Florida Division of Workers' Compensation 2009 Annual Report

ALEX SINK
CHIEF FINANCIAL OFFICER
STATE OF FLORIDA
Florida Department of Financial Services

REPRESENTING

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CHIEF FINANCIAL OFFICER
STATE OF FLORIDA

September 15, 2009

Dear Governor Crist, President Atwater and Speaker Cretul:

It is my honor and privilege to present the 2009 Division of Workers' Compensation Annual Report as required by Section 440.59, Florida Statutes.

We continue to implement programs and processes that are necessary to administer Florida's workers' compensation system. All of our initiatives are driven by the Division's mission 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 Division is required to collect proof of coverage data, claims information and medical data. This Annual Report highlights these data collection processes, but more importantly focuses on how the Division in turn uses that data to benefit the workers' compensation system. We believe it is important for all of our stakeholders to know what is collected, what the Division does with all of the data that is collected and how that information can be accessed, since the data question most often posed to the Division is, "What does the Division use all that data for?"

The Division will continue to meet its regulatory responsibilities in the most cost effective and efficient means possible and we will strive to improve Florida's workers' compensation system so all of its stakeholders benefit from it.

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

Sincerely,

Tanner Holloman
Director

Division of Workers' Compensation 2009 Annual Report

Table of Contents

THE MISSION

The mission of the Department of Financial Services is to safeguard the people of Florida and the State's assets through financial accountability, education, advocacy, fire safety and enforcement. The Division's mission, focus and accomplishments during FY 2008-2009 continued to contribute to the Department's mission in many significant ways.

Financial Accountability:

The Bureau of Monitoring and Audit

- Reviewed and monitored financial statements and reports for individual self-insurers to ensure they had the financial strength and ability to pay current and future workers' compensation liabilities for injured workers.

The Bureau of Compliance

- Referred 908 delinquent employer accounts to the Division of Accounting & Auditing for submission to the Department's contracted collection agency and collected $186,496 from those referred accounts.

- Identified 463 payments that were returned to the Division for insufficient funds. Monitored and tracked employer accounts which resulted in $17,203 in secured funds being received and verified.

- Issued 200 Notices of Intent to Revoke to exemption-holders whose exemption application fees were returned for insufficient funds. Revoked 6 Certificates of Election to be Exempt for failure to submit secured funds.

- Processed 4,676 electronic payments submitted via the Online Penalty Payment Service, which represented 23% of payments submitted to the Bureau.

The Office of Medical Services

- Resolved 1,687 petitions contesting insurer reimbursement for medical services to ensure that health care providers receive appropriate reimbursement for services rendered.

The Bureau of Data Quality and Collection

- Collected 100% of all submitted medical bills and Proof of Coverage filings in electronic format consisting of 4,221,599 medical bills and 714,821 Proof of Coverage filings.

- Collected 55.7% of claim-related filings (non-medical) via the new national Claims EDI Release 3 format, representing a total of 291,074 electronic claim filings.

The Office of Special Disability Trust Fund

- Saved $5,780,898 for Florida's employers by adjusting 1,806 Reimbursement Requests which were approved for payment after audit; Approved $67,825,897 for payment out of $73,606,795 requested.

- Reimbursed employers or their carriers $71,454,858 in audited and approved reimbursements.

- Of the 3,732 Reimbursement Requests audited, 1,802 were returned to the carrier for improper documentation or expenses unrelated to the Special Disability Trust Fund claim.

The Assessments Unit

- Calculated the imputed premiums and applicable Workers' Compensation Administration Trust Fund and Special Disability Trust Fund assessments for 428 individual self-insurers.

- Validated the accurate payment of insurance company assessments through the reconciliation of insurer premiums reported to the Office of Insurance Regulation and the National Association of Insurance Commissioners.

Education and Advocacy:

The Bureau of Compliance

- Obtained licensure to provide continuing education credits in workers' compensation and workplace safety for electrical contractors, fire protection system contractors and water well contractors.

- Conducted 66 education workshops in 20 different geographic locations around the state at no charge for employers, contractors and other stakeholders regarding workers' compensation coverage and compliance requirements.

Educated 1,798 employers and stakeholders who attended those workshops.

The Bureau of Employee Assistance and Ombudsman Office

- Contacted 25,271 injured workers by telephone, who had experienced lost-time injuries to provide benefit information, answer questions or concerns about the workers' compensation system and advise them of services available to them through EAO, including the toll-free telephone line and Division website for assistance.

- Served as an ongoing resource for injured workers who had benefit concerns and worked with claims-handling entities to facilitate injured workers' receipt of statutorily required medical treatment and indemnity payments.

- Assisted injured workers in securing indemnity benefits valued at $645,803 and obtained 879 authorizations for medical treatment on their behalf.

