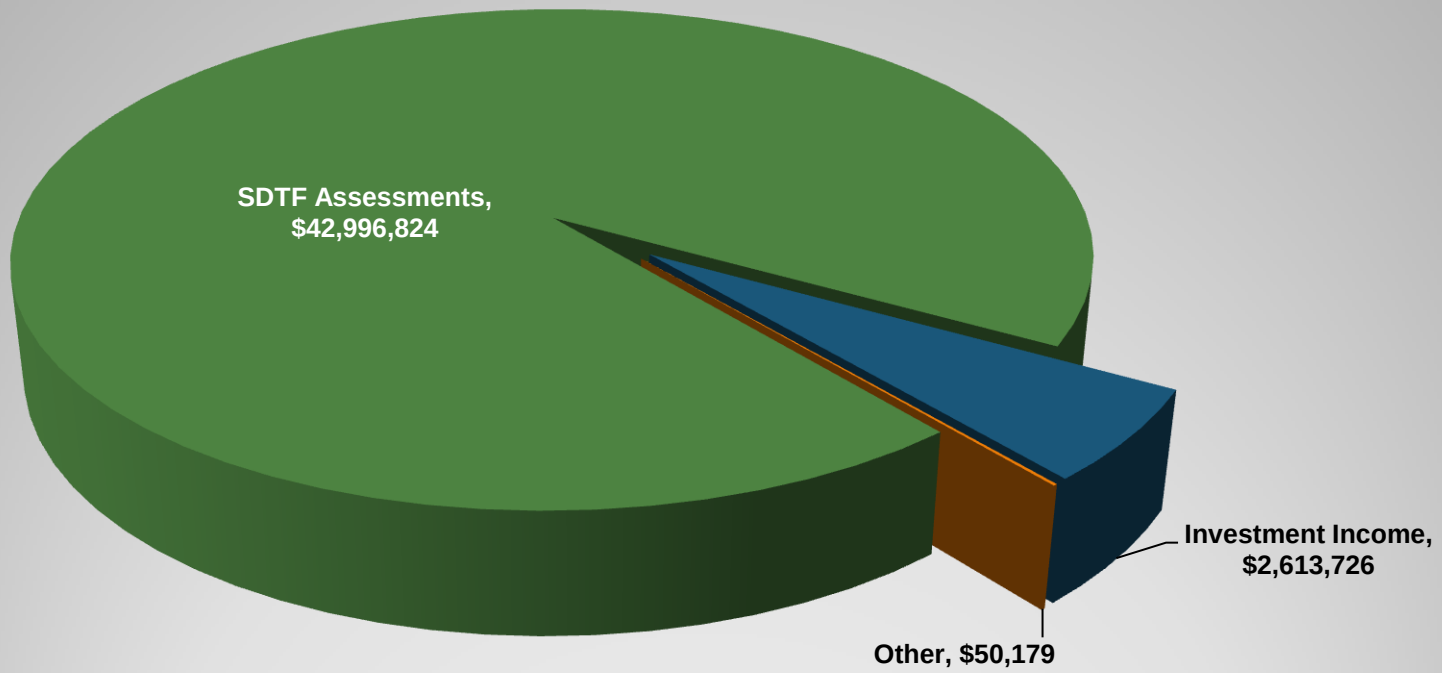
Total - $89,871,901

Workers' Compensation Administration Trust Fund (WCATF) Expenses for Fiscal Year 2012-2013



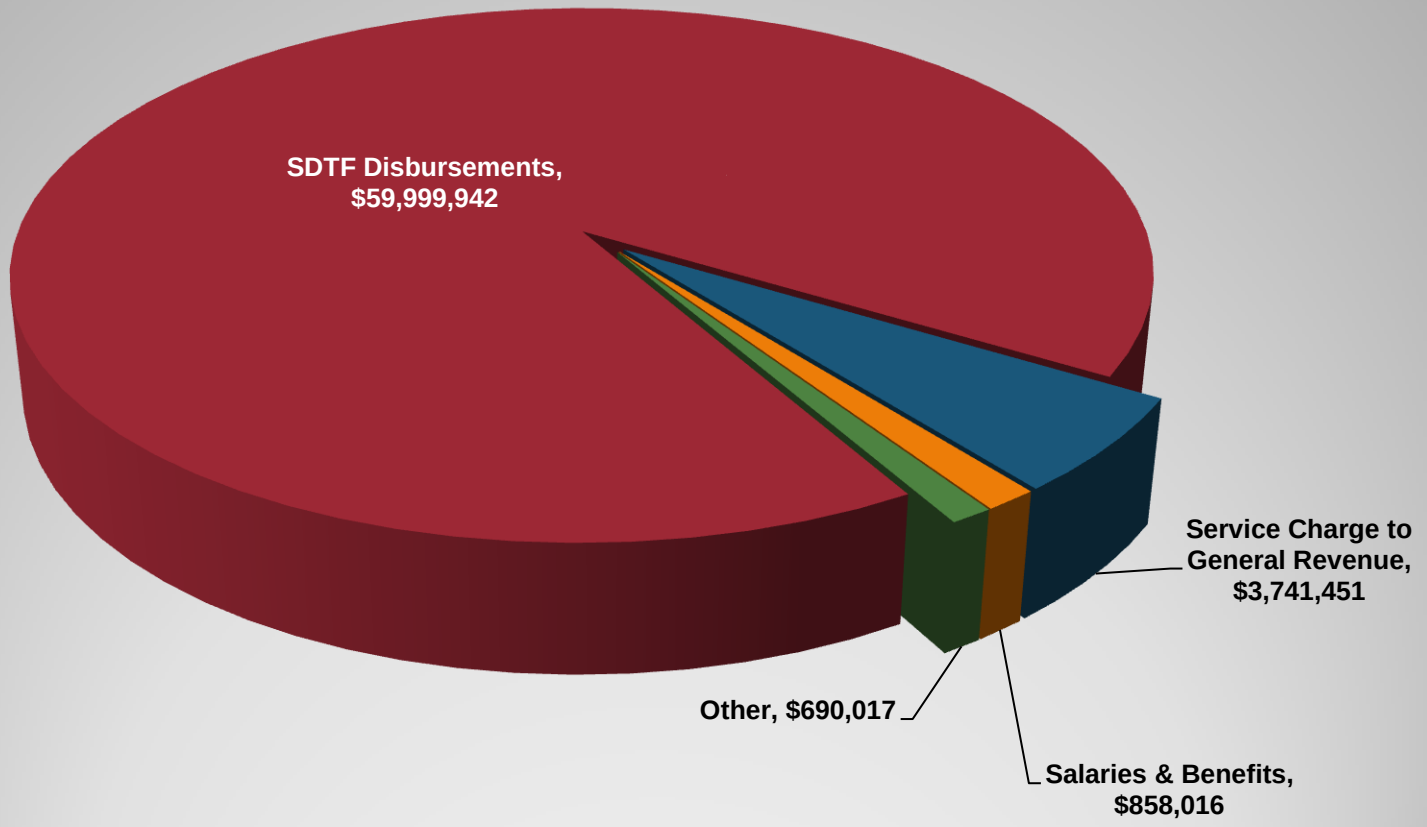
Total - $77,309,764

Special Disability Trust Fund (SDTF) Revenues
Fiscal Year 2012-2013



Total - $45,660,729

Special Disability Trust Fund (SDTF) Expenses
Fiscal Year 2012-2013



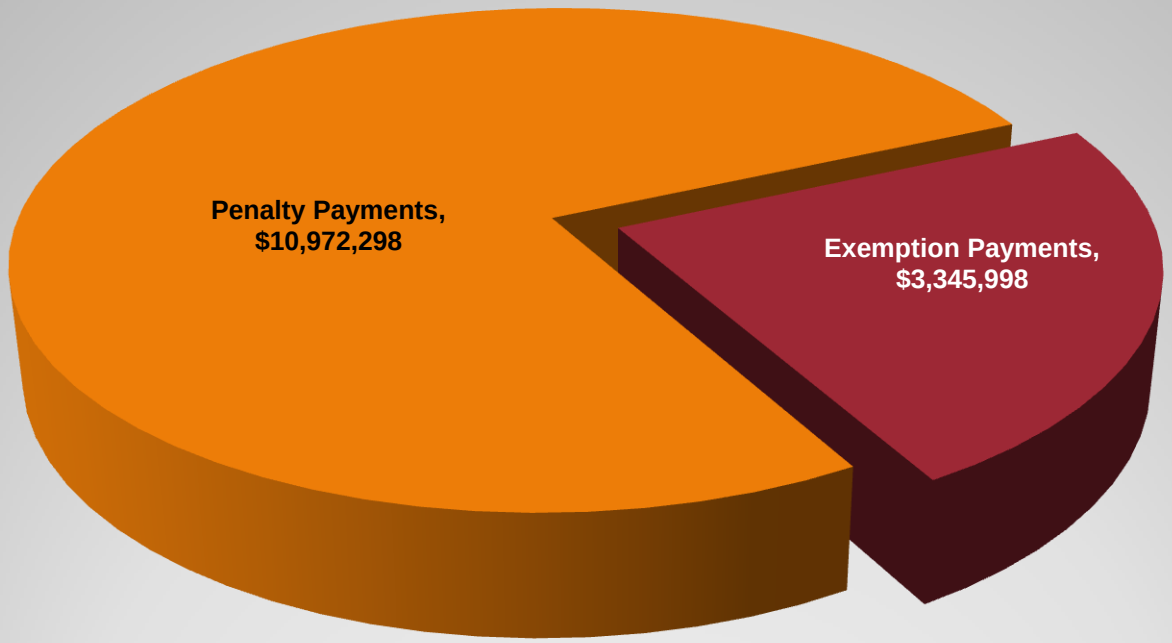
Total - $65,289,426

Bureau of Financial Accountability

Financial Accountability Section

The Financial Accountability Section (FAS) supports the activities pursuant to Section 440.107, Florida Statutes, by performing the following functions: collects and monitors revenues associated with payments from employers in the construction industry who elect to exempt themselves from workers' compensation benefits, collects and monitors revenues associated with employers who were out of compliance with the workers' compensation laws and have been assessed a penalty, and monitors monthly penalty payments associated with employers who have been assessed a penalty and have entered a Periodic Payment Agreement Schedule.

Financial Accountability Section Revenues
Fiscal Year 2012-2013



Total- $14,318,296

Bureau of Financial Accountability

Penalty Payment Count Break-down by Payment Category for Fiscal Year 2012-2013:

Payment Count Break-Down	Totals	Average Monthly Count	Average % of Total Count
Payment In Full	1,131	94	4%
Down Payments	1,177	98	4%
PPA Payments	27,179	2,265	91%
Collection Payments	325	27	1%
TOTALS	29,812		

Payment Amount Break-Down	Totals	Average Monthly Amount	Average % of Total Amount
Payment In Full	$2,145,505.51	$178,792	20%
Down Payments	$1,773,825.21	$147,819	16%
PPA Payments	$6,911,459.67	$575,955	63%
Collection Payments	$141,507.37	$11,792	1%
TOTALS	$10,972,297.76		

Bureau of Financial Accountability

Self-Insurance Section

The Self-Insurance Section is responsible for approving self-insurance programs for governmental and private entities that have met statutory requirements and demonstrated the required financial strength to fund their Florida workers' compensation liabilities.

To ensure the financial stability of Florida self-insurers, the Self-Insurance Section contracts with the Florida Self-Insurers Guaranty Association (FSIGA) to review financial statements and monitor a self-insurer's ability to pay current and future workers' compensation liabilities.

The Self-Insurance Section, in conjunction with FSIGA: evaluates security deposits; grants self-insurance privileges; and collects, examines and processes self-insurance payroll, loss data, outstanding liabilities and financial statements.

Bureau of Financial Accountability

The Self-Insurance Section conducts payroll audits of current and former self-insurers. The audits are conducted to determine the accuracy of payroll data reported annually on Self-Insurers Payroll Reports (DFS-F2-SI-5). During Fiscal Year 2012-2013, the Self-Insurance Section performed 19 desk audits, reviewed 73,995 employee payroll records, identified $14,298,129 in underreported payroll and $447,445 in under reported premium.

Entities applying for self-insurance authorization pursuant to Section 440.38(1)(b), Florida Statutes, shall submit a complete application package at least 90 days prior to the desired effective date of the self-insurance authorization.

For private entities, the application package shall be submitted to FSIGA, Inc. Governmental entities shall submit their application package to the Division of Workers' Compensation.

During Fiscal Year 2012-2013, the Self-Insurance Section approved four entities to self-insure their workers' compensation liabilities and processed nine entities' notices of self-insurance terminations.

Bureau of Financial Accountability

The Self-Insurance Section reviews applications requesting authorization to provide workers' compensation claims services to insurers and self-insurers. Once approved, these entities become Qualified Servicing Entities (QSEs) and must annually submit an Annual Report Form (DFS-F2-S1-23) for re-certification by March 1st to the Self-Insurance Section.

During Fiscal Year 2012-2013, the Self-Insurance Section reviewed and processed 97 Qualified Servicing Entities' re-certifications and 3 Qualified Servicing Entity notifications of withdrawal from servicing self-insurers, approved four entities to self-insure their workers' compensation liabilities and processed nine entities' notices of self-insurance terminations.

The tables below illustrate the total number of active Self-Insurers and Qualified Servicing Entities as of each fiscal year's end.

Fiscal Year	Self-Insurers
FY 09-10	418
FY 10-11	410
FY 11-12	410
FY 12-13	404

Fiscal Year	Qualified Servicing Entities
FY 09-10	96
FY 10-11	100
FY 11-12	97
FY 12-13	97

Bureau of Financial Accountability

Special Disability Trust Fund Section

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.

If the employee experienced a new injury subsequent to being hired and that work-related injury resulted in a greater permanent impairment, the SDTF would reimburse the employer for excess costs.

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

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, insurers and individual self-insured employers continue to be assessed to fund the run-off claims.

Bureau of Financial Accountability

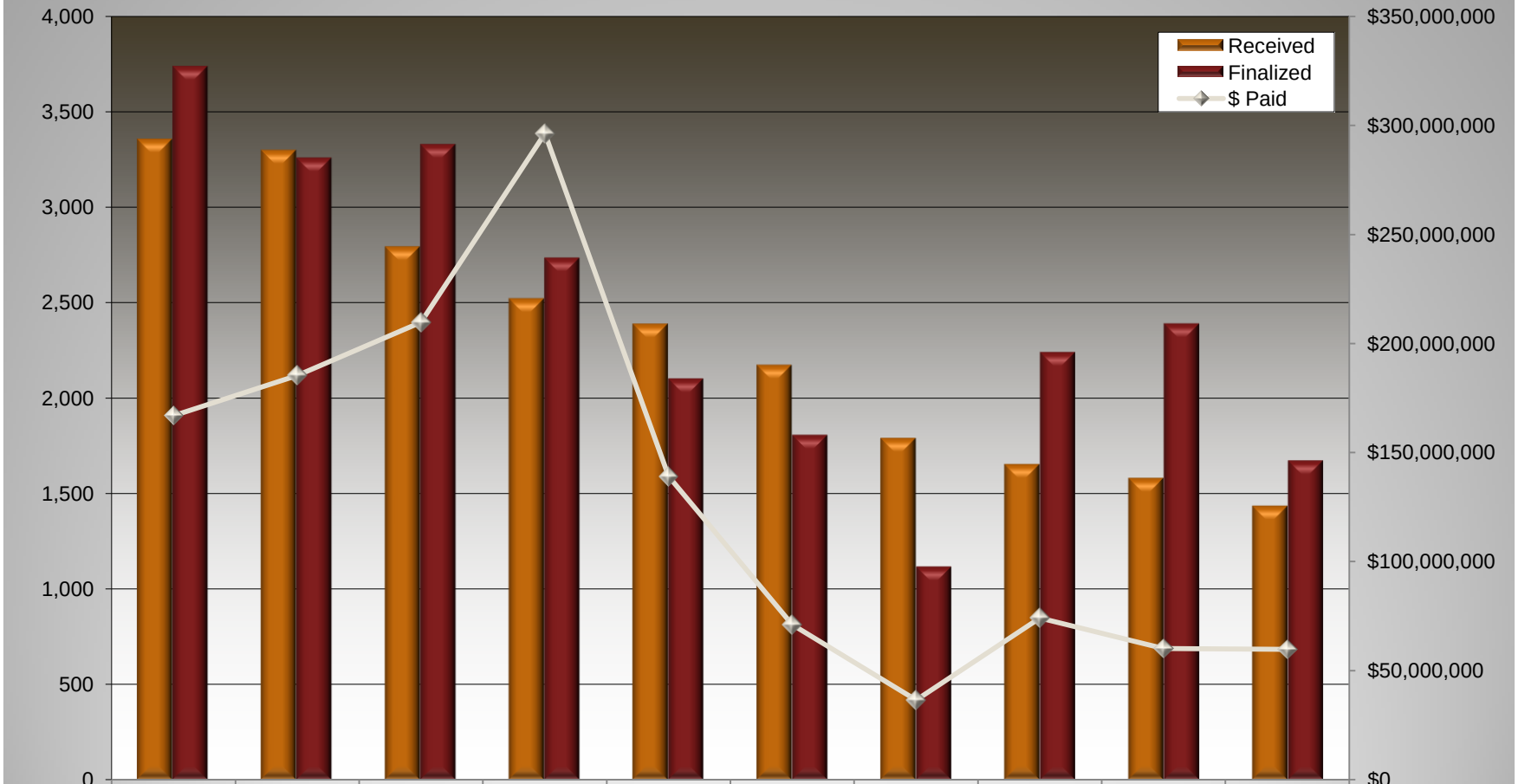
Presently, the SDTF has three primary business processes: (1) review all filed Proofs of Claim to determine if the claim meets eligibility requirements for reimbursement of benefits paid by the carrier and subsequently notify the carrier whether the claim has been accepted or denied; (2) determine eligibility for reimbursement by the Fund through auditing Reimbursement Requests and supporting documentation submitted by the carrier on claims that have been accepted; and (3) issue accurate reimbursements.

The Fund has created a new Computer Assisted Auditor Tool Suite which leverages the Medical EDI data submitted to the Division for use in evaluating and reviewing Reimbursement Requests submitted to the Fund.

The next step will be to integrate this system into an electronic web portal to be used in the submission, review, and approval of Reimbursement Requests. The Fund will be able to utilize electronic data presently collected by the Division for use in this process, which will prevent the need for resubmission of some data by the carrier.

Implementation of such a system will: dramatically reduce the paper used; allow for and encourage more fluid communication between the Fund and its customers; reduce the time between submission and final disposition of requests; and provide educational information.

Reimbursement Requests



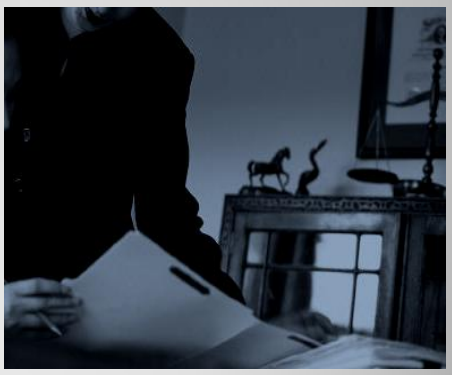
	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13
Received	3,351	3,292	2,789	2,516	2,384	2,170	1,787	1,650	1,578	1,432
Finalized	3,735	3,255	3,326	2,732	2,099	1,805	1,116	2,237	2,387	1,671
$ Paid	$166,980,684	$185,319,701	$209,781,409	$296,412,026	$139,121,165	$71,113,533	$36,443,562	$74,158,800	$60,137,393	$59,800,291

Bureau of Monitoring & Audit

The Bureau of Monitoring and Audit (M&A) is responsible for ensuring that the practices of insurers and claims-handling entities meet the requirements of Chapter 440, Florida Statutes and the Florida Administrative Code.

The Bureau's mission is to ensure the timely and accurate payment of benefits to injured workers, timely filing and payment of medical bills, and timely and accurate filing of required claims forms and other electronic data.

The Bureau of Monitoring and Audit consists of the following key areas: Audit Section, Permanent Total Disability Section, Penalty Section, and the Medical Services Section.



Bureau of Monitoring & Audit

Audit Section

The Audit Section examines claims-handling practices of insurers, self-insurers, self-insurance funds, and other claims-handling entities pursuant to Sections 440.20, 440.185, and 440.525, Florida Statutes and the rules of the Florida Administrative Code. Examinations and investigations are conducted by the Section to 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 forms and reports; and to enforce compliance with compensation orders of Judges of Compensation Claims.

Additionally, the Audit Section reviews Explanations of Bill Review (EOBR) for compliance with Rule 69L-7.602(5), Florida Administrative Code, to ensure complete reimbursement communications between insurers and providers.

