DIVISION OF WORKERS' COMPENSATION ANNUAL REPORT

2003

TOM GALLAGHER, CHIEF FINANCIAL OFFICER

DEPARTMENT OF FINANCIAL SERVICES

Message from the Director

September 15, 2003

The Honorable Jeb Bush, Governor of Florida
The Honorable James King, President of the Senate
The Honorable Johnnie Byrd, Jr., Speaker of the House

Dear Governor, Mr. President and Mr. Speaker:

It has been an honor and privilege to serve the citizens of the state of Florida, Chief Financial Officer Tom Gallagher, and the employees of the division, as the Director of the Division of Workers' Compensation, during our first successful fiscal year as part of the Florida Department of Financial Services.

As required by Florida Statute, the following annual report details the administration of Chapter 440, F.S., an accounting of the Workers' Compensation Administration Trust Fund, and a description of the causes of workers' compensation injuries. In addition to the required information, this report contains a description of the division's mission and goals and how the functions of each bureau or office contribute to the accomplishment of these goals; a description of law changes passed by the Legislature during the 2003 special session; trends in division productivity; and a summary of claims data.

In an effort to ensure exemplary implementation of the workers' compensation law and provide the greatest level of customer service and benefits to the citizens of the state of Florida, the division has redefined its mission and set higher standards. The division's new mission is as follows:

> *To actively ensure the self-execution of the workers' compensation system through educating and informing all stakeholders in the system of their rights and responsibilities, compiling and monitoring system data, and holding parties accountable for meeting their obligations.*

Message from the Director

To parallel our new mission and to maximize the self-execution of the system, the division has set three overarching goals that must be addressed over the next few years. They are as follows:

- Serve as a comprehensive resource to all system stakeholders
- Create an unparalleled real-time workers' compensation information environment and measure the health of the workers' compensation system
- Be the leading catalyst in promoting and advocating accident prevention in the workplace.

Finally, SB 50-A is the most significant workers' compensation reform legislation in ten years. During the 2004 Fiscal Year, the division will be the leader in implementing many of the administrative and regulatory provisions of the bill, and educating system stakeholders about the legislative changes.

The Legislature provided the division with greater regulatory authority with respect to employer and carrier compliance and enforcement. The Legislature and the Governor also should be commended for recognizing the need for compliance resources by funding 35 new compliance investigator positions to combat premium evasion and fraud.

With the support of the Legislature, the Governor, and Chief Financial Officer Tom Gallagher, the Division of Workers' Compensation is continuing on the path of becoming the best division in state government. We welcome any suggestions, questions, and comments you may have regarding the contents of this report. Please feel free to contact me at any time.

Sincerely,

Tanner Holloman
Director

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Annual Report 2003 Executive Summary

This issue of the Division of Workers' Compensation Annual Report contains a detailed summary of the 2003 workers' compensation reforms (SB 50-A); an update of the division's mission, goals, and accomplishments; data regarding assessments, revenues, and disbursements; a discussion of important claims data; a list of division contacts; and a glossary of workers' compensation terms.

Legislation

- SB 50-A is the most comprehensive workers' compensation legislation passed since 1993. It contains many of the recommendations that were included in the Governor's Commission on Workers' Compensation Reform Final Report and in the report of the House Select Committee on Workers' Compensation. SB 50-A seeks to increase the affordability and availability of workers' compensation insurance and reduce overall system costs.

Administration

- The division's new mission is to actively ensure the self-execution of the workers' compensation system through educating and informing all stakeholders in the system of their rights and responsibilities, compiling and monitoring system data, and holding parties accountable for meeting their obligations.
- The Legislature provided the division with more compliance and enforcement tools by funding thirty-five additional compliance investigators and strengthening the division's statutory compliance authority.
- The division's website has been restructured to provide more real-time information for system stakeholders. Construction contractors have been provided a database to track the policy changes of their subcontractors. Data users can now obtain aggregate statistics on lost-time claims and costs, which can be sorted by selected characteristics. The division's website is www.fldfs.com/WC/.
- The division hopes to build upon the success of the Early Intervention Program by improving the success rate for contacting injured employees and reducing the number of Petitions for Benefits submitted.
- The Bureau of Monitoring and Audit redefined its audit process by emphasizing claim performance information from data filed by claims handlers with the division and by complaints generated from customers.
- Since taking responsibility for the collection of workers' compensation medical data, the division has improved the completeness and accuracy of the medical data that are used by the Three-Member Panel in determining reimbursement rates.
- Emphasis has also been placed on expanding Electronic Data Interchange (EDI) to promote efficiency in data collection and auditing.
- The division has increased its outreach activities by holding workers' compensation informational meetings throughout the state with workers' compensation system stakeholders.
- With an inclusion of deductible policy premium discounts in the premium base, the Administration Trust Fund assessment rate was reduced to 1.75% on 1/1/2003, with a further reduction to 1.5% scheduled for 1/1/2004.

Paid Claims Data Reported By Insurers

- For mature data years (1994-1999) the total number of lost-time claims has leveled off at slightly more than 80,000 per year. 83,677 lost-time injuries were reported in 2000, the highest of any year since 1992. However, the actual injury rate has continued to drop because of the increase in total employment in Florida.
- The Services and Retail Trade industries continue to account for approximately one half of all lost-time claims.
- The risk classifications with the highest number of claims reported were restaurants, clerical and office, grocery stores, and police officers. Many of the top-ranked risk classifications have a large employment base, which contributes to the high number of injuries, rather than necessarily a high injury rate.
- The age of lost-time claimants (at the time of injury) has continued to show a slow rise since 1990. The current age distribution of claimants is similar to that of all employed workers in Florida.
- The average weekly wage of injured workers has remained at 85-90% of the statutory maximum compensation rate. About ten percent of claimants have salaries high enough that their indemnity benefits are limited by the statutory maximum.
- Sprains and strains continue to be the most frequent cause and nature of injury. More than half of all injuries affect the upper or lower extremities.
- Over the reporting period, DeSoto and Hendry Counties have had consistently high injury rates based on total county employment. Wakulla had among the lowest county injury rates during this period.
- A slight decrease in the time from injury to reaching maximum medical improvement and from injury to case closure has been observed.
- During the reported injury years, 15-30% of claimants have been assigned a permanent impairment rating. There has been a slight long-term decline in average impairment ratings, but the average has remained well below 10% for the entire period. For recent injury years with mature data, less than half of all claimants with a permanent impairment rating have had a rating of more than 5%.
- Both total and average benefits of all types (indemnity, medical, and settlement) have remained below their 1990-1993 (i.e., pre-reform) levels.
- Medical costs in Florida have consistently represented approximately 60% of total benefit costs (excluding settlements), with indemnity costs representing the remainder. Nationally, the ratio is closer to 50%/50%.
- Severity of injury has a significant effect on total claim costs. Workers with Permanent Total disability account for only 2% of all claimants, but 19% of total benefits. Those with Permanent Partial disability (including Permanent Impairment, Wage Loss, Impairment Income, and Supplemental Income) are approximately one fourth of all claimants, but account for almost half of all benefit expenditures.

Senate Bill 50-A Summary

Senate Bill 50-A passed during the first special session of the Legislature in 2003, making changes to the workers' compensation system designed to reduce litigation, provide greater compliance and enforcement authority for the Department of Financial Services to combat fraud, revise certain indemnity benefits for injured workers, increase medical reimbursements for physicians and for surgical procedures, and increase availability and affordability of coverage. Some provisions of the bill became effective on July 15, 2003, when Governor Bush signed the bill; most provisions will become effective on October 1, 2003; other provisions of the bill will go into effect on January 1, 2004.

Here is a summary of the major law changes included in the bill.

Definitions: s. 440.02, F.S.

The following amendments are effective July 15, 2003:

- An injury or disease caused by exposure to a toxic substance, including fungus or mold, is not an injury by accident unless there is clear and convincing evidence of exposure to a specific substance at levels that can cause the injury.
- The provisions stating that corporate officer, partner, and sole proprietor exemptions do not apply to commercial construction projects valued at $250,000 or more are repealed.
- The definition of catastrophic injury is repealed.
- The term "statement" must include the exact fraud language in s. 440.105(7), F.S.
- The specificity requirements for a Petition for Benefits are defined in more detail.

The following amendments will be effective January 1, 2004:

- "Construction industry" does not include homeowners' acts of construction on their own premises if the owner does not intend to sell, resell, or lease the premises within one year after construction begins.
- "Employee" means any person who receives remuneration from an employer for performing any work or service.
- Up to three corporate officers of a corporation or any group of affiliated corporations in the construction industry may elect to be exempt. Each officer must be a shareholder owning at least 10 percent of the stock of the corporation and must be listed as an officer with the Division of Corporations.
- "Employee" includes an independent contractor working or performing services in the construction industry; a sole proprietor or partner engaged in the construction industry; all persons being paid by a construction contractor, unless the subcontractor has a valid exemption.
- Independent contractor status applies only to individuals not engaged in the construction industry. Independent contractor status applies only if the individual meets at least four of the six listed criteria defining an independent contractor. An individual who does not meet at least four of the criteria defining an independent contractor may still be presumed to be an independent contractor by meeting any one of seven listed conditions.
- An individual claiming to be an independent contractor has the burden of proving that he or she is an independent contractor.
- The term "employer" includes employment agencies and employee leasing companies and similar agents who provide employees to other persons.

Election and Revocation of Exemption: s. 440.05, F.S.

The following amendments will be effective January 1, 2004:

- A corporate officer in the construction industry must include a copy of the stock certificate showing the officer has at least a 10 percent

owner interest in the corporation when applying for an exemption.
- Certificates of election to be exempt only apply to the corporate officer named on the exemption and apply only within the scope of the business or trade listed on the exemption.
- The department shall revoke an exemption if it determines that the officer no longer meets the requirements for exemption.
- Exempt officers may not recover workers' compensation benefits and the carriers may not consider the exempt officer as an employee for determining premium.
- A corporate officer is not eligible for an exemption if he or she is "affiliated" with a person who is delinquent in paying a stop-work order or penalty assessment. "Affiliated Person" is defined.

Coverage: s. 440.09, F.S.

The following amendments become effective October 1, 2003:

- "Major Contributing Cause" is defined as the cause that is more than 50 percent responsible for the injury as compared to all other causes.
- "Major Contributing Cause" must be demonstrated by medical evidence only.
- Pain or other subjective complaints alone, in the absence of objective relevant medical findings, are not compensable.

Mental and Nervous Injuries: s. 440.093, F.S.

The following amendments become effective October 1, 2003:

- A compensable mental or nervous injury shall be demonstrated by clear and convincing medical evidence from a licensed psychiatrist. It must meet criteria in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.
- A mental or nervous injury is not compensable unless the physical injury is and remains the major contributing cause of the mental injury, and the physical injury must be at least 50 percent responsible for the mental injury.
- Temporary benefits for a compensable mental or nervous injury are limited to no more than 6 months after the date of maximum medical improvement for the physical injury and shall be included in the 104 weeks for temporary benefits.

Liability for Compensation: s. 440.10, F.S.

The following amendments become effective October 1, 2003:

- A contractor is required to request evidence of workers' compensation insurance or a valid exemption from all subcontractors.
- A subcontractor is not liable for the payment of compensation to the employees of another subcontractor or a contractor and is protected by the exclusiveness-of-liability provisions only if the subcontractor or contractor has secured coverage for the subcontractor's employees and if the subcontractor's own gross negligence was not the major contributing cause of the accident.
- All construction employers must obtain a Florida endorsement or purchase a Florida workers' compensation policy for its employees. The coverage must utilize Florida class codes, rates, rules, and manuals. Failure to do so constitutes a second-degree felony.

Employer workplace safety program: s. 440.1025, F.S.

The following amendments become effective October 1, 2003:

- Private employers are eligible for premium discounts for establishing workplace safety programs.
- The division must publicize safety program resources on its website.

Building Permits: s. 440.103, F.S.

The following amendment becomes effective October 1, 2003:

- Every employer, when applying for and receiving a building permit, must show proof and certify to the permit issuer that it has secured coverage.

Prohibited activities and penalties: s. 440.105, F.S.

The following amendments become effective October 1, 2003:

- All employers must update an application for coverage within 7 days of any change information.
- Any employer that knowingly employs any person who has used false, fraudulent, or misleading oral or written statements as evidence of identity commits a first degree misdemeanor.
- A violation of a stop-work order constitutes insurance fraud.
- An injured employee or any other party claiming benefits must personally sign a document attesting that he or she has reviewed, understands, and acknowledges the required fraud statement. If the injured employee or party refuses to sign the document, benefits shall be suspended until the signature is obtained.

Department powers to enforce employer compliance with coverage requirements: s. 440.107, F.S.

The following amendments become effective October 1, 2003:

- In addition to not obtaining coverage, failure to secure the payment of compensation also includes materially understating or concealing payroll; materially misrepresenting or concealing employee duties to avoid proper premium classification; and materially misrepresenting or concealing information pertinent to the computation of an experience modification factor.
- The department's powers to ensure compliance are defined.
- The department is granted rulemaking authority to determine the business records employers must maintain and produce.
- A stop-work order is effective upon all work sites for an employer.
- The department may require any employer who has been found non-compliant to file periodic reports with the department for two years.
- Stop-work orders and penalty assessment orders shall be in effect against any successor corporation or business entity with the same principals or officers.
- A $1,000 penalty shall be assessed against an employer for each day of non-compliance. In addition, the non-compliant employer shall pay 1.5 times the manual premium the employer would have paid during the period of non-compliance or $1,000, whichever is greater.
- Any subsequent violation of compliance by the employer within 5 years after the most recent violation shall constitute insurance fraud.
- The division may impute payroll for penalty calculation purposes.

Exclusiveness of liability: s. 440.11, F.S.

The following amendment becomes effective October 1, 2003:

- An employer's actions shall be deemed to constitute an intentional tort and not an accident only when the employee proves, by clear and convincing evidence that the employer deliberately intended to injure the employee; or the employer engaged in conduct that the employer knew, based on prior similar accidents or on explicit warnings identifying a known danger, was virtually certain to result in the employee's injury or death, and the employee was not aware of the

risk because the danger was not apparent, and the employer deliberately concealed or misrepresented the danger.

Medical services: s. 440.13, F.S.

The following amendments become effective October 1, 2003:

- Medical services in excess of established practice parameters and protocols of treatment constitute overutilization.
- The maximum number of chiropractic treatments allowed is increased from 18 to 24 treatments, and the number of weeks of treatment is increased from 8 to 12 weeks.
- Attendant care requirements: The carrier or employer is not responsible for providing attendant care until it receives a prescription for such care from the physician. The prescription shall specify the time periods for such care, the level of care required, and the type of assistance required. Attendant care shall not be prescribed retroactively.
- An employee may seek his or her own medical care at the carrier's expense if the carrier fails to provide the initial care within a reasonable time after the initial care is requested.
- A carrier must authorize a change of physician within five days after receiving the request. If the carrier fails to respond within five days, the employee may select the physician, and that physician becomes authorized. When a new physician becomes authorized, the original physician becomes deauthorized. If the carrier fails to timely comply with a request for a change of physician, the carrier is subject to penalties as provided in s 440.525, F.S.
- Health care providers can charge no more than $0.50 per page for producing copies of medical records.
- An employee who reports an injury or illness waives any physician-patient privilege. A release of medical information by a health care provider does not require authorization from the employee. If the health care provider is not subject to the jurisdiction of Florida Law, the injured employee shall sign an authorization allowing for the carrier to obtain the medical records from the health care provider.
- The employee and the employer/carrier are each entitled to only one independent medical examination per accident and not one per medical specialty. The party requesting and selecting the independent medical examination is responsible for all costs related to the examination. If the employee prevails in a medical dispute as determined by a judge of compensation claims, or if benefits are paid or treatment is provided based on the independent medical examination, the carrier must pay for the examination.
- Each party is bound by the opinions of his or her selected independent medical examiner.
- Upon mutual agreement of the parties, a "consensus independent medical examination" may be requested to resolve a medical dispute. A mutually agreed upon physician specializing in the diagnosis and treatment of the medical condition at issue will conduct the examination. The findings and conclusions of the consensus independent medical examiner are binding on the parties and constitute a resolution of the medical dispute. Agreeing to a "consensus independent medical examination" does not affect the parties' entitlement to their one-per-accident, independent medical examination.
- Utilization review shall include an evaluation of compliance with practice parameters and protocols of treatment.
- Reports of overutilization to the Agency for Health Care Administration (AHCA) shall include reports of non-compliance with the practice parameters and protocols of treatment.
- AHCA must contract with a provider of expert medical advisors (EMA).
- The party requesting an EMA examination is responsible for paying the costs. If the employee requests the EMA examination,

and prevails based on the findings of the examination, the carrier is responsible for the costs. If a judge of compensation claims orders an EMA examination on his or her own motion, the carrier is responsible for the costs.

- Outpatient observation status shall not exceed 23 hours.
- Deviations from the established fee schedules are allowed when carriers enter into written agreements with a physician or health care provider to provide enhanced services or care to injured workers.
- Practice parameters and protocols shall be those adopted by the U.S. Agency for Healthcare Research and Quality in effect on January 1, 2003.
- Medical standards of care and treatment are established.
- Failure to comply with section 440.13, F.S. is subject to penalties in section 440.525, F.S.
- The reimbursement amount for prescription medication is reduced to the wholesale price plus $4.18 for the dispensing fee, except if the carrier has contracted for a lower amount.

The following amendments become effective January 1, 2004:

- Payments for outpatient physical, occupational, and speech therapy by hospitals are limited to the amount allowed to non-hospital providers.
- Payments for scheduled outpatient, non-emergency radiological and laboratory services that are not provided in conjunction with a surgical procedure are limited to the amount allowed to non-hospital providers.
- Payments for outpatient, scheduled surgeries are reduced from 75 percent to 60 percent of charges.
- Maximum reimbursements for physicians and osteopaths are increased to 110 percent of the amount allowed by Medicare if greater than the Florida medical fee schedule.
- Maximum reimbursements for surgical procedures are increased to 140 percent of the amount allowed by Medicare if greater than the Florida medical fee schedule.

Workers' Compensation Managed Care Arrangement: s. 440.134, F.S.

The following amendments become effective October 1, 2003:

- A "grievance" is a written complaint, other than a Petition for Benefits, filed by an injured worker pursuant to the requirements of the managed care arrangement.
- Chiropractors and podiatrists may serve as medical care coordinators.
- A managed care plan must allow the employee to obtain an independent medical examination as provided in s. 440.13(5), F.S. The carrier shall pay for the cost of an IME, if the physician selected is in the carrier's managed care arrangement. The independent medical examination, requested by the claimant and paid by the carrier, shall constitute the claimant's one IME per accident under s. 440.13(5), F.S.
- Medical treatment obtained outside the managed care arrangement is not compensable, regardless of the purpose of the treatment.

Determination of pay: s. 440.14, F.S.

The following amendments become effective October 1, 2003:

- Average weekly wage is determined based on the accident date.
- In defining average weekly wage, "substantially the whole of 13 weeks" is defined as the 13 calendar weeks before the accident, excluding the week during which the accident occurred and shall be not less than 75 percent of the total customary hours of employment.

Compensation for disability: s. 440.15, F.S.

The following amendments become effective for accidents occurring on or after October 1, 2003:

- No compensation for permanent total

disability is payable if the employee is engaged in, or is physically capable of engaging in at least sedentary employment.

- An employee is presumed to be permanently and totally disabled if the employee has one of the following injuries, unless the employer or carrier establishes that the employee is physically capable of engaging in at least sedentary employment within a 50 mile radius of the employee's residence:
  - Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;
  - Amputation of an arm, hand, foot, or leg;
  - Severe brain or closed-head injury;
  - 2nd or 3rd degree burns of 25 percent or more of the total body surface;
  - 3rd degree burns of five percent or more of the face and hands; or
  - Total or industrial blindness.

  In all other cases, permanent total disability may be awarded if the employee is not able to engage in at least sedentary employment within a 50-mile radius of the employee's residence, due to his or her physical limitation.
- Permanent total disability benefits end at age 75, unless the employee is not eligible for Social Security benefits because the employee's injuries prevented working sufficient quarters to become eligible.
- If the employee is age 70 or older when the accident occurs, permanent total disability benefits are payable for no more than five years.
- Permanent total supplemental benefits are not payable after the employee reaches age 62, regardless of whether the employee has applied for or is eligible for Social Security benefits, unless the employee is not eligible for Social Security benefits because the employee's injuries prevented working sufficient quarters to become eligible.
- An employee is not eligible for "catastrophic" temporary total disability benefits if the employee is eligible for, entitled to, or is collecting permanent total disability benefits.
- Permanent impairment benefits are paid bi-weekly rather than weekly.
- Permanent impairment benefits increase from 50 percent to 75 percent of the temporary total disability benefit amount.
- Permanent impairment benefits are reduced by 50 percent for each week in which the employee earned income equal to or in excess of the employee's average weekly wage.
- Permanent impairment benefits for psychiatric impairment are limited to one percentage point in the permanent impairment rating.
- The duration of permanent impairment benefits are as follows:
  - Two weeks for each percentage point from 1 to 10 percent;
  - Three weeks for each percentage point of impairment from 11 to 15 percent;
  - Four weeks for each percentage point of impairment from 16 to 20 percent;
  - Six weeks for each percentage point of impairment from 21 percent or higher.
- The timing of payments for temporary partial disability benefits is defined.
- Permanent impairment supplemental benefits are repealed.
- Temporary partial disability benefits are not payable if the employee is terminated for misconduct.
- If the employee has suffered a previous injury, only the disability or need for medical care associated with the compensable injury is compensable. The degree of disability, or medical condition for preexisting conditions is to be excluded from the impairment rating. Impairment ratings must apportion out the preexisting condition. Medical benefits shall be paid apportioning out the percentage attributable to the preexisting condition.
- If a judge of compensation claims determines that an employee, receiving temporary partial disability benefits, left his or her employment without just cause, temporary partial benefits are payable for those weeks based on deemed earnings of the employee as if she or he had remained employed.
- The obligation to rehire provision is repealed.

Occupational disease: s. 440.151, F.S.

The following amendments become effective October 1, 2003:

- The nature of employment must be the major contributing cause of the occupational disease. Major contributing cause must be shown by medical evidence only. Both causation and sufficient exposure to a specific, harmful substance shall be proven by clear and convincing evidence.
- Occupational diseases are diseases for which there are epidemiological studies showing that exposure to the specific substance, at the levels of actual exposure, may cause the precise disease sustained by the employee.

Compensation for death: s. 440.16, F.S.

The following amendments become effective October 1, 2003:

- Maximum funeral benefits increase from $5,000 to $7,500.
- Maximum death benefits increase from $100,000 to $150,000.

Notice of injury or death: s. 440.185, F.S.

The following amendments become effective October 1, 2003:

- The maximum penalty assessed against the employer for late reporting of any form, report, or notice increases from $500 to $1,000 for each failure.
- If the employer fails to timely report to the carrier more than 10 percent of its notices of injury or death, within a calendar year, the employer shall be subject to a maximum penalty of $2,000 for each late report.
- Upon receiving a notice of injury for an employee, the employer or carrier shall provide the employee with a written notice describing the availability of services from the Employee Assistance Office.