- Assisted injured workers in navigating the workers' compensation system, aided in the resolution of complex disputes and when appropriate, explained the procedure for filing Petitions for Benefits.

- Served as a resource for employer questions about statutory requirements for workers' compensation coverage and the criteria for qualifying for and obtaining an exemption.

- Resolved 329 complaints by injured workers who were improperly billed for medical treatment by health care providers. These resolutions prevented injured workers' credit ratings from being negatively impacted by the improper billings. The total charges for medical treatment improperly billed to injured workers for medical care was $3,936,298.

The Bureau of Data Quality and Collection

- Conducted a two-day training session for claims-handling entities on the new EDI Release 3 Claims format. Two hundred thirty individuals attended this session.

- Provided on going training and education on EDI Release 3 issues via teleconferences and email. Division staff provided electronic training and education through an average of 2,016 emails per month to claims-handling entities.

- Published training materials and "Helpful Resource" documents on the Division's website to assist claims-handling entities in their implementation of EDI Release 3.

The Bureau of Monitoring and Audit
The Bureau of Employee Assistance and Ombudsman Office
The Office of Medical Services

- Provided education and outreach programs for insurers, claims handling entities, medical providers, employers and contractors regarding the various technological, process and regulatory improvements initiated by the Division.

- Revised and published the Workers' Compensation System Guide, which describes the roles and responsibilities for employers, injured workers, carriers and health care providers under Florida's Workers' Compensation Law.

Enforcement:

The Bureau of Monitoring and Audit

- Monitored and audited the claims-handling practices of workers' compensation insurers, self-insurers, self-insurance funds and claims-handling entities through on-site audits.

- Verified the timeliness and accuracy of indemnity payments, filing of required Division forms or their electronic equivalents, mailing of required Division notices to injured workers and validated the accuracy of data electronically reported to the Division.

- Conducted 49 on-site audits, during which 5,891 claim files and 2,845 First Reports of Injury or Illness were reviewed. Identified $282,459 in underpayments and penalties and interest due (and subsequently paid) to injured workers as a result of the audits.

- Evaluated and monitored insurer performance for timely disposition and timely filing of medical bills through the Centralized Performance System (CPS).

- Evaluated and monitored the accuracy and timeliness of First Report of Injury or Illness Form filings by employers, insurers and claims-handling entities through CPS.

- Reviewed the performance of employers, insurers and third-party administrators for timeliness

of initial indemnity benefit payments to injured workers through CPS.

- Analyzed information from 57,821 First Report of Injury or Illness Forms for compliance with the Division's timely payment and timely filing standards. Assessed penalties against insurers in the amount of $763,238 due to late payments to injured workers and $2,951,600 due to late filings. Assessed penalties against employers in the amount of $27,841 due to late payments and $152,000 due to late filings.

- Analyzed information from 4,241,840 medical bills for compliance with the Division's timely disposition and timely filing standards. This analysis resulted in $427,925 in assessed penalties due to late dispositions and $5,067,170 in assessed penalties due to late filings.

- Conducted 21 payroll and premium audits on self-insured employers which included 33,322 employee payroll records to ensure accurate assessments for the Workers' Compensation Administration Trust Fund, the Special Disability Trust Fund and the Florida Self-Insurers Guaranty Association. As a result of the audits, $23,069,553 in underreported payroll was discovered. Additionally, $1,107,891 in over reported premium was identified for assessment purposes due to improper employee classification.

- Examined permanent total and permanent total supplemental benefit payments to ensure timely and accurate payments to injured workers. Through collaborative work between SDTF staff and Audit Section staff, identified $1,320,516 in permanent total benefit underpayments, penalties and interest due from the insurer to injured workers.

The Bureau of Compliance

- Conducted 29,166 on-site investigations of employer worksites to determine employer compliance.

- Issued 1,945 Stop-Work Orders.

- Assessed $49,772,529 in fines against non-compliant employers Who failed to secure the payment of compensation or worked in violation of a Stop-Work Order.

- Caused $4,481,667 to be added to the premium base that had been previously evaded due to non-compliance.

- Initiated revocation proceedings for 254 exemption holders determined to no longer meet exemption eligibility requirements.

- Investigated 1,305 referrals alleging employer non-compliance.

- Conducted 55 employer investigations for underreporting or concealing payroll and misclassifying employees. Caused $61,773 to be added to the premium base that had been previously evaded.

- To date, 6,650 contractors are registered in the Construction Policy Tracking Database allowing contractors to receive automatic email notification about changes to the workers' compensation coverage status for any contractors they use. Those 6,650 general contractors are monitoring coverage on 30,924 contractor policies.