Compliance Review	FY 10-11	FY 11-12	FY 12-13
Data Points Reviewed	13,769	33,769	29,714
Data Points Compliant	7,050	27,915	28,040
Overall Compliance	51%	83%	94%

Bureau of Monitoring & Audit

During Fiscal Year 2012-2013, the Audit Section completed 61 on-site insurer audits and examined 5,096 insurer claim files. Of the 5,096 files examined, 3,289 were indemnity claim files. The Section discovered 390 of the indemnity claim files contained underpayments. These findings resulted in additional injured worker payments of $163,421 for indemnity benefits, penalties, and interest.

The table below illustrates penalties assessed during audits for untimely indemnity payments and untimely First Reports of Injury or Illness. These penalties were paid to the Division.

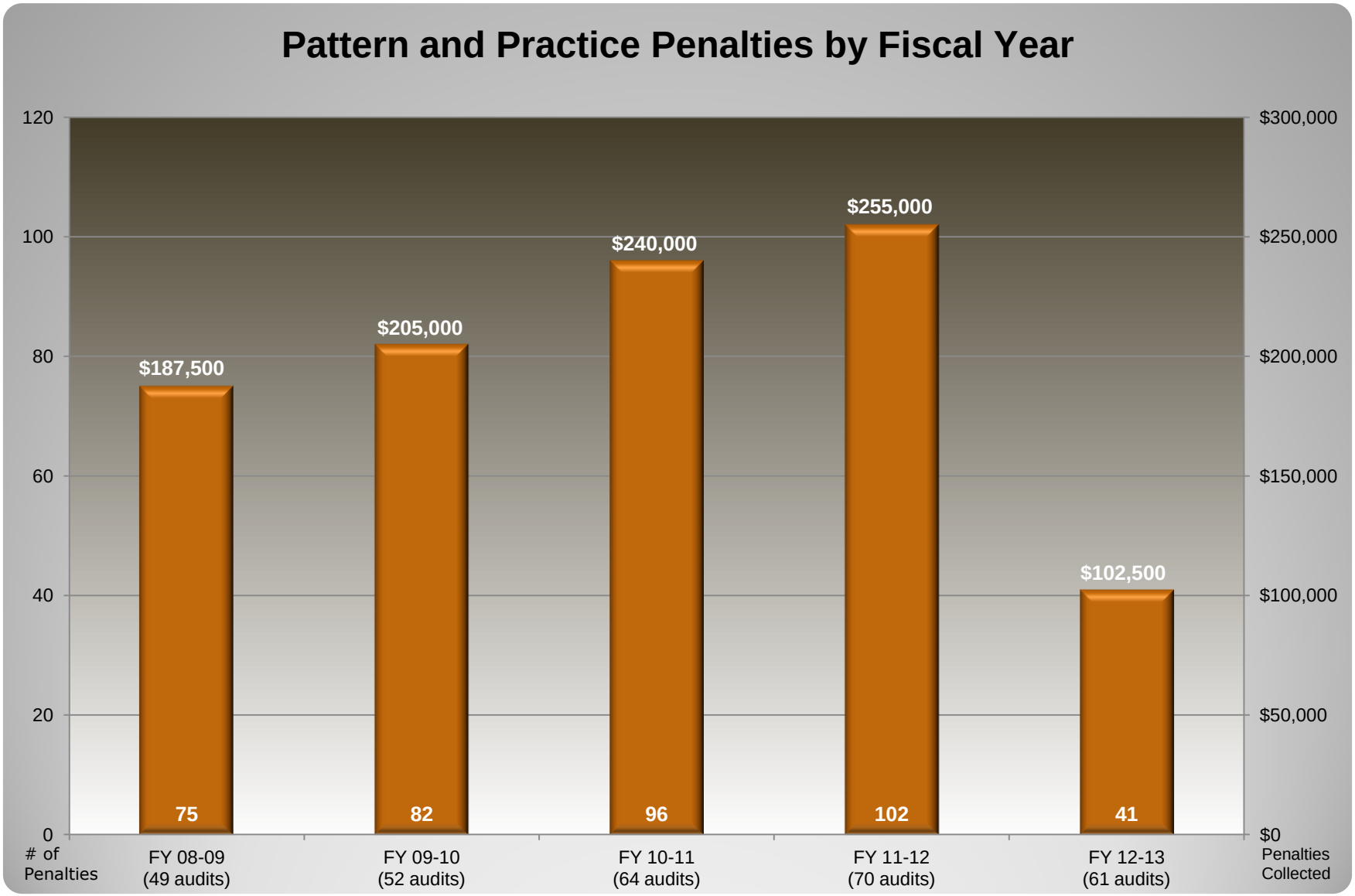
Fiscal Year	Total Amount of Penalties Issued for Late Indemnity Payments	Total Amount of Penalties Issued for Untimely First Reports of Injury or Illness
08-09	$110,150	$16,300
09-10	$78,600	$35,100
10-11	$90,400	$66,600
11-12	$87,000	$51,200
12-13	$64,200	$27,500

Bureau of Monitoring & Audit

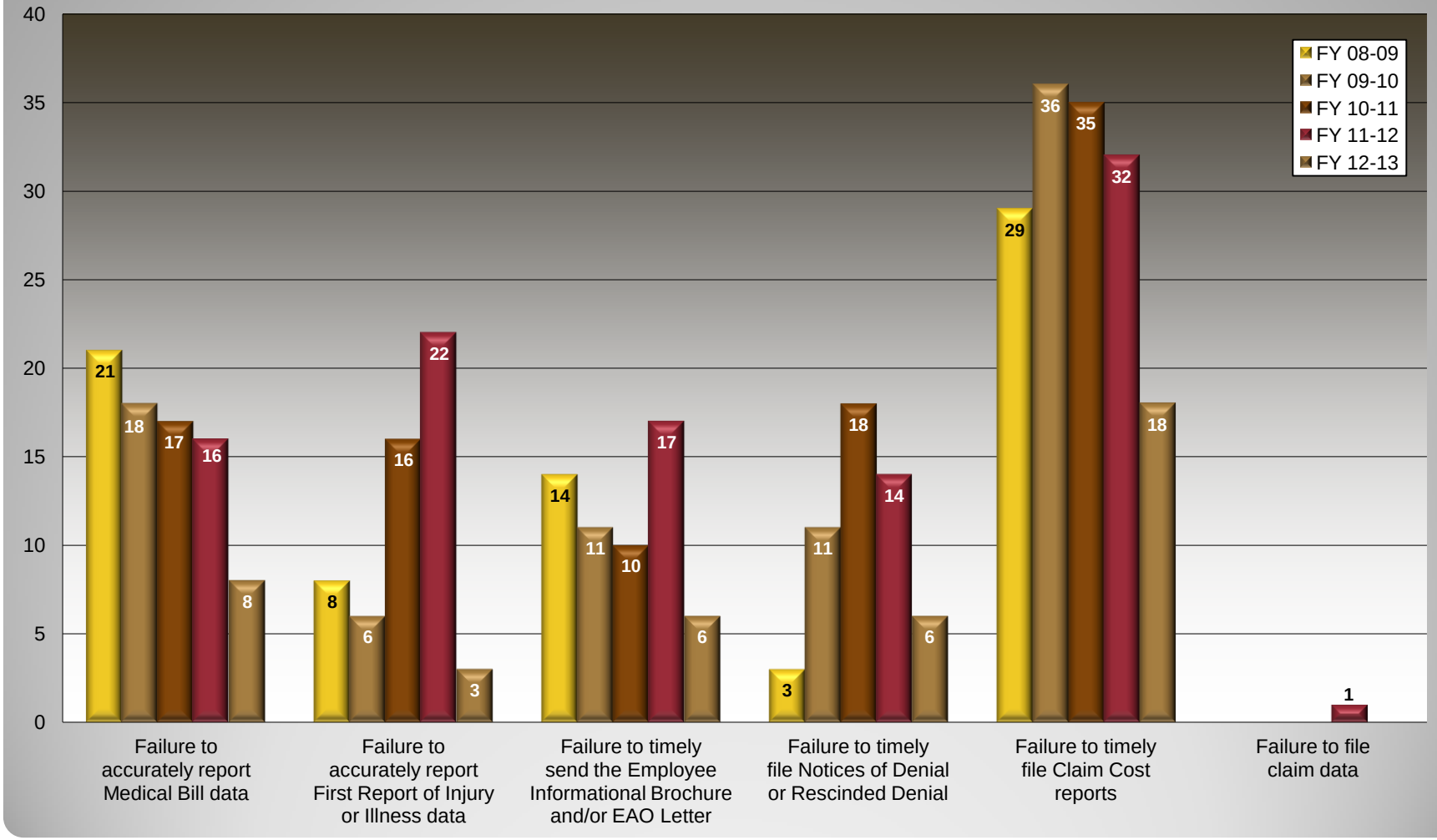
The graphs on the next two pages illustrate non-willful pattern and practice penalties assessed during audits for various claims-handling violations. Each pattern and practice penalty is assessed at $2,500. These penalties were paid to the Division.

Fiscal Year 2012-2013 saw a significant decrease in assessed non-willful pattern and practice penalties. This illustrates an increase in industry performance. Audits have enabled the industry to improve claims-handling practices.

Pattern and Practice Penalties by Fiscal Year



Non-Willful Pattern & Practice Penalties by Category and Fiscal Year



Bureau of Monitoring & Audit

Permanent Total Disability Section

The Permanent Total Disability (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.

During Fiscal Year 2012-2013, the PT Section calculated, approved, and processed supplemental benefits for 1,271 claims totaling $17,921,584.

On a continuing basis, the PT Section verifies eligibility of injured workers' entitlement to supplemental benefits by reviewing the following resources: Vital Statistics Report (Department of Health); Inmate records (Department of Corrections); Employee Earnings Reports; PT Claims data electronically submitted by insurer; and Judges of Compensation Claims data.

Additionally, the PT Section verifies the accuracy and timeliness of permanent total and permanent total supplemental benefits due and paid by insurers. This includes verifying that payments are suspended, reduced, or cancelled based on statutory amendments or case law and that benefit offsets are correctly applied.

Bureau of Monitoring & Audit

Permanent Total Disability Section

During Fiscal Year 2012-2013, the PT Section reviewed 33,219 electronic claims transactions and obtained $234,151 in past due benefits, penalties, and interest for 27 injured workers.

The PT Section works in collaboration with other Division staffing units to determine the accuracy of benefits that are due to an injured worker including Special Disability Trust Fund, Bureau of Employee Assistance and Ombudsman Office, and the Audit Section.

Bureau of Monitoring & Audit

Penalty Section

The Penalty Section evaluates and assesses insurer performance of timely payments of initial indemnity benefits and medical bills.

The Penalty Section also monitors the timely filing of First Reports of Injury or Illness and medical bills monthly using the Centralized Performance System (CPS). CPS is a web based application that electronically provides essential insurer performance information and trends. CPS also enables the Division and its stakeholders to monitor performance and respond to penalty assessments for untimely filing and untimely payment in real-time.

The volume of First Reports of Injury and Illness reviewed by the Centralized Performance System is shown in the table on the right.

Fiscal Year	# of First Reports Received and Reviewed
FY 08-09	57,821
FY 09-10	52,768
FY 10-11	53,285
FY 11-12	53,211
FY 12-13	51,690

Bureau of Monitoring & Audit

Performance for timely payment of initial indemnity benefits has remained relatively constant over the last five fiscal years. Timely filing of First Reports of Injury and Illness initially showed an increase in performance. It then leveled to a constant over the same time period.

Fiscal Year	Timely Initial Benefit Payments	Timely Filing of First Reports
FY 08-09	94%	87%
FY 09-10	95%	93%
FY 10-11	95%	95%
FY 11-12	95%	95%
FY 12-13	95%	95%

Performance Percentages of Medical Bills

Fiscal Year	Timely Medical Bill Payments	Timely Medical Bill Filings
FY 08-09	99%	99%
FY 09-10	98%	97%
FY 10-11	98%	98%
FY 11-12	99%	99%
FY 12-13	98%	96%

Bureau of Monitoring & Audit

Medical Services Section

The Medical Services Section responsibilities include establishing rules and policy, implementing the Three Member Panel's uniform schedules for Maximum Reimbursement Allowances (MRAs), and resolving medical reimbursement disputes between providers and payers.

The Medical Services Section received 10,195 Reimbursement Disputes during Fiscal Year 2012-2013, which is a decrease of 32% from last fiscal year. The volume of Medical Reimbursement Disputes filed by practitioners decreased during Fiscal Year 2012-2013, and this trend is expected to continue in Fiscal Year 2013-2014.

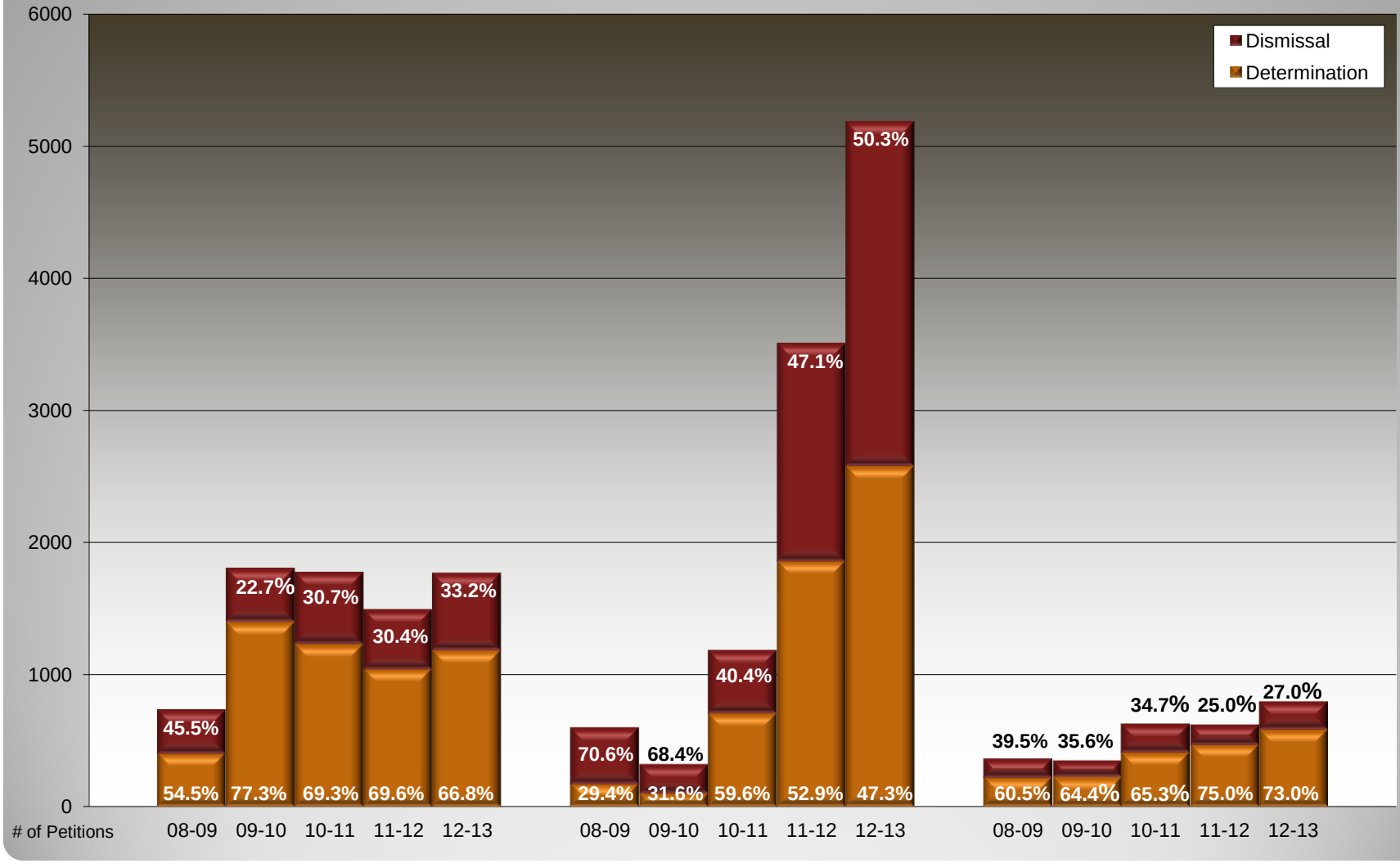
Petitions Submitted by Provider Type					
	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13
Practitioner	568	296	1,308	12,718	7,805
ASC	349	373	655	687	737
Hospital Inpatient	244	330	436	332	350
Hospital Outpatient	745	1,071	1,378	1,273	1,303
Total	1,906	2,070	3,777	15,010	10,195

Bureau of Monitoring & Audit

The Medical Services Section resolved 7,747 Reimbursement Disputes during Fiscal Year 2012-2013. This represents approximately a 37.75% increase over Fiscal Year 2010-2011. Out of the 7,747 Reimbursement disputes, the Medical Services Section issued 4,339 determinations (56%) and 3,408 dismissals (44%) in Fiscal Year 2012-2013.

During Fiscal Year 2012-2013, a Reimbursement Dispute had to be filed within 30 days from receipt of the carrier's notice of disallowance or adjustment of payment. As of July 1, 2013, which was the start of the Fiscal Year 2013-2014, a Reimbursement Dispute must be filed within 45 days from receipt of the carrier's notice of disallowance or adjustment of payment. This past fiscal year, the number of Reimbursement Disputes dismissed due to untimely filing increased 37.95%, from 930 to 1,283.

Petition Outcomes by Provider Type



Bureau of Monitoring & Audit

Historically, the primary reason for dismissing a Reimbursement Dispute has been due to the petitioner's failure to cure a deficiency in the petition following notice from the Medical Services Section.

However, in Fiscal Year 2012-2013, the filing of an untimely petition was the most frequent reason for dismissal.

The number of petitions withdrawn in Fiscal Year 2012-2013 increased by 167% over Fiscal Year 2011-2012. Withdrawals were the second most frequent reason for dismissing a petition.

Though nominal in actual numbers, the number of correct payments found and overpayments found are increasing.

The Medical Services Section discovered that the petitioner had been underpaid in 89.21% of all determinations issued for Fiscal Year 2012-2013. However, in most cases, the amount reimbursed to the provider rarely equaled the billed amount. Therefore, the amount found to be due was typically less than the billed charge.

Bureau of Monitoring & Audit

Determinations Issued by Reason per Fiscal Year					
	08-09	09-10	10-11	11-12	12-13
Under-Payment	715	1,635	2,181	3,095	3,871
Correct Payment	28	25	41	83	118
Over-Payment	19	34	28	75	96
Other Finding	19	2	5	3	10
No Additional Payment Due	25	25	90	109	244

The Medical Services Section certifies Health Care Providers (HCPs) and Expert Medical Advisors (EMAs). As of June 30, 2013 there were 37,277 certified HCPs and 114 certified EMAs. Beginning July 1, 2013, the State of Florida no longer requires a HCP to be certified in order to provide health care services to injured workers.

The Medical Services Section has the responsibility of investigating reports of provider violations. In Fiscal Year 2012-2013, the Medical Services Section processed 68 reports which included 20 reports carried over from FY 2011-2012. Out of the 68 reports processed, 3 were referrals from injured employees or employers, 14 were internal Division of Workers' Compensation referrals, and 51 were referrals from insurers or attorneys.

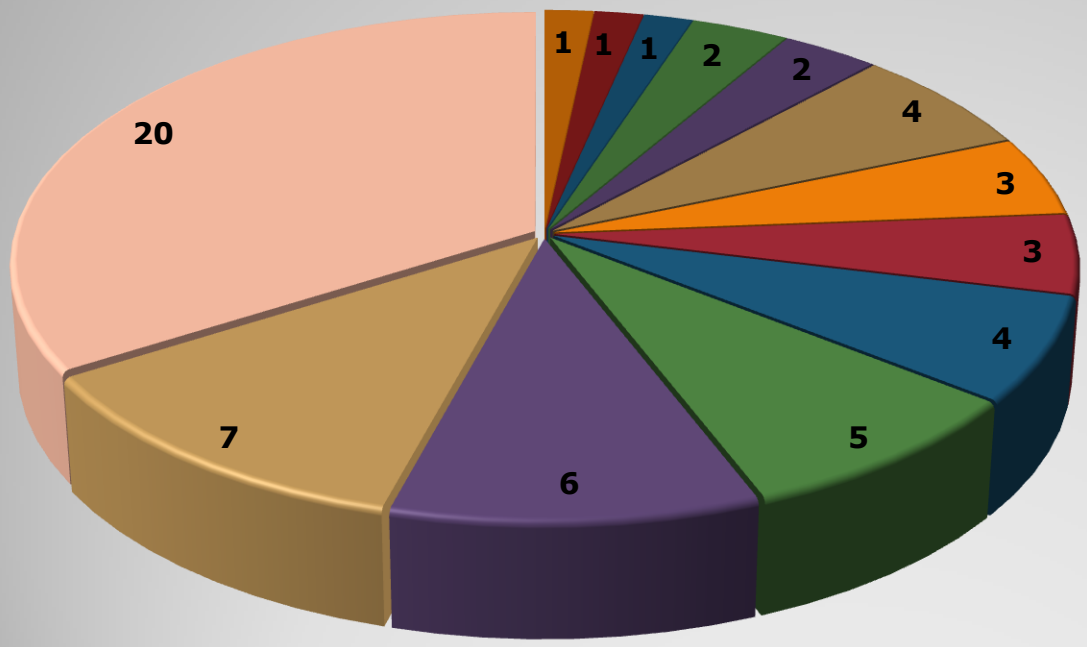
Bureau of Monitoring & Audit

The table below illustrates the end of year case status for reports of provider violations processed during Fiscal Year 2012-2013. Open cases are carried over into the next fiscal year for further processing. The outcome of these cases will be included in the report of Fiscal Year 2013-2014 activities.