Procedure for resolving benefit disputes: s. 440.192, F.S.

The following amendments become effective October 1, 2003:

- A Petition for Benefits may be filed only for benefits that are ripe, due, and owing, and it must meet the specificity requirements defined in s. 440.02, F.S.
- A copy of the physician's request, authorization, or recommendation for requested treatment, care, or attendance must accompany the Petition for Benefits.
- Only those claims that are ripe, due, and owing when the petition is filed and that have undergone mediation can be considered for adjudication by a judge of compensation claims.

Alternate dispute resolution; claim arbitration: s. 440.1926, F.S.

The following amendment becomes effective October 1, 2003:

- The parties, upon consent of a judge of compensation claims, may resolve all issues in dispute regarding an injury through binding arbitration in lieu of any other remedy. The Florida Arbitration Code governs arbitration under this section.

Time for payment of compensation and medical bills: s. 440.20, F.S.

The following amendment becomes effective October 1, 2003:

- The carrier must make the first payment for total disability or death or deny compensability within 14 calendar days after the employer receives notification of the injury or death, when the disability is immediate and continuous for eight or more calendar days. If the first seven days of disability are non-consecutive, the first payment is due on the sixth day after the first eight calendar days of

disability.
- Medical, dental, pharmacy, or hospital bills must be paid, disallowed, or denied within 45 days after receipt.
- The carrier must provide all benefits or compensation while it commences an investigation of the employee's entitlement to benefits.
- All medical bills for services performed on or after January 1, 2004, must be paid or denied within 45 days after the carrier's receipt. Carriers who fall below the timely performance standard will be assessed the following penalties:
  - $25.00 for each bill falling between 90 percent and 95 percent timely performance standard;
  - $50.00 for each bill falling below a 90 percent timely performance standard.
- A 95 percent timely performance standard must be met for the payment of compensation. Carriers who fall below the timely performance standard will be assessed the following penalties:
  - $50.00 for each late installment of compensation falling between the 90 percent and 95 percent timely performance standard;
  - $100.00 for each late installment falling below the 90 percent timely performance standard.

Procedures for mediations and hearings: s. 440.25, F.S.

The following amendments become effective October 1, 2003:

- A judge of compensation claims must notify the parties within 40 days after a Petition for Benefits is filed that a mediation conference has been scheduled, unless the parties have notified the judge that a private mediation has been scheduled. A public or private mediation must be held within 130 days after a Petition for Benefits is filed.
- A judge of compensation claims (JCC) must consolidate multiple pending petitions, including petitions filed after the mediation is scheduled, into one mediation.
- The requirement that the parties submit any applicable motions to the judge of compensation claims no later than three days before the mediation is repealed.
- The requirement that the parties complete the pretrial stipulation at the conclusion of the mediation is also repealed.

Attorney fees: s. 440.34, F.S.

The following amendments become effective October 1, 2003:

- The attorney fee for benefits secured is limited to the current 20 percent of the first $5,000 of benefits secured, 15 percent of the next $5,000 of benefits secured, 10 percent of the remaining amount of benefits secured to be provided during the first 10 years after the claim is filed, and 5 percent of the benefits secured after 10 years. Judges of compensation claims may not award attorney fees that exceed the schedule.
- At least 30 days prior to the final hearing, if the carrier provides a written settlement offer addressing each pending issue and the injured employee refuses the offer, attorney fees paid by the carrier will be calculated only on the amount secured above those specified in the offer to settle.
- As an alternative to the contingency fee schedule, a judge of compensation claims may, for medical only cases, approve an attorney's fee not to exceed $1,500, only once per accident, based on a maximum rate of $150 per hour if the JCC determines that the fee schedule, based on benefits secured, fails to fairly compensate the attorney.
- Attorneys are not entitled to any remuneration for pursuing issues that were ripe, due, and owing and that reasonably could have been addressed but were not addressed during the pendency of other issues for the same injury.

Security for compensation: s. 440.38, F.S.

The following amendment becomes effective October 1, 2003:

- An employer who has a policy of insurance issued outside the state must maintain the required coverage under a Florida endorsement using Florida rates and rules pursuant to payroll reporting that reflects the work performed in this state by such employees.

Applications for coverage: s. 440.381, F.S.

The following amendments become effective October 1, 2003:

- Submitting false, misleading, or incomplete information on a workers' compensation application for coverage with the purpose of avoiding or reducing the amount of premium constitutes a second-degree felony.
- If the department determines that an employer has provided materially incorrect workers' compensation coverage information to avoid proper premium calculations, the department must immediately inform the employer's insurance carrier which then must commence an on-site audit of the employer within 30 days. If the carrier fails to commence the audit, the department may contract with an auditor to conduct the audit at the carrier's expense. The carrier is not required to conduct the on-site audit if the carrier gives written notice of cancellation to the employer within 30 days after receiving notification from the department and an audit is conducted in conjunction with the cancellation.

Insurance policies: s. 440.42, F.S.

The following amendment becomes effective October 1, 2003:

- Notice of policy cancellation for non-payment of premium must precede cancellation by ten days.

Reemployment of injured workers: s. 440.491, F.S.

The following amendments become effective October 1, 2003:

- Injured workers capable of earning at least 80 percent of the compensation rate are ineligible for training and education benefits.
- Benefits for training and education authorized by the Department of Education and funded by the Workers' Compensation Administration Trust Fund may include payment to attend community college or a vocational-technical school. Securing a G.E.D. is included within "appropriate training and education" when necessary to retrain an injured worker.
- Temporary total benefits paid during authorized training and education are restricted to, and not added to, the maximum 104 weeks provided for temporary total benefits.
- An employee who refuses to accept training and education forfeits any additional training and education and any additional compensation.

Examination and investigation of carriers and claims-handling entities: s. 440. 525, F.S.

The following amendments become effective October 1, 2003:

- Third party administrators, servicing agents, and other claims-handling entities are added to insurers as parties that may be subject to examination or investigation to ensure compliance with the requirements of the law.
- If, upon examination or investigation, the department finds the claims-handling entity has engaged in patterns or practices that violate the law, the department may impose penalties not to exceed $2,500 for each pattern or practice constituting a non-willful violation, not to exceed an aggregate amount of $10,000 for all non-willful violations arising out of the same action. Administrative penalties imposed for a non-willful violation

cannot duplicate any administrative penalty previously imposed.

- The department may also impose an administrative penalty for patterns or practices constituting a willful violation in an amount not to exceed $20,000 for each willful practice or pattern. Such fines cannot exceed $100,000 for all violations arising out of the same action.

Other provisions

The following amendments become effective October 1, 2003:

- Carriers must submit an annual report to the department detailing specified data with respect to the operation of their anti-fraud investigative unit; failure to submit the report will result in penalties.
- Certain violations of Chapter 440, F.S., are incorporated in the Offense Severity Ranking Chart to assist in the prosecution and sentencing of workers' compensation fraud by establishing rankings for these violations.
- The Bureau of Workers' Compensation Fraud and the Division of Workers' Compensation of the Department of Financial Services must produce a joint annual report with specifically defined content to provide greater accountability regarding compliance and enforcement activities.
- At least every other year the Financial Services Commission is required to hire a contractor to conduct an independent actuarial review of any workers' compensation rating organization.
- A Joint Select Committee on Workers' Compensation Rating Reform consisting of three senators and three representatives must submit a report by December 1, 2003.
- Effective July 26, 2003, an additional sub-plan (sub-plan D) was added to the Florida Workers' Compensation Joint Underwriting Association (JUA). The premiums for employers in the new sub-plan with 15 or fewer employees and an experience modification of 1.10 or less will be capped at 125 percent of the voluntary market manual rate. Premiums for charitable organizations meeting certain criteria with an experience modification factor of 1.10 or less will be capped at 110 percent of the voluntary market rate. Any deficits for the plan will be assessed against members of sub-plan D.
- The composition of the JUA Board of Governors will change.
- The JUA Board of Governors is required to submit a report by January 1, 2005. The report is to include, among other things, an evaluation of the effectiveness of the bill with regard to increasing availability of coverage and an independent actuarial review of all rates under the plan.

The Division of Workers' Compensation: Mission, Goals, and Functions

The Division of Workers' Compensation mission is **to actively ensure the self-execution of the workers' compensation system through educating and informing all stakeholders in the system of their rights and responsibilities, compiling and monitoring system data, and holding parties accountable for meeting their obligations.** To facilitate the accomplishment of this mission, it will pursue three goals over the next several years. The goals are as follows: To maximize the self-execution of the system, the division will:

- Serve as a comprehensive resource to all system stakeholders;
- Create an unparalleled real-time workers' compensation information environment and measure the health of the workers' compensation system; and
- Be the leading catalyst in promoting and advocating accident prevention in the workplace.

Some of the key objectives for achieving each goal are listed below.

To maximize the self-execution of the system, the division will serve as a comprehensive resource to all system stakeholders

- The division website will serve as an informational tool for all system stakeholders to provide knowledge and guide decisions that support the self-execution of the system.
- System stakeholders will be continuously informed of their roles and obligations in the system through media appropriate to each audience.
- Injured workers will receive early and continued contact from division specialists to assist in making their claims proceed smoothly and avoid potential disputes.
- Every division employee will have the knowledge and understanding of the workers' compensation system needed to educate and assist our customers.

To maximize the self-execution of the system, the division will create an unparalleled real-time workers' compensation information environment and measure the health of the workers' compensation system

- Florida employers, employees, and insurers will be informed of their obligations and rights under the law and division rules and of the consequences for not meeting their obligations.
- The division will have an information system for internal and external customers that provides for efficient collection of, access to, and sharing of data and information.
- The division will implement a system to continuously monitor the health of the workers' compensation system.

To maximize the self-execution of the system, the division will be the leading catalyst in promoting and advocating accident prevention in the workplace

- Partnerships will be forged with public and private entities interested in promoting safety.
- Through division education efforts, we will promote employers who exemplify best safety practices.

Each bureau and office in the division, through implementation of its core processes, contributes to the division's goals.

Regulation

An important reason to create an unparalleled real-time workers' compensation information system is to support the division's regulatory activities. The division regulates employers to ensure that all employers required to carry workers' compensation coverage have purchased adequate insurance for their employees. It also regulates insurers to ensure that appropriate and timely benefits are provided to injured workers.

Bureau of Compliance

The mission of the Bureau of Compliance is to ensure that all employers comply with Chapter 440, Florida Statutes, by having appropriate workers' compensation insurance coverage for all affected employees. The benefits of employer compliance include promoting a level playing field for all employers, ensuring injured workers have coverage to receive their statutory benefits, and adding premium into the system that was previously evaded due to non-complaince. The bureau uses the following strategies to accomplish its mission:

- Enforcement through investigations, stop work orders, and penalty assessments. Investigations identify employers violating the workers' compensation laws and bring them into compliance through assessing monetary penalties pursuant to s. 440.107, F.S.,
- Customer Service. The bureau responds to inquiries from the public and local and private entities regarding the workers' compensation laws and other general information regarding the Bureau of Compliance.
- Exemptions. The bureau processes applications from eligible employers seeking to utilize the exemption provision of the workers' compensation law.

Accomplishments

Last year, the bureau increased its enforcement efforts with non-construction-related businesses and Professional Employer Organizations (PEOs). During Fiscal Year 2003, the bureau sanctioned fifteen (15) large PEOs for failure to maintain workers' compensation insurance for their employees, with each sanctioned PEO having contracted with more than 100 client companies.

In addition, through its compliance and investigative efforts, the bureau:

- Exceeded the prior year's amount of evaded premium that was added to the system. In Fiscal Year 2002, $20.8 million in evaded premium were added to the premium base; while in Fiscal Year 2003, $47.4 million in evaded premium were added (see Table 1).
- Exceeded the prior year's number of new employees covered under the workers' compensation law. In Fiscal Year 2002 13,532 employees obtained coverage; while in Fiscal Year 2003, 34,546 employees gained coverage.

Several legislative changes were made in SB 50-A that will assist in employer enforcement efforts including:

- Up to three corporate officers of a corporation or any group of affiliated corporations in the construction industry may elect to be exempt. Each officer must be a shareholder owning at least 10 percent of the stock of the corporation and must be listed as an officer with the Division of Corporations.
- "Employee" includes an independent contractor working or performing services in the construction industry; a sole proprietor or partner engaged in the construction industry; all persons being paid by a construction contractor, unless the subcontractor has a valid exemption
- A corporate officer must include a copy of the stock certificate showing the officer has at least a 10 percent owner interest in the corporation when applying for an exemption.
- Certificates of election to be exempt only apply to the corporate officer named on the exemption and apply only within the scope of the business or trade listed on the exemption.
- All employers must update an application for coverage within 7 days of any change information.
- A violation of a stop-work order constitutes insurance fraud.
- In addition to not obtaining coverage, failure to secure the payment of compensation also includes materially understating or concealing payroll; materially misrepresenting or concealing employee duties to avoid proper premium classification; and materially misrepresenting or concealing information pertinent to the computation of an experience modification factor.
- The department may require any employer who has been found non-compliant to file periodic reports with the department for two years.
- Stop-work and penalty assessment orders shall be in effect against any successor corporation or business entity with the same principals or officers.
- Any subsequent violation of compliance by the employer within 5 years after the most recent violation shall constitute insurance fraud.
- The division may impute payroll for penalty calculation purposes.
- Submitting false, misleading, or incomplete information on a workers' compensation application for coverage with the purpose of avoiding or reducing the amount of premium constitutes a second-degree felony.
- If the department determines that an employer has provided materially incorrect workers' compensation coverage information to avoid proper premium calculations, the department must immediately inform the employer's insurance carrier which then must commence an on-site audit of the employer within 30 days. If the carrier fails to commence the audit, the department may contract with an auditor to conduct the audit at the carrier's expense. The carrier is not required to conduct the on-site audit if the carrier gives written notice of cancellation to the employer within 30 days after receiving notification from the department and an audit is conducted in conjunction with the cancellation.

Measures

In Fiscal Year 2003, the Bureau of Compliance conducted 26,980 employer investigations. This represents a 21% decrease from Fiscal Year 2002 levels (see Table 1). The change is due to a broadening of the types of employers that are subject to investigation. In Fiscal Year 2003, the bureau made a commitment to continue investigating high risk construction employers but to add investigations of employee leasing companies or professional employee organizations (PEOs). Employee leasing companies are much larger than the average construction company and have more complex records to investigate. Therefore, an investigation of an employee leasing company takes longer, resulting in fewer investigations. The dramatic (128%) increase in new premium dollars generated (from $20.8 million to $47.4 million) for Fiscal Year 2003 is a result of bringing large PEOs (with large premiums) into compliance.

Table 1

Fiscal Year

	1997	1998	1999	2000	2001	2002	2003
Employers Contacted for Investigation	30,861	27,310	30,694	36,539	37,433	34,268	26,980
New premium dollars added to the system (millions)	$12.6	$11.9	$14.4	$22.7	$21.1	$20.8	$47.4

Source: Division of Workers' Compensation

Goals

The bureau will:

- Better inform and educate employers and consumers of the requirements of Florida's workers' compensation law
- Cause more employers to come into compliance with the workers' compensation law
- Contact more employers to determine their workers' compensation status
- Increase the amount of workers' compensation premium generated as a result of new policies being purchased
- Closely monitor the workers' compensation insurance activity of employee leasing arrangements

Bureau of Monitoring and Audit

The mission of the Bureau of Monitoring and Audit is to ensure timely and accurate benefits to injured workers, timely payments for medical services, as well as accurate payroll reporting and coverage for self-insured employers. The bureau uses a wide variety of strategies to accomplish this mission.

- The audit section monitors insurer performance through review of division claims data using the Automated Carrier Performance System, and regularly scheduled division-wide meetings on claims activity. This monitoring activity results in compliance audits of insurer claims-handling practices that include timely and accurate payments of compensation, timely payments of medical bills, and timely filing of claims forms with the division. Enforcement of statutory requirements in these areas is conducted through the issuance of penalties and the education of claims administrators. The audit section also investigates and enforces compliance with compensation orders of judges of compensation claims (JCCs).
- The penalty section reviews and investigates claim facts reported to the division by insurers, and other pertinent documentation, which is necessary to assess penalties against employers, insurers, third party administrators (TPAs), and self-insurers as applicable under sections 440.021, 440.13, 440.15, 440.185, and 440.20, Florida Statutes.
- The permanent total section ensures the accuracy and timeliness of the payment of Permanent Total benefits and Permanent Total Supplemental benefits.
- The self-insurance section monitors the self-insurance programs of governmental entities and public utilities, calculates experience modifications, and certifies TPAs.
- The payroll audit section conducts payroll audits of active individual self-insurers, which includes governmental and private entities. Payroll reports are monitored for accuracy, timeliness, and fluctuations in the reported payroll amounts. After correction of inaccurate payroll information, the resulting audited annual payroll is used to determine the audited manual premium.

Accomplishments

In Fiscal Year 2003, the division redefined its audit process by emphasizing claim performance information from data filed by claims handlers with the division and by complaints generated from customers. The System Data Review Process, developed last year, was used to review 215 of the largest insurer entities. Audits were scheduled and completed for 77 insurers, and 4,240 claims files were reviewed.

As a result of examination of data submitted by insurers, 7,783 penalties were assessed totaling $924,249. Employers and carriers were required to pay over $140,000 to injured workers as a result of late first indemnity payments. In addition, carriers and employers were assessed almost $800,000, payable to the Workers' Compensation Administration

Trust Fund, for late filings of First Reports of Injury or Illness. The bureau developed a more thorough method for auditing the payment of Permanent Total benefits, which resulted in identifying more than $200,000 in incorrect payments.

Measures

In Fiscal Year 2003, The Bureau of Monitoring and Audit examined 54,999 claims.

Insurers are required to make the first indemnity benefit payment to injured workers within 14 days of employer knowledge that the case is a lost-time claim, defined as a case in which the injured worker misses 8 or more days from work. In Fiscal Year 2003, the division investigated 32% of the suspected cases of late reporting and late payments for penalty assessment. The bureau is enhancing its information system to allow for more effective investigations, which result in a higher percentage of cases investigated.

When the division finds that an insurer has not met its obligations under chapter 440, F. S., or division-established rules, the division may assess penalties. To the extent that insurers follow the law without division intervention, fewer penalties will be assessed. Indeed, the assessment of no or minimal penalties would be an indication that insurers are meeting their obligations. Beginning October 1, 2003, the division will have more authority to assess penalties for poor insurer performance. Table 2 shows that, for the past three fiscal years, the division has assessed penalties of over $3 million. With increased division authority and higher statutory penalties, the annual penalties assessed may increase over the next few years.

Table 2

Fiscal Year

	2001	2002	2003
Total insurer/TPA/Self insured employer penalties assessed	$861,389	$1,287,120	$896,715

Source: Division of Workers' Compensation

Goals

- Next fiscal year the audit section will expand the audit function to include special investigations of material violations of Chapter 440, F.S., as identified through a data monitoring process, consumer feedback, or industry complaints.

- The audit section has worked with other division sections to develop a process for reviewing industry complaints, which will become part of the audit scheduling process in the coming year. In addition, medical claims data will become part of the audit section's review and monitoring process by the end of this next fiscal year.

- Audits will continue to focus on the accuracy and timeliness of medical and indemnity payments and will be more responsive to information gathered throughout the division. Audits will include larger samplings of data, and will involve a more detailed review of claims office procedures. The audit process will fully utilize all division data, which will be instrumental in determining the focus of audits.

- Education on the provisions of Senate Bill 50-A, especially on the new audit requirements and procedures, and on the electronic filing of claims information will be a major focus of all interactions with insurers.

- The bureau will automate collection of payroll and loss data for self-insured employers to improve accuracy and efficiency.

Employee Assistance and Ombudsman Office

The mission of the Employee Assistance and Ombudsman Office (EAO) is to help prevent and resolve disputes between injured workers and employers/carriers by facilitating the provision of benefits that are due. Its activities include the following:

- The Early Intervention Program (EIP) provides early and proactive contact with the injured employee, which allows EAO to disseminate information to the employee about his or her rights and obligations under the workers' compensation law. This helps to prevent and resolve disputes between the employee and the employer/insurance carrier. Through this personal contact with injured employees EAO also serves a monitoring function by documenting and reporting any findings of non-compliance with the workers' compensation law.

- EAO assists the employee in drafting a Petition for Benefits and explains the procedures for filing.

- EAO investigates unpaid medical bills submitted by the health care provider or facility in an attempt to effect a resolution.

- EAO reviews and investigates Notices of Denials (DWC-12s) submitted to the division by the employer/carrier.

Accomplishments

For Fiscal Year 2003, over 88,000 injured employees were contacted through the Early Intervention Program. 24,000 injured employees had direct personal contact with a member of the Employee Assistance Office. EAO was unable to directly speak to the remaining 64,000 employees; however, an EIP informational letter was sent to them.

Goals

In Fiscal Year 2004, EAO will promote the self-execution of the system by:

- Proactively promoting the benefits of the EIP to employers and carriers. It is important for employers and carriers to understand the value of resolving disputes in an informal manner rather than through litigation. Statistics have shown that when an EAO representative directly speaks with an injured employee through the EIP, that injured employee is less likely to file a Petition for Benefits. Therefore, EAO will increase the percent of cases with verbal contact with injured employees.

- Enhancing its database to better track employees that receive benefits through intervention from an EAO representative. This enhancement will permit quantitative measurement of success in achieving the EAO mission.

- Increasing training and education about the workers' compensation system. This is critical for EAO in helping prevent and reduce disputes. A formalized internal training program will be created to expand the workers' compensation knowledge and skill set for all EAO representatives.

Measures

EAO helps prevent litigation in the workers' compensation system through outreach and education, primarily directed to injured workers. These activities contribute to the division goal to serve as a comprehensive resource to all stakeholders, maximizing the self-execution of the system. As soon as the division receives a First Report of Illness or Injury (DWC-1), an EAO representative contacts the injured worker. The EIP began in mid-1998 with a pilot program in two counties. Each year since 1998, the program has expanded, contacting more and more injured workers. An evaluation of EIP conducted in 2001 indicated that injured workers with whom the EAO made actual oral contact were less likely to submit Petitions for Benefits, which initiate formal litigation, than were injured workers who were not reached at all or those who were reached by letter only. Therefore, EAO makes two attempts to reach injured workers by telephone before sending a letter informing them of EAO's services.

Table 3

Fiscal Year

	2000	2001	2002	2003
Percent of Early Intervention Attempts resulting in Voice Contact	NA	NA	22.5%	22.6%
Percent of cases with DWC-1s with Petitions for Benefits within 24 months of the date of injury	23.8% IY* 1998	22.9% IY* 1999	21.9% IY* 2000	19.0% IY** 2001

Source: Division of Workers' Compensation

*IY= injury year

**IY 2001 data only include injuries with 24-month maturity as of May 30, 2003.

Data regarding the percent of injured workers with whom voice contact was established have only been available since July 1, 2001. That percentage has been steady at about 23% for the past two fiscal years. The percent of cases with Petitions for Benefits by 24 months after the date of injury has slowly but steadily declined. Data from all 2001 injuries will not be available until after December 2003, but preliminary results summarized in Table 3 are a promising indicator of continued decline in Petitions for Benefits.