Reports of Provider Violations Case Statuses as of June 30, 2013	
Status	**Number of Cases**
Open	9
Closed	59

The pie chart on the following page describes the distribution of the various provider violation case outcomes for those cases closed during Fiscal Year 2012-2013. The most common reason for closure was the failure of the entity making the report of violation to reasonably support the report with documentation of a violation.

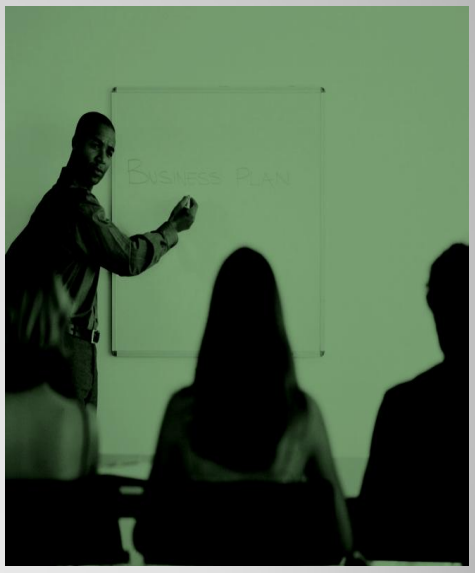
59 Closed Reports of Provider Violations By Reason



- Non-HCP Violations
- Untimely submission
- Provider deceased
- Duplicate file created
- Referral withdrawn after issuance of Intent to Revoke
- Issue resolved prior to determination
- Invalid referral related to RD petition
- Not a violation per Rule 69L-34, F.A.C.
- Valid referral received during on-going review period for same violation previously cited
- Internal referral violation addressed in RD determination supporting carrier's disallowance
- Improper format not on DWC-2000 Referral Form
- Valid referral HCP Education Letter issued
- Failure to reasonably support violation insufficient documentation

Bureau of Monitoring & Audit

The Medical Services Section provides educational assistance and consultation on issues related to medical bill filing and reimbursements, and administrative support to the Three-Member Panel who adopts uniform schedules of maximum reimbursement allowances for physicians, hospitals, ambulatory surgical centers (ASCs), and other service providers.



Bureau of Employee Assistance & Ombudsman Office

The Bureau of Employee Assistance and Ombudsman Office (EAO) was established pursuant to Section 440.191, Florida Statutes, 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 print and electronic media, one-on-one interaction with individual shareholders, and group presentations to promote the self-execution of the system.

To effectively fulfill its mission, EAO utilizes a team structure to focus on each specific area of its statutory responsibilities. 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; and resolving disputes between injured workers and carriers to avoid undue expense, costly litigation or delay in the provision of benefits.

Bureau of Employee Assistance & Ombudsman Office

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.

Customer Service Call Volume FY 2012-2013	
1st Qtr	23,878
2nd Qtr	17,734
3rd Qtr	23,486
4th Qtr	25,787
Total	90,885

Bureau of Employee Assistance & Ombudsman Office

First Report of Injury Team

Within two business days of the Division's receipt of a First Report of Injury or Illness, the First Report of Injury Team identifies and contacts injured workers who have lost more than seven days of work due to the job related injuries to provide educational information about the Workers' Compensation System, advise injured workers of their statutory responsibilities, and inform workers of EAO's services.

During Fiscal Year 2012-2013, the Team contacted 31,303 injured workers by telephone and contacted 3,342 employers/carriers, when unable to reach injured workers, to inquire about the status of injured workers' claims and to advise of EAO's services. The Team mailed letters or responded by email to 45,047 injured workers to inform them of EAO's services and offer assistance.

The increased contact success rate is attributed to EAO establishing a team dedicated to this function.

Injured Worker Contacts		
Fiscal Year	**# Contacted**	**% Contacted**
07-08	26,140	58%
08-09	25,271	63%
09-10	28,768	69%
10-11	32,140	71%
11-12	32,966	73%
12-13	31,303	81%

Bureau of Employee Assistance & Ombudsman Office

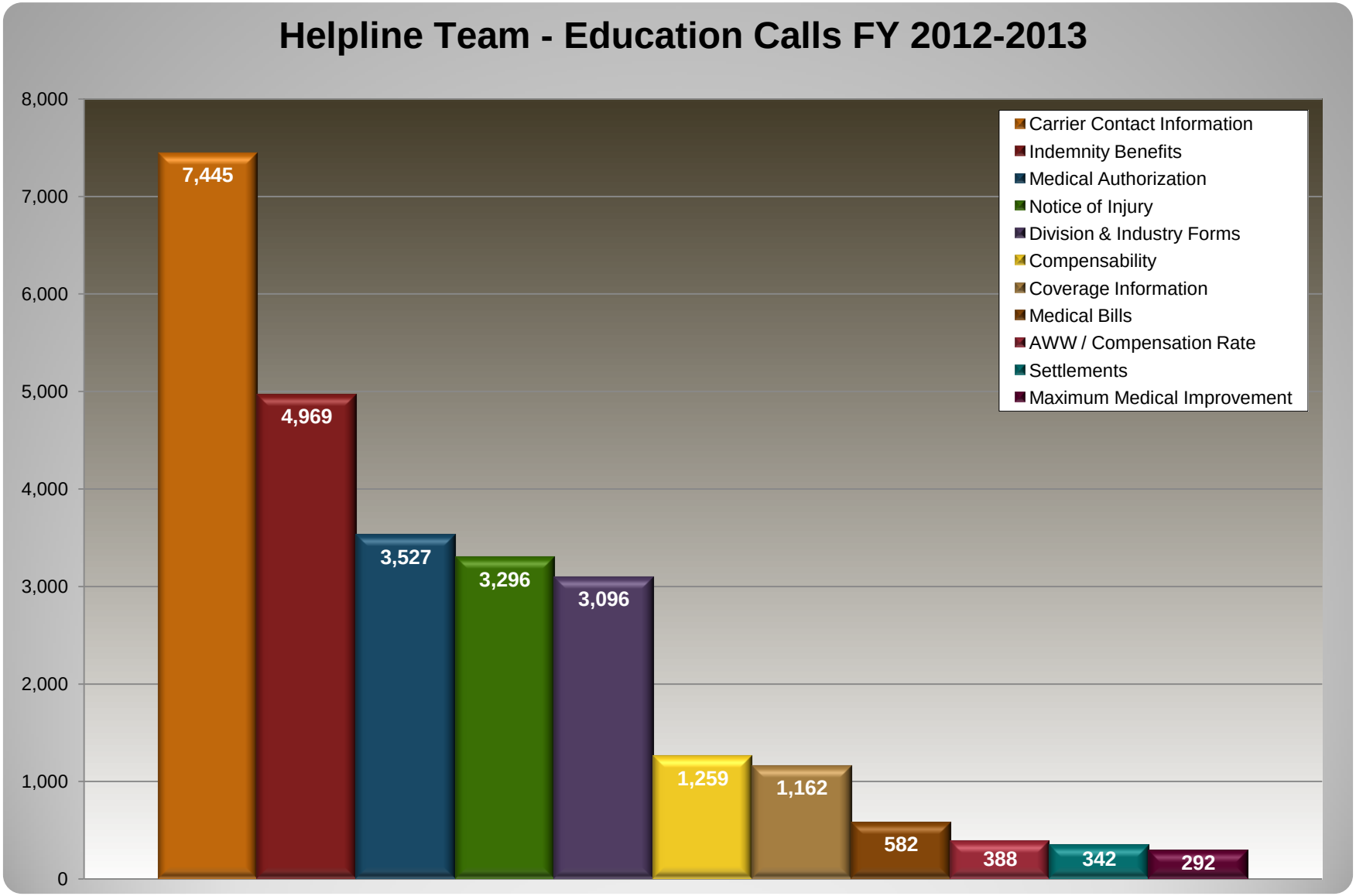
Injured Worker Helpline Team

The Injured Worker Helpline Team receives calls from system stakeholders including injured workers, employers, carriers, medical providers, attorneys, and the general public. The Team educates callers who contact the Division's toll-free telephone line about the requirements of Florida's Workers' Compensation Law and provides assistance to injured workers experiencing issues 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 Fiscal Year 2012-2013, the Injured Worker Helpline Team provided workers' compensation educational information and assistance to 54,155 callers, including 8,696 Spanish speaking callers, and resolved 87% of the 447 disputes received.

Helpline Team - Education Calls FY 2012-2013



Bureau of Employee Assistance & Ombudsman Office

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.

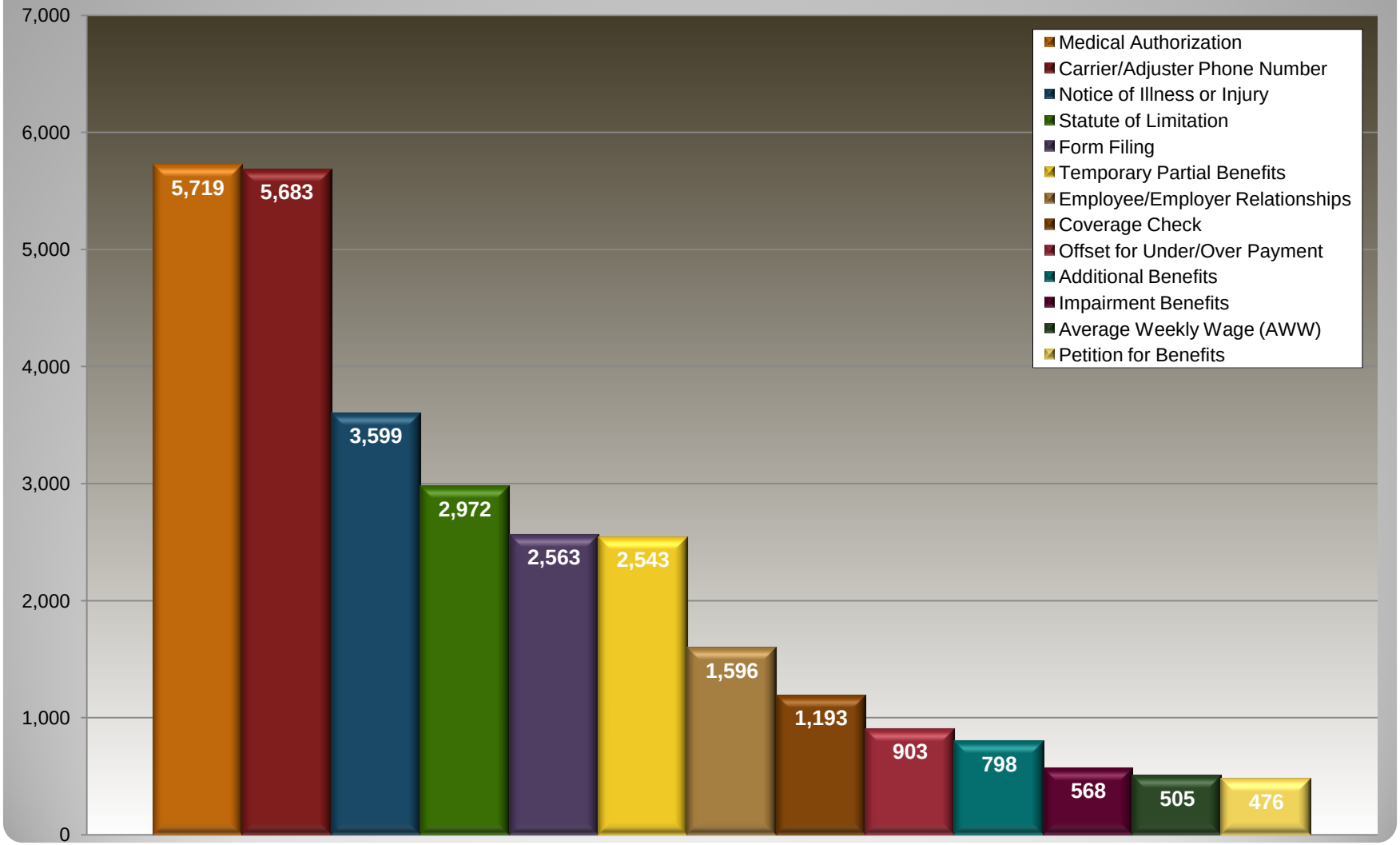
The Ombudsman Team provides early intervention services to injured workers with catastrophic or severe injuries, assists walk-in customers in six offices throughout Florida resolving disputes and providing workers' compensation information applicable to each injured worker's claim, including guidance on the Petition for Benefits process, and assists injured workers referred from the Governor's and CFO's Offices, legislators, and other elected officials.

During Fiscal Year 2012-2013 the Ombudsman Team resolved 85% of the 977 disputes received; resolved 95% of the 99 medical bill disputes received, totaling $117,087 in previously unpaid medical bills; and prevented 4,771 potential disputes by educating injured workers and providing them with in-depth case specific information.

Ombudsman Intervention FY 2012-2013			
Issue	**Resolved**	**Unresolved**	**% Resolved**
Average Weekly Wage	9	3	75%
Medical Authorization	391	14	97%
Notice of Injury	49	1	98%
Indemnity - TPD	51	21	71%
Indemnity - TTD	62	17	78%
Compensability	7	28	20%
Penalties & Interest	29	4	88%
Medical Mileage	78	2	98%
Medical Bills	94	46	67%
Impairment Income Benefits	6	1	86%
Other	13	3	81%
Total	789	140	85%

The participants with questions can contact the Ombudsman Team at wceao@myfloridacfo.com.

Issues Addressed by Ombudsman and Helpline Teams FY 2012-2013



Bureau of Employee Assistance & Ombudsman Office

Reemployment Services Team

The Reemployment Services Team educates injured employees about reemployment services they may be eligible for to assist them in returning to suitable gainful employment. These services include vocational counseling, job seeking skills, job analysis, job placement, and training and education. The Team guides injured employees in submitting requests for screening for services through the Division's web portal and informs them of documentation that should be provided to support their requests. Furthermore, the Reemployment Services Team educates carriers on the requirements of Florida's Worker's Compensation Law relating to reemployment services.

During Fiscal Year 2012-2013 the Reemployment Services Team received 280 requests for screenings submitted through the Injured Worker Web Portal; screened 282 injured workers for services; and assisted 166 injured workers (98% of the injured workers eligible to receive reemployment services) to return to work. Additionally, the Reemployment Services Team responded to 225 emails and 919 phone inquires for services.

Participants with questions regarding Reemployment Services, please contact us via email at WCRES@myfloridacfo.com.

Bureau of Data Quality & Collection

The Bureau of Data Quality and Collection (DQC) receives and manages large volumes of data from claims-handling entities and vendors for Claims, Medical, and Proof of Coverage data as required by Chapter 440, Florida Statutes, and various corresponding Florida administrative rules.

DQC's mission is to collect data in an efficient and effective manner in order to provide accurate, meaningful, timely and readily accessible information to all stakeholders within the workers' compensation system. DQC is responsible for collecting, storing, and retrieving information to support the Division. To ensure 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.

DQC develops and maintains business processes that comingle with other Division systems to facilitate the monitoring of injured worker benefits, employer coverage and compliance, and health care provider payments.

Bureau of Data Quality & Collection

Proof of Coverage EDI Data Collection

With the exception of self-insurers, every insurer is required by Administrative Rule 69L-56, Florida Administrative Code, to file policy information with the Division for the following types of filings: Certificates of Insurance, Notices of Reinstatement, Endorsements, and Cancellations.

One hundred percent of all workers' compensation Proof of Coverage (POC) data is collected and inspected via Electronic Data Interchange (EDI). EDI is the structured transmission of data between organizations by electronic means. It is used to transfer electronic documents or business data from one computer system to another computer system, i.e. from one trading partner to another trading partner, without human intervention.

Bureau of Data Quality & Collection

POC EDI data is used to populate several online Division databases including:

"Proof of Coverage" database which provides information that can be used to verify if an employer currently has workers' compensation coverage in force; to view a prior policy period; or to validate if a person has a workers' compensation exemption; and

"Construction Policy Tracking" database which provides the policy status of every subcontractor a contractor has chosen to track. Features include the electronic notification of any changes to a subcontractor's coverage status.

Proof of Coverage Accepted Filings				
	FY 09-10	FY 10-11	FY 11-12	FY 12-13
New Policies	248,448	253,998	262,301	267,264
Reinstatements	86,885	80,306	79,958	78,089
Endorsements	249,438	225,425	208,553	246,040
Cancellations	167,873	155,987	157,405	150,321
Total	752,644	715,716	708,217	743,189

If you have any questions or require assistance regarding the electronic reporting of Proof of Coverage information, contact the Bureau of Data Quality and Collection via email at poc.edi@myfloridacfo.com.

Bureau of Data Quality & Collection

Medical EDI Data Collection

The Florida Workers' Compensation Medical Services Billing, Filing, and Reporting Rule, 69L-7.602, Florida Administrative Code, was last amended and became effective on October 23, 2012; however, this amendment did not contain changes that directly impacted the collection of medical data submitted to the Division.

Electronic Medical Bills Accepted	
Fiscal Year	**Bills Accepted**
FY 09-10	4,014,501
FY 10-11	3,884,341
FY 11-12	3,834,451
FY 12-13	3,929,214

To assist Medical EDI submitters with the management of rejected bills and to allow comparison benchmarking among the industry, DQC generates monthly report cards that denote the primary reasons for initial medical bill rejection.

If you have any questions or require assistance regarding Medical EDI reporting, contact the Bureau of Data Quality and Collection via email at MedicalDataManagementTeam@myfloridacfo.com.

Bureau of Data Quality & Collection

Claims EDI Data Collection

Claims EDI data populates the Division's main accident database and several online web databases. This data is collected pursuant to Rule 69L-56, Florida Administrative Code. The EDI Team conducted 11 EDI Webinar and/or teleconference training classes in Fiscal Year 2012-2013 with individual trading partners covering: Gross and Net Weekly Amount calculations, Specific Maintenance Type Codes, Event vs. Sweep Benefit Segments and First Report of Injury (FROI)/Subsequent Report of Injury (SROI) combo filings.

Accepted Claims Forms			
Fiscal Year	**EDI**	**Paper**	**Total**
FY 09-10	485,403	10,696	496,099
FY 10-11	526,908	6,316	533,224
FY 11-12	500,613	2,223	502,836
FY 12-13	474,780	422	475,202

If you have any questions or require assistance regarding the reporting of Claims EDI data, contact the Bureau of Data Quality and Collection via email at claims.edi@myfloridacfo.com.

Bureau of Data Quality & Collection

Records Management Section

Florida's Public Records Law and Civil Rules of Procedure require the release of certain information for public inspection upon request. Once a request is received, documents must be identified, located, printed, assembled from various mediums, inspected for confidentiality pursuant to Chapter 119, Florida Statutes and appropriate administrative rules, and redacted. To ensure quality and excellence, multiple quality reviews are performed prior to the release of records.

During Fiscal Year 2012-2013, DQC responded to 3,478 subpoenas and 3,087 public records requests. On average, subpoenas were invoiced in less than three business days of receipt. Public records requests were invoiced, or documents provided if no charge, in less than three business days of receipt. Documents are redacted and mailed upon receipt of the requestor's invoice payment as authorized by Section 119.07, Florida Statutes, if applicable. Public record requests may be submitted via email to the Division at DWCPublicRecordsRequest@myfloridacfo.com.

The Electronic Document Management (EDM) Team, as part of the Records Management Section, assists Division Bureaus by converting previous paper files and microfilm documents to electronic records by scanning, indexing and verifying documents. The EDM team scanned 2,441,242 pages for Fiscal Year 2012-2013.

Bureau of Data Quality & Collection

Records Privacy Requests

Florida's public records law requires most workers' compensation accident information to be released to any party upon request. Section 119.071(4)(d), Florida Statutes, allows certain occupational classes (e.g., law enforcement personnel, correctional officers, firefighters, judges, etc.) to request an agency to exempt their personal information (i.e., home address, telephone number, and date of birth) from public records release. In Fiscal Year 2012-2013, DQC received and processed 7,429 requests for workers' compensation profiles to be exempt from public records inspection under Section 119.071(4)(d), Florida Statutes. This is a 414% increase in profiles marked exempt from last year. For a list of qualifying occupations, visit http://www.myfloridacfo.com/division/WC/employee/records.htm.

Records privacy requests are processed in two or less business days on average due to the creation of on-line educational information on the Division's website, including revised forms to expedite the request process. DQC has a follow-up email process to notify the requestor of the status of his/her exemption request. Questions regarding records privacy can be emailed to DWCRecordsPrivacy@myfloridacfo.com.

Bureau of Compliance

The Bureau of Compliance (BOC) accomplishes its mission to ensure employers comply with statutory obligations to obtain workers' compensation insurance coverage for employees by conducting investigations and issuance of enforcement actions in accordance with Section 440.107, Florida Statutes; processing workers' compensation exemptions to qualified applicants in accordance with Section 440.05, Florida Statutes; and providing educational outreach and training to employers and insurance industry representatives on workers' compensation coverage laws.

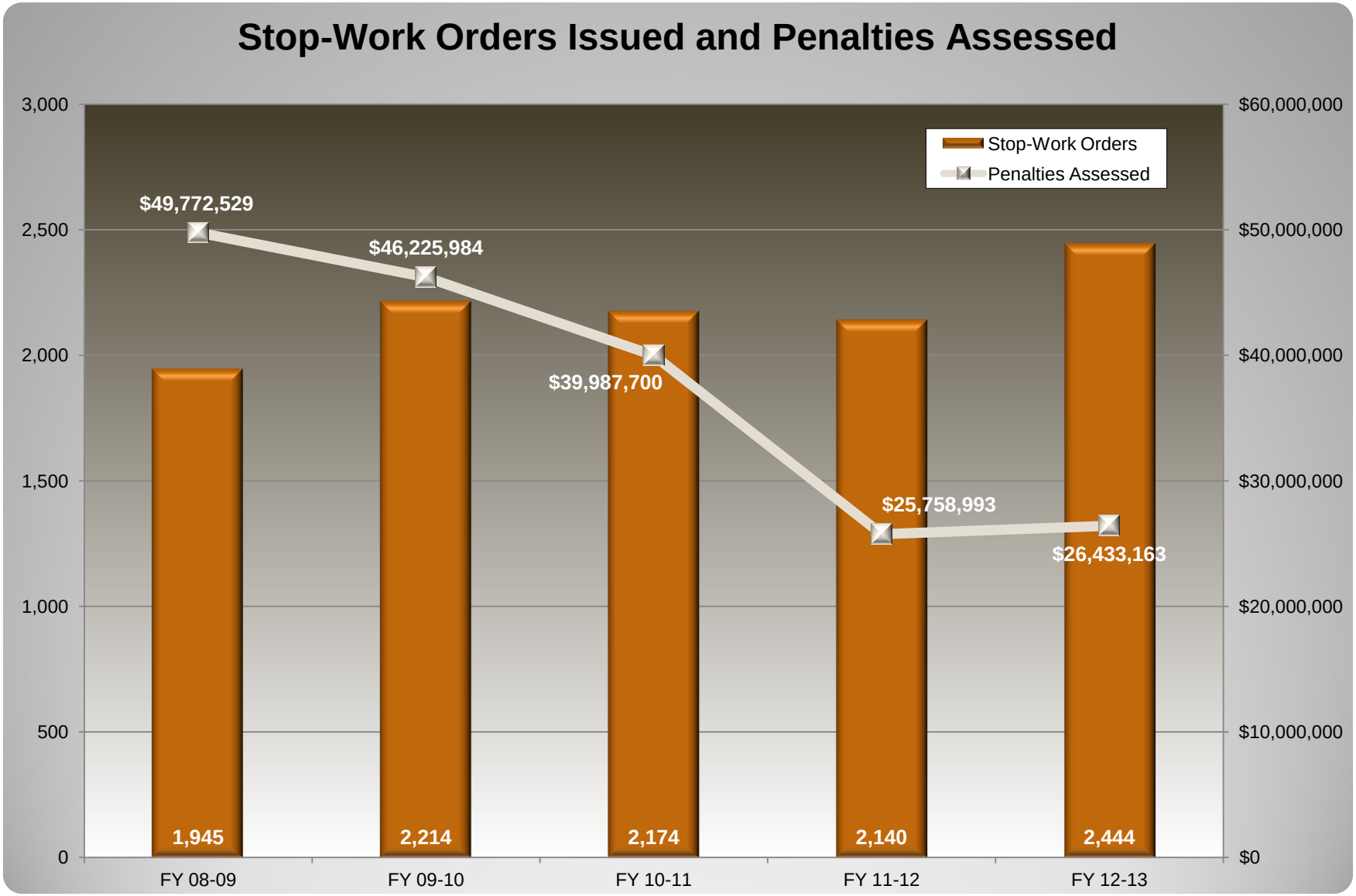
The Bureau's key initiatives include implementation of an online filing system for workers' compensation exemptions to increase efficiency and reduce processing costs, 99% of filings processed within five days of receipt; successfully utilized data from multiple agencies to identify and target non-compliant employers; investigated 1,731 public referrals alleging non-compliance; conducted 66 free training sessions and 34 webinars on workers' compensation and workplace safety for over 2,906 employers statewide; and increased enforcement actions by 14%, increasing the number of employees covered by workers' compensation by 44% over the prior fiscal year.

Bureau of Compliance

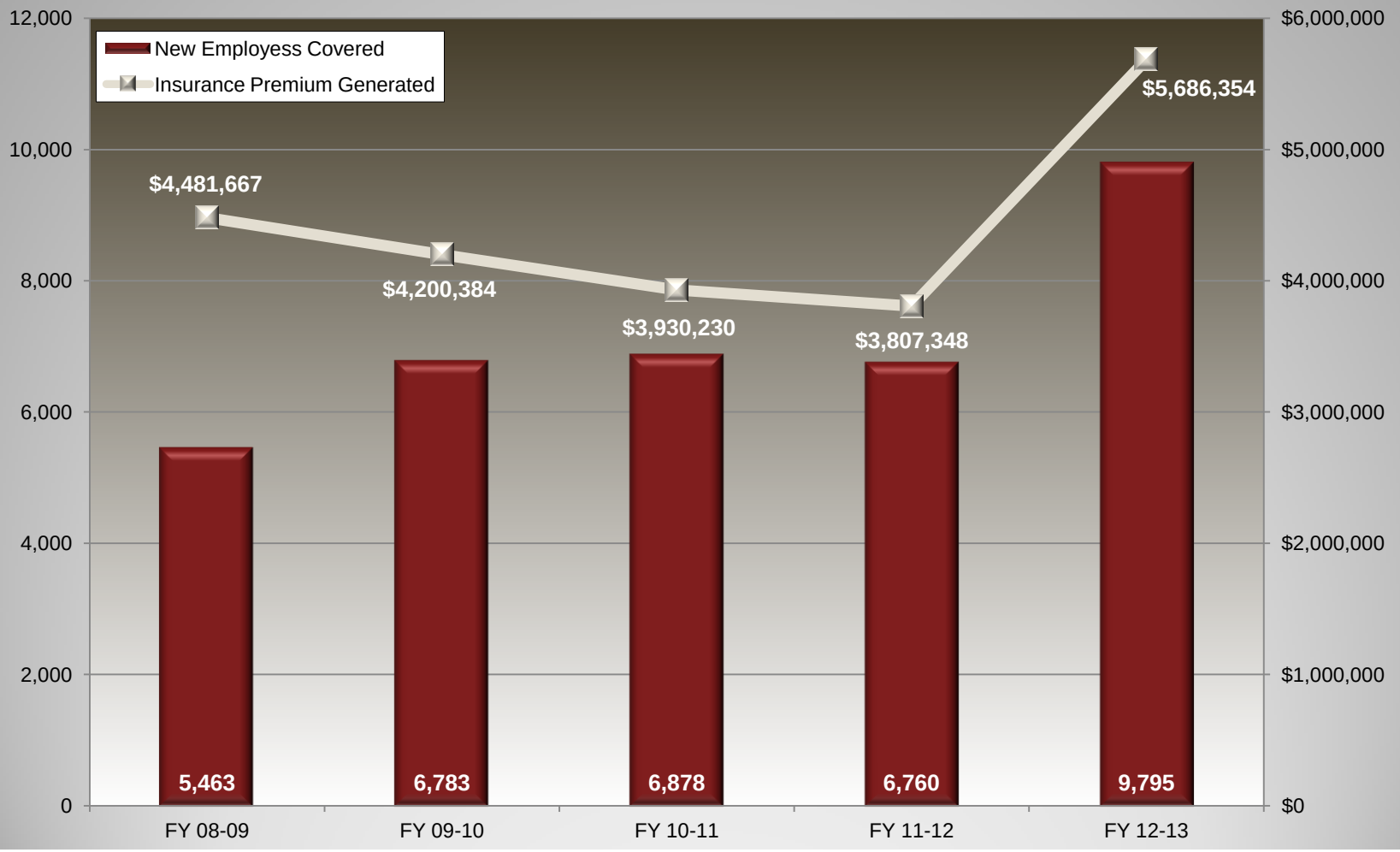
Investigations conducted are physical, on-site inspections of an employer's job-site or business location to determine compliance with workers' compensation coverage requirements.

Investigations Conducted	
FY 08-09	29,166
FY 09-10	33,235
FY 10-11	34,252
FY 11-12	34,780
FY 12-13	34,150

Stop-Work Orders Issued and Penalties Assessed



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

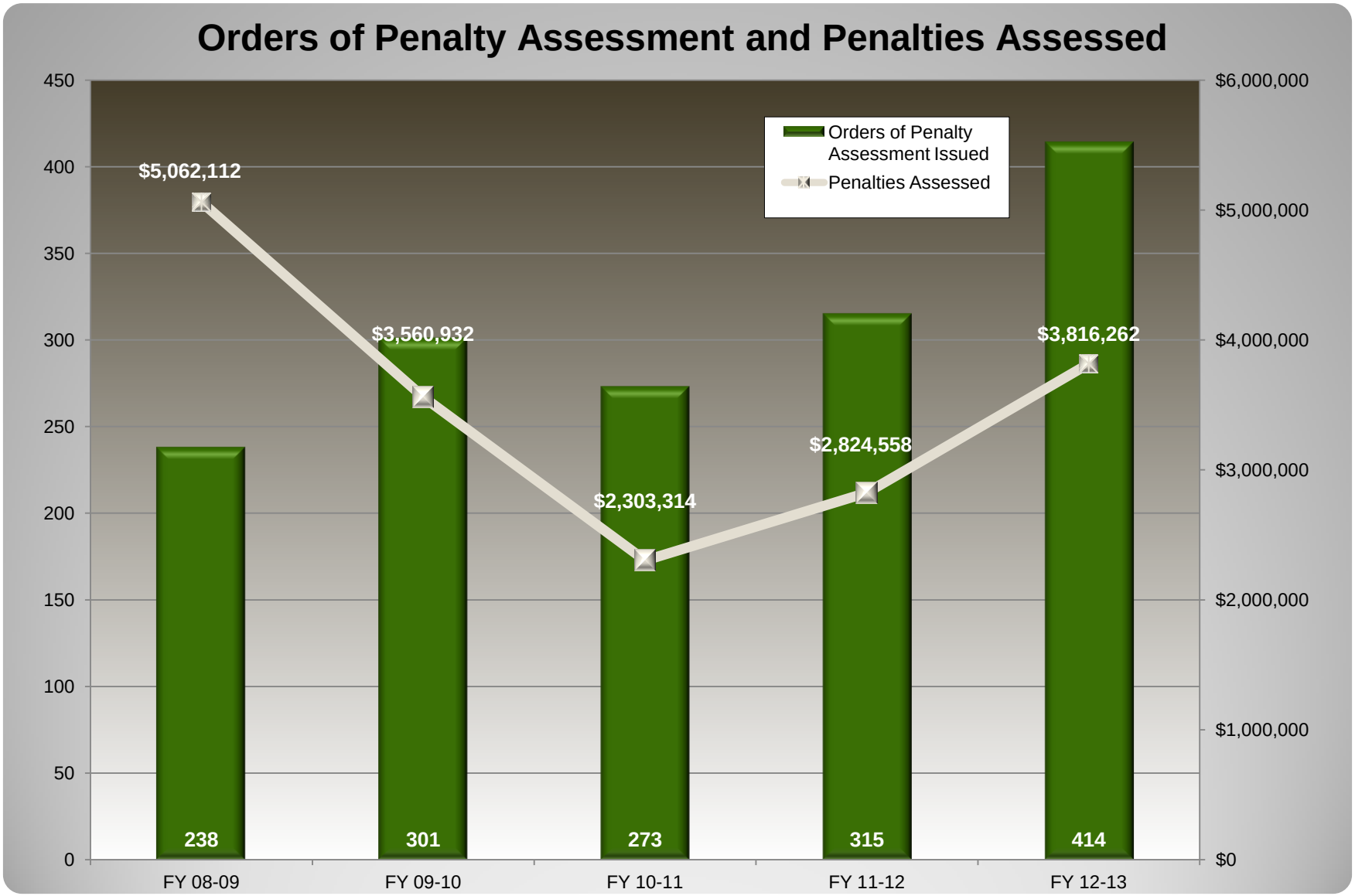


This graph illustrates the number of employees covered as a direct result of the Bureau's enforcement efforts and issuance of Stop-Work Orders and the monies added to the workers' compensation premium base that had been previously evaded.

Bureau of Compliance

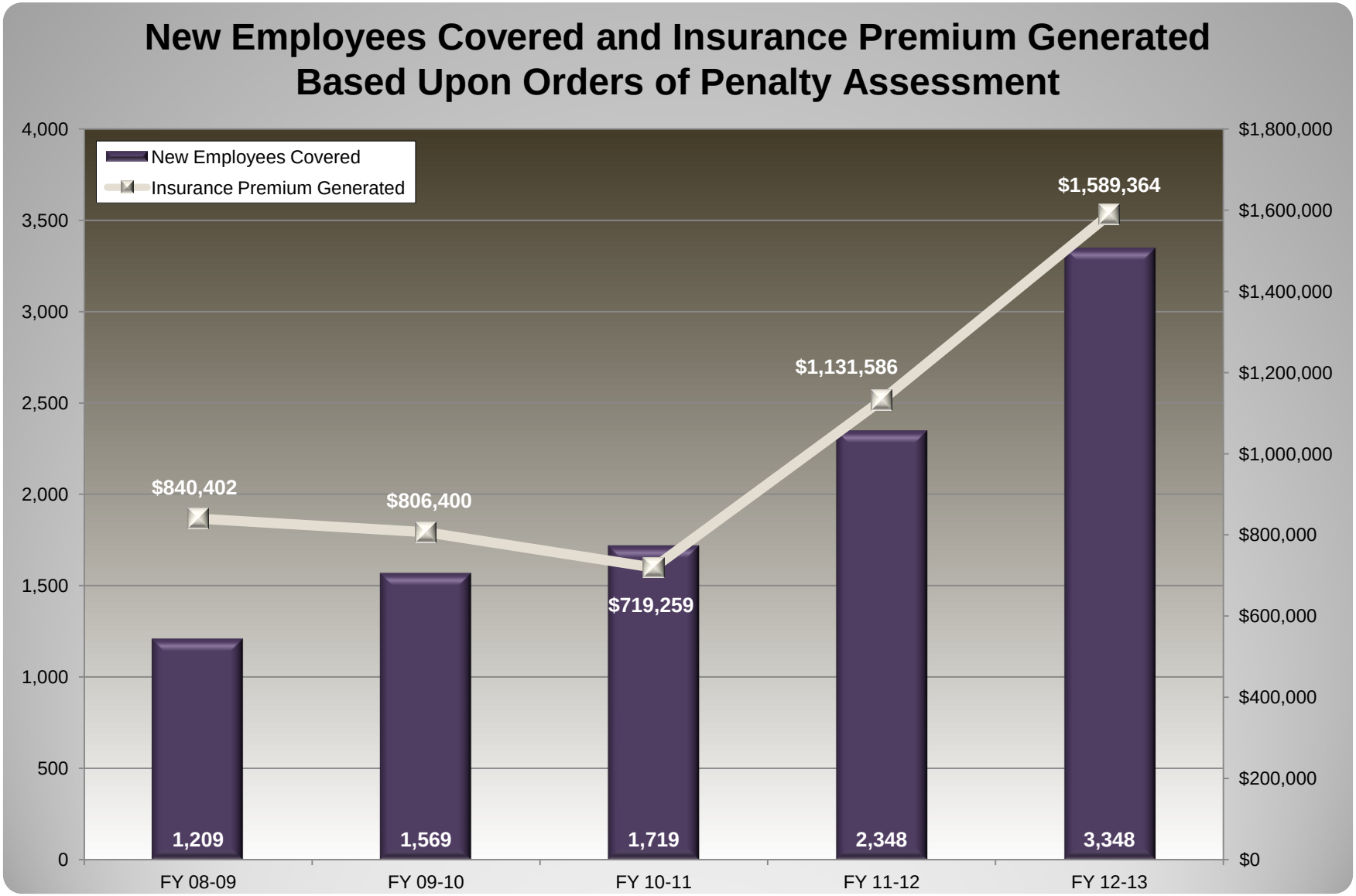
The following two graphics pertain to Orders of Penalty Assessment, when the employer obtained coverage subsequent to the commencement of an investigation which made the issuance of the Stop-Work Order unnecessary.

Orders of Penalty Assessment and Penalties Assessed



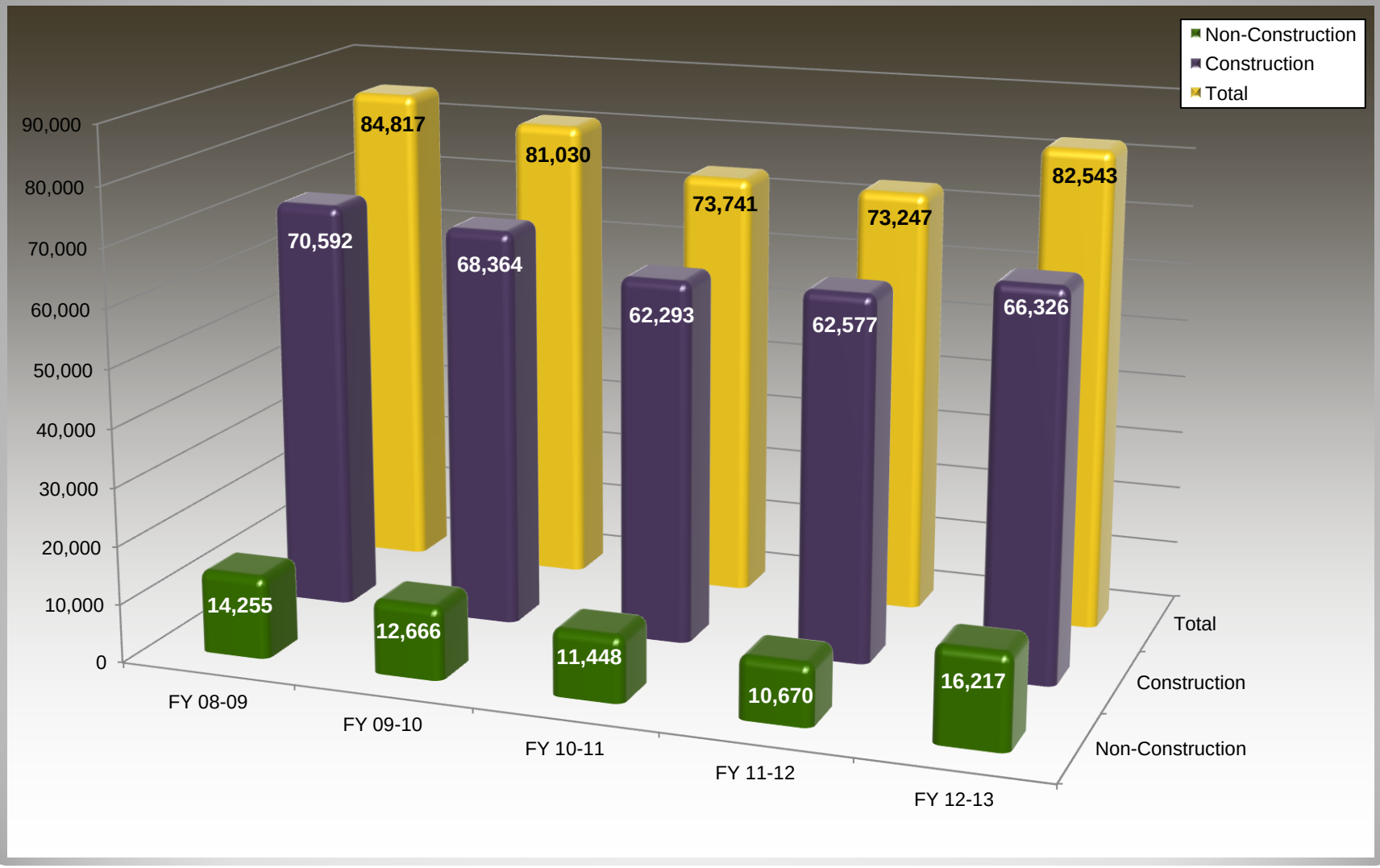
This chart illustrates the volume of Orders of Penalty Assessments issued and penalties assessed.