Bureau of Operations and Support

The Bureau of Operations and Support is composed of the assessment section and the Special Disability Trust Fund (SDTF) section. The mission of each area is as follows:

Assessment section: To ensure the availability of resources to pay for the administration of the Workers' Compensation Administration and Special Disability Trust Funds through the calculation and collection of assessments from carriers and self-insurers.

SDTF: To encourage the employment of workers with pre-existing permanent physical impairments; to reimburse employers or their carriers for benefits provided to an employee with a pre-existing impairment who was subsequently injured in a covered workers' compensation accident on or after January 1, 1998; to determine the eligibility of the claim for reimbursement; and to audit and process reimbursement requests.

The assessment section accomplishes its goal by:

- Calculating assessment rates for the Workers' Compensation Administration and Special Disability Trust Funds
- Invoicing carriers and self-insurers
- Maintaining and monitoring the cash receipts process

The SDTF accomplishes its mission by:

- Determining the eligibility of claims for reimbursement
- Auditing and processing reimbursement requests

Measures

One of the major functions of the Bureau of Operations and Support is to reimburse insurance carriers for benefits they have paid to injured workers who had pre-existing permanent impairments before the covered workplace injury occurred. Reimbursements are funded through the Special Disability Trust Fund (SDTF). Although the SDTF has been prospectively abolished for injuries occurring on or after January 1, 1998, carriers are still due reimbursements based on payments for earlier injuries. In Fiscal Year 2003, SDTF paid out over $167 million in reimbursements to insurers. To ensure that SDTF funds are distributed fairly, requests for reimbursement are audited before they are approved for payment. The Bureau of Operations and Support has audited between 7,000 and 10,500 reimbursement requests each fiscal year since 1997, depending upon the number of requests received. (see Table 4).

Table 4

Fiscal Year

	1997	1998	1999	2000	2001	2002	2003
Number of reimbursement requests audited	10,380	8,798	7,652	8,492	9,008	8,893	7,470
Costs avoided as a result of the reimbursement audit process (in millions)	NA	NA	$13.3	$10.5	$14.3	$11.2	$10.7

Source: Division of Workers' Compensation

The reimbursement process has saved the system over $10 million dollars every year (see Table 4). Due to the reduction in reimbursement requests, both the number of reimbursement requests audited and the costs avoided by the audit process have declined since Fiscal Year 2001.

Office of Data Quality and Collection

The mission of the Office of Data Quality and Collection (DQC) is to collect workers' compensation claims, medical, and proof of coverage 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. It accomplishes its mission by:

- Collecting and monitoring workers' compensation medical data from claims submitted by health care providers (physicians, dentists, hospitals and pharmacists) to ensure data quality and compliance with statutory payment and filing requirements.
- Examining and collecting claims data for all lost-time workers' compensation injuries so the division can monitor the provision of benefits to injured workers.
- Collecting and evaluating all workers' compensation proof of coverage data including policy, endorsement, cancellation, and reinstatement information via electronic data interchange.
- Collecting and evaluating workers' compensation accident and claims information via electronic data interchange (EDI).
- Processing and complying with public records and subpoena requests by disseminating requested workers' compensation information.
- Serving as records repository for workers' compensation claims records archived via electronic imaging technology.

Accomplishments

During its first fiscal year of existence, DQC has improved the division's performance in several areas including the following:

- By marketing EDI technology, DQC increased the electronic receipt of the claims forms, DWC-1 and DWC-13, from 33% to 37%.
- The Proof of Coverage EDI Team assisted the Bureau of Compliance in enhancing their system to send cancellation referrals to investigators the day after the effective date of a cancellation.
- DQC re-engineered the business processes within its records section to increase the efficiency and quality of handling requests for public records and subpoenas. This resulted in a turnaround reduction from an average of 13 days to 2 days for public records and from 5 to 2 days for subpoena requests. Accuracy of initially retrieved documents for these types of requests rose from 89% to 99%, and the quality step of adding an additional final quality assurance review resulted in 100% accuracy for release of information.

- The electronic submission of medical claim form DWC-9 increased from 80% to 88% of all the DWC-9 forms.
- Submitters of electronic filings of medical data receive immediate e-mails when submitted data fail structural edits. This results in improved data transfer efficiency.

Measures

Key components of the creation of an unparalleled real time workers' compensation information environment are the completeness and the quality of data collected by the division. DQC is implementing strategies to increase the completeness and accuracy of data submitted and loaded into the division's databases. As one strategy to improve accuracy, the division is moving towards collecting more data electronically.

Table 5

Fiscal Year

	1999	2000	2001	2002	2003
Number of forms loaded into the division's databases (claims, medical, coverage)	1,792,969	3,159,231	3,881,831	3,827,433	4,026,580
Percent of claims, medical, and coverage forms successfully submitted electronically	70.40%	82.09%	88.15%	85.94%	89.89%

Source: Division of Workers' Compensation

Since 1999 the number of forms loaded into the division's databases each fiscal year has, with few exceptions, increased. The change from 3.1 million forms in Fiscal Year 2000 to 4.0 million forms in Fiscal Year 2003 represents a 27% increase (see Table 5). There has been a gradual but nearly continuous rise in the percent of documents submitted electronically. Since the bulk of forms submitted to the division are medical forms (in Fiscal Year 2003, 2.7 million out of 4.0 million forms loaded), increases in electronic submission of other forms are somewhat masked. For example, in Fiscal Year 2003 electronic filing of proof of coverage information was required. All POC documents are filed electronically, but there was only a 3.95 percentage point increase in the percent of all documents submitted electronically.

Goals

In order to assist the division in creating an unparalleled real-time workers' compensation information environment and measuring the health of the workers' compensation system, the Office of Data Quality and Collection has set the following goals:

- Optical Character Recognition. The office will develop and implement new technological methods to capture claims data, specifically, the Claims Cost Report, DWC-13. For Fiscal Year 2003, the division received over 237,000 DWC-13 report filings. Of these, 35 percent were received electronically, while all others were received via paper. Data collection via traditional paper processing techniques is labor-intensive and expensive. A strategy will be undertaken by DQC to advance the collection of claims data from the DWC-13 form by Optical Character Recognition (OCR) scanning technology. OCR technology will allow the data to be captured quickly and efficiently. As most data from this particular form are initially accepted, successful implementation of OCR data capture will allow the DWC-13 form to be examined and analyzed by exception only when problems arise with respect to the data integrity of the submitted form (forms that fail quality edits after scanning).
- Electronic Data Interchange (EDI). The Office of Data Quality and Collection will aggressively seek methods and opportunities to advance the EDI technology and promulgate the electronic reporting rule 4L-56, Florida Administrative Code, to mandate electronic reporting of first and subsequent reports.
- Medical Data Collection. Pursuant to new legislation s. 440.20 (6), F. S., a duty was created for the Department of Financial Services, effective January 1, 2004, to require that all medical, hospital, pharmacy, and dental bills be timely paid within 45 days, when properly submitted, and to assess appropriate administrative penalties when timely payment compliance falls below certain statutory performance standards. The division receives in excess of 3.5 million medical billings/reports annually. Currently, the division receives nearly 80 percent of this medical information electronically. In order to fulfill its statutory obligation to monitor all payments for timeliness and assess appropriate penalties when necessary, the Office of Data Quality and Collection will revise and promulgate the medical billing rule 4L-7.602, Florida Administrative Code, to mandate electronic reporting of all medical bills/reports.

Office of Research Services

The mission of the Office of Research Services (ORS) is to provide high quality information on the workers' compensation system and work-related injuries, illnesses, and fatalities to the public, policymakers, and others. Its activities contribute to all three division goals using the following mechanisms:

- Producing the division's annual report
- Monitoring and revising the content on the division's website, including the addition of safety information
- Planning and implementing the division's education efforts, including workplace safety information
- Producing an annual report on timeliness of first payments of indemnity
- Responding to requests for division data
- Conducting an annual survey of private sector workplace injuries
- Tracking workplace fatalities

Accomplishments

During Fiscal Year 2003 The Office of Research Service (ORS) made the following improvements for the division:

- The office, in collaboration with the Division of Insurer Services, completed a statutorily mandated report entitled *A Study of the Availability and Affordability of Workers' Compensation Coverage for the Construction Industry in Florida.*
- The division added queriable databases to its website regarding expiring workers' compensation insurance policies and statistical reports about workers' compensation claims.
- The office coordinated the effort to review claims data elements, making recommendations regarding continued collection and improvements in data quality.
- The office worked closely with DQC to improve completeness and accuracy of data for statutorily required reports.

Goals

To move the division closer to accomplishing its mission ORS will:

- Establish a post-reform monitoring system that will measure and report the impact of reforms and measure the health of the system.
- Begin to publish a web-based report regarding the timeliness of first workers' compensation indemnity payments.
- In conjunction with a division-wide team, continuously improve the division's website.
- In collaboration with programmatic bureaus, establish a coordinated external education program.
- Expand the division's efforts to educate division employees, to provide them with the tools they need to provide excellent and informed customer service.

Assessments and Funding

The Division of Workers' Compensation manages two trust funds: the Workers' Compensation Administration Trust Fund (WCATF) and the Special Disability Trust Fund (SDTF). Both funds are supported by annual assessments applied to workers' compensation insurance premiums, actual or estimated. For insurance companies, self-insurance funds, the Workers' Compensation Joint Underwriting Association, and assessable mutual insurance companies, assessments are based on premiums from compensation policies written in Florida. For self-insured employers, assessments are calculated from imputed premiums determined as if insurance had been purchased in the voluntary market.

The Workers' Compensation Administration Trust Fund (WCATF)

Prior to the implementation of statutory changes passed by the 2000 Florida Legislature, the Division of Workers' Compensation, in accordance with section 440.51, F.S., determined the funding level for the WCATF for a fiscal year, based upon administrative expenses for the previous fiscal year. Assessments were calculated by prorating these total expenses among insurance companies, self-insurance funds, assessable mutuals, the Workers' Compensation Joint Underwriting Association, and self-insurers. The assessment was a percentage of net premiums collected, or for self-insurers net premiums calculated, not to exceed 4%.

Since January 1, 2001, the assessment rate changes in January each year, rather than at the beginning of the fiscal year, and the rate is limited to 2.75%. The calendar-year rate is set by July 1 each year and is based on the anticipated expenses of administering the workers' compensation statute during the following calendar year. Effective July 1, 2001, insurers were required to include deductible policy premium discounts in the premium to be assessed for the WCATF.

Table 6 summarizes the WCATF assessment rates and revenues generated for the past 12 fiscal years. Even though the assessment rate has been declining, the amount of revenue generated by assessments has increased steadily since 1999. Since the modification of the method for calculating reported premium became effective in July of 2001, reported premium revenues increased over 33%, from over $119 million in Fiscal Year 2001 to almost $159 million in Fiscal Year 2003 while the assessment rate has declined over 53% from 3.74% to 1.75%.

Table 6
Workers' Compensation Administration Trust Fund Assessment Rates and Total Revenues

Fiscal Year	Assessment Rate	Revenues
1992	1.50%	$ 53,000,000
1993	1.40%	$ 51,000,000
1994	1.66%	$ 62,017,600
1995	3.22%	$ 93,436,220
1996	3.15%	$ 98,710,066
1997	2.50%	$ 90,165,687
1998	2.40%	$ 92,485,615
1999	2.75%	$ 82,953,596
2000	3.48%	$103,738,676
*2001	3.74%/2.75%	$119,419,182
2002	2.75%/2.56%	$146,752,416
2003	2.56%/1.75%	$158,889,383

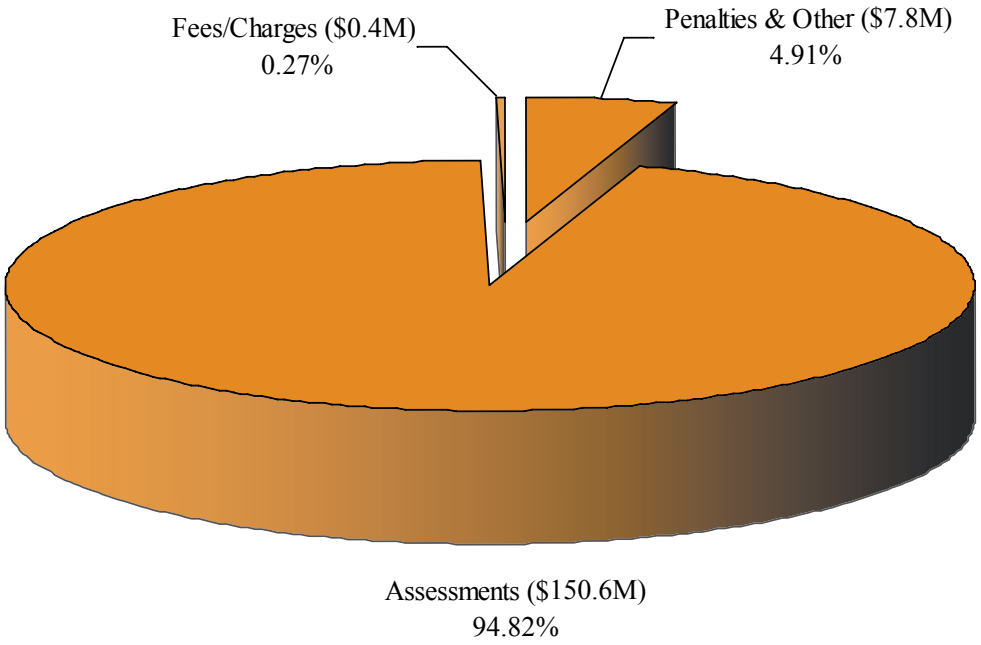
* Chapter 2000-150, Laws of Florida, changed the assessment period to a calendar year, effective January 1, 2001. The assessment rate of 3.74% was effective July-December 2000, 2.75% was effective for calendar year 2001, 2.56% for calendar year 2002, and 1.75% for calendar year 2003.
Source: Division of Workers' Compensation

Revenues derived from Workers' Compensation Trust Administration Fund assessments cover expenses for the Division of Workers' Compensation (administrative costs as well as payment of Permanent Total Supplemental Benefits), the Office of the Judges of Compensation Claims and a portion of the Agency for Health Care Administration, the Department of Education, the Bureau of Workers' Compensation Fraud. Figures 1 and 2 illustrate the breakout of revenue sources and disbursements for Fiscal Year 2003. The excess of revenues over disbursements will be applied to expenditures during the next fiscal year and permits a further reduction in the assessment rate to 1.5% beginning January 1, 2004.

Figure 1

Fiscal Year 2003

Workers' Compensation Administration Trust Fund Revenues

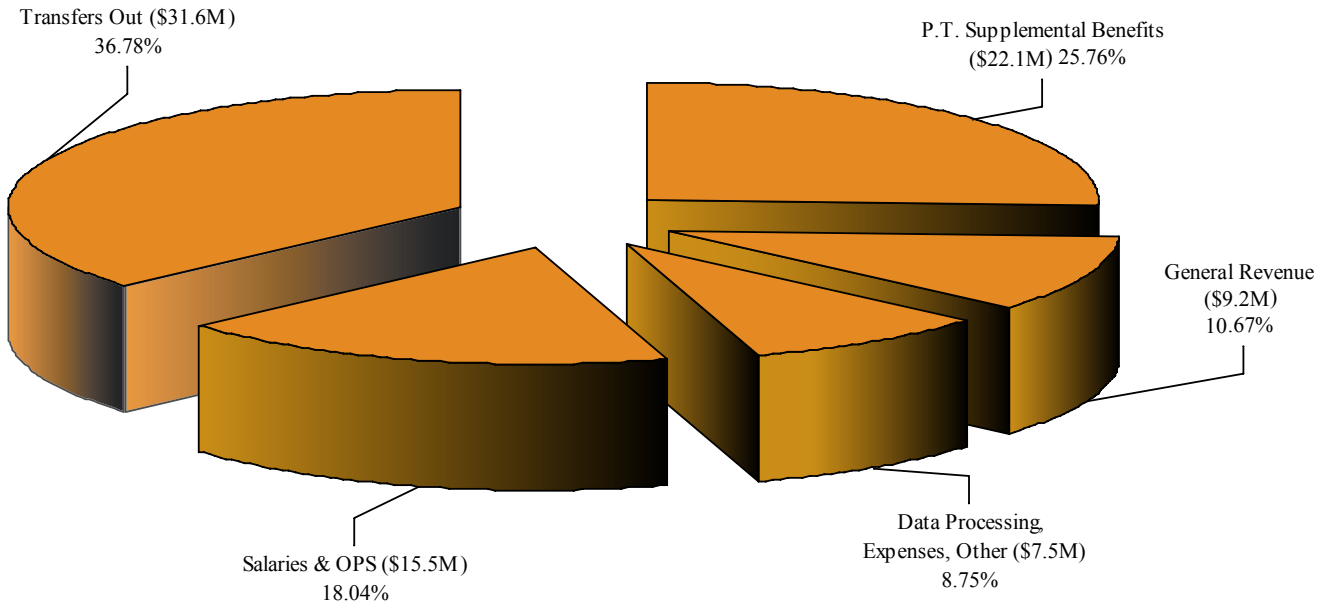


Source: Division of Workers' Compensation

Figure 2

Fiscal Year 2003

Workers' Compensation Administration Trust Fund Disbursements



Source: Division of Workers' Compensation

The Special Disability Trust Fund (SDTF)

Annual assessments for the SDTF are used primarily to provide reimbursement to self-insurers and carriers for costs generated whenever a covered worker with a previous impairment sustains a subsequent work-related injury. A small portion of the assessment revenues funds administrative operations required to make the reimbursements. Having been prospectively abolished by the Legislature, the SDTF does not accept new claims for injuries sustained on or after January 1, 1998.

The annual assessment calculation is defined in section 440.49, F.S., and is based on the disbursements from the fund over the past four years and the balance remaining in the fund. However, since legislation has capped the SDTF assessment rate at 4.52% since 1995, the cap has determined the assessment rate rather than the statutorily defined calculation since that date.

The assessment rates and revenues for the SDTF since Fiscal Year 1992 are listed in Table 7. Note that total revenues for Fiscal Year 2003 rose by over four million dollars, the fourth consecutive annual increase, despite the unchanged assessment rate. The increase in revenue can be attributed to a clarification of the definition of net premium in 2000. Breakouts of fund revenues and disbursements during Fiscal Year 2003 are displayed in Figures 3 and 4. More than nine out of every ten dollars from the SDTF (94.6%) reimbursed carriers and self-insurers for payments made to injured workers for subsequent workers' compensation injuries.

Table 7
Special Disability Trust Fund Assessment Rates and Total Revenues

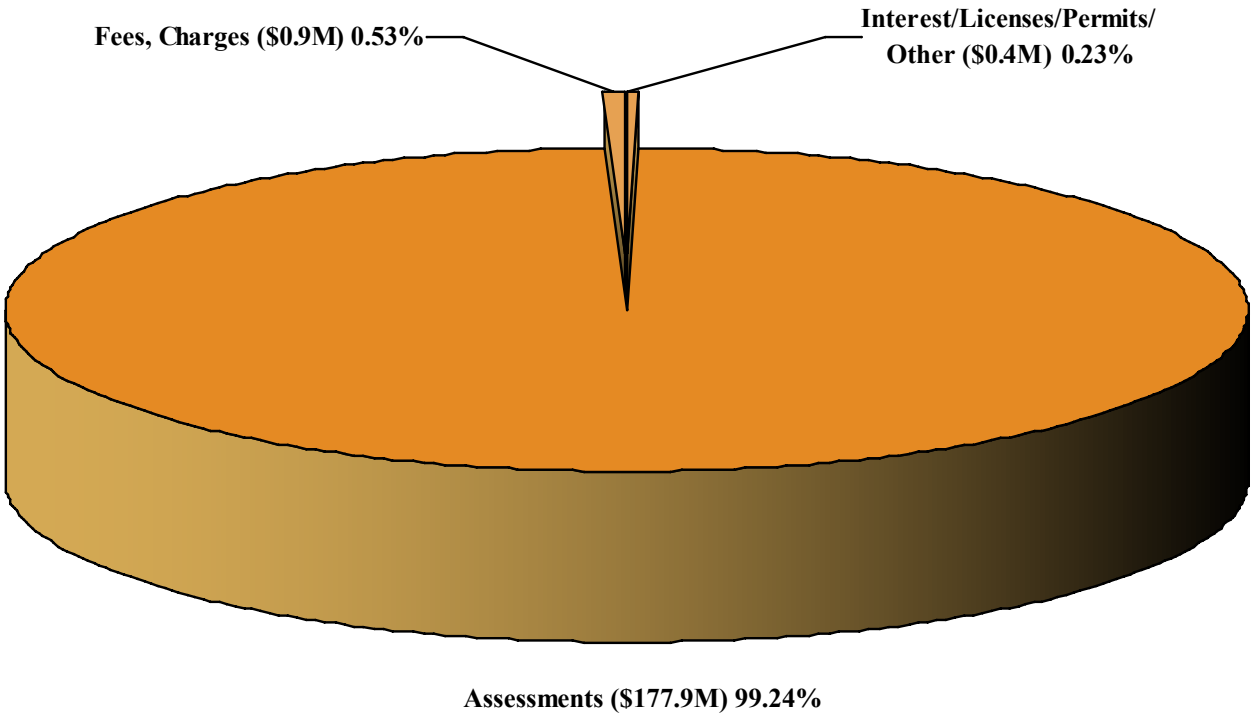
Fiscal Year	Assessment Rate	Revenues
1992	2.14%	$ 70,708,906
1993	2.72%	$ 95,946,973
1994	3.36%	$115,380,449
1995	4.52%	$166,827,717
1996	4.52%	$172,868,903
1997	4.52%	$139,176,056
1998	4.52%	$140,898,077
1999	4.52%	$132,339,956
2000	4.52%	$138,006,002
2001	4.52%	$166,434,403
2002	4.52%	$174,885,932
2003	4.52%	$179,233,662