New Employees Covered and Insurance Premium Generated Based Upon Orders of Penalty Assessment



This chart illustrates the new employees covered and premium generated as a result of those Orders after the employers purchased workers' compensation insurance.

Exemption Applications Processed

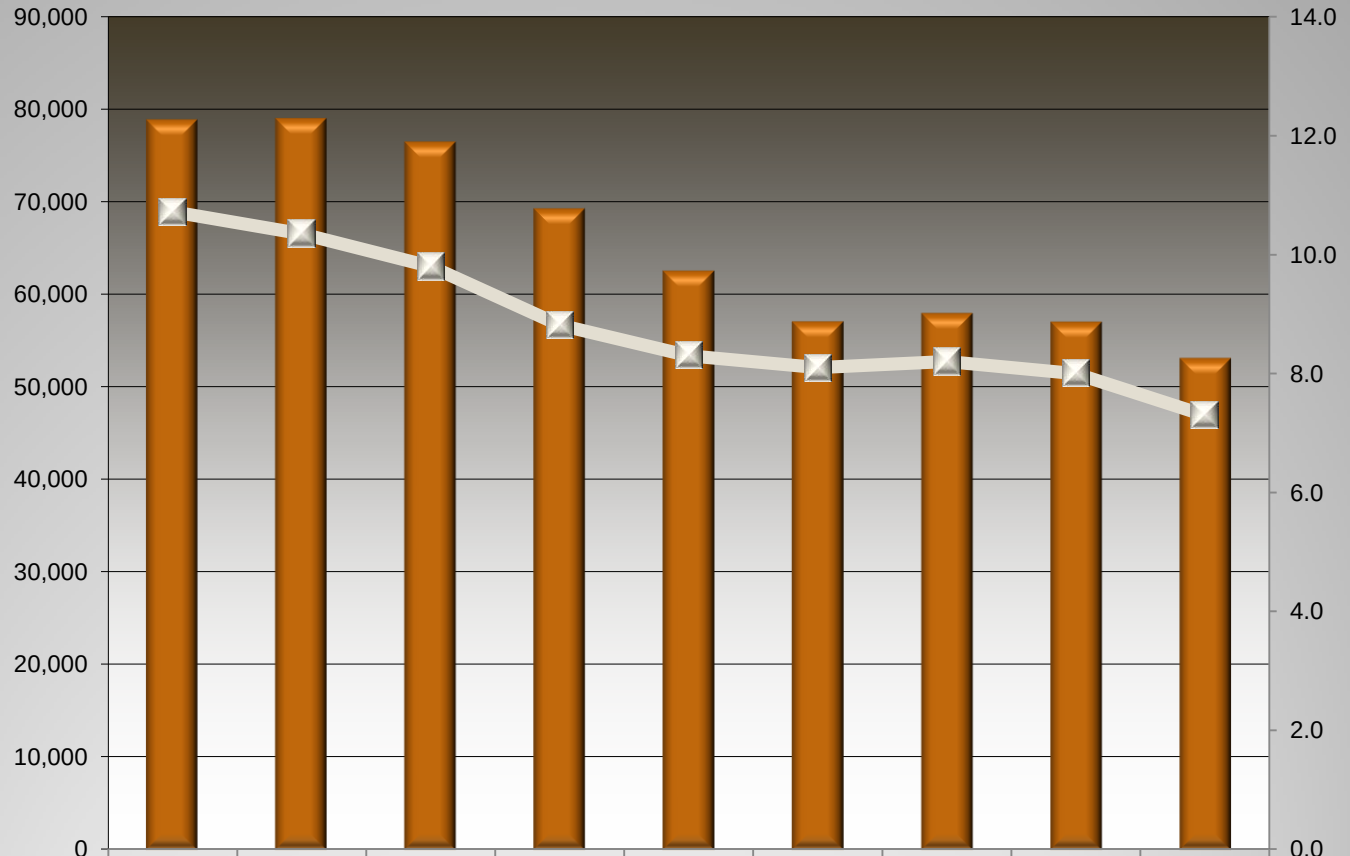


Lost-Time Claims Data

Under Florida's workers' compensation statute, workers sustaining a compensable injury are entitled to receive medically necessary treatment. If the injury results in disability for more than seven days, the injured worker is entitled to payment for a portion of lost wages. Additional benefits are paid for injuries resulting in a permanent impairment. Payment of survivor dependent benefits and funeral expenses may be provided for injuries resulting in workplace fatalities.

The injured worker's prior earnings, the nature and extent of the injury, the length of the healing period, and the worker's ability to return to work are all factors upon which benefit payments for lost wages or permanent impairments depend. If an injured worker's disability results in a benefit payment(s) for lost wages, a permanent impairment, or a settlement, it is considered to be a Lost-Time case.

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



	2004	2005	2006	2007	2008	2009	2010*	2011*	2012*
Lost-Time Claims	78,741	78,893	76,362	69,150	62,431	56,964	57,862	56,925	53,024
Rate Per 1,000 Employees	10.7	10.4	9.8	8.8	8.3	8.1	8.2	8.0	7.3

*Preliminary Data

Source: Florida Department of Economic Opportunity, 2003-2012 Current Employment Statistics

**Lost-time claim frequencies as of 6/30/13, based on the most recent information from insurers about determinations & dispositions.

Lost-Time Claims Data

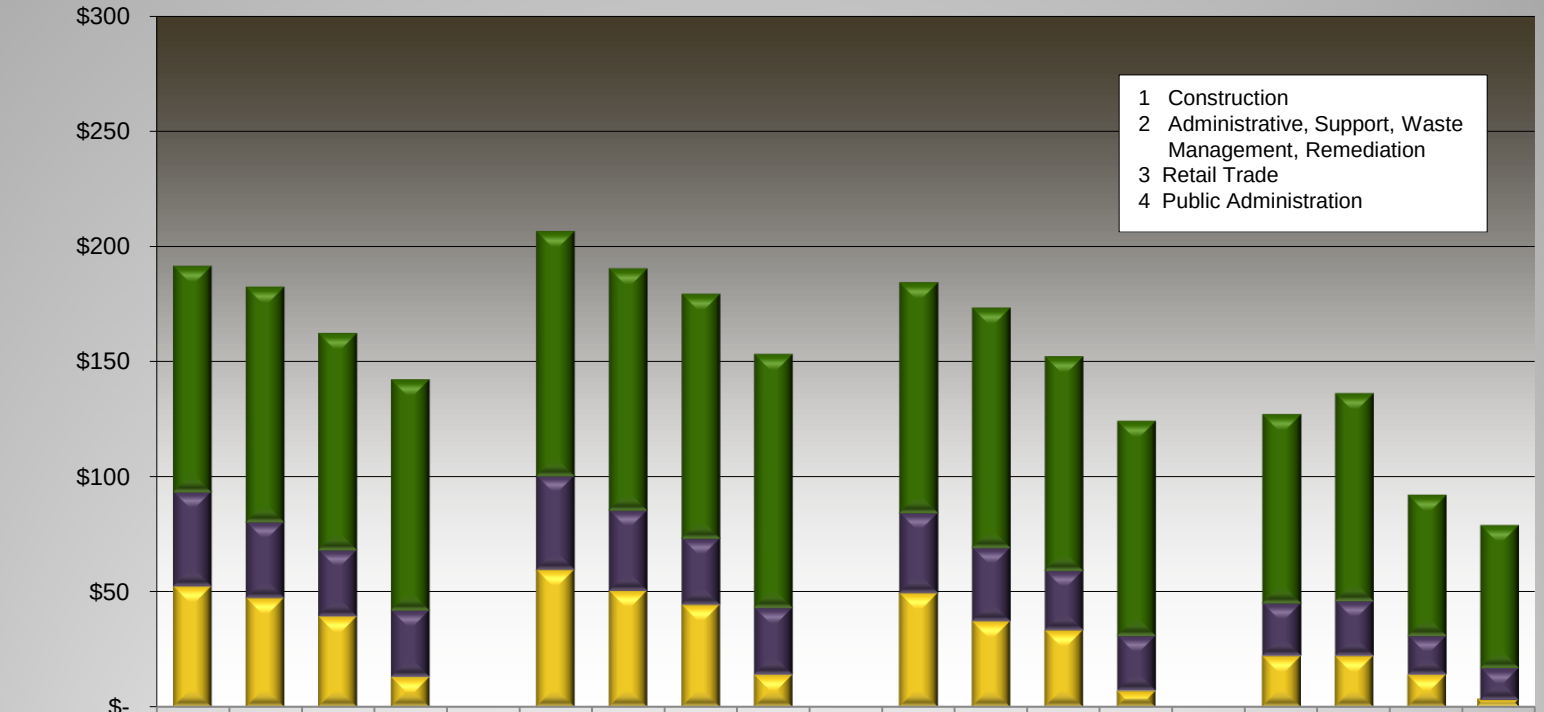
Top Ten Industrial Classifications for 2012 Lost-Time Claims	
	Number of Claims
Administrative, Support, Waste Management, Remediation	6,888
Retail Trade	6,077
Health Care & Social Assistance	5,171
Construction	4,676
Accommodation & Food Services	4,606
Public Administration	4,484
Manufacturing	3,842
Transportation & Warehousing	3,313
Educational Services	3,234
Wholesale Trade	1,837

Lost-Time Claims Data

The following chart illustrates the total benefit payments for the four industrial classifications whose benefit payments for medical, indemnity, and settlement benefits are the highest. Historically, construction has consistently incurred the highest benefit payments of all the industrial classifications.

Benefit Payments for the Four Leading Industrial Classifications

$ value in millions



	1	2	3	4		1	2	3	4		1	2	3	4		1	2	3	4
Medical	$98	$102	$94	$100		$106	$105	$106	$110		$100	$104	$93	$93		$82	$90	$61	$62
Indemnity	$41	$33	$29	$29		$41	$35	$29	$29		$35	$32	$26	$24		$23	$24	$17	$14
Settlement	$52	$47	$39	$13		$59	$50	$44	$14		$49	$37	$33	$7		$22	$22	$14	$3
Injury Yr	2009					2010*					2011*					2012*			

*Preliminary Data

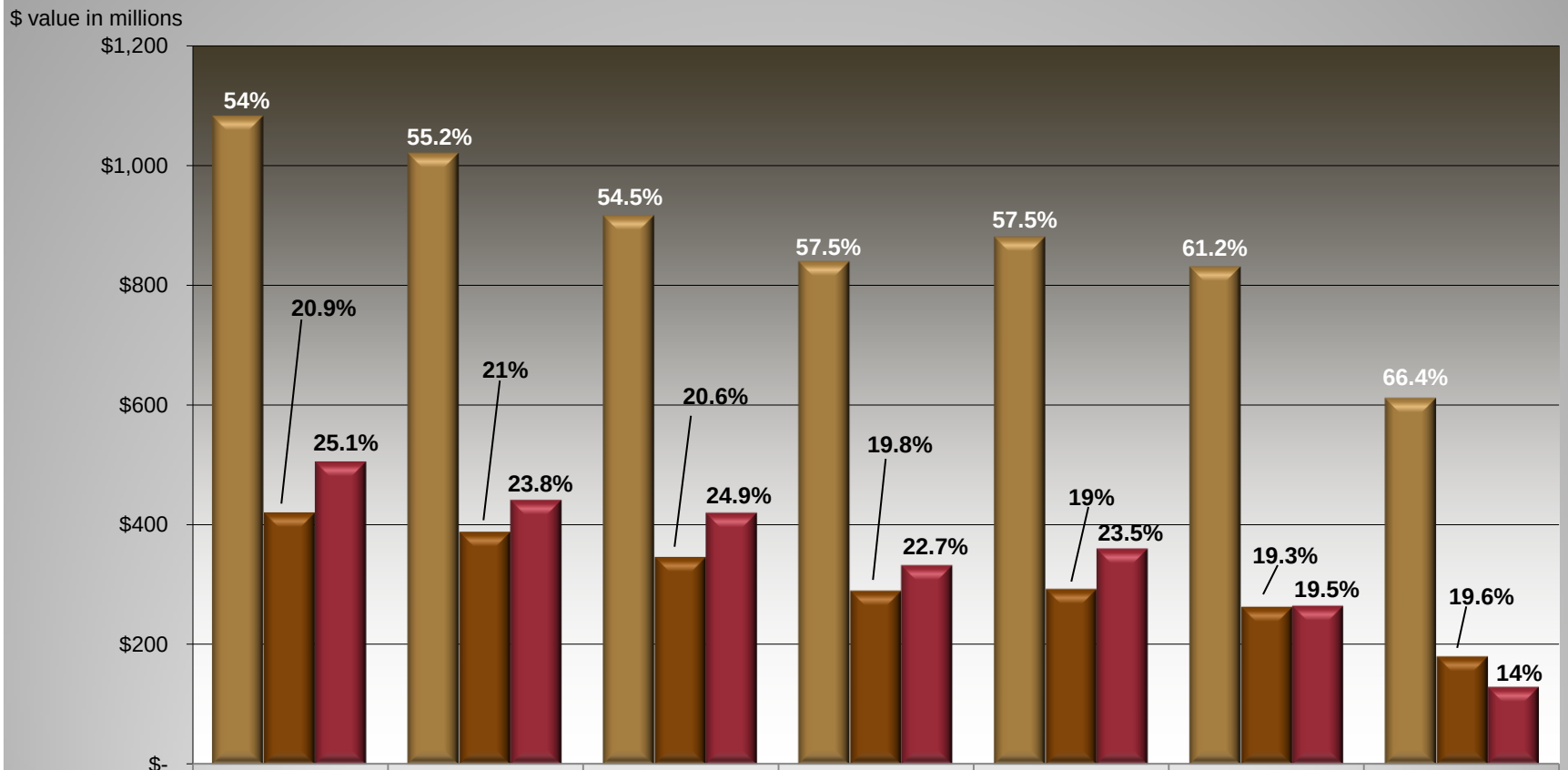
Each illustrated year represents a different level of data maturity, with only the earliest year, 2009, deemed mature. This offers a perspective for comparing the impact of claim development on benefit payments.

Lost-Time Claims Data

Treatment for a work-related injury, as deemed medically necessary, may involve services of physicians, physical therapists, chiropractors, dentists, or other health care providers; services of hospitals, ambulatory surgical centers, or skilled nursing facilities; and medicines, supplies, equipment, and related items such as prosthetic devices or implants. Medical benefits continue throughout the period of recovery.

Differences regarding claim development reveal the priority of medical services early in the life of a claim and the increase in settlements as claims progress.

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



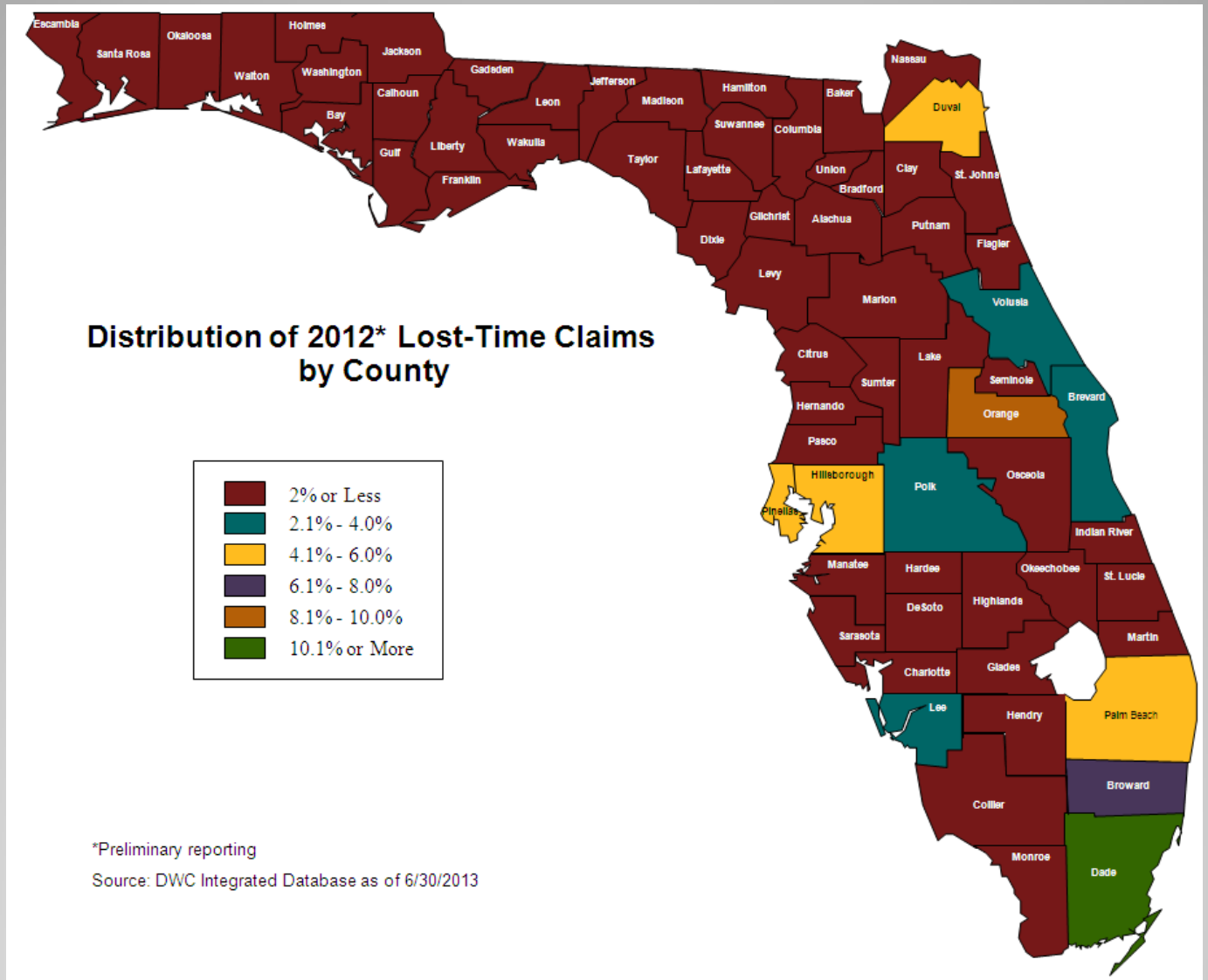
	2006	2007	2008	2009	2010*	2011*	2012*
Medical	$1,081.5	$1,019.8	$915.3	$839.1	$879.7	$830.4	$611.3
Indemnity	$419.0	$386.7	$345.0	$289.0	$291.8	$262.0	$180.0
Settlements	$503.4	$439.8	$418.5	$331.3	$359.0	$264.1	$129.1

*Preliminary data, amounts unadjusted for inflation

Lost-Time Claims Data

Medical Payments for Lost-Time Claims				
Calendar Year	Health Care Providers, Dental, Ambulatory Surgical Center	Hospital	Pharmacy	All Other Medical
2006	39.7%	35.7%	6.9%	17.8%
2007	39.3%	35.2%	6.5%	19.0%
2008	41.2%	34.3%	5.7%	18.8%
2009	41.8%	35.6%	5.0%	17.6%
2010*	33.6%	44.6%	5.1%	16.7%
2011*	31.1%	47.6%	4.4%	16.9%
2012*	29.7%	52.4%	3.4%	14.5%