Source: Division of Workers' Compensation

Figure 3

Fiscal Year 2003

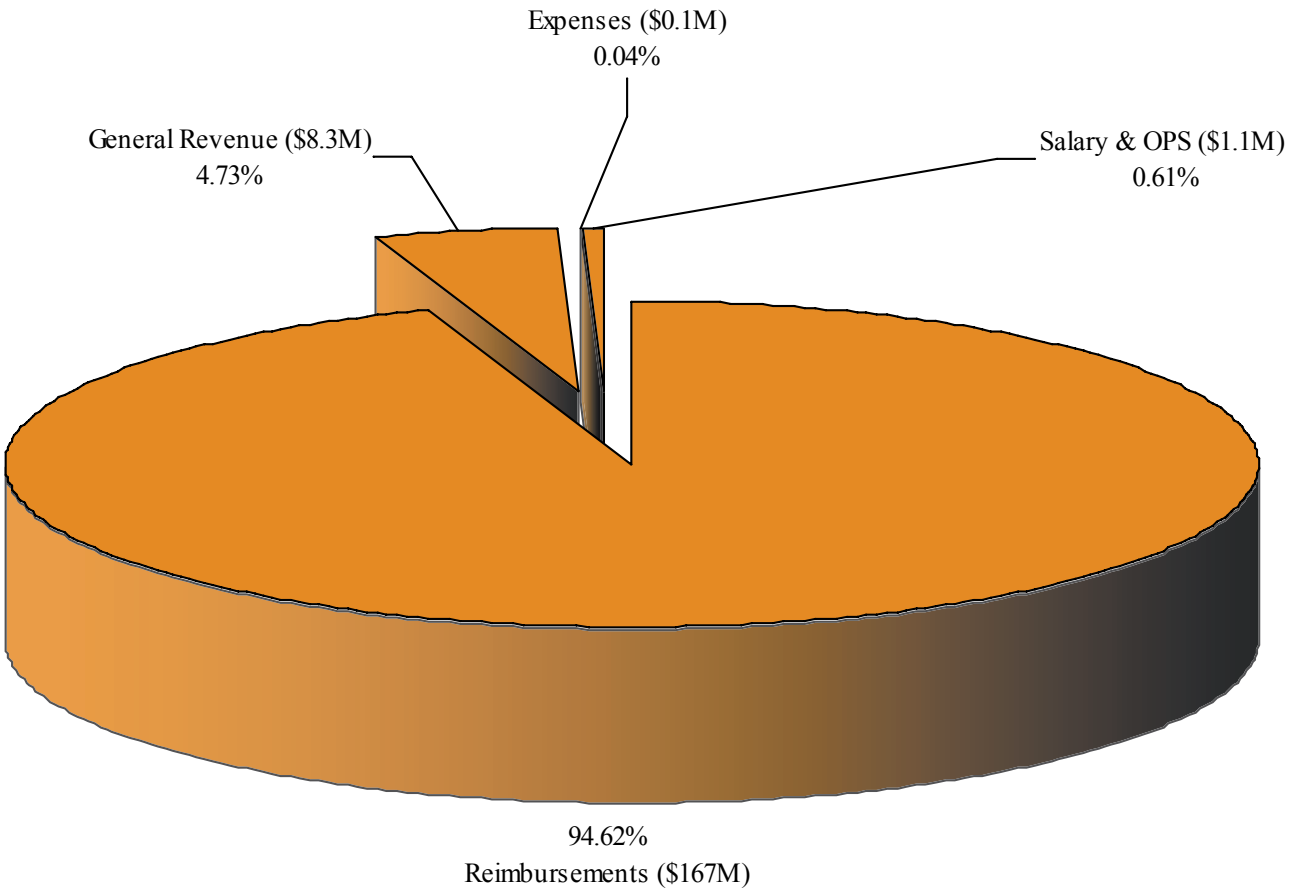
Special Disability Trust Fund Revenues



Source: Division of Workers' Compensation

Figure 4

Fiscal Year 2003
Special Disability Trust Fund Disbursements



Source: Division of Workers' Compensation

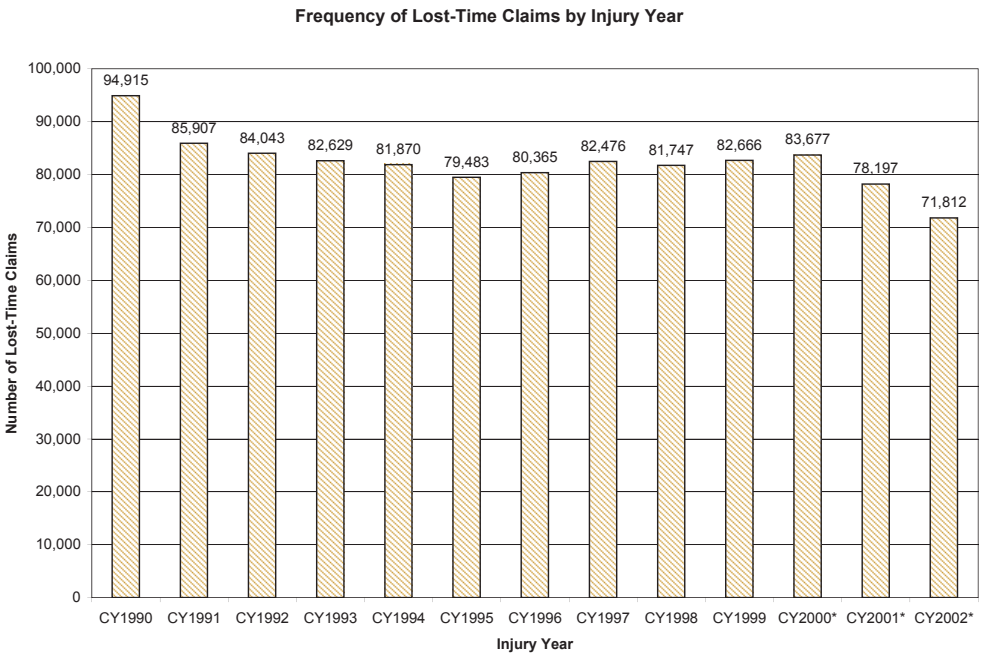
Workers' Compensation Claims Data

Data on lost-time claims in Florida come primarily from two sources, both submitted by insurers. The DWC-1 First Report of Injury or Illness provides basic information on the injured worker, employer, carrier, and severity and characteristics of the injury. Additional information on benefit payments is later provided on the DWC-13 Claim Cost Report, including details on compensation (or indemnity) payments by type of disability, medical costs, and settlement amounts. This year's Annual Report narrative deviates from previous years' editions in the discussion of claims data. Detailed tables are included on the compact disc in the pocket of the back cover of this report. Many readers will likely want to review interesting and relevant highlights of data related to workers' compensation (WC) injuries. To meet that need, this section presents these findings primarily in a graphic format, with brief accompanying explanatory narrative.

*Preliminary data

Claims Incidence

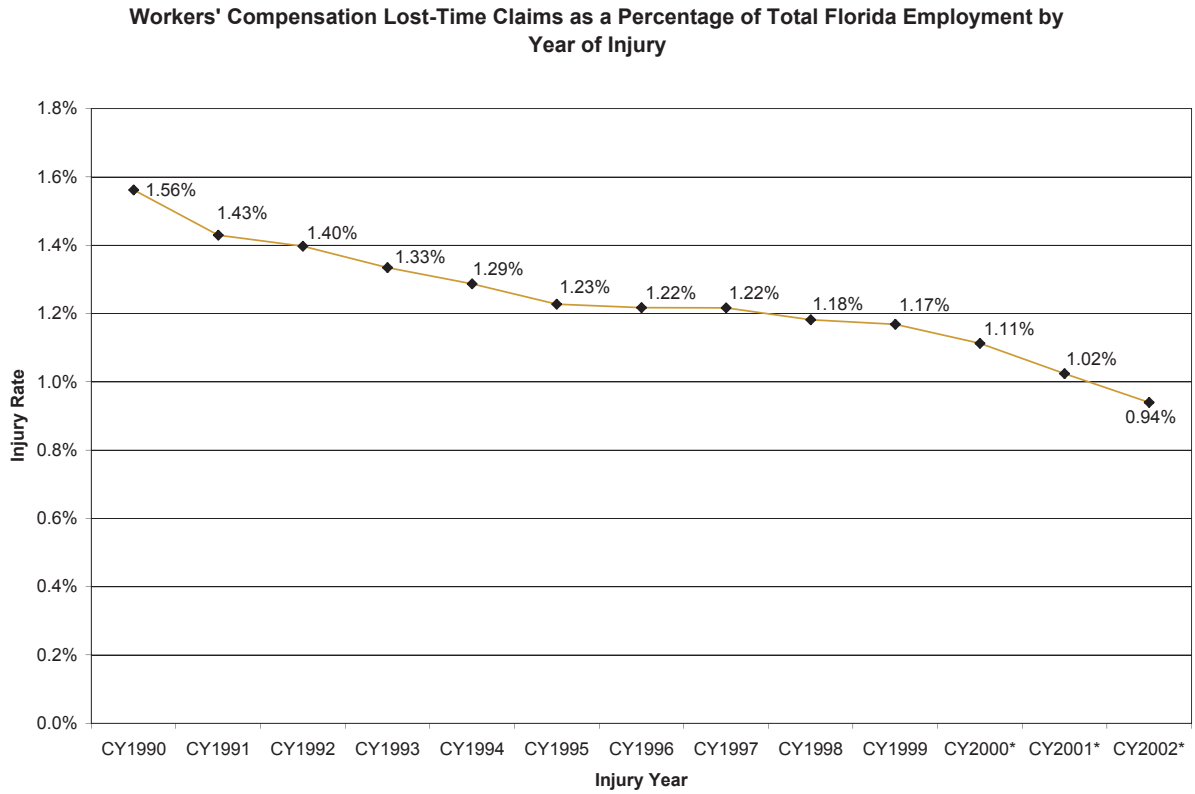
Figure 5



Source: Division of Workers' Compensation Intergrated Database as of July 31, 2003

Claim Counts: Figure 5 shows counts of lost-time claims since 1990. There was a decline in the number of lost-time claims during the early 1990s. Preliminary data compiled during the following years appeared to show a continuing decline, but more complete data now show that the volume of claims leveled off at a little over 80,000 per year through the end of the decade. In fact, the count of claims in 2000 was the highest of any year since 1992. However, it is useful to note that total employment in Florida continued to grow during most of this period, so that the injury rate declined even as the number of claims remained steady. Figure 6 shows an estimate of the change in injury rates over time. Note also that the claims counts for the past two years reflect immature data and not necessarily a drop in claims.

Figure 6



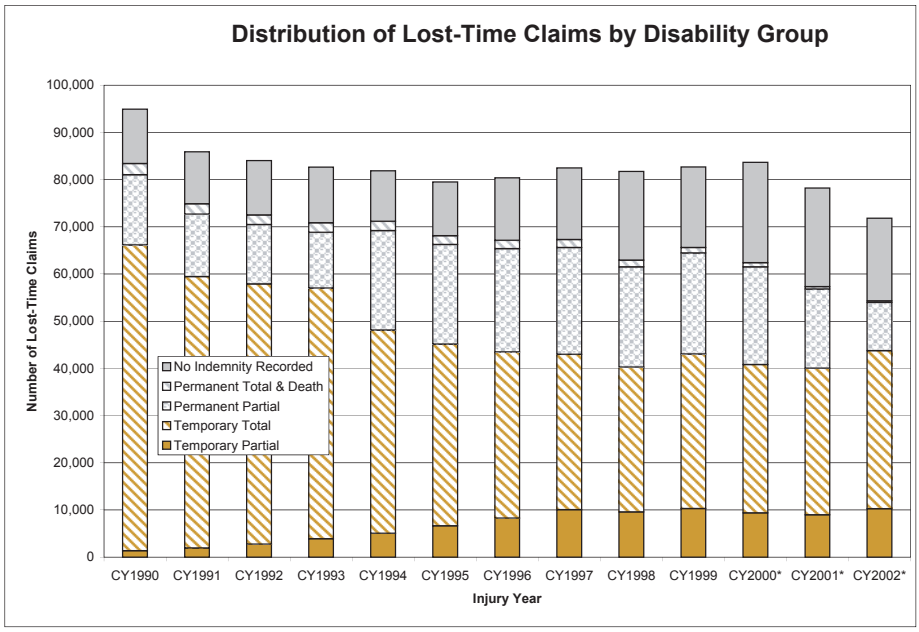
*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003, and Office of Labor Market Statistics, Florida Agency for Workforce Innovation, Local Area Unemployment Statistics program, in cooperation with the Bureau of Labor Statistics, U.S. Department of Labor

Disability Type: Perhaps the primary variable for analysis of lost-time claims data is disability type. Disability type, as described in Table 8, identifies whether an injury is partial or total, and temporary versus permanent. This can have a vital effect on how long a claim is open and the amount of benefits paid. Figure 7 shows the data from Figure 5 separated into disability groupings. The companion Figure 8 shows the same data presented as a percentage distribution to highlight some trends.

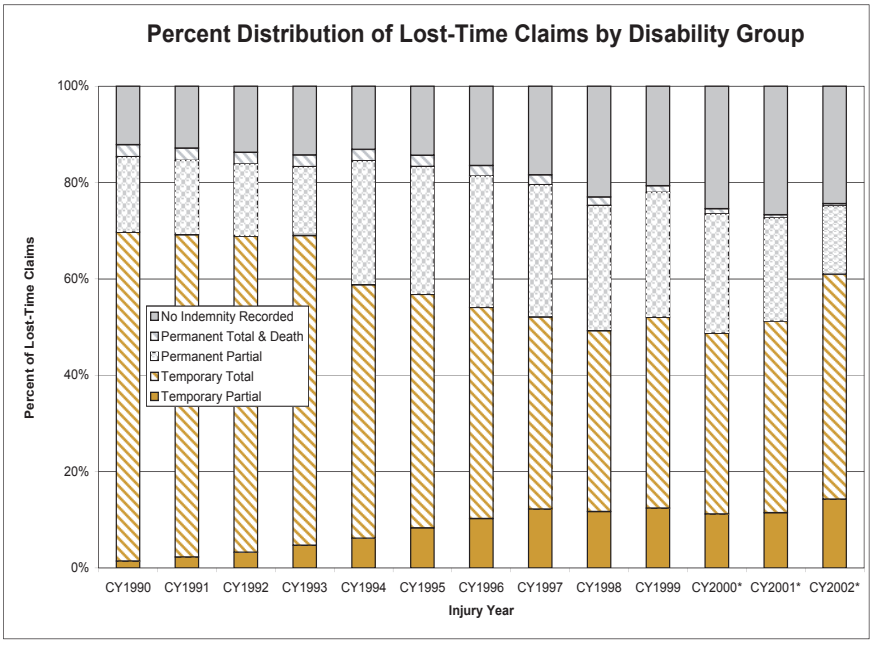
The figures show several important trends. The effect of data maturity is shown in the last four years. The number of "no indemnity recorded" claims reflects cases for which a DWC-13 has not yet been submitted to provide indemnity payment information. There are many claims for these recent years which have not yet reached maximum medical improvement and for which temporary disability payments are still being made, but will eventually qualify for permanent disability benefits. Also, the effect of the 1993 reforms can clearly be seen in the shift in proportion of temporary total to permanent partial (Impairment Income) disability claims from 1993 to 1994. The reforms sought to reduce the amount of permanent partial benefits, but broadened the standards for permanent partial eligibility. Another less dramatic trend was the increase in temporary partial claims from 1990 to 1997.

Figure 7



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003 *Preliminary data

Figure 8



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003 *Preliminary data

Table 8:
Disability Type Definitions

Disability Type is initially reported on the DWC-1 "First Report of Injury or Illness" and subsequently updated based on benefits reported on the DWC-13 "Claim Cost Report." Disability Type is defined by the initial classification on the DWC-1, or by the most severe classification of benefits received, based on the hierarchy listed below. For example, if a worker's injury resulted in the need for the individual to change to part-time or light duty work, the initial classification type would be shown as temporary partial. If the effects of the injury lingered and required a complete absence from work, the worker would then receive temporary total benefits. If it was later determined that the injury resulted in a permanent disability, the disability type would be again reclassified based on the worker's receipt of Impairment Income benefits.

Temporary Partial
Temporary Total
Permanent Impairment Only*
Wage Loss Only*
Wage Loss and Permanent Impairment*
Impairment Income**
Supplemental Income**
Permanent Total
Death

* These disability types apply only to injuries occurring before 01/01/1994.
** These disability types apply only to injuries occurring on or after 01/01/1994.
If a user is making state-to-state comparisons, the Florida categories of Permanent Impairment Only, Wage Loss Only, Wage Loss and Permanent Impairment, Impairment Income, and Supplemental Income may be combined to create the "Permanent Partial" disability group. The following are more detailed definitions of disability types.

Temporary Partial – disability that is not permanent in nature, permitting a return to work with restrictions that reduce the worker's pre-injury earning capacity.

Temporary Total – disability that is not permanent in nature and completely prevents an immediate return to gainful employment. This category also includes Temporary Total-Catastrophic and Temporary Total-Training and Education. (See below.)

Permanent Impairment Only – an anatomical or functional abnormality or loss continuing to exist after the worker has reached Maximum Medical Improvement. (See below.) Such impairment may or may not reduce a worker's earning capacity.

Wage Loss Only – benefits to supplement a worker's permanent reduction of earning capacity.

Wage Loss and Permanent Impairment– a combination of the two situations above.

Impairment Income – benefits for workers who have reached Maximum Medical Improvement and have been issued an impairment rating. These benefits may be received even after the individual has returned to work.

Supplemental Income – benefits which may be paid after Impairment Income benefits have expired if: the worker has an impairment rating of 20% or more and a post-injury earning capacity of 80% or less than pre-injury capacity.

Permanent Total – a non-fatal injury that permanently and totally incapacitates an employee, preventing return to gainful employment.

Death – may also include cases where death ultimately resulted from a workplace injury or illness and occurred no more than five years after the injury/illness occurred or was first reported.

In addition to these nine disability types, the division also defines two others for purposes of complete reporting of lost-time claims.

Settled, No Indemnity Recorded refers to cases with settlement dollars reported on the DWC-13, but no indemnity benefits recorded.

Lost-Time, No Indemnity Recorded refers to claims reported as lost-time, but which do not (yet) have indemnity or settlement dollars reported.

Table 8 Continued

Additional related terms:

Temporary Total Catastrophic – benefits paid to a worker with a catastrophic injury. Benefits are paid at a rate of 80% of pre-injury earnings for six months, compared to a normal rate of 66⅔%.

Temporary Total Training and Education – benefits paid to an employee obtaining training and education to obtain suitable employment, typically for a period of no more than 26 weeks.

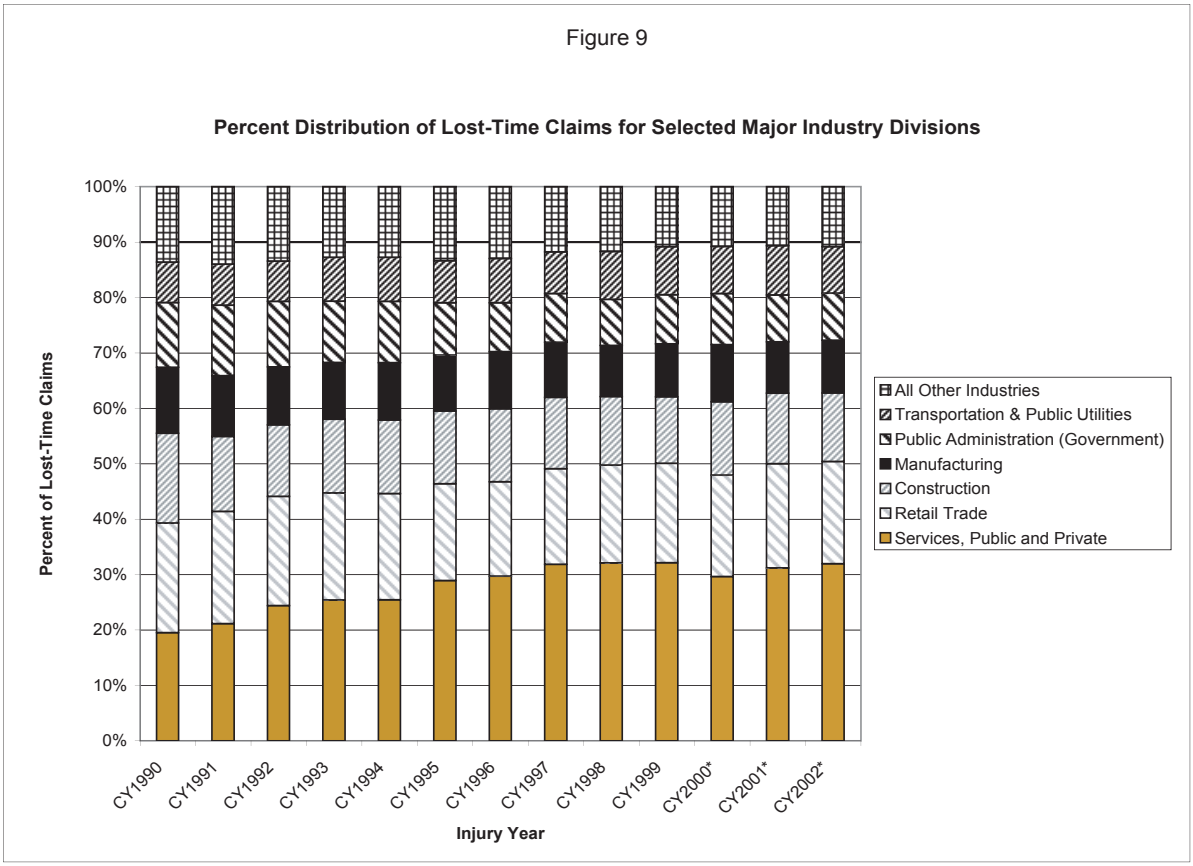
Maximum Medical Improvement (MMI) – the point at which further recovery from or lasting improvement to an injury or disease can no longer be expected based on reasonable medical probability.

Impairment Rating – determination of an injured worker's loss of physical function as a percentage of total bodily function or mobility.

Source: Division of Workers' Compensation website

Major Industry Division: Data in Figure 9 on claims by the employer's industry division show (see legend in Figure 9) relative consistency over the thirteen year period, with the largest proportions of claims in Services (27.5%), Retail Trade (18.7%), Construction (13.4%), and Manufacturing (10.3%). The one notable trend was the increase in Services, which was about 20% of all claims in 1990, and increased to over 30% by the latter part of the decade. The overall pattern of claims reflects the gradual long-term shifting of the Florida and national economies away from goods-producing (manufacturing, construction, mining, and agriculture) towards service-producing industries.

Figure 9



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003 *Preliminary data

Risk Classification: Risk classification describes the business of an employer within a state. In general, each classification includes all the various types of labor found in a business. It is the business that is classified, not the individual employments, occupations, or operations within a business. There are more than 600 valid risk classification codes in Florida, but 30 (including one combination of redefined codes), listed in Table 9, accounted for more than half of all lost-time claims from 1990 through 2002. In fact, the top-ten ranked classifications accounted for almost a third of all lost-time claims, and the top three for more than 15%. The ranking in many cases is more dependent on the size of the industry than on its injury rate. Three of the top six classifications are in retail trade. Table 9 includes eight construction classifications, but none are in the top ten.