*Preliminary data


Distribution of 2012* Lost-Time Claims by County
2% or Less
2.1% - 4.0%
4.1% - 6.0%
6.1% - 8.0%
8.1% - 10.0%
10.1% or More
*Preliminary reporting
Source: DWC Integrated Database as of 6/30/2013
Escambia
Santa Rosa
Okaloosa
Walton
Holmes
Washington
Jackson
Calhoun
Gadsden
Leon
Jefferson
Madison
Hamilton
Baker
Nassau
Duval
Bay
Gulf
Liberty
Wakulla
Taylor
Lafayette
Suwannee
Columbia
Union
Bradford
Clay
St. Johns
Franklin
Gilchrist
Alachua
Putnam
Flagler
Dixie
Levy
Marion
Volusia
Citrus
Lake
Sumter
Seminole
Brevard
Hernando
Orange
Pasco
Hillsborough
Polk
Osceola
Pinellas
Indian River
Manatee
Hardee
Okeechobee
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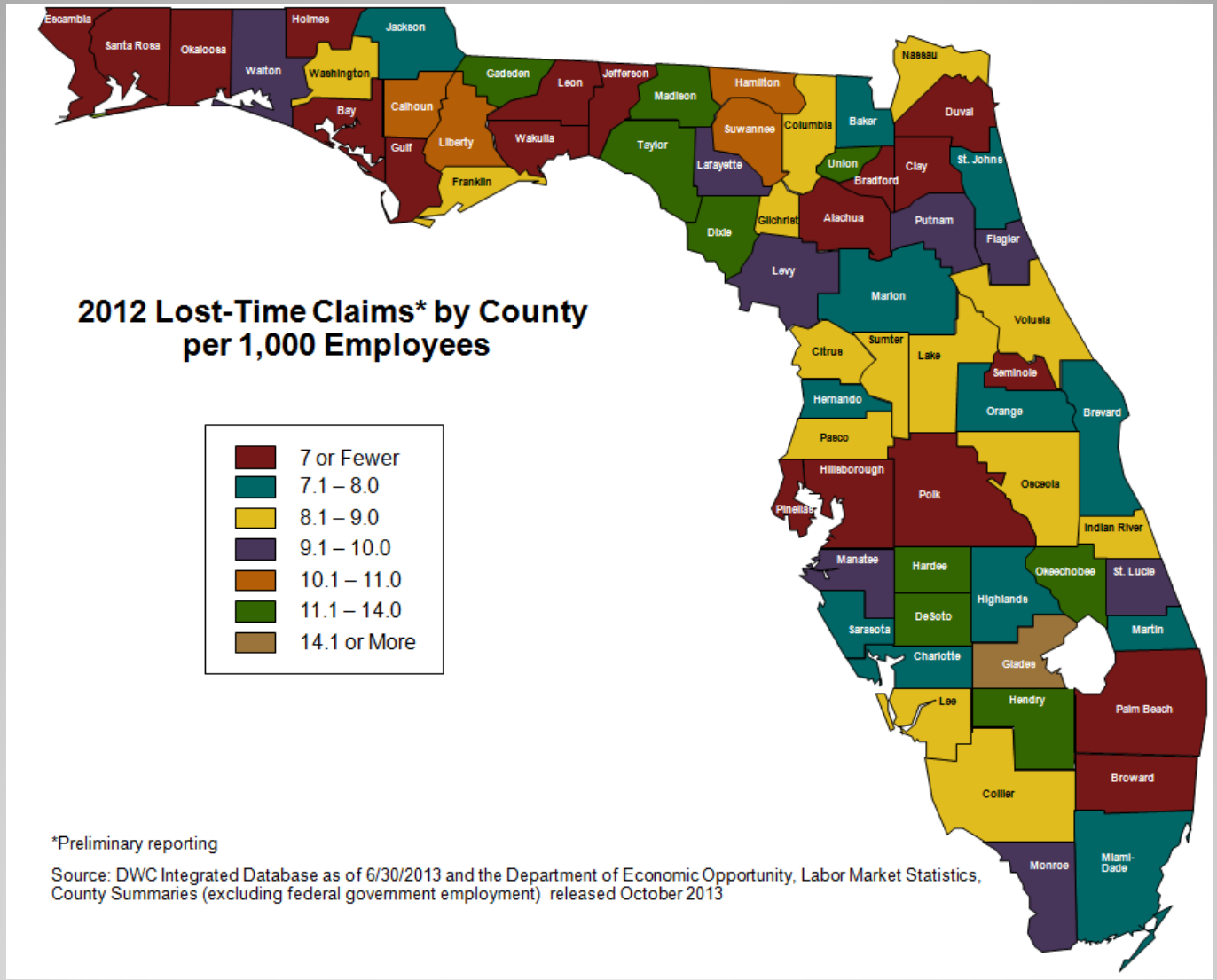
Glades
Lee
Hendry
Palm Beach
Broward
Collier
Monroe
Dade



*Preliminary reporting

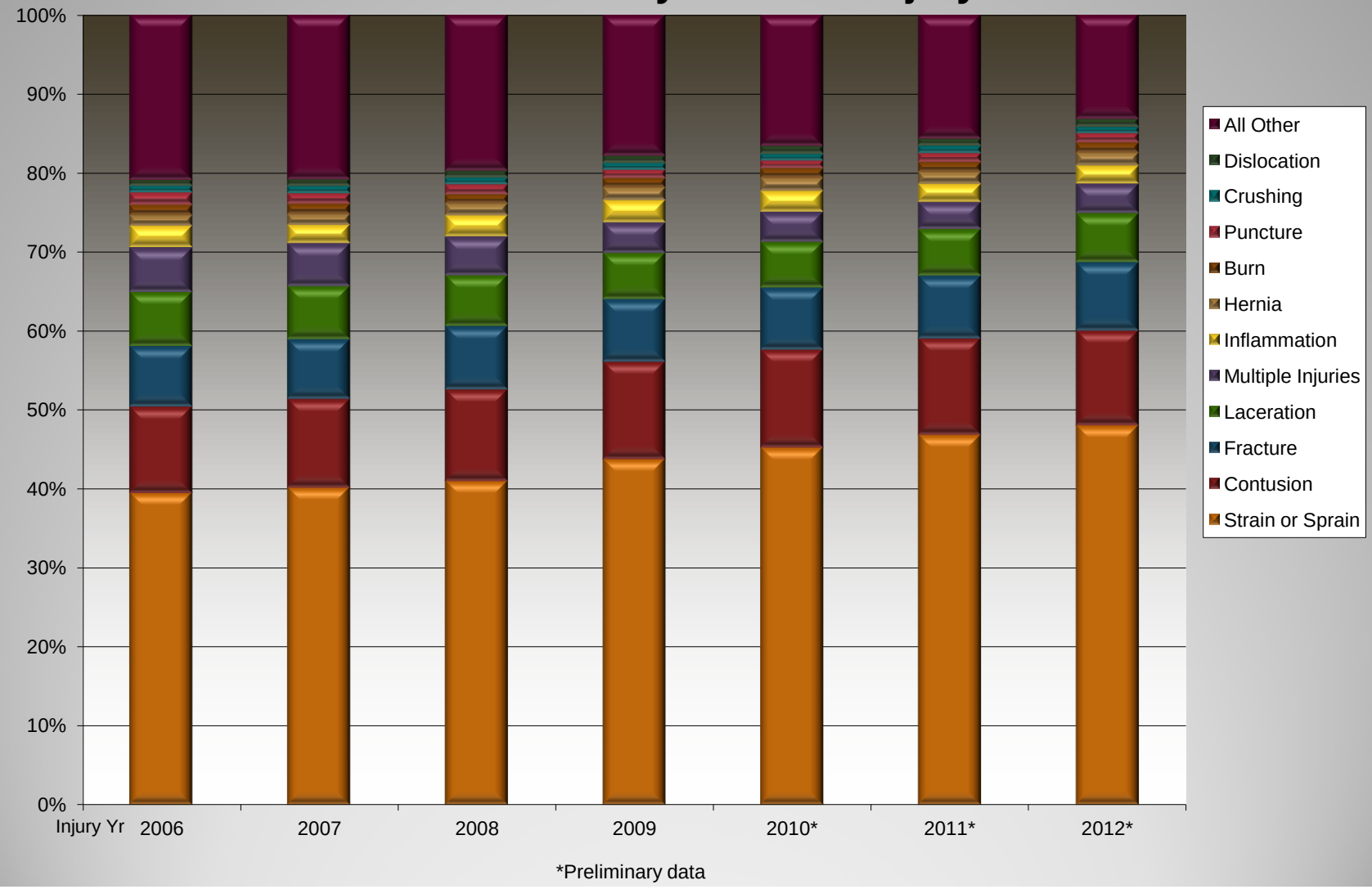
Source: DWC Integrated Database as of 6/30/2013 and the Department of Economic Opportunity, Labor Market Statistics, County Summaries (excluding federal government employment) released October 2013

Nature, Cause & Body Location of Injury

As part of the First Report of Injury or Illness, employers or claim administrators provide information on the nature, cause, and body part of each workplace injury. The following charts summarize that information to depict recent and historical patterns of lost-time injuries.

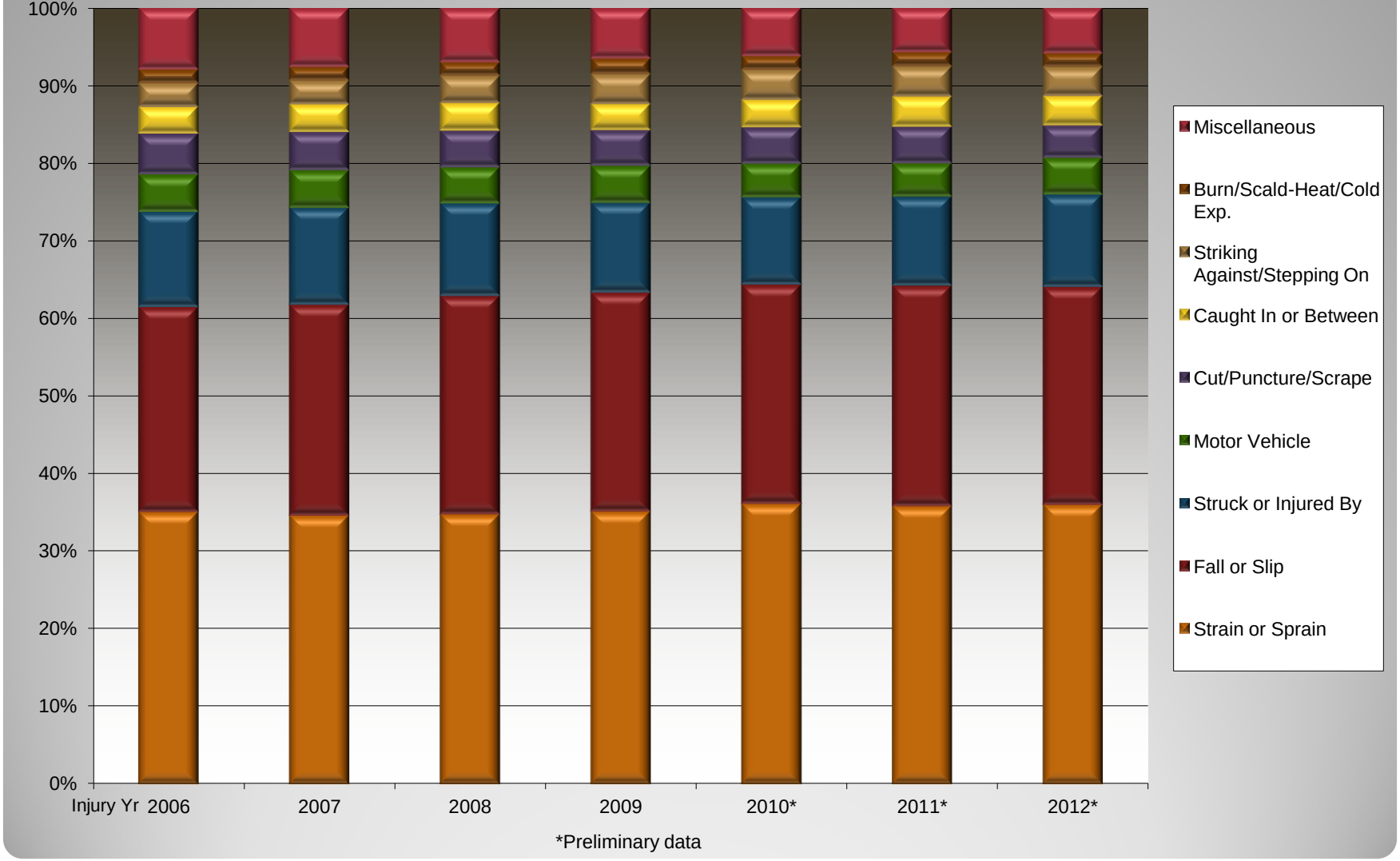
Because the information is reported on the First Report of Injury or Illness, it may not correspond to a diagnosis made by a health care professional. Additionally, the figures may change slightly over time due to preliminary reporting of data.

Lost-Time Claims by Nature of Injury



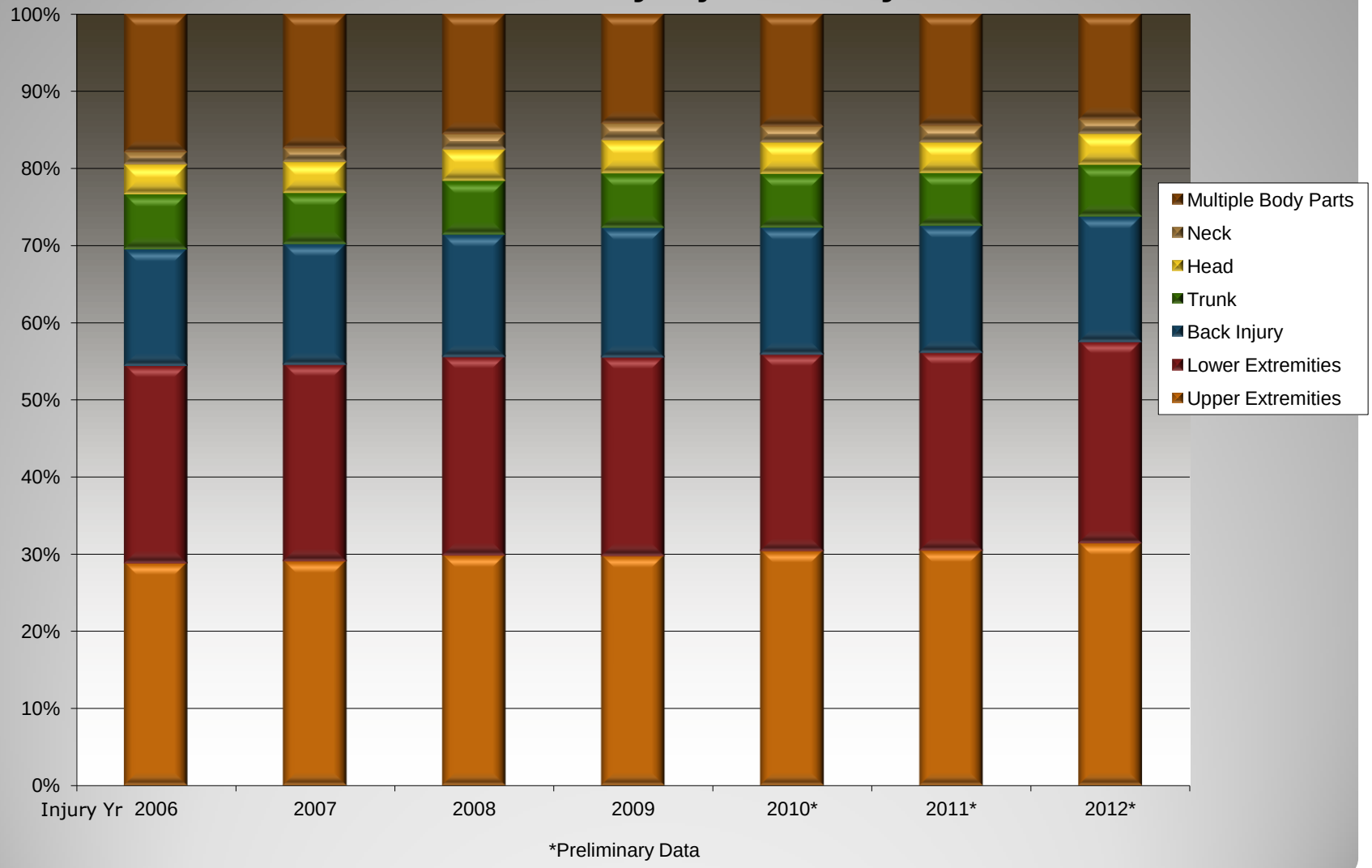
*Preliminary data

Lost-Time Claims by Cause of Injury

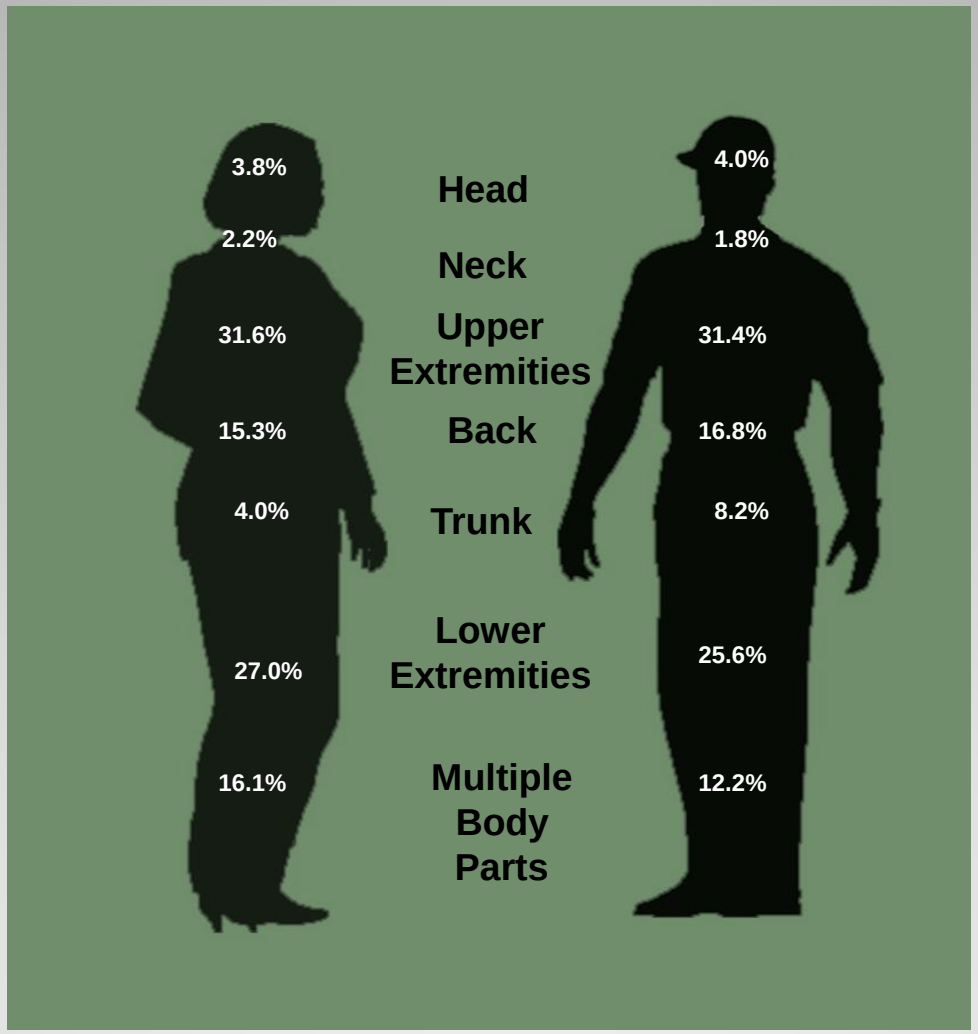


*Preliminary data

Lost-Time Claims by Injured Body Part



Injury Body Location by Gender for 2012 Lost-Time Claims



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.

Reporting of medical data begins with a workplace injury that required medical care from a physician, hospital, ambulatory surgical center (ASC), pharmacy, or other health care provider. The providers then submit medical bills to the applicable claim administrator for services rendered using the applicable medical claim forms (or electronic equivalents). The claim administrator or contracted medical bill review vendor adjudicates the medical bill.

Medical bill reimbursement amounts may be based on prices negotiated by the claim administrator or the maximum reimbursement allowance approved by the Three-Member Panel and contained in reimbursement manuals adopted by the Division of Workers' Compensation.

Prescription reimbursement amounts are based on prices negotiated by the claim administrator, managed care contracts, or the statutory formula contained in Chapter 440, Florida Statutes.