Table 9
Counts of the Thirty Most Frequently Reported Risk Classification Codes on Lost-Time Claims for Injury Years 1990-2002

Risk Classification Code and Title		Year of Injury														% of valid codes	
		CY1990	CY1991	CY1992	CY1993	CY1994	CY1995	CY1996	CY1997	CY1998	CY1999	CY2000*	CY2001*	CY2002*	Total	Individ.	Cumul.
	Restaurants - combined (9079/9082/9083)	773	1,109	1,611	3,197	3,215	4,071	3,633	4,247	4,428	4,084	3,506	3,213	3,185	40,272	6.3%	6.3%
8810	Clerical Office Employees NOC	717	1,023	1,844	2,099	1,887	2,757	3,276	3,209	3,178	3,905	3,799	3,122	2,820	33,636	5.2%	11.5%
8033	Meat, Combined Grocery/Provision Stores	337	550	1,037	1,667	1,841	2,291	2,480	2,554	3,027	3,047	2,832	2,612	2,707	26,982	4.2%	15.7%
7720	Police Officers	470	666	1,263	1,520	1,197	1,549	1,885	1,949	1,913	1,918	1,969	1,653	1,679	19,631	3.1%	18.8%
9101	Colleges/Schools All Other Employees	263	444	1,006	1,067	902	1,564	1,696	1,772	1,863	1,711	1,696	1,764	1,746	17,494	2.7%	21.5%
8017	Store Risks Retail NOC	158	269	354	557	895	1,437	1,744	2,048	1,970	1,778	1,732	1,767	1,658	16,367	2.5%	24.0%
8833	Hospitals Professional Employees	392	562	1,189	1,310	1,155	1,456	1,519	1,436	1,413	1,455	1,316	1,212	1,022	15,437	2.4%	26.4%
8868	Colleges/Schools Professional Employees	176	419	745	848	802	1,308	1,494	1,429	1,437	1,420	1,428	1,476	1,403	14,385	2.2%	28.7%
7380	Chauffeurs, Drivers, & Their Helpers NOC	325	498	807	1,008	993	1,265	1,367	1,415	1,380	1,301	1,172	1,098	1,082	13,711	2.1%	30.8%
9052	Hotels	333	539	1,157	1,157	990	1,176	1,179	1,359	1,255	1,215	1,197	1,029	998	13,584	2.1%	32.9%
8742	Salesmen/Collectors/Messengers Outside	371	503	777	897	758	970	1,025	975	997	989	871	852	888	10,873	1.7%	34.6%
5190	Electrical Wiring in Buildings	336	370	584	797	684	929	1,058	1,087	1,097	958	1,004	952	901	10,757	1.7%	36.3%
9040	Hospitals All Other Employees	211	336	796	924	887	1,196	1,120	1,011	986	819	831	782	768	10,667	1.7%	37.9%
9015	Buildings NOC Operation by Owner/Lessee	115	211	309	523	496	1,139	1,157	1,184	1,162	1,083	860	804	825	9,868	1.5%	39.5%
8380	Automobile Service/Repair Center/Drivers	210	334	464	749	497	78	122	388	453	642	1,199	1,138	1,262	7,536	1.2%	40.6%
8835	Public Health Nursing Assoc. All Employees	118	208	387	552	593	777	794	965	701	619	618	611	554	7,497	1.2%	41.8%
7704	Fire Fighters	121	194	427	547	413	649	703	663	689	734	788	738	703	7,369	1.1%	43.0%
8841	Nursing Homes Professional Empl./Clerical	199	326	498	707	607	788	778	643	595	472	496	532	581	7,222	1.1%	44.1%
5645	Carpentry Constr. of Detached Residences	217	229	475	634	542	771	829	720	719	656	514	507	383	7,196	1.1%	45.2%
5183	Plumbing NOC	212	293	439	479	463	563	655	666	648	632	583	566	637	6,836	1.1%	46.3%
9102	Parks NOC All Employees	107	154	345	487	439	640	670	670	678	662	589	592	663	6,696	1.0%	47.3%
9060	Clubs, Country/Golf/Fishing/Yachting	166	248	456	550	459	605	659	536	512	486	484	487	474	6,122	1.0%	48.3%
9403	Garbage/Ashes/Refuse Collecting	152	192	393	478	390	485	488	467	547	682	550	696	476	5,996	0.9%	49.2%
5022	Masonry NOC	209	233	319	421	484	600	661	658	650	516	394	386	385	5,916	0.9%	50.1%
5403	Carpentry NOC	324	325	406	431	424	488	561	554	580	552	518	390	352	5,905	0.9%	51.0%
8018	Store Risks Wholesale or Combined NOC	155	204	356	510	434	474	586	560	598	493	472	481	582	5,905	0.9%	52.0%
5551	Roofing All Kinds	164	252	507	699	425	599	616	554	549	422	395	330	322	5,834	0.9%	52.9%
5221	Concrete Work, Floors/Driveways/Sidewalks	135	180	281	429	434	565	586	617	615	556	472	446	443	5,759	0.9%	53.8%
3724	Millwright Work NOC	206	282	380	460	402	518	536	519	482	472	454	499	463	5,673	0.9%	54.6%
9410	Municipal/Township/County/State Empl. NOC	141	234	493	610	305	407	423	521	504	484	530	441	414	5,507	0.9%	55.5%
	All Other Valid Codes	7,926	10,966	18,170	22,820	19,108	24,287	26,324	27,088	26,489	25,896	26,938	25,314	24,681	286,007	44.5%	100.0%
	Claims with Valid Codes	15,739	22,353	38,275	49,134	43,121	56,402	60,624	62,464	62,115	60,659	60,207	56,490	55,057	642,640		
	* preliminary data																
	NOC - not otherwise classified																

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

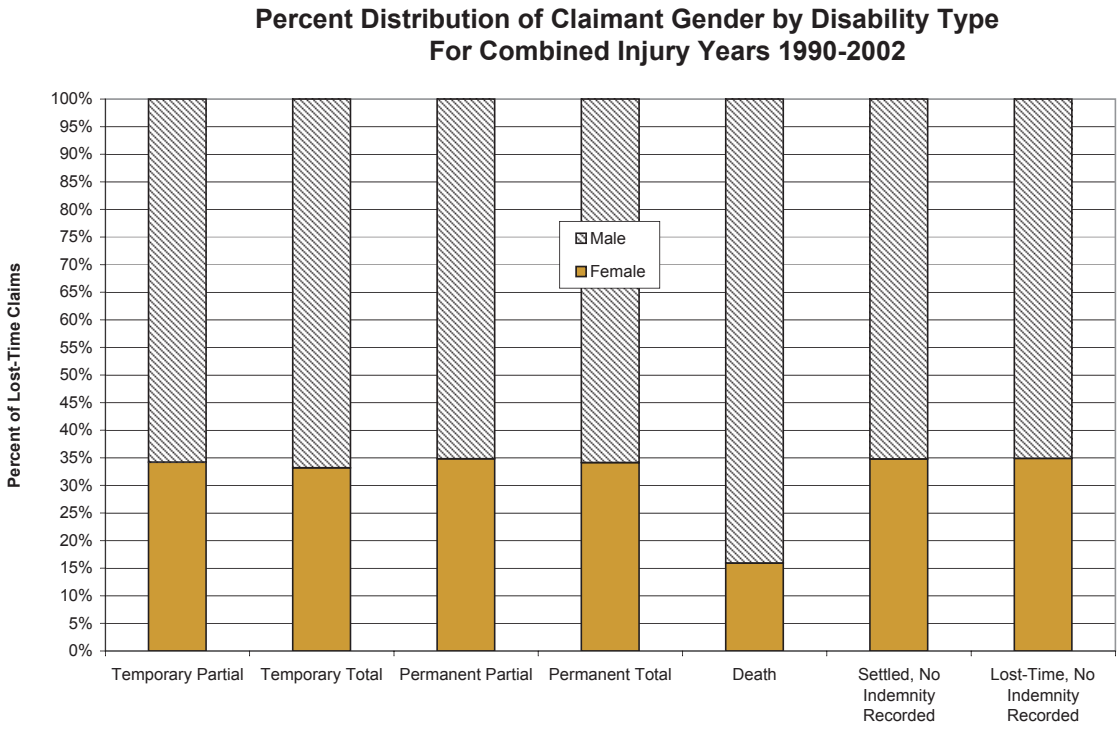
Gender: Over the entire reporting period women have remained at about one third of all lost-time claimants. Gender data for the top 30 risk classifications, displayed in Table 10, show patterns that reflect traditional occupational choices by gender. There are six classifications in which more than two thirds of claimants are female; four of these are in the healthcare industry. At the other end of the spectrum, there were six classifications in which less than 3% of claimants were female; all six were in construction trades. Separation of gender data by disability type in Figure 10 shows that women make up about one third of claimants for each disability type, except in the case of death, where the proportion of females is 16%. The difference in death rate by gender likewise reflects differences in the proportion of women in the most dangerous industries in terms of fatalities.

Table 10
Gender Distribution of the Top Thirty Most Frequently Reported Risk Classification Codes for Combined Injury Years 1990-2002

Risk Classification Code and Title		Lost-Time Claim Counts			
		Female	Male	Total	% Female
8841	Nursing Homes Professional Empl./Clerical	6,482	643	7,125	91.0%
8835	Public Health Nursing Assoc. All Employees	6,545	870	7,415	88.3%
8833	Hospitals Professional Employees	12,462	2,789	15,251	81.7%
8868	Colleges/Schools Professional Employees	10,920	3,338	14,258	76.6%
8810	Clerical Office Employees NOC	22,645	10,669	33,314	68.0%
9040	Hospitals All Other Employees	7,036	3,513	10,549	66.7%
9052	Hotels	8,545	4,846	13,391	63.8%
8017	Store Risks Retail NOC	9,167	7,054	16,221	56.5%
note	Restaurants - combined (9079/9082/9083)	22,174	17,660	39,834	55.7%
9101	Colleges/Schools All Other Employees	8,381	8,918	17,299	48.4%
8033	Meat, Combined Grocery/Provision Stores	11,950	14,699	26,649	44.8%
8742	Salesmen/Collectors/Messengers Outside	3,751	7,030	10,781	34.8%
9060	Clubs, Country/Golf/Fishing/Yachting	1,772	4,289	6,061	29.2%
9410	Municipal/Township/County/State Empl. NOC	1,439	4,007	5,446	26.4%
7720	Police Officers	5,130	14,317	19,447	26.4%
8018	Store Risks Wholesale or Combined NOC	1,458	4,400	5,858	24.9%
9015	Buildings NOC Operation by Owner/Lessee	2,038	7,758	9,796	20.8%
7380	Chauffeurs, Drivers, & Their Helpers NOC	2,553	11,033	13,586	18.8%
9102	Parks NOC All Employees	756	5,888	6,644	11.4%
7704	Fire Fighters	727	6,600	7,327	9.9%
8380	Automobile Service/Repair Center/Drivers	555	6,916	7,471	7.4%
9403	Garbage/Ashes/Refuse Collecting	267	5,646	5,913	4.5%
3724	Millwright Work NOC	199	5,437	5,636	3.5%
5190	Electrical Wiring in Buildings	322	10,375	10,697	3.0%
5403	Carpentry NOC	152	5,701	5,853	2.6%
5183	Plumbing NOC	175	6,608	6,783	2.6%
5221	Concrete Work, Floors/Driveways/Sidewalks	128	5,591	5,719	2.2%
5645	Carpentry Constr. of Detached Residences	153	6,998	7,151	2.1%
5551	Roofing All Kinds	92	5,695	5,787	1.6%
5022	Masonry NOC	87	5,769	5,856	1.5%
	NOC - not otherwise classified				

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

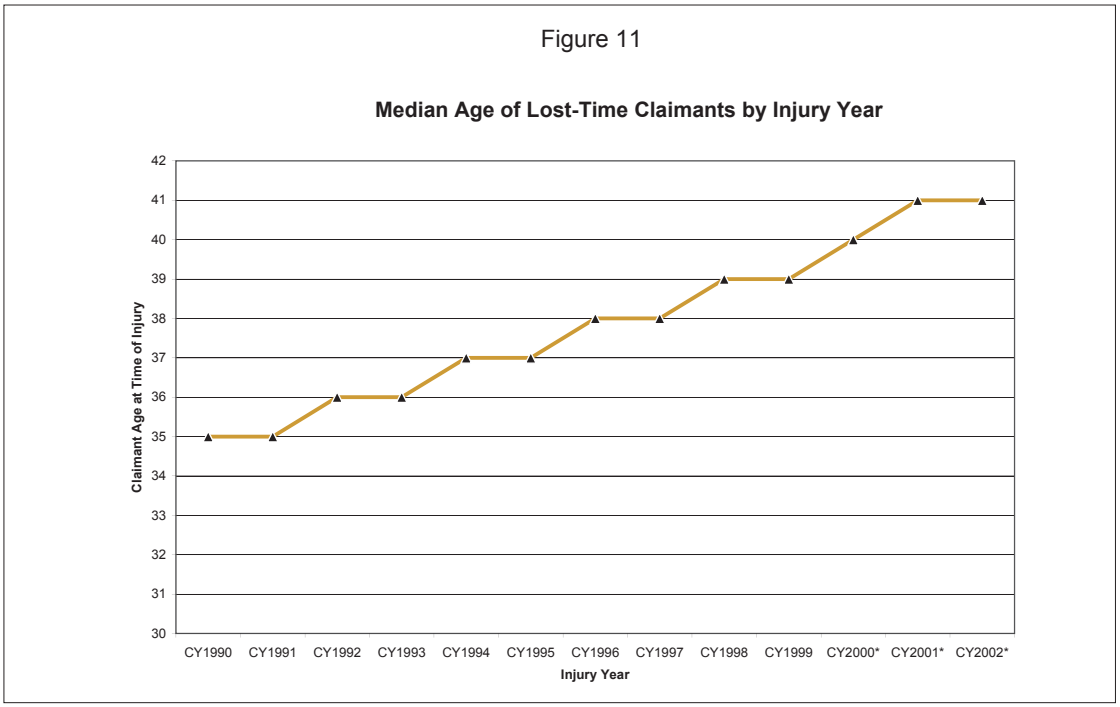
Figure 10



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

Age: Figure 11 shows that there has been a long-term increase in the median age of lost-time claimants, amounting to about six months for each respective injury year. Detailed data by age group (not shown) reveal that this is a gradual shift in the entire distribution of claimant age data and not due to changes in injury rates for the very youngest or oldest workers. Data on a sample of employed workers surveyed through the Current Population Survey (from which the national unemployment rate is determined) were downloaded from the Bureau of Labor Statistics website to examine how the age of lost-time claimants compares to that of all employed workers. The data show that the median age of the entire workforce has increased more slowly: from 38 in 1994 to 41 in 2002. The median workforce age is overlaid on the claimant data in Figure 12. This reveals that during the 1990s WC claimants were a bit younger than other employed workers, but for the past few years the age of claimants has matched, and actually surpassed, that of all workers.

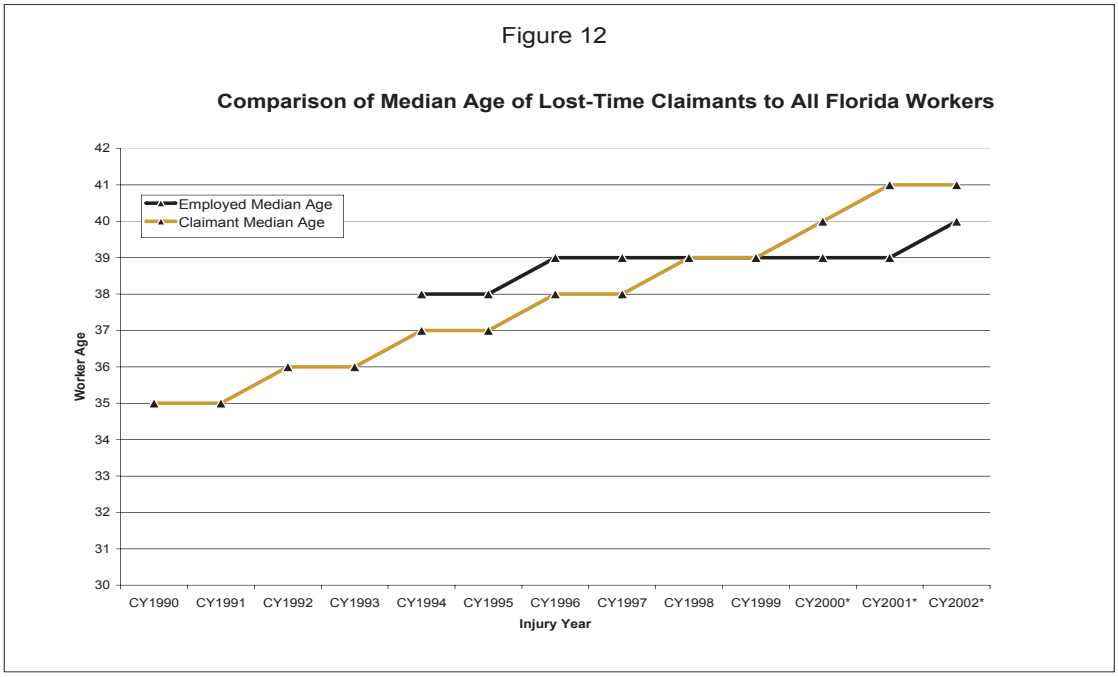
Figure 11



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

*Preliminary data

Figure 12

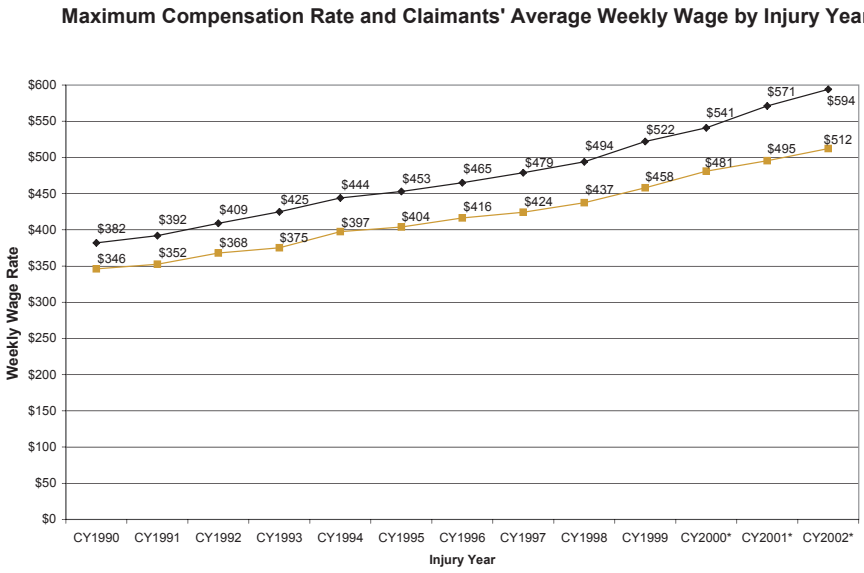


Source: Division of Workers' Compensation Integrated Database as of July 31, 2003 and special data extracted from the Current Population Survey

*Preliminary data

Average Weekly Wage: Figure 13 shows a comparison of the reported average weekly wage (AWW) of lost-time claimants compared to the maximum compensation rate, defined by statute as the statewide average weekly wage (SAWW) of all employees covered by the state Unemployment Compensation law. The two graphs track closely, with claimants' actual aggregate AWW staying at about 85% of the SAWW.

Figure 13

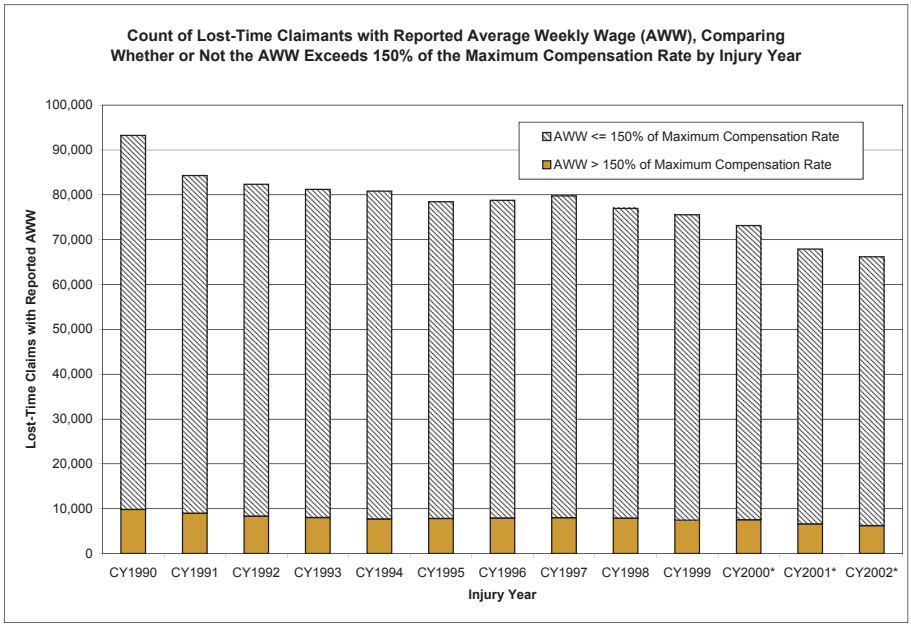


*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

Indemnity benefits for Temporary Total disability, which is the most common disability type, are two thirds of the worker's pre-injury wage, subject to the maximum compensation rate. In other words, injured workers whose previous wage was more than 150% of the SAWW will receive the maximum compensation rate, even though this rate is less than two thirds of their pre-injury wage. Figure 14 shows the number of all lost-time claimants whose indemnity benefits have been limited by the maximum compensation rate. This proportion has remained consistently at approximately 10% of all claimants for the entire reporting period. Even among this small subgroup, about 70% make no more than twice the SAWW. Overall, most injured workers earn less than the SAWW and thus are not affected by the maximum compensation rate.

Figure 14

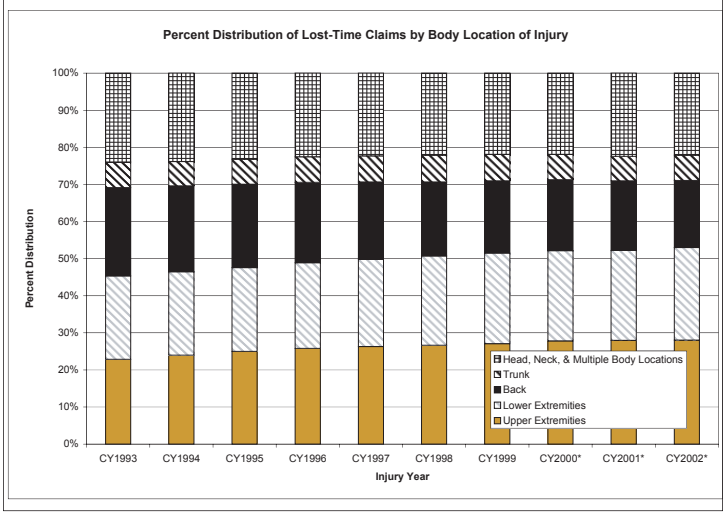


*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

Body Part: Data intially reported on injured body parts have remained fairly steady over the past ten years, as shown in Figure 15, although there has been some slight increase in the proportion of injuries to upper and lower extremities and a corresponding decrease in the proportion of back injuries. Among single (localized injury) identified body parts, those most frequently mentioned were: lower back (20%), knee (10%), finger(s) (5%), ankle, hand, foot, wrist (4% each), and upper arm and shoulder(s) (3% each).