Medical Data

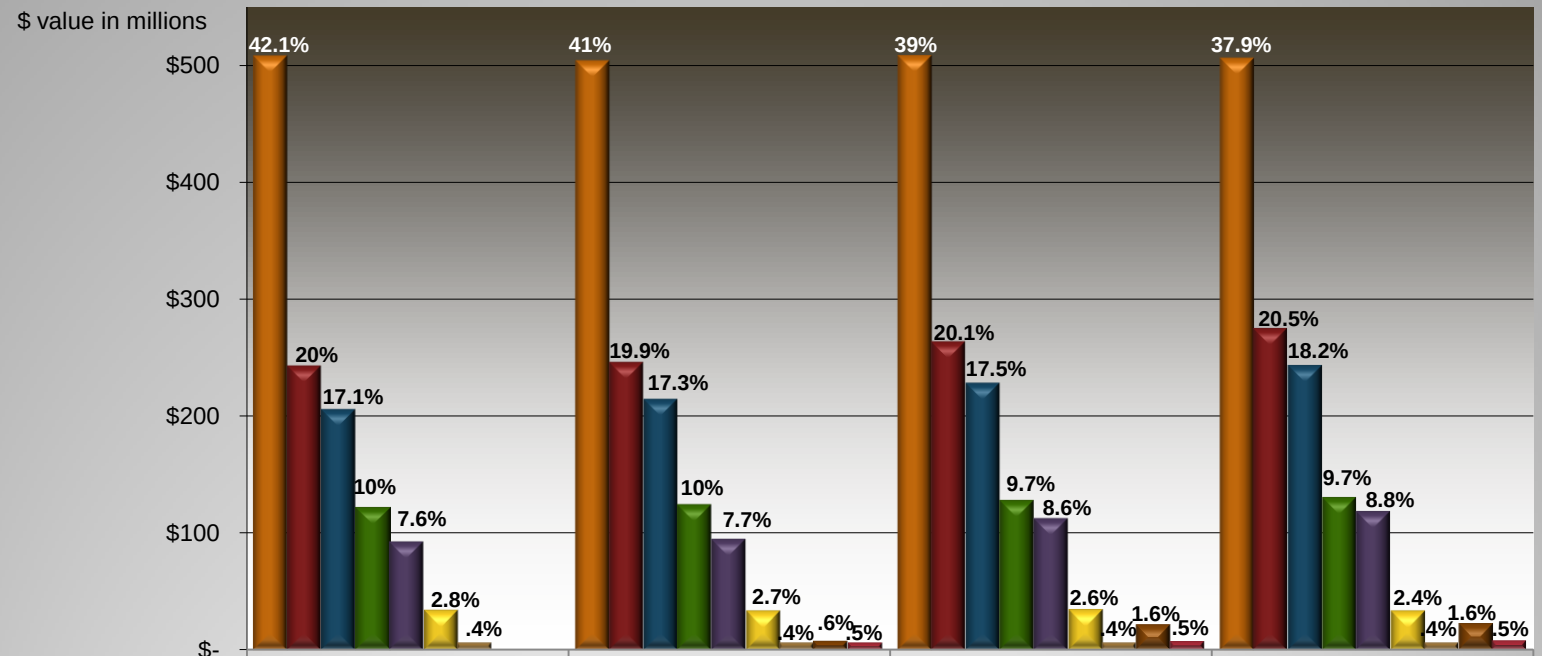
Adjudication results and information about the medical services provided are transmitted via proprietary electronic formats to the Division, as required by administrative rule.

When medical bills are received, the Division screens them by applying hundreds of edits that reject bills that do not meet Division requirements. The submitter is notified immediately if the submitted bill failed the edits and subsequently rejected. Rejected medical bills are not considered timely filed until corrected, re-submitted, and accepted by the Division.

The following charts pertain 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 is restricted to medical bills received and accepted by the Division no later than six months after the end of that year.

Payment totals may differ in comparison to previous Division yearly reports due to payment disputes being resolved or adjustments to previously submitted medical bill data.

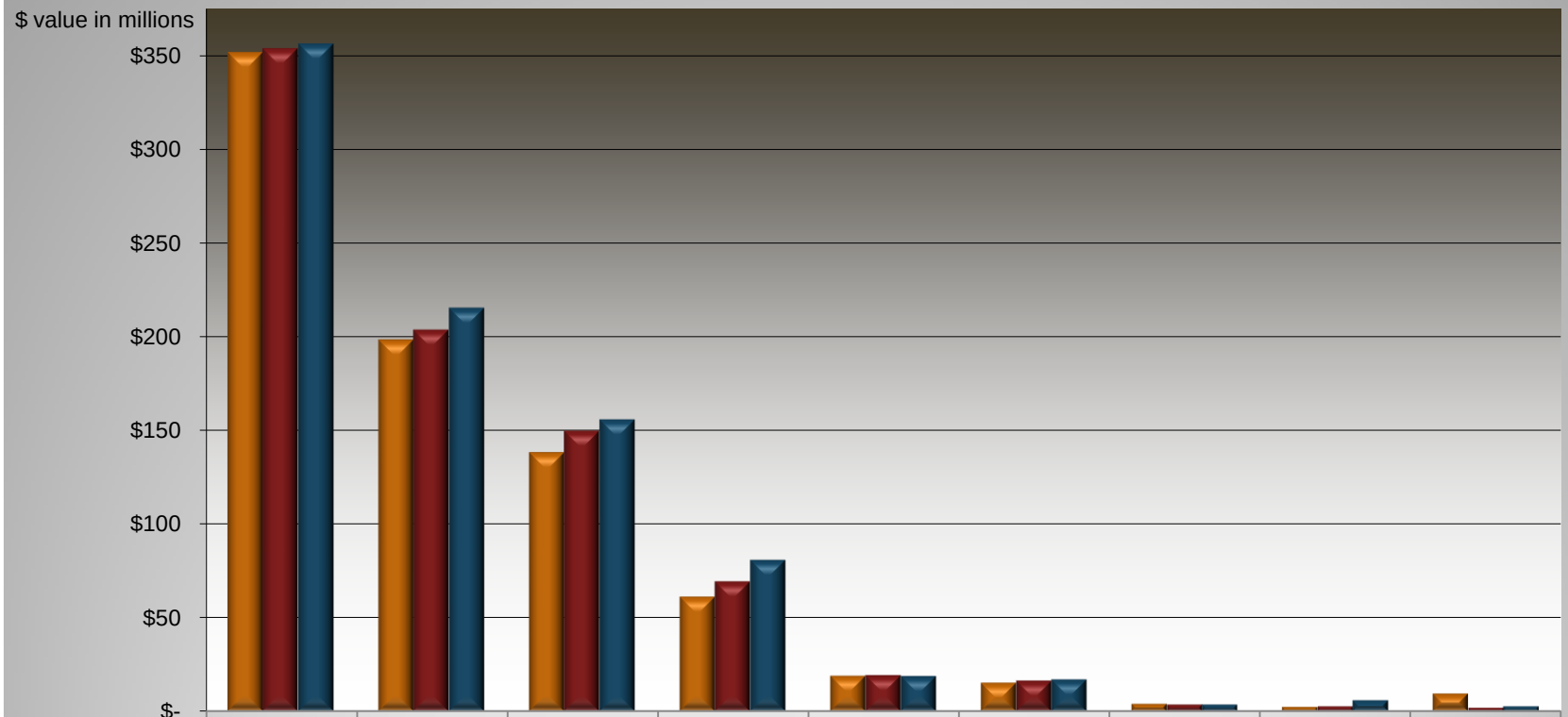
Medical Payments* by Cost Type and Distribution



	2009	2010	2011	2012
Health Care Provider	$507.80	$503.80	$508.20	$505.90
Hospital Outpatient	$241.50	$244.50	$262.20	$273.30
Hospital Inpatient	$205.10	$213.80	$227.60	$242.60
Pharmacy	$120.60	$123.00	$126.60	$129.00
Ambulatory Surgical Center	$92.00	$94.10	$111.70	$117.70
Medical Supplies	$33.20	$32.50	$33.70	$32.50
Dental	$4.80	$4.90	$4.90	$4.90
Home Health Services	n/a	$7.40	$20.80	$21.70
Nursing Home	n/a	$5.60	$6.50	$7.20

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

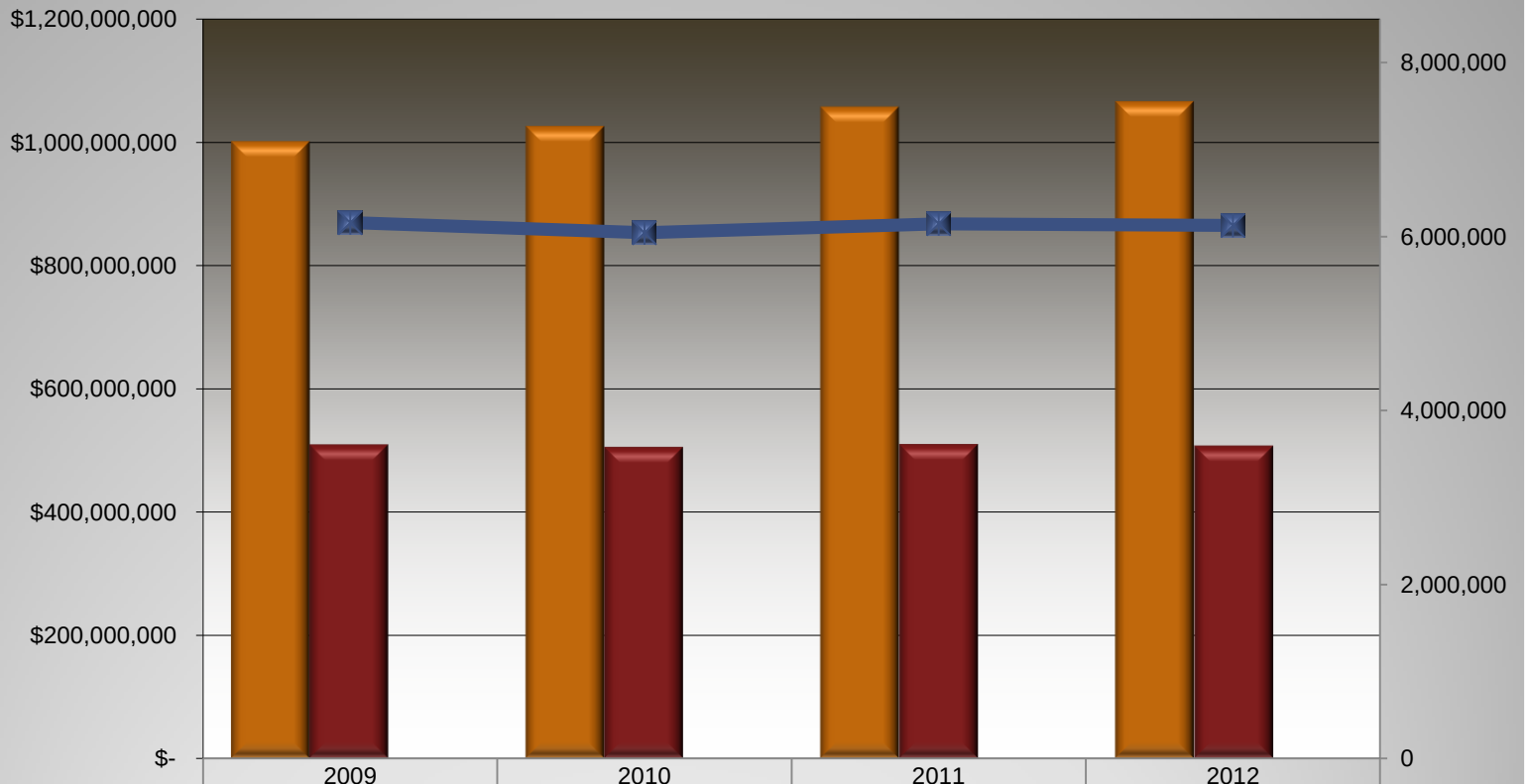
Total Medical Paid* for Services Provided within 12 Months of Injury



Injury Yr	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental	Home Health Services	Nursing Home
2009	$351.1	$198.0	$138.0	$61.2	$19.0	$15.4	$4.0	$2.5	$9.5
2010	$353.6	$203.5	$149.6	$69.3	$19.3	$16.5	$3.7	$2.8	$2.0
2011	$356.0	$215.2	$155.6	$80.8	$18.8	$17.1	$3.7	$6.0	$2.7

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

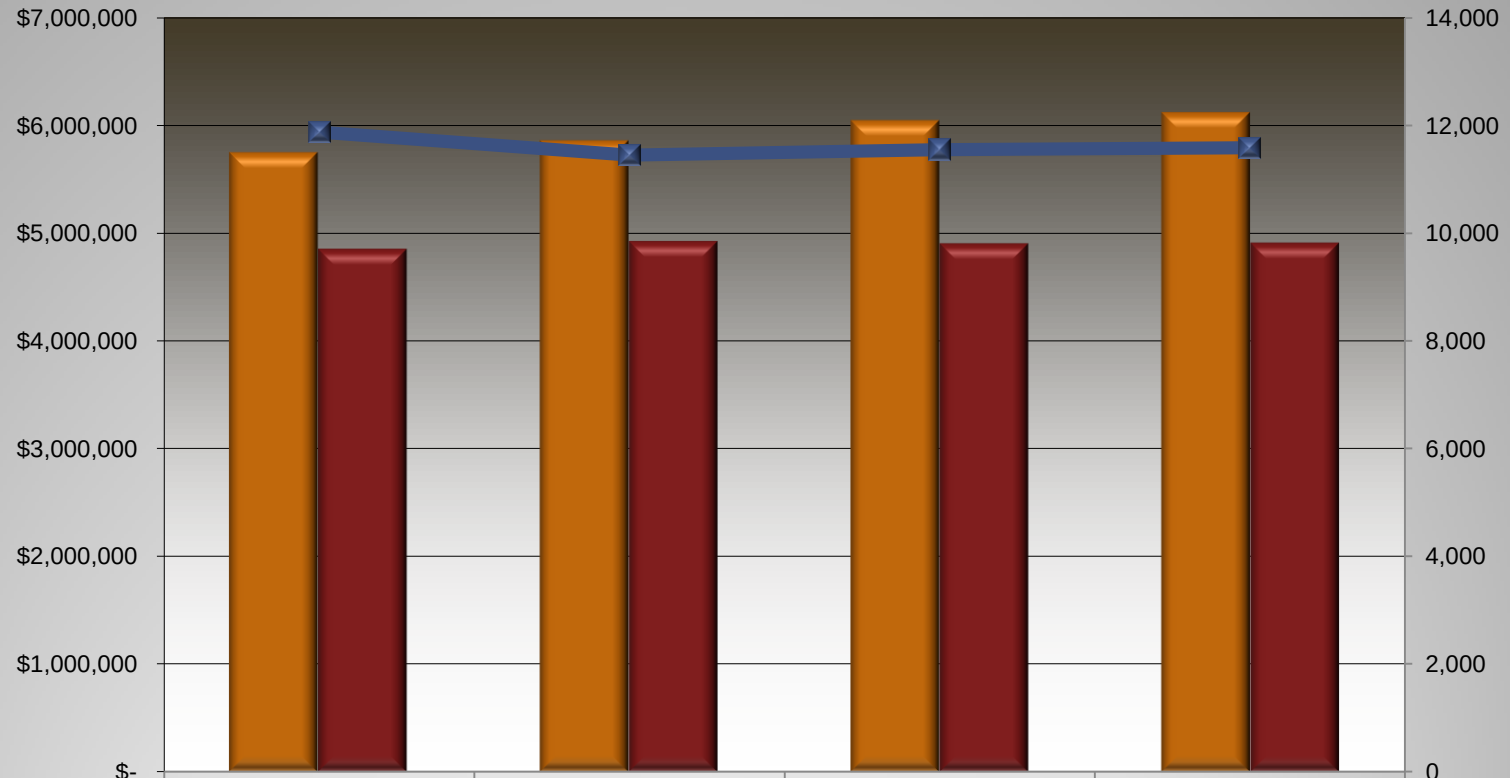
Total Charges and Total Paid for Health Care Provider Services



	2009	2010	2011	2012
Charges	$1,000,192,051	$1,025,039,475	$1,056,279,704	$1,065,314,928
Paid	$507,861,451	$503,770,404	$508,176,133	$505,987,819
Avg Charge/Per Line Item	$162.38	$169.61	$171.80	$173.84
Avg Paid/Per Line Item	$82.45	$83.36	$82.65	$82.57
Total Line Items	6,159,668	6,043,476	6,148,357	6,127,960

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

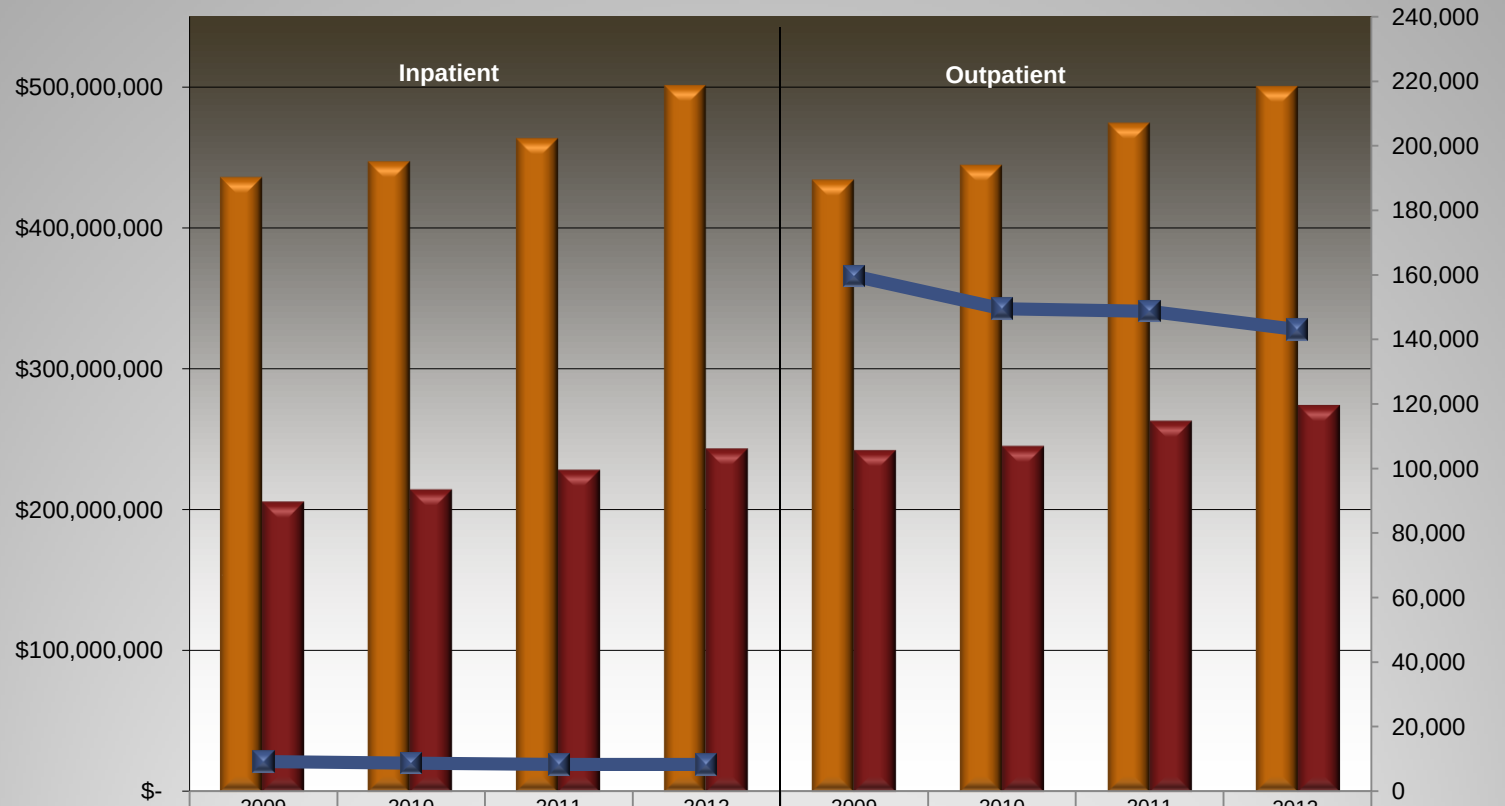
Total Charges and Total Paid for Dental Services



	2009	2010	2011	2012
Charges	$5,744,138	$5,854,252	$6,042,045	$6,115,923
Paid	$4,837,921	$4,908,907	$4,888,152	$4,893,504
Avg Chg Per Line Item	$483	$511	$523	$528
Avg Paid Per Line Item	$407	$429	$423	$422
Total Line Items	11,882	11,452	11,554	11,586