Figure 15

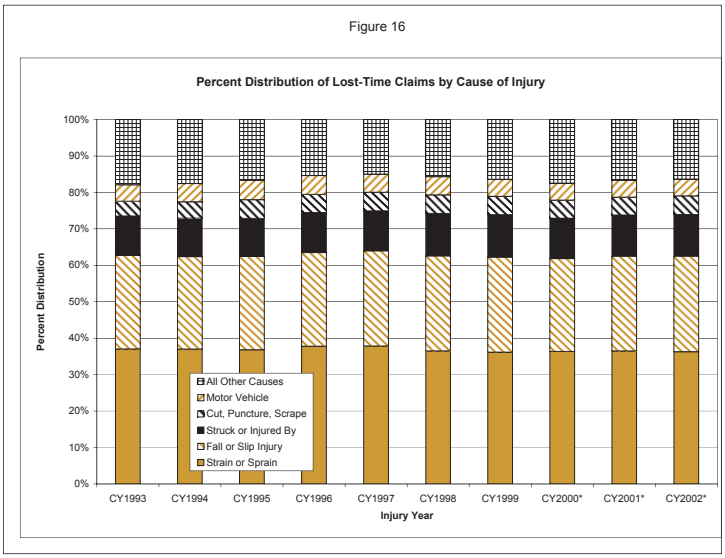


*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

Cause: Data by cause of injury, shown in Figure 16, likewise show consistency over the past ten years, with approximately three quarters in three broad categories: strain or sprain, fall or slip injury, and struck or injured by.

Figure 16

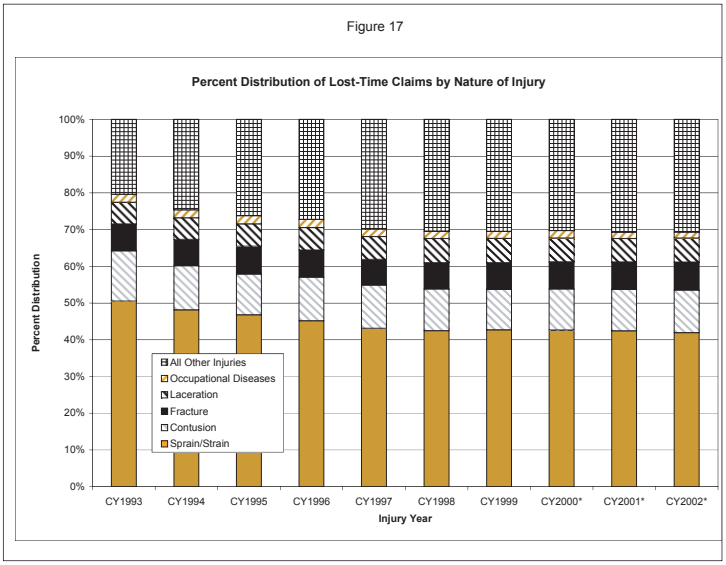


*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

Nature: The Sprain/Strain grouping dominated the nature of injury data, as shown in Figure 17, accounting for more than 40%, although there was a slight decline in this proportion during the mid-1990s. Among the more detailed nature codes reported, the largest proportions were for strain (37%), contusion (12%), sprain (8%), fracture (7%), laceration (6%), and hernia (2%).

Figure 17



*Preliminary data

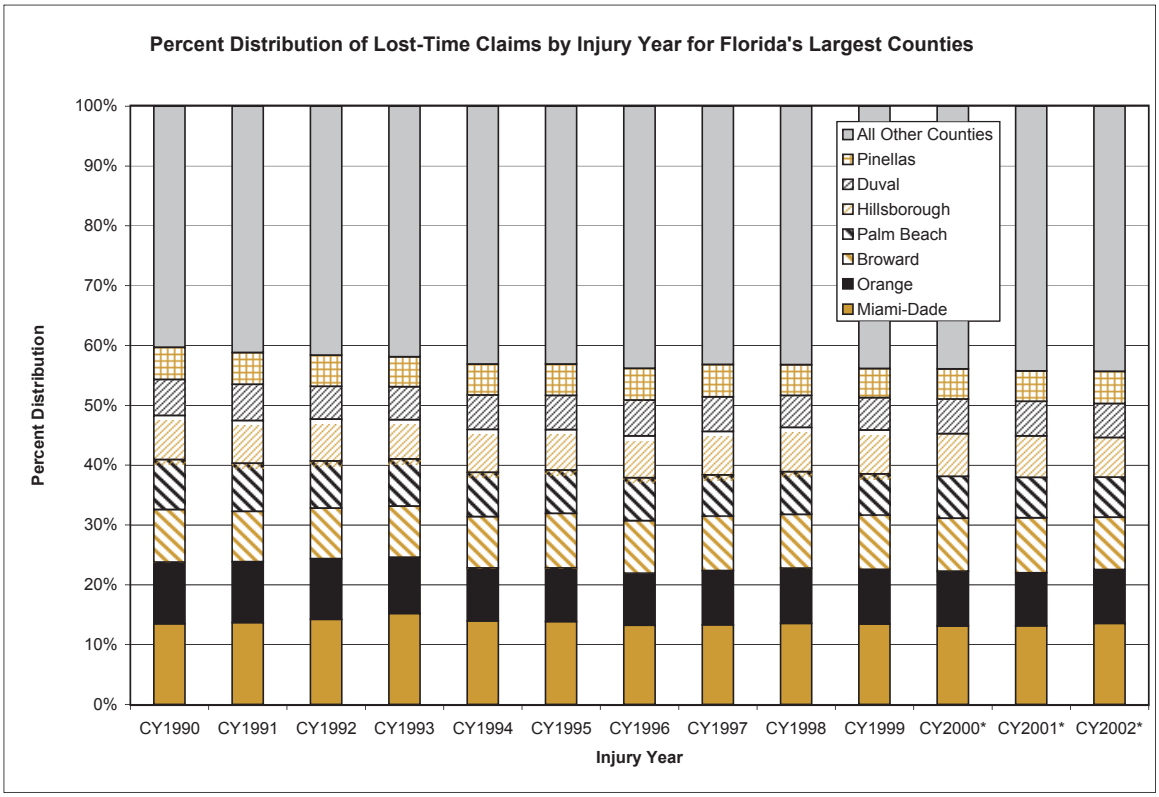
Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

County: Florida has 67 counties, of which seven contain more than half of the state's population, labor force, and lost-time cases: Miami-Dade, Orange (Orlando), Broward (Ft. Lauderdale), Palm Beach (West Palm Beach), Hillsborough (Tampa), Duval (Jacksonville), and Pinellas (St. Petersburg). Figure 18 shows data on claims for these counties as a proportion of all lost-time claims. As in the case of the state as a whole, it is possible to calculate injury rates by county, and thus to make geographic comparisons. Experience has also shown that for the less-populous counties, injury rates may be fairly volatile over the short run because of their relatively small workforces. However, examining annual totals over a number of years does show some systematic differences from the statewide average for a small subgroup of counties, as shown in Table 11. DeSoto and Hendry Counties, in particular, have been known to have relatively high injury rates over the years, which may be related to their industrial composition.

An analysis of county employment covered by the Florida Unemployment Compensation Law revealed that these two counties, along with Hardee (ranked #5), are notable for having a very high percentage (>30%) of employment in agriculture. Union, Florida's smallest county in land area, is unique in that it houses a large state prison and approximately half its employment is classified in state government.

Figure 19 is a map showing the counties with the highest and lowest annual average injury rates over the entire reporting period. There were eleven counties with an average injury rate above 1.5% and nine with a rate below 0.9%. Although there was variation in injury rates from year to year, particularly for the less populous counties, the eleven high-rate counties consistently had higher rates in every injury year than the nine counties at the bottom of Table 11.

Figure 18



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

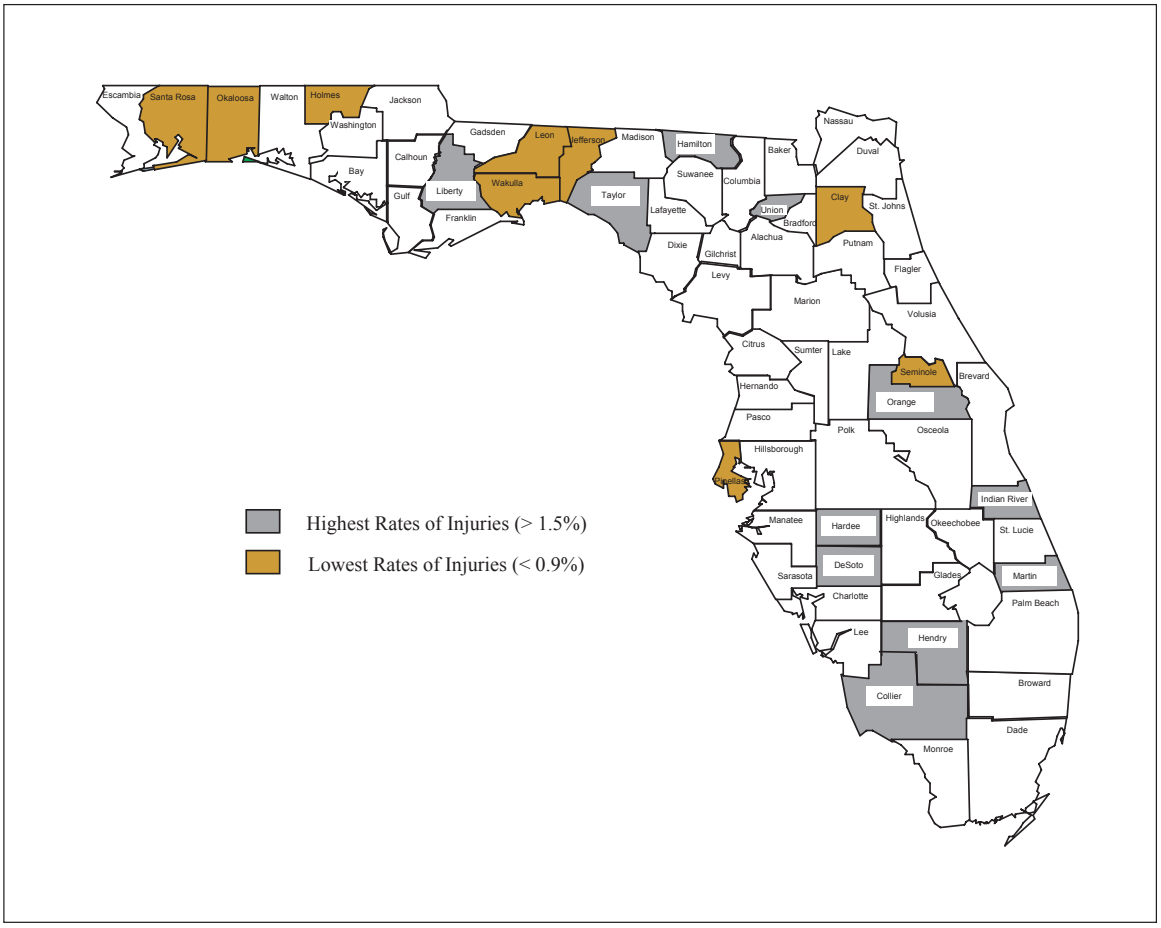
*Preliminary data

Table 11
County Comparison of Annual Average Lost-Time Injury Rates for Combined Injury Years 1990 - 2002

Rank	County	Injury Rate		Rank	County	Injury Rate
1	DeSoto	2.34%		35	Putnam	1.11%
2	Hendry	2.25%		36	Manatee	1.10%
3	Union	1.97%		37	Monroe	1.10%
4	Hamilton	1.80%			**FLORIDA**	**1.10%**
5	Hardee	1.69%		38	Suwannee	1.09%
6	Taylor	1.67%		39	Gulf	1.09%
7	Collier	1.67%		40	Volusia	1.07%
8	Orange	1.60%		41	Lafayette	1.06%
9	Martin	1.54%		42	Lake	1.06%
10	Indian River	1.52%		43	Hillsborough	1.05%
11	Liberty	1.52%		44	Escambia	1.05%
12	Highlands	1.49%		45	Bradford	1.04%
13	Gadsden	1.48%		46	Miami-Dade	1.04%
14	Marion	1.43%		47	Glades	1.02%
15	Dixie	1.39%		48	Franklin	1.01%
16	Okeechobee	1.37%		49	Alachua	0.97%
17	Jackson	1.32%		50	Levy	0.97%
18	St. Lucie	1.31%		51	Osceola	0.95%
19	Baker	1.31%		52	Washington	0.95%
20	Lee	1.27%		53	Nassau	0.94%
21	Citrus	1.27%		54	Columbia	0.93%
22	Bay	1.27%		55	Calhoun	0.93%
23	Madison	1.27%		56	Broward	0.93%
24	Palm Beach	1.21%		57	Pasco	0.92%
25	Sarasota	1.19%		58	St. Johns	0.91%
26	Polk	1.19%		59	Pinellas	0.89%
27	Duval	1.18%		60	Okaloosa	0.88%
28	Flagler	1.18%		61	Jefferson	0.80%
29	Gilchrist	1.17%		62	Holmes	0.77%
30	Hernando	1.16%		63	Leon	0.72%
31	Charlotte	1.14%		64	Santa Rosa	0.66%
32	Brevard	1.14%		65	Seminole	0.66%
33	Sumter	1.12%		66	Clay	0.66%
34	Walton	1.11%		67	Wakulla	0.51%

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003, and Office of Labor Market Statistics, Florida Agency for Workforce Innovation, Local Area Unemployment Statistics program, in cooperation with the Bureau of Labor Statistics, U.S. Department of Labor

Figure 19
Florida Counties with Highest and Lowest Injury Rates for Combined Years 1990-2002



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003, and Office of Labor Market Statistics, Florida Agency for Workforce Innovation, Local Area Unemployment Statistics program, in cooperation with the Bureau of Labor Statistics, U.S. Department of Labor

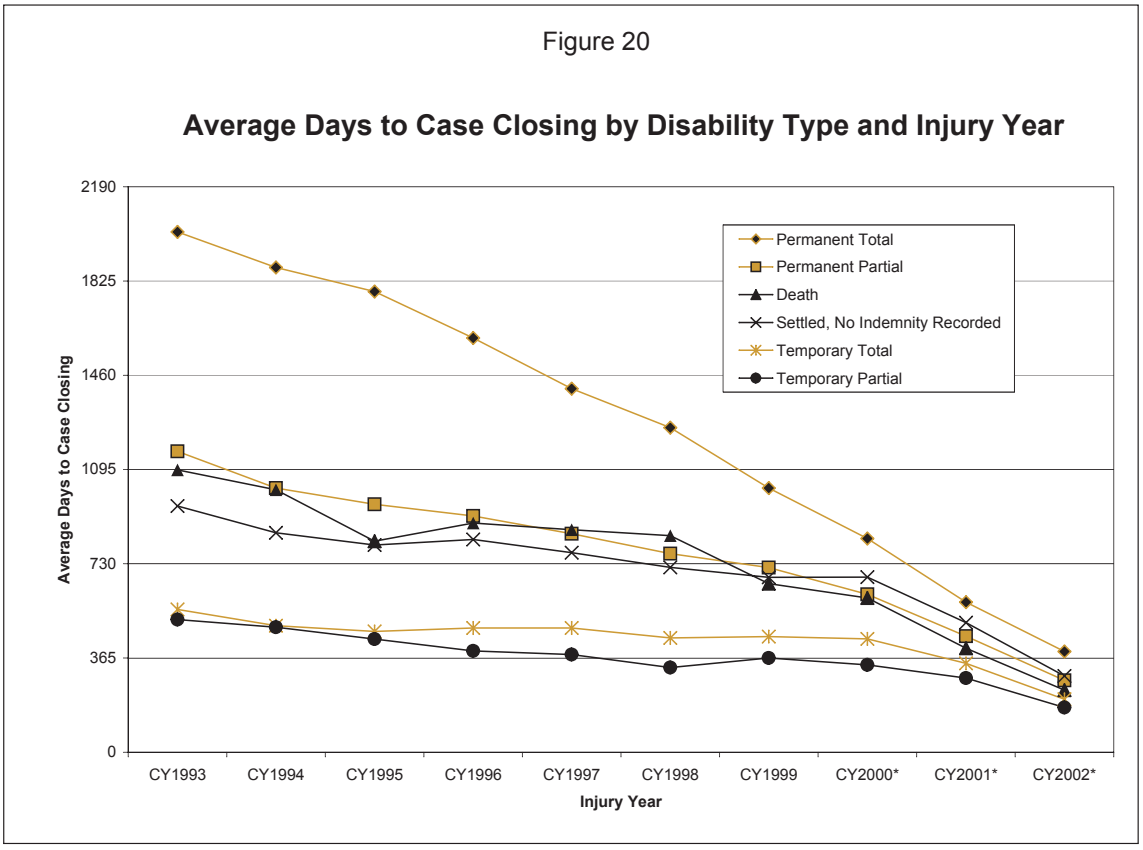
Time to Closing: Table 12 shows that for mature injury years it has taken an average of between one-and-a-half and two years for lost-time claims to be reported as closed. Since case closure is reported on the DWC-13 along with benefit payments, there may be a delay between the last benefit payment and the reported closure of the file, so the data for the last three or four years may be considered preliminary. It might be expected that the time to closure would be highly dependent on whether or not the injury results in permanent disability. Figure 20 shows that this is the case. Interestingly, even claims involving only temporary disability generally take on average over a year to close. Claims involving death, permanent partial disability, or settlement (with no other indemnity benefits reported) take about twice as long to close as temporary disability cases. In the case of Permanent Total disability claims, even for 1993-1994 injuries, fewer than half have closure dates. The slope of the graph also confirms that the data for these claims are still not mature even ten years after the date of injury, so this portion of the graph will continue to change over time.

Table 12
Summary Data on Time to Claim Closure

Year of Injury	Count of Lost-Time Claims	Cases with Reported Valid Closing Date		Average Time from Injury to Claim Closure in:		
		Number	Percent	Days	Months	Years
1993	82,629	62,981	76.2%	681	22	1.9
1994	81,870	63,146	77.1%	670	22	1.8
1995	79,483	60,106	75.6%	638	21	1.7
1996	80,365	57,589	71.7%	630	21	1.7
1997	82,476	56,283	68.2%	605	20	1.7
1998	81,747	51,936	63.5%	550	18	1.5
1999	82,666	53,974	65.3%	531	17	1.5
2000*	83,677	48,921	58.5%	491	16	1.3
2001*	78,197	41,785	53.4%	367	12	1.0
2002*	71,812	27,834	38.8%	217	7	0.6
* preliminary data						

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

Figure 20

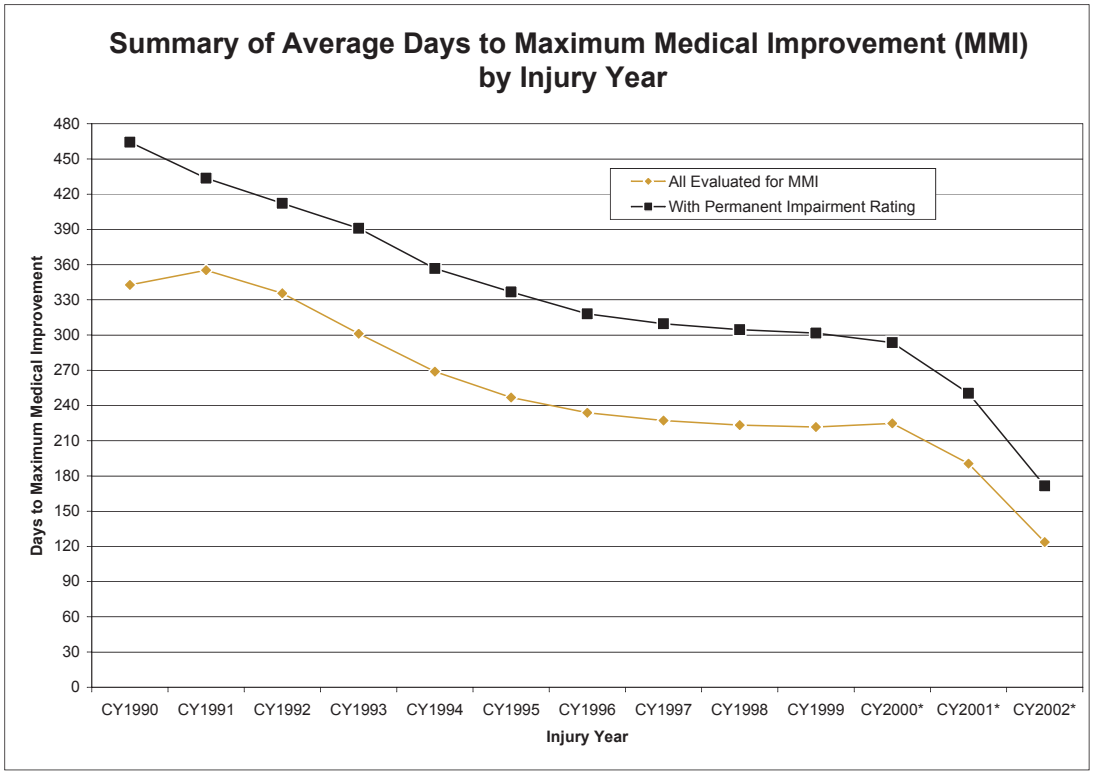


Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

*Preliminary data

Days to Maximum Medical Improvement (MMI): Prior to implementation of the 1993 reforms, it took on average, ten to twelve months for a claimant to reach MMI, as shown in Figure 21. After the reforms, when a greater proportion of claimants were evaluated for a PIR, the reported time to MMI dropped to the range of seven to nine months. As would be expected, those claimants judged to have a permanent disability took longer to reach MMI than those whose evaluation at MMI did not show any degree of permanent impairment. In summary, despite concerns about data maturity, there does appear to be a long-term trend of moderate decline in both duration from injury to MMI and in the average time that claims remain open.

Figure 21



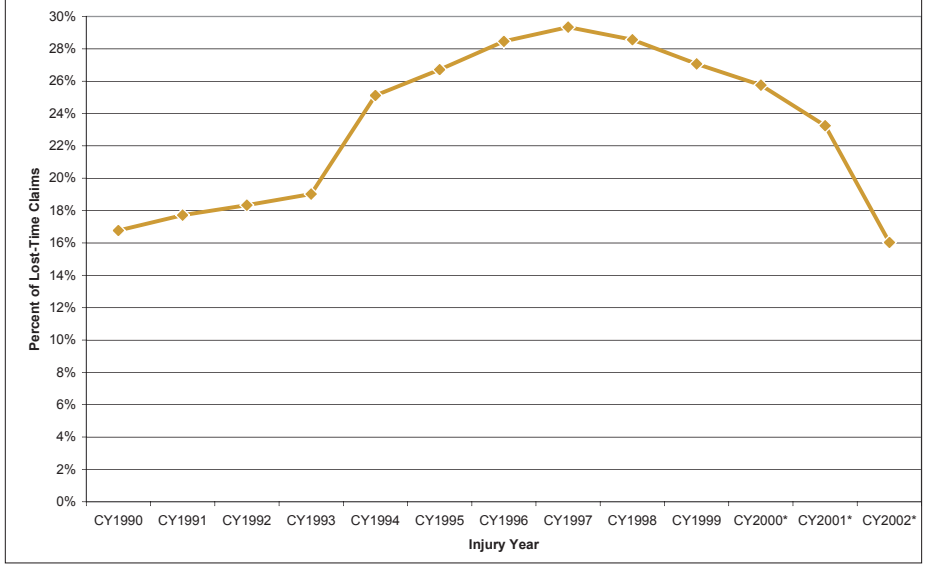
*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

Permanent Impairment Rating: Figures 22 and 23 show information on claimants who have been assigned a (non-zero) permanent impairment rating (PIR). Together, these figures show the effects of the 1993 reforms. With replacement of Permanent Impairment and Wage Loss with Impairment Income (i.e., redefining permanent partial indemnity benefits) a larger proportion of claimants became eligible for permanent partial benefits. Injured workers were now eligible for Impairment Income benefits even if they had returned to work, so the addition of this pool of workers had the effect of lowering the average and median PIR. For mature post-reform years, the median PIR has remained at 5%, meaning that half or fewer of these claimants have a rating of over 5%. In fact, less than one quarter of all post-reform impairment ratings exceed 10%. This helps to explain the very low utilization of Supplemental Income indemnity benefits, which require a 20% PIR threshold.

Figure 22

Percent of Lost -Time Claims with a Permanent Impairment Rating by Injury Year



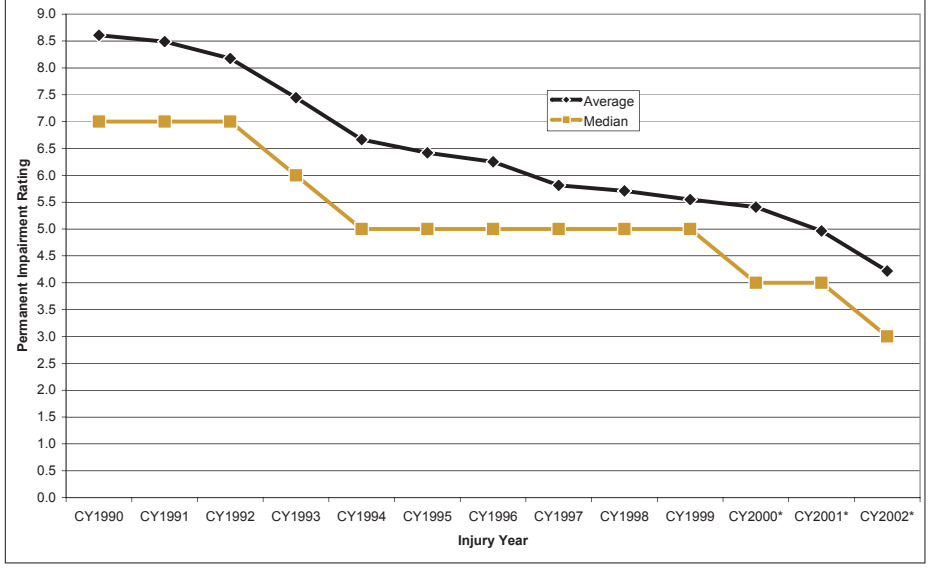
*Preliminary data

Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

In looking at trends in permanent impairment ratings it may be useful to note that different standards were used during this time, although it is unknown if these had a measurable effect on the distribution of impairment ratings. The American Medical Association (AMA) 3rd Edition was used prior to 07/01/1990. The Minnesota Guide was used from 07/01/1990 to 06/20/1993. The 1993 Florida Impairment Rating Guide (FIRG) was used from 06/21/1993 to 01/07/1997. The 1996 Florida Uniform PIR Schedule was used from 01/08/1997 to date. However, the average and median impairment ratings do not appear to show a significant break in series in relation to the changes in rating guides.

Figure 23

Summary of Average and Median Permanent Impairment Ratings by Injury Year



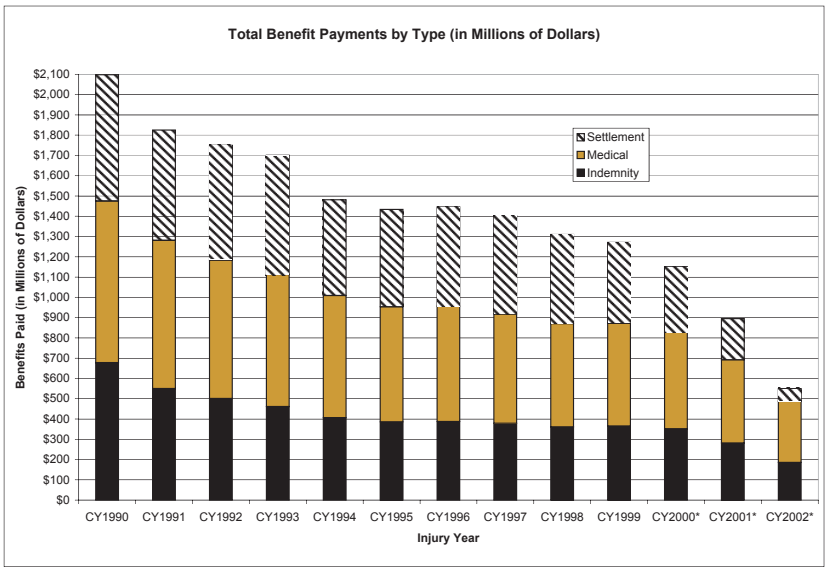
*Preliminary data

Note that both of these figures also show the effect of data immaturity for recent years. The more serious injuries are likely to take a longer time to reach Maximum Medical Improvement, and thus to be assigned an impairment rating. Thus, as time passes, not only will the percentage of claimants with a PIR increase, but the average and median PIR should rise as well.

Benefits Paid to Injured Workers

The importance of data maturity was noted earlier in the discussion of counts of lost-time claims. This issue is even more pronounced in the analysis of benefits data. Benefits payments are reported on the DWC-13 Claim Cost Report. The first DWC-13 is not due until six months following the date of accident, and then on subsequent anniversary dates of the injury until the case is closed. For this reason there may be a long delay between the payment of benefits and reporting this information to the division. For example, it typically takes at least a year or two for a settlement payment to be reported to the division. In cases of permanent disabilities, medical benefits may be paid out over many years. It is for this reason that it takes many years to develop a reliable estimate of the ultimate cost of benefits that will be paid for injuries occurring in a given year.

Figure 24



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

*Preliminary data

Total Benefits: The effect of data maturity on reported benefit dollars paid is clearly shown in Figure 24, which also gives subtotals for indemnity, medical, and settlements. The data are displayed in a slightly different format in Figure 25 to show the effect of data maturity on the three components relative to each other. For example, this figure shows that indemnity benefit data are mostly mature four to five years after the date of injury. The medical and settlement data may take six or seven years to mature, and these series continue to show modest increases even after that point.

The 1993 reforms permitted the settlement of both the indemnity and medical components of claims. This rule also applied retroactively to injuries occurring before 1/1/1994, but reliable trend data are not available on what proportion of settlement amounts are for indemnity versus medical benefits. However, other data on actual indemnity and medical benefits paid out (i.e., prior to settlements) displayed in Figure 26 confirm the finding of the National Council on Compensation Insurance that claims payments in Florida are approximately 60% for medical and 40% for indemnity benefits. This compares to a roughly half-and-half split for the country as a whole.

Figure 25 shows that total benefits in all three categories are lower for every post-1993-reform year than for any pre-reform year. At least part of this trend is caused by the decline in claim *frequency* from its peak in 1990. However, as shown in Figure 27, average benefit amounts (excluding claims with no benefits in each respective category) also declined after the 1993 reforms. Average reported medical benefits were greater than $9,000 for each of the four pre-reform years, and less than $9,000 for all post-reform years. Similarly, average indemnity benefits exceeded $6,000 for each pre-reform year, but were less than this amount for every subsequent year.

Figure 25

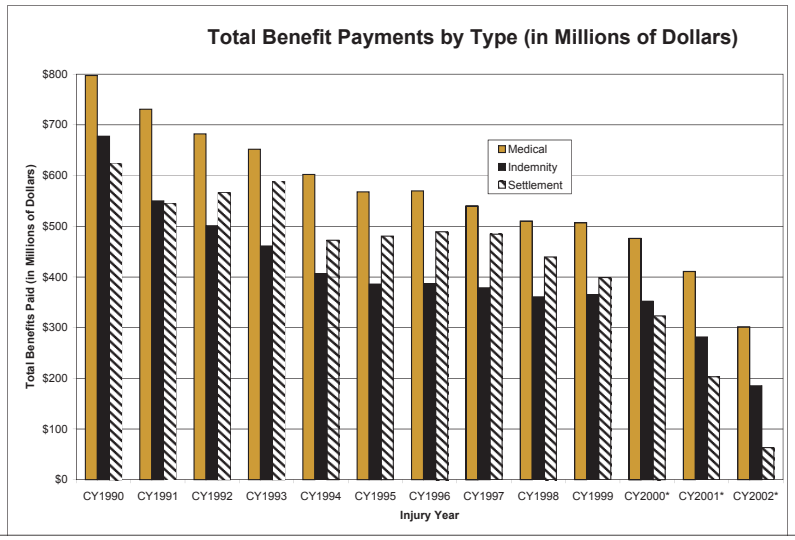


Figure 26

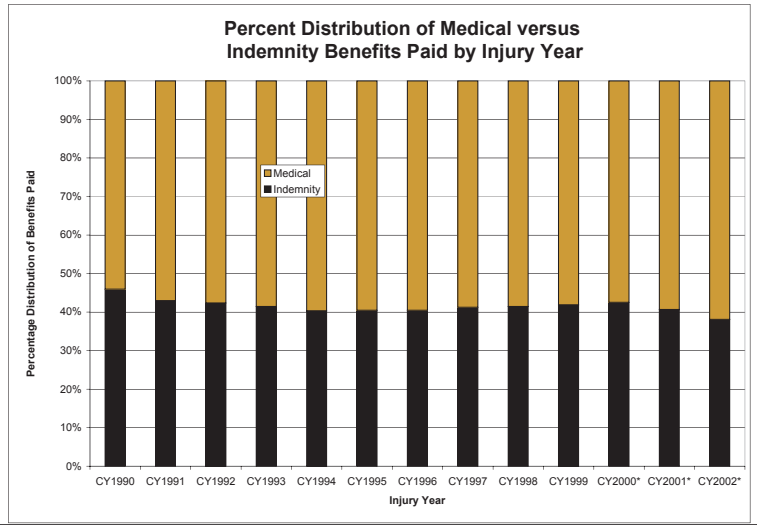
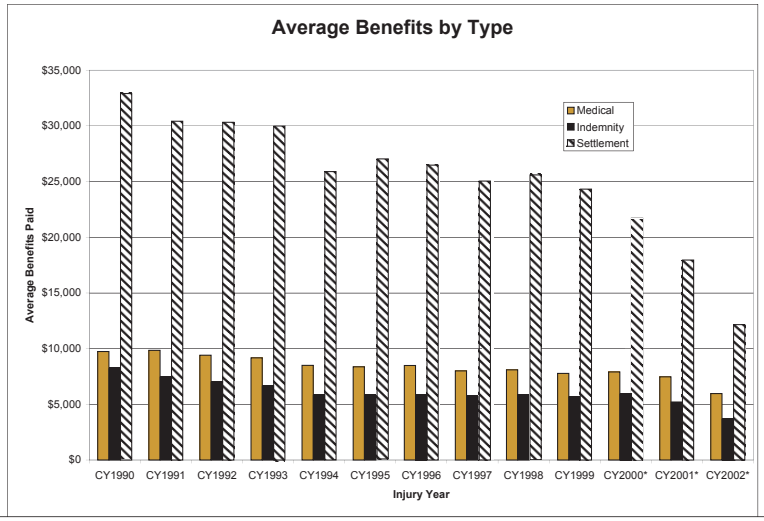


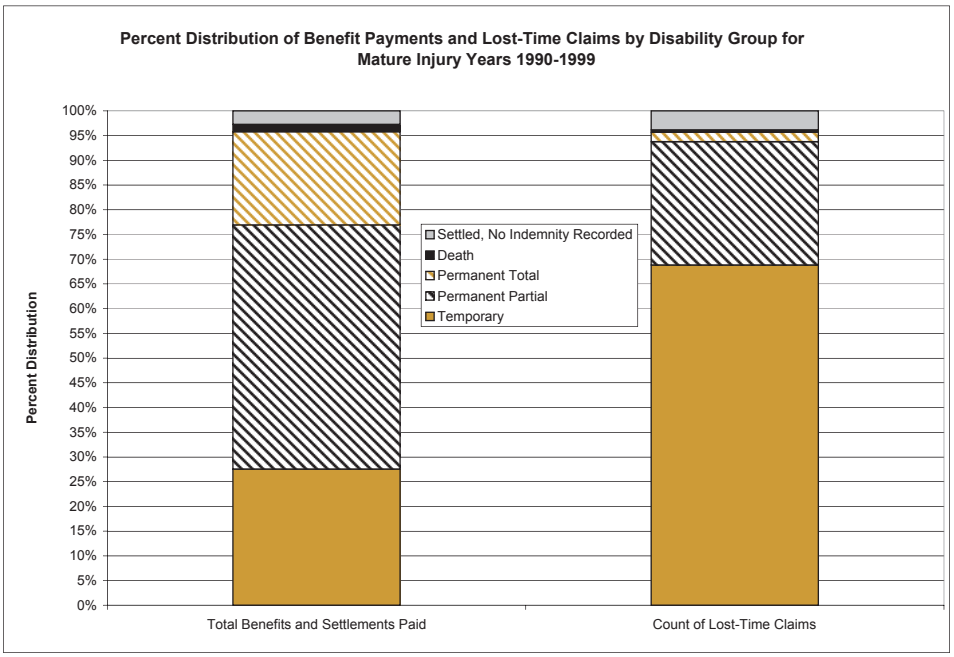
Figure 27



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

*Preliminary data

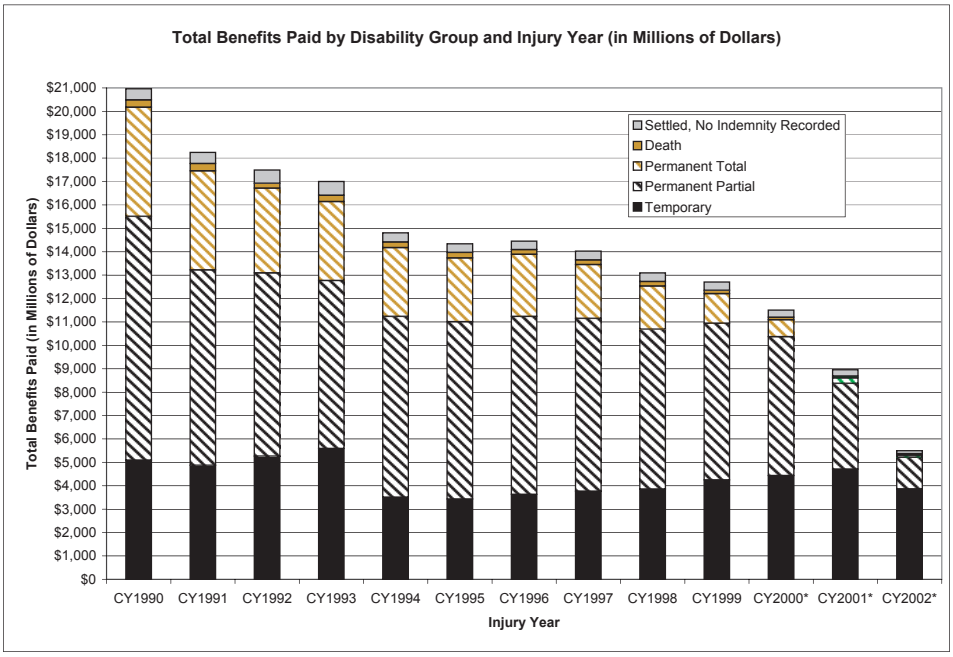
Figure 28



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

Benefits for Permanent Disabilities: Eligibility criteria and benefit formulas for permanent disabilities have received much attention in discussions of the Florida WC statute. Figure 28 shows the comparison of percentage distributions of lost-time claims by disability group versus total benefits paid for mature injury years 1990-1999. Permanent Total claims are 2% of lost-time claims but 19% of total benefits, and Permanent Partial are 25% of claims and 49% of benefits paid. Clearly, a small number of claims can have a large effect on overall system costs. The division receives data only on claims for injuries occurring in Florida. However, data from the National Council on Compensation Insurance show that the proportion of claims classified as Permanent Total in Florida remains unusually high compared to other states, and has been identified a cost driver for the state's high WC premium rates.

Figure 29



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003 *Preliminary data

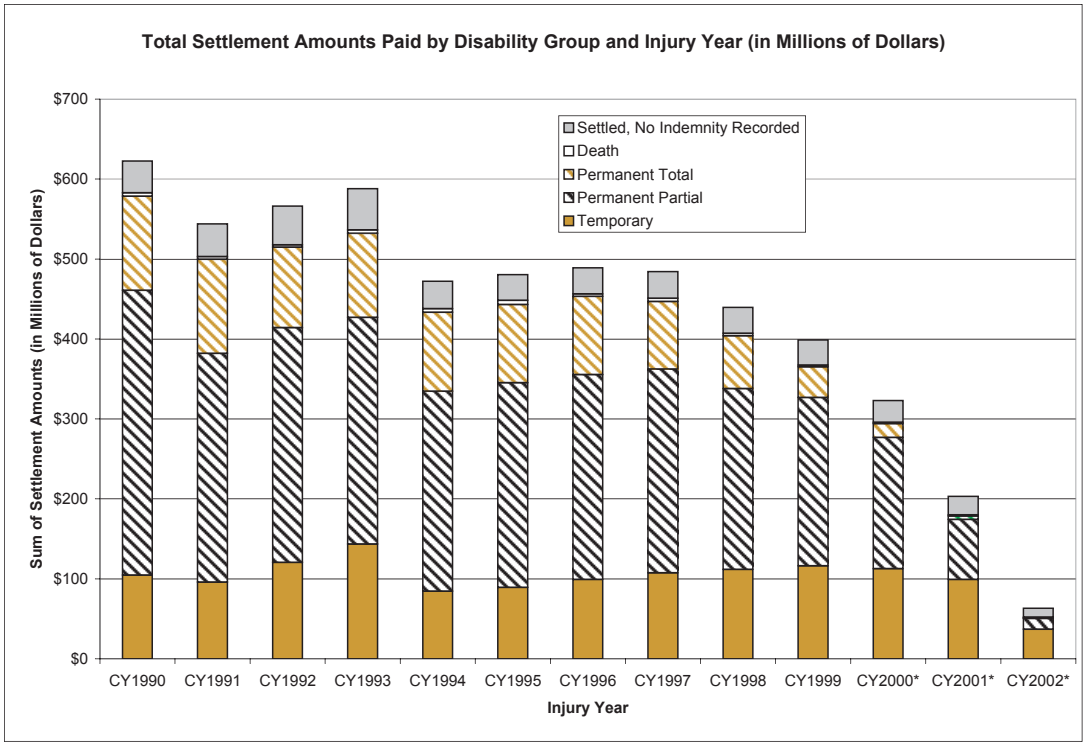
Settlements: A notable pre- to post-reform change was in settlement amounts, which dropped both in total amount and per-claim average. This change was influenced by the change in benefit structure and duration. Temporary benefits were limited to 104 weeks, and Wage Loss (Permanent Partial) benefits replaced with Impairment Income. Eligibility for Impairment Income benefits was broadened, since a worker could still receive these payments after returning to work, but the amount of benefits was curtailed. As shown in Figure 29, the net effect of broader eligibility and smaller benefits was mostly a wash in terms of total

Permanent Partial benefits paid. The drop in temporary benefits paid was a combination of a shortened eligibility period and the fact that some claimants who were not eligible for pre-reform Permanent Partial benefits (i.e., primarily Wage Loss) were eligible to be classified as Permanent Partial (Impairment Income) after the reforms. The redefinitions in indemnity benefits lowered the expected "ultimate cost" of many lost-time claims, and thus settlement amounts, as shown in Figure 30.

This is further shown by the data on average settlement amounts by disability group and year in Figure 31. Average settlement amounts for Permanent Partial claims exceeded $30,000 for each pre-reform year and have remained below that since then. Note in contrast that average settlement amounts for Permanent Total and Death cases do not show a similar change in level before and after the 1993 reforms. (It might also be noted that average settlement amounts for the "Settled, No Indemnity Recorded" claims are relatively low: close to those for Temporary Partial claims, so it seems clear that these cases are for injuries that are not severe.)

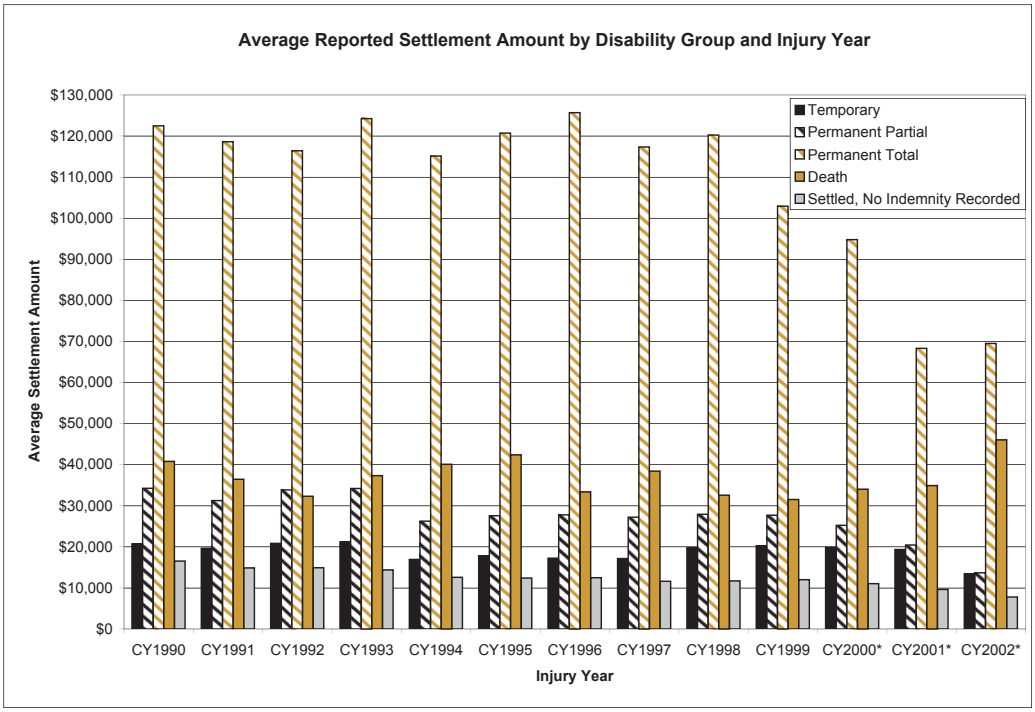
The effect on Permanent Partial disability is also shown in Figure 32, which shows the percentage of claims settled by disability group. The pre-reform Wage Loss category had a settlement rate of almost 70%, whereas the rate dropped to less than 50% for post-reform Impairment Income claims. No other disability group showed a similarly well-defined change in settlement rates after the 1993 reforms.