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

Total Charges and Total Paid by Hospital Bill Type



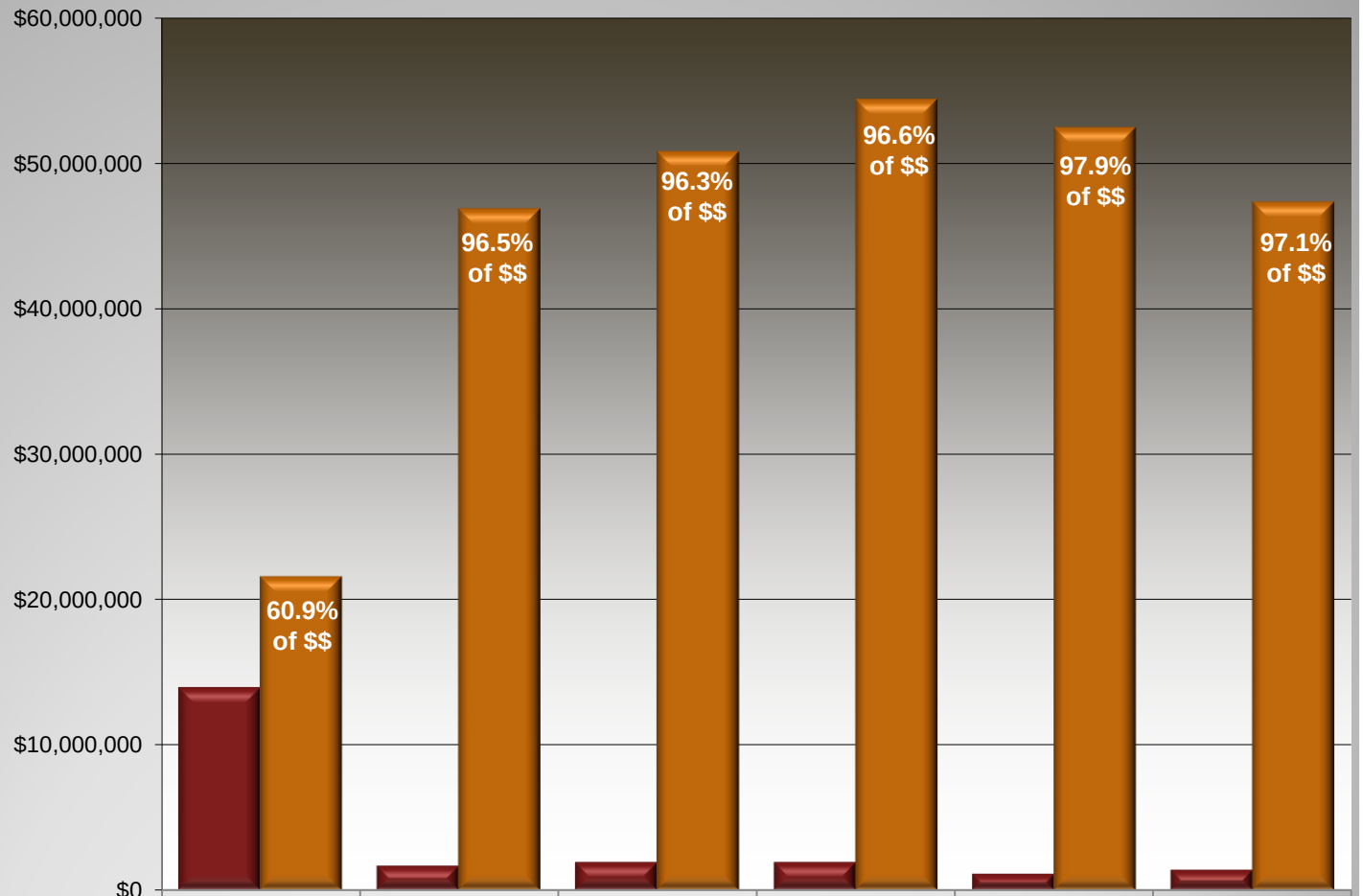
	2009	2010	2011	2012	2009	2010	2011	2012
Charges	$434,852,551	$446,077,218	$462,467,977	$500,013,210	$433,006,709	$443,575,409	$473,400,718	$499,167,766
Paid	$205,145,874	$213,837,882	$227,554,325	$242,579,304	$241,492,538	$244,490,221	$262,160,857	$273,310,077
Avg Charge/Bill	$47,333	$51,303	$56,138	$60,659	$2,712	$2,967	$3,182	$3,490
Avg Paid/Bill	$22,330	$24,593	$27,623	$29,429	$1,513	$1,635	$1,762	$1,911
Total Bills	9,187	8,695	8,238	8,243	159,643	149,525	148,761	143,043

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

Medical Data

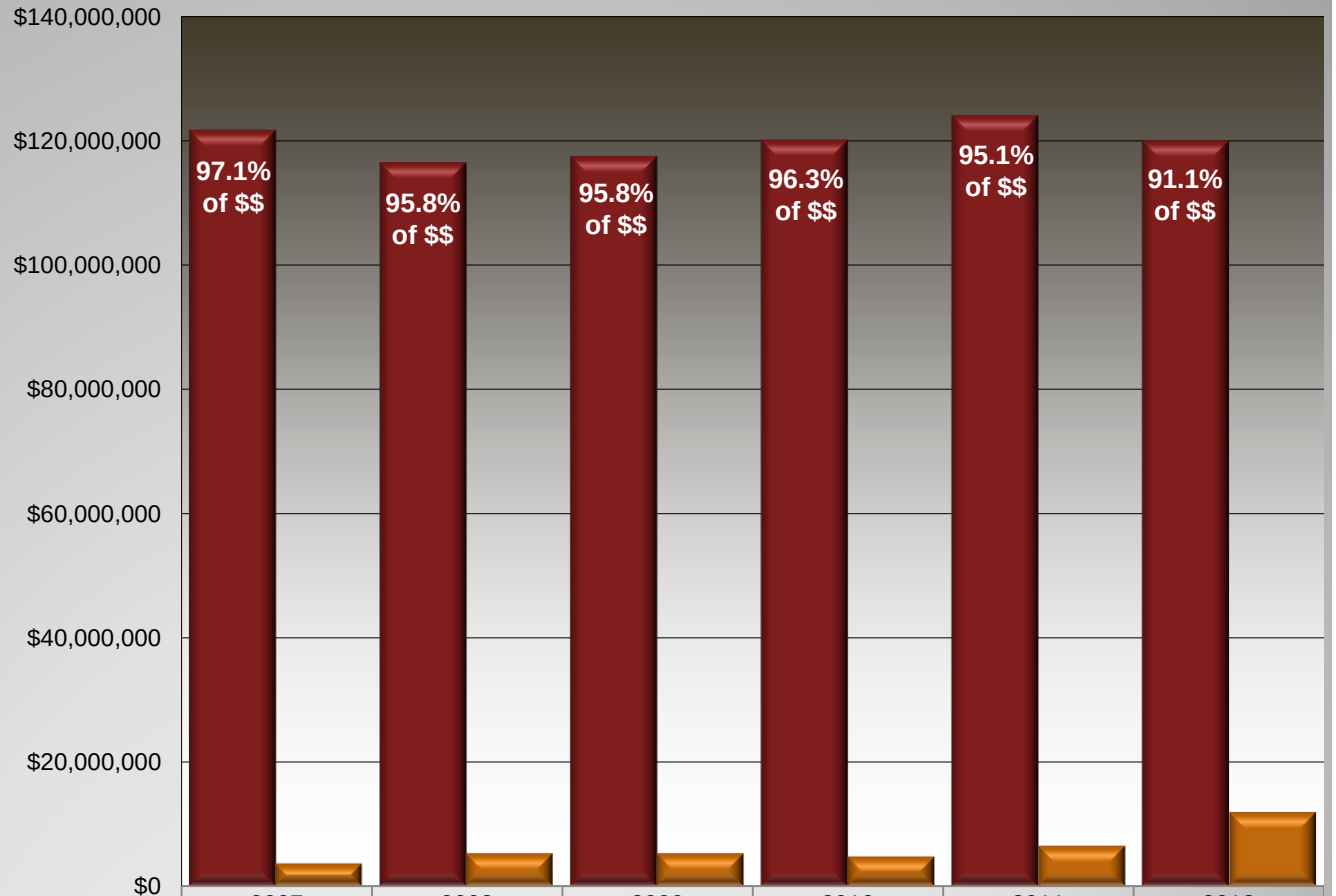
The following four charts compare drugs billed on DWC-10 forms (dispensed by pharmacies) to drugs billed on DWC-9 forms (dispensed by physicians). The reference to line items on the Pharmacy vs. Physician Repackaged and Nonrepackaged Drugs charts also means per prescription.

Pharmacy vs. Physician Repackaged Drug Payments



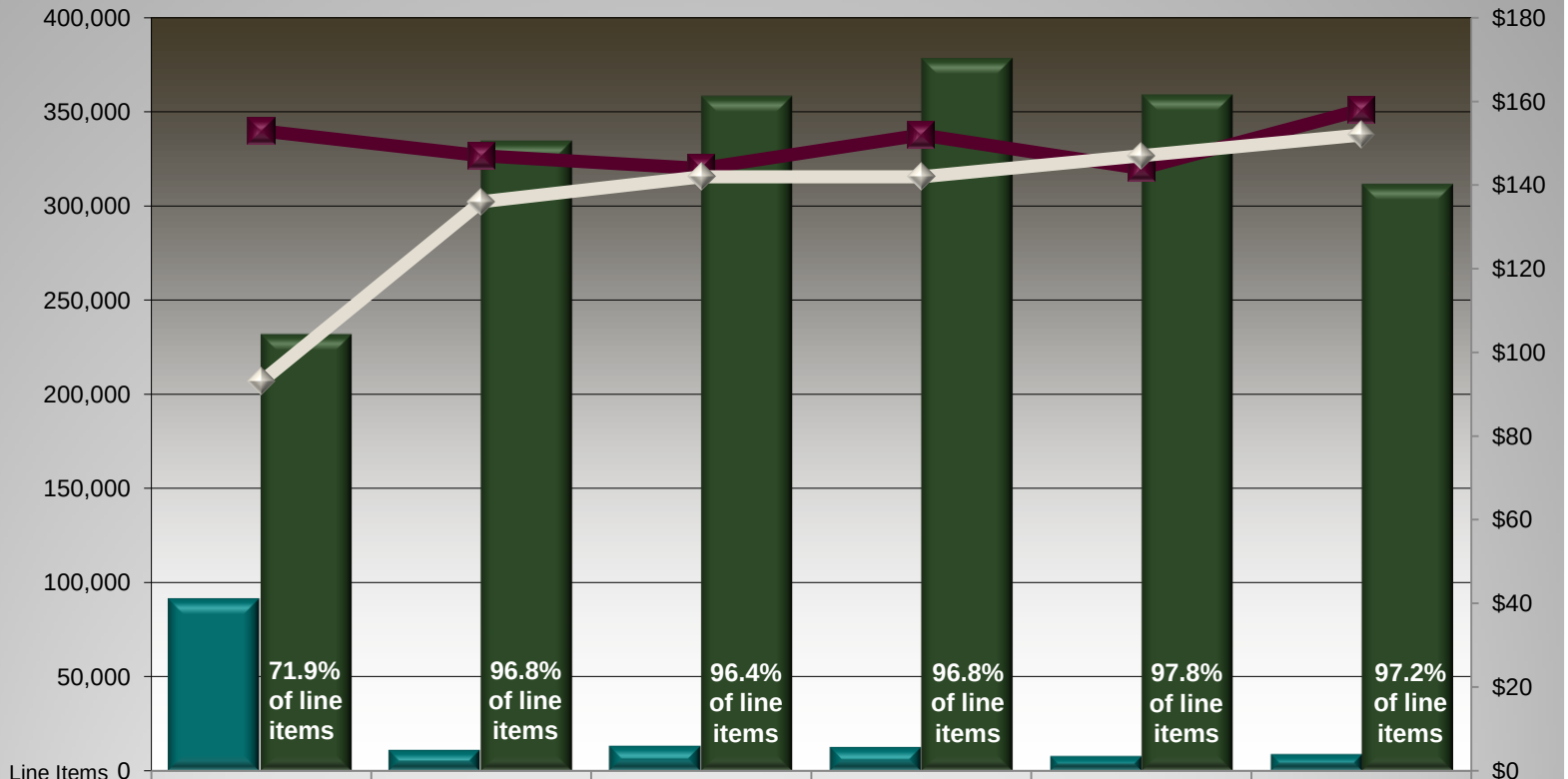
	2007	2008	2009	2010	2011	2012
Pharmacy Repackaged Total Payments	$13,871,993.50	$1,689,552.89	$1,929,485.82	$1,927,952.07	$1,133,483.99	$1,404,551.01
Physician Repackaged Total Payments	$21,565,750.37	$46,834,571.96	$50,754,717.87	$54,357,929.06	$52,400,461.43	$47,294,727.95

Pharmacy vs. Physician Nonrepackaged Drug Payments



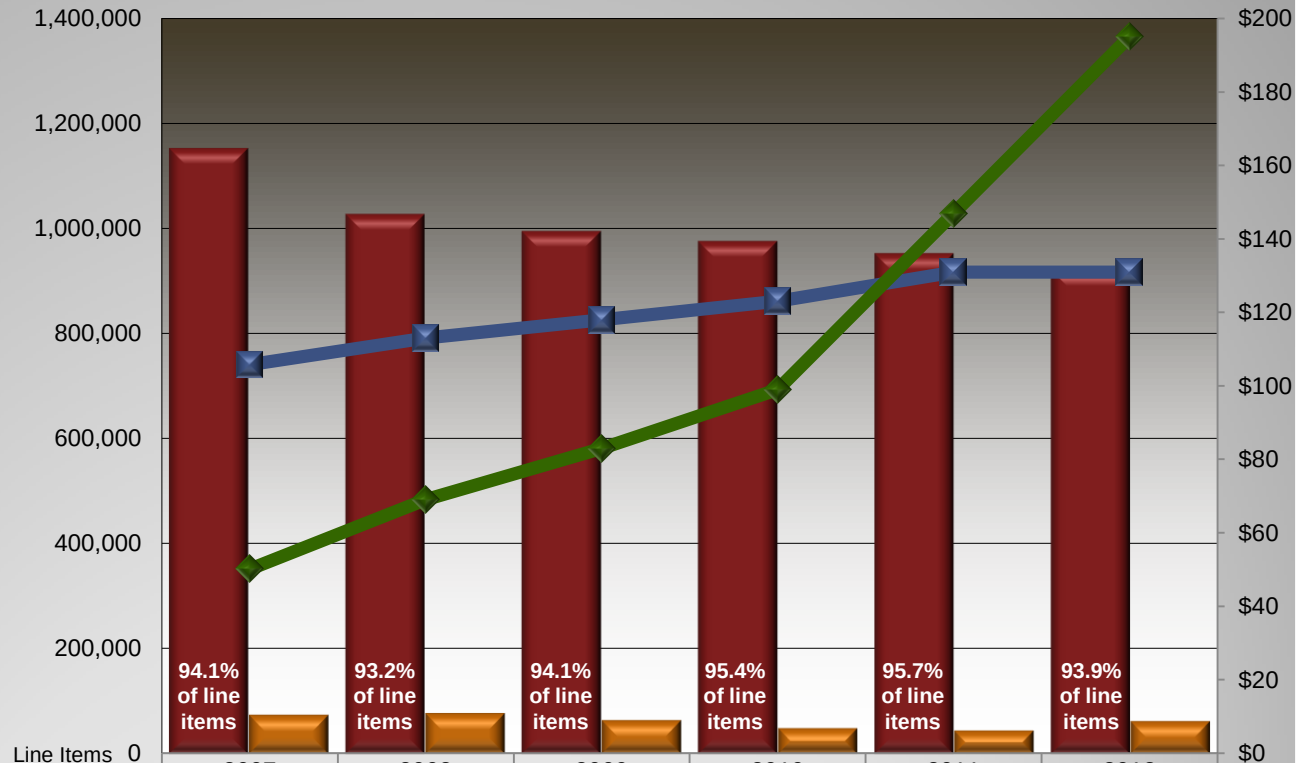
	2007	2008	2009	2010	2011	2012
Pharmacy Nonrepackaged Total Payments	$121,632,090.71	$116,463,276.45	$117,428,303.46	$120,067,745.04	$123,998,513.22	$119,938,165.08
Physician Nonrepackaged Total Payments	$3,581,951.08	$5,169,333.97	$5,143,651.86	$4,640,892.98	$6,344,811.09	$11,665,589.51

Pharmacy vs. Physician Repackaged Drugs



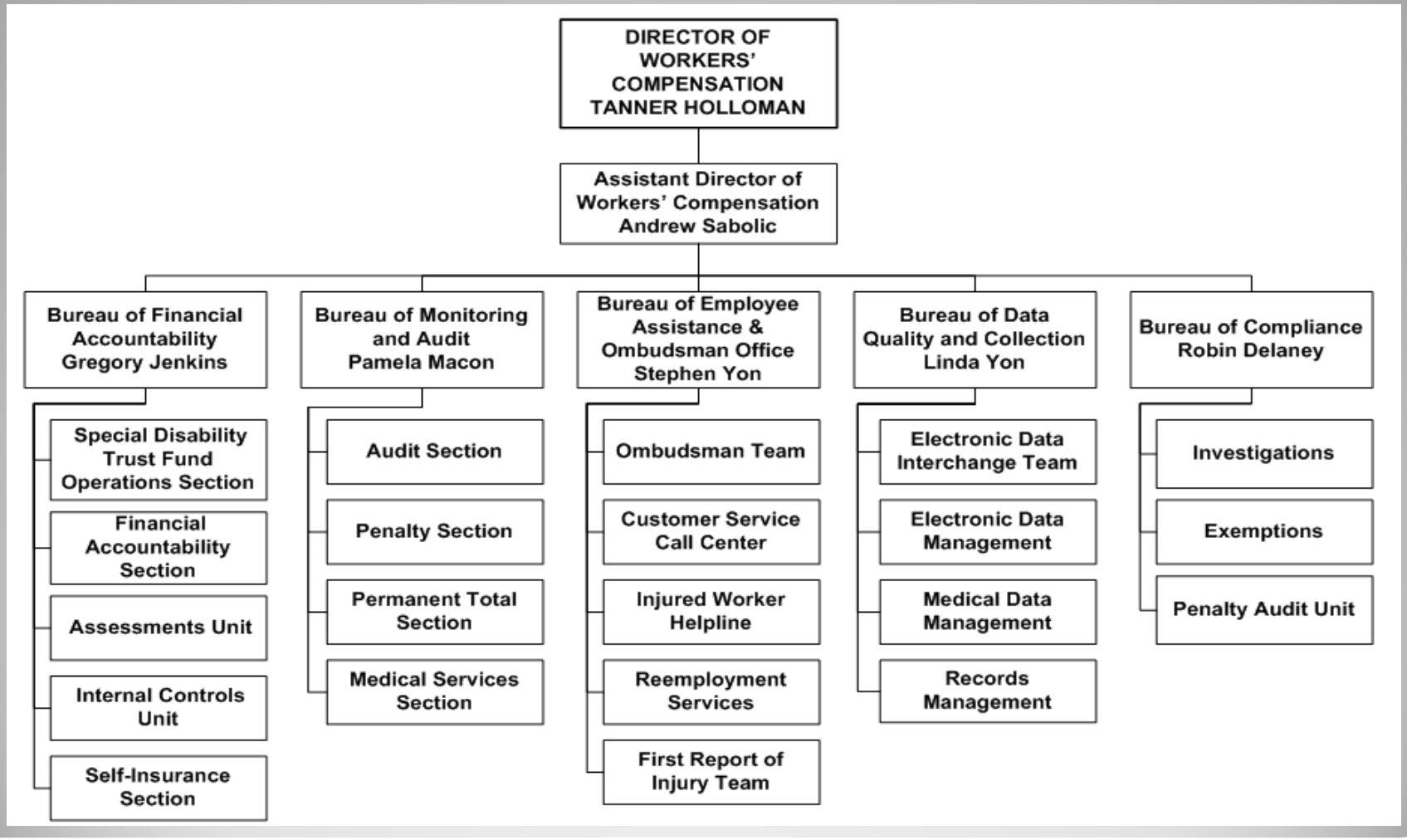
	2007	2008	2009	2010	2011	2012
Pharmacy Repackaged Line Items	90,948	11,226	13,372	12,684	7,893	8,892
Physician Repackaged Line Items	231,793	334,307	357,983	378,022	358,789	311,370
Pharmacy Repackaged Avg $ Per Line Item	$153.00	$147.00	$144.00	$152.00	$144.00	$158.00
Physician Repackaged Avg $ Per Line Item	$93.00	$136.00	$142.00	$142.00	$147.00	$152.00

Pharmacy vs. Physician Nonrepackaged Drugs



	2007	2008	2009	2010	2011	2012
Pharmacy Nonrepackaged Line Items	1,149,801	1,024,752	992,258	973,255	950,135	918,710
Physician Nonrepackaged Line Items	71,459	74,582	61,963	46,998	43,102	59,820
Pharmacy Nonrepackaged Avg $ Paid Per Line Item	$105.79	$113.00	$118.00	$123.00	$131.00	$131.00
Physician Nonrepackaged Avg $ Paid Per Line Item	$50.13	$69.00	$83.00	$99.00	$147.00	$195.00

DWC Organizational Chart



DWC Contacts

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Andrew Sabolic, Assistant Director

Bureau of Financial Accountability: (850) 413-1630
Greg Jenkins, Bureau Chief

Bureau of Monitoring and Audit: (850) 413-1608
Pam Macon, Bureau Chief

Bureau of Employee Assistance: (850) 413-1610
Stephen Yon, Bureau Chief

Bureau of Data Quality and Collection: (850) 413-1607
Linda Yon, Bureau Chief

Bureau of Compliance: (850) 413-1609
Robin Delaney, Bureau Chief

Special Disability Trust Fund: (850) 413-1604
Vacant

Office of Medical Services: (850) 413-1608
Eric Lloyd, Program Administrator

DWC Hotlines & Websites

Hotlines:

Reporting Deaths: (800) 219-8953

Compliance Fraud Referral Hotline: (800) 742-2214

Employee Assistance Office Hotline: (800) 342-1741

Customer Service Center: (850) 413-1601

Websites:

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.

The Division of Workers' Compensation website home page is located at: http://myfloridacfo.com/division/wc and provides direct information access for all stakeholders in the Workers' Compensation System. The website organizes items of interest by stakeholder group with tabs for Employer, Insurer, Employee, and Provider.