Figure 30



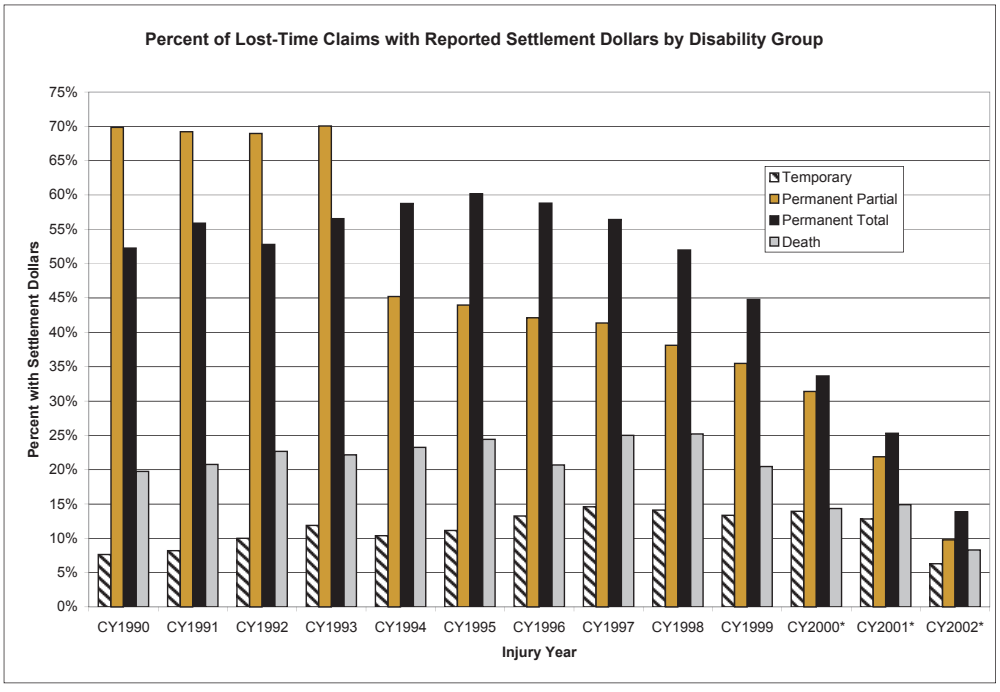
Source: Division of Workers' Compensation Integrated Database as of July 31, 2003 *Preliminary data

Figure 31



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003 *Preliminary data

Figure 32



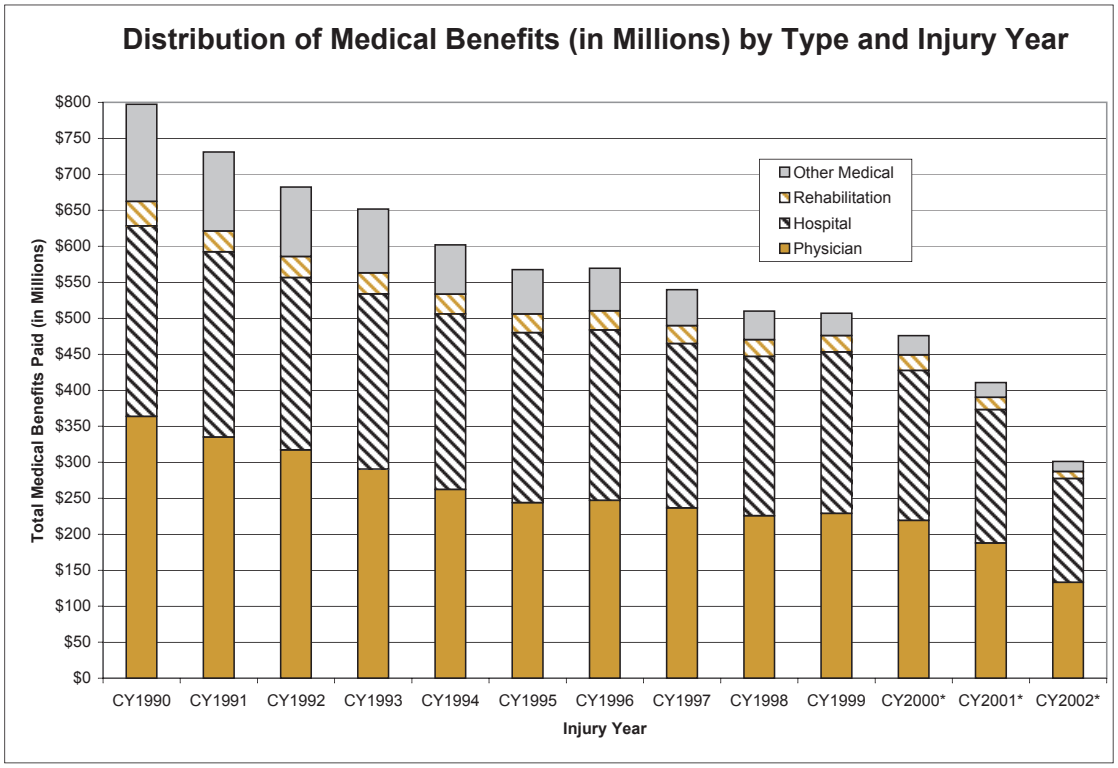
Source: Division of Workers' Compensation Integrated Database as of July 31, 2003 *Preliminary data

Medical Benefits: Data on medical benefits are also reported by type of payment, as shown in Figure 33, for physician, hospital, rehabilitation, and all other. All other medical benefits include transportation, drugs and supplies, home attendant care, and skilled nursing care. Figure 33 shows a pattern of almost unbroken declines, although there again are issues of data maturity since it is possible for workers with permanent disabilities to receive related medical care indefinitely. Figure 34 shows the same data as a percentage distribution. It reveals that physician benefits have remained at about 45% of medical benefits across all injury years, with the proportion of rehabilitation remaining at slightly less than five percent. For recent injury years, hospital benefits account for about 45% of medical benefits. However, as time progresses from the year of injury the "all other" category, which includes items more typical of long-term care, accounts for a larger share of medical costs.

Average per-claim medical benefit data (shown above in Figure 27) are separated by type of payment in Figure 35. The decline in average physician benefits tracks that for medical benefits as a whole. The decline in average rehabilitation benefits is more pronounced, but is influenced by the fact that "older" injuries may be more in need of these services. (The recent increase in average "other medical" benefits may reflect the fact of a small population base; that is, a relatively small number of recent claims have these kinds of medical benefits, so a few high-cost claims can have a disproportionate effect on the average.)

There is a marked contrast in the trends in average hospital costs, which show a long-term increase from around $5,100 in the early 1990s to more than $5,500 in four of the last five injury years. This does appear to provide evidence in support of studies of the Workers' Compensation Research Institute indicating that hospital costs are a driver of high medical costs in Florida.

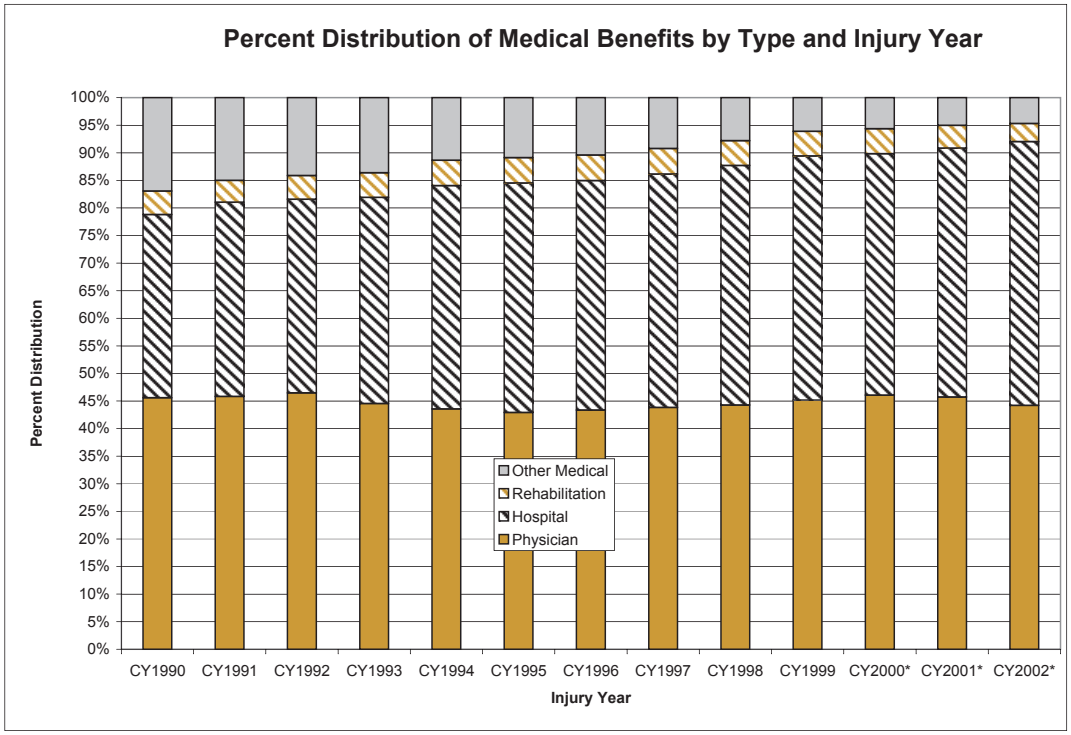
Figure 33



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

*Preliminary data

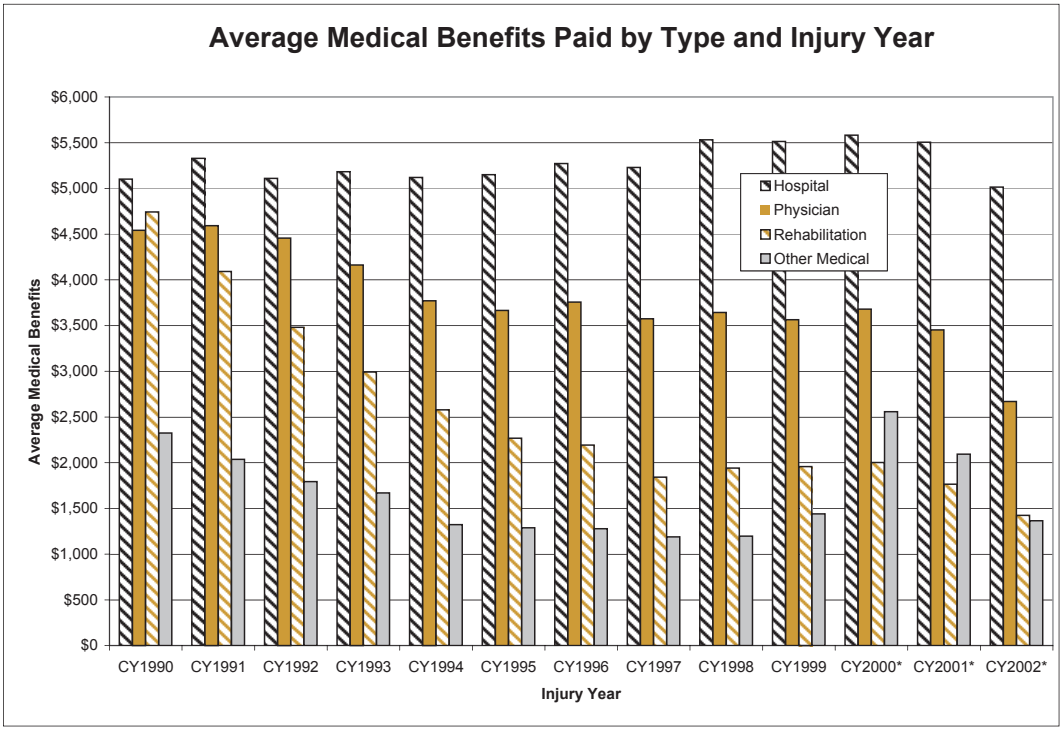
Figure 34



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

*Preliminary data

Figure 35



Source: Division of Workers' Compensation Integrated Database as of July 31, 2003

*Preliminary data

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City	Address	Phone Number	Fax Number
Ft. Myers	12381 South Cleveland Avenue, Suite 506 Ft. Myers, Florida 33907-3853	239-278-7246	239-278-7249
Jacksonville	9000 Regency Square Blvd., Suite 212 Jacksonville, Florida 32211-8100	904-798-5806	904-723-5705
Miami	401 N.W. Second Avenue, Suite S-321 Miami, Florida 33128-1740	305-377-5385	305-377-7239
Ocala	1111 NE 25th Avenue, Suite 403 Ocala, Florida 34470	352-401-5350	352-401-5344
Orlando	400 W. Robinson Street Room # 211, North Tower Orlando, Florida 32801-1756	407-245-0896	407-999-5570
Panama City	2686 Chapman Drive Panama City, Florida 32405	850-747-5425	850-747-5426
Pensacola	3670-A North L Street Pensacola, Florida 32505-5217	850-595-5505	850-595-5510
Plantation	499 Northwest 70th Avenue, Suite 116 Plantation, Florida 33317	954-585-2660	954-585-2657
Sarasota	1718 Main Street, Suite 201 Sarasota, Florida 34236	941-361-6025	941-361-6042
Tallahassee	2012 Capital Circle S.E. Hartman Building, Suite 209 Tallahassee, Florida 32399-2161	850-413-1609	850-488-7565
Tampa	Tampa Employment Service Center, 9215 N. Florida Avenue, Suite #107 Tampa, Florida 33612-7905	813-930-7547	813-930-7645
West Palm Beach	3111 South Dixie Highway, Suite 123 West Palm Beach, Florida 33405	561-837-5412	561-837-5416

Employee Assistance Office District Offices
1-800-342-1741

City	Address	Phone Number	Fax Number
Daytona Beach	955 Orange Avenue Daytona Beach, Florida 32114	386-323-0907	386-947-1746
Ft. Myers	12381 South Cleveland Avenue, Suite 506 Ft. Myers, Florida 33907-3853	239-278-7091	239-278-7249
Jacksonville	9000 Regency Square Blvd., Suite 210 Jacksonville, Florida 32211	904-798-5807	904-723-5704
Miami	401 N.W. Second Avenue, Suite S-321 Miami, Florida 33128-1740	305-536-0307	305-377-5625
Ocala	Oakbrook Professional Center 1111 NE 25th Avenue Suite 403 Ocala, Florida 34470	352-401-5339	352-401-5344
Orlando	400 W. Robinson Street, Suite N-602 Orlando, Florida 32801	407-245-0758	407-245-0891
Pensacola	3670A North L Street Pensacola, Florida 32505	850-595-5508	850-595-5510
Plantation	499 N.W. 70th Avenue, Suite 116 Plantation, Florida 33317	954-321-2907	954-585-2657
Tallahassee	2012 Capital Circle SE Hartman Building, Suite 301 Tallahassee, Florida 32399-4225	850-413-1610	850-410-0669, 850-922-8427
Tampa	Tampa Employment Service Center 9215 N. Florida Avenue, Suite #107 Tampa, Florida 33612-7905	813-930-7545	813-930-7569
West Palm Beach	3111 South Dixie Highway, Suite 123 West Palm Beach, Florida 33405	561-837-5293	561-837-5416

Glossary

Average Weekly Wage (AWW): The basis for calculating benefits for lost wages. It is the weekly average earned by an injured worker during the 13 full calendar weeks prior to the injury. Depending on the date of accident, the AWW may or may not include income from jobs other than the one where the injury occurred.

Claim Cost Report (DWC-13): The form used to provide information on benefits paid and settlement amounts for every lost-time case.

Compensation Rate (Comp Rate or CR): 66 2/3 percent of the injured worker's average weekly wage, up to a maximum of the Statewide Average Weekly Wage (SAWW).

Disability: Incapacity, due to an injury, that limits the employee's ability to earn, in the same or any other employment, the same wages received at the time of the injury.

Experience Rating: A mandatory program of risk rating that compares an employer's past actual experience to the expected or average employer's experience. If an employer's past experience is better or worse than average, its premium is adjusted downward or upward, respectively.

Fee schedules: In accordance with section 440.13, F.S., fee schedules are promulgated to establish the maximum reimbursement allowance that may be paid to an authorized health care provider for services rendered to an injured employee. The statutes mandate the establishment of fee schedules for four primary areas of workers' compensation medical costs: 1) Hospitals; 2) Healthcare Providers; 3) Ambulatory Surgical Centers; and 4) Work Hardening and Pain Programs.

First aid case: A work injury or illness that is treated at the workplace, does not require medical treatment for which charges are incurred, and does not cause the employee to miss more than one shift of work.

First Report of Injury or Illness (DWC-1): The document required to be completed by an employer in the event of an on-the-job injury to an employee.

Fiscal Year: Florida's fiscal year runs from July through June. For example, Fiscal Year 2003 covers the period from July 1, 2002 through June 30, 2003.

Fraud: To knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person regarding the provisions of Chapter 440, F.S. Some examples of fraud are: Employers misrepresenting their payroll to their insurance carrier; injured workers misrepresenting an aspect of their injury; doctors misrepresenting treatment for an injury.

Impairment Income Benefits (IIB): A category of benefits paid after reaching maximum medical improvement (MMI) to those workers who have been issued an impairment rating. Injured employees may receive this benefit even though they have returned to work.

Impairment rating: A determination of an injured worker's loss of physical function as a percentage of total bodily function or mobility. This percentage represents the extent a work-related injury has permanently impaired the injured worker.

Impairment Rating Guide: The impairment guide is designed to aid medical providers in establishing an impairment rating associated with the loss of a body part, or loss of bodily function or mobility. This impairment rating is established only after maximum medical improvement has been reached by the injured worker. The impairment rating assigned to the injured worker by the physician is then used to determine the amount of permanent partial disability benefits to be provided.

Indemnity benefits: Cash benefits paid to replace part of an injured worker's wages lost as a result of a workplace injury.

Independent medical examination (IME): An objective medical or chiropractic evaluation of the injured employee's medical condition and work status, performed by a physician. An IME may be requested only by non-physician parties, such as attorneys, insurance companies, injured workers, and judges of compensation claims. An IME usually encompasses a study of previous history and medical care information, e.g., x-rays, laboratory studies, and usually an examination and evaluation of the patient.

Typically, an IME is requested to permit a judgment regarding the need for further medical services, the need to discontinue further medical services, and the return-to-work status of the injured worker.

Injury: Personal injury or death arising out of and in the course of employment. For an injury to be compensable, the workplace accident must be more than 50% responsible for the injury.

(Office of the) Judges of Compensation Claims (JCC): The organizational unit within the Division of Administrative Hearings, Department of Management Services, that consists of the Deputy Chief Judge and judges of compensation claims. This office is responsible for administering the provisions of the workers' compensation law relating to mediation, pretrial hearings, final hearings, and emergency hearings.

Loss ratio: The percentage of each premium dollar an insurer spends on claims.

Lost-Time case: A work injury or illness that has caused the employee to be out of work for more than seven days.

Managed care arrangement: An agreement between an insurer and health care provider(s) for which a plan of operation is approved by the Agency for Health Care Administration to provide and manage the medical treatment of injured employees.

Maximum Medical Improvement (MMI): The date after which further recovery from or lasting improvement to an injury or disease can no longer be anticipated based upon reasonable medical probability.

Maximum Reimbursement Allowance (MRA): The maximum amount that may be paid to an authorized health care provider for services rendered to an injured employee. These amounts are determined by the Three-Member Panel and are set forth in the Reimbursement Manuals distributed by the Division of Workers' Compensation. The Maximum Reimbursement Allowances are commonly referred to as fee schedules.

Medical only case: A work-related injury that requires treatment for which medical charges will be billed to the insurance carrier, but which does not cause the employee to miss more than seven days of work.

Modified duty work (also known as "light duty"): Employment that is within the physical capabilities of the injured worker as defined by the doctor. It may include a change in duties consistent with physical capabilities, number of hours he or she is able to work or a medically necessary break schedule.

Notice of Denial (DWC-12): The form used by carriers and employers to deny an employee's request for benefits.

Overutilization: The provision of medically unnecessary services to an injured employee. Unnecessary medical services are often rendered by the same provider, who may continue treatment to an injured worker beyond the time those services are needed. However, overutilization may also occur when a series of providers, many of whom specialize in different disciplines, render concurrent or consecutive treatment to an injured employee.

Permanent impairment: Any anatomical or functional abnormality or loss, existing after the date of maximum medical improvement, which results from the injury.

Permanent Partial Disability (PPD): Any permanent disability remaining after maximum medical improvement but which is not completely disabling and, hence, would allow return to gainful employment.

Permanent Total Disability (PTD): Any non-fatal injury that permanently and totally incapacitates an employee, preventing return to gainful employment. Specific qualifying conditions are defined by statute.

Petition for Benefits (PFB): A form filed by an injured worker and/or his/her attorney with the judges of compensation claims requesting the provision of benefits that have been denied by the employer's insurance carrier.

Practice parameters: Guidelines used by medical providers to determine the appropriate course and level of treatment rendered to patients. These parameters are viewed as an effective method of both reducing and containing medical costs. When providers render a course of treatment that is within the parameters, it is considered proper, absent extenuating circumstances, and may be used as evidence that the treatment provided was correct under the circumstances.

Re-employment assessment: Written assessment developed by a qualified rehabilitation provider that provides an analysis of the vocational rehabilitation client and a cost effective treatment plan.

Response to Petition: A form filed with the judges of compensation claims by an insurance carrier indicating a provision or denial of benefits requested in a Petition for Benefits.

Safety program: A comprehensive program designed to provide a safe work environment for all workers, including, but not limited to, safe working practices and procedures, employee training on equipment, proficiency training for all workers, job specific safety rules, and personal protective equipment.

Supplemental Income Benefits: A category of indemnity benefits that may be paid to workers after Impairment Income benefits are exhausted. To be eligible for this benefit, the injured employee must have a permanent impairment rating of 20 percent or more. In addition, the employee must not have returned to work, or else, must be earning less than 80 percent of the pre-injury average weekly wage.

Temporary Partial disability (TPD): A disability that is not permanent in nature; the doctor has released the injured worker to return to work with restrictions. Under these circumstances, and when the injury reduces the earning capacity of the injured worker to below the full rate of pay, the injured worker may be entitled to continued payment of indemnity benefits.

Temporary Total at 80 percent (TT-80%): A benefit type paid to an injured employee who has sustained a catastrophic injury. This benefit is paid at a rate of 80 percent of the injured employee's average weekly wage for a 6-month period instead of the 66 2/3 percent that the injured worker normally receives.

Temporary Total disability (TTD): A disability that is not permanent in nature, resulting from an injury that completely incapacitates the injured worker, preventing return to gainful employment for a period of time.

Temporary Total-training and education: Benefits paid to an employee while the employee receives training and education to obtain suitable employment. These benefits are generally for a period not to exceed 26 weeks. This period may be extended for an additional 26 weeks, or less, if such extended period is determined to be necessary by a judge of compensation claims. However, for dates of accident on or after October 1, 2003, these benefits may not be paid so that the duration of temporary benefits exceeds 104 weeks.

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