All of the above activities and accomplishments also focus specifically on the mission of the Division of Workers' Compensation:

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.

SPOTLIGHT ON DATA COLLECTION, USAGE AND TRANSPARENCY

THE ROLE OF DATA IN THE DIVISION OF WORKERS' COMPENSATION

A key component of the Division's Mission Statement is to actively ensure the self-execution of the workers' compensation system. One of the ways the Division promotes that self-execution is through the compilation and monitoring of system data. The data question most often posed to the Division is, "What does the Division use the data for?" This section will discuss what data are collected by the Division, how the Division collects, uses and makes the data accessible and transparent to stakeholders and policymakers.

Data are reported to meet statutory and administrative rule requirements and in support of business processes performed by the Division. It is important to note that many of the individual data elements collected are confidential and exempt from public access under provisions of Chapters 119 and 440, F.S. and the Insurance Code. However, whenever possible, the Division makes aggregate information about those data elements available to the public on the Division's website or in the Division's annual report.

Paper Form Collection

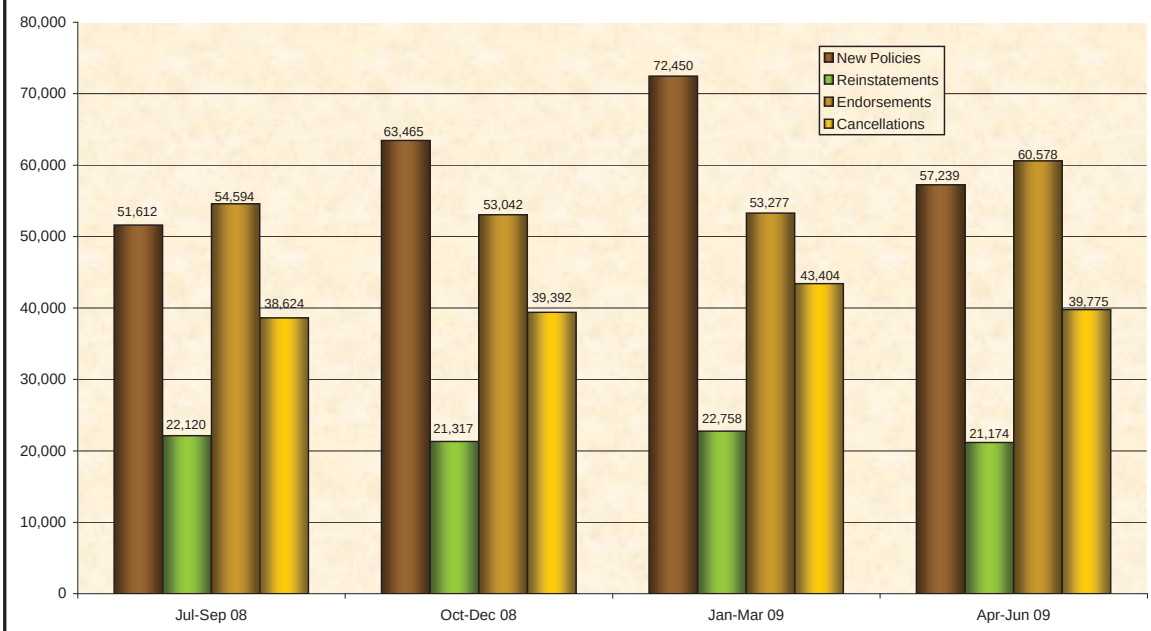
All proof of coverage, medical reports and claims data were originally collected on paper forms which required the forms to be delivered to the Division, separated by type of form, date stamped, then reviewed and routed to each bureau within the Division for manual recording of the data into their respective databases. As technology advanced, paper claim forms transitioned to electronic imaging after receipt from a document processing center. The data were then loaded into an electronic work queue, from which the information was examined, analyzed and manually entered into the Division's database. If the data now submitted electronically were submitted on paper, the annual stack of documents would be almost six times the height of Florida's 22-story Capitol building. However, the magnitude of paper that was received and processed by the Division created many obstacles to timely, accurate recording and reporting of the data. Some of those obstacles included:

- Time delays in receipt of data due to mailing time;
- Time delays in entering information because of manual processes;
- Propensity for human error in data entry, file establishment and routing by the data submitters and the Division;
- Tendency for backlogs since incoming workloads were uneven, resulting in resource allocation issues;
- Postage costs to mail paper forms; and
- Inability to comprehensively measure timeliness of all filings due to the large volume received that required measurement.

Migration to Electronic Data Interchange (EDI) for Proof of Coverage, Medical Reporting and Claims Data

Electronic Data Interchange (EDI) is the transfer of information in a standardized computer format by those entities that are registered and approved by the Division to act as trading partners in the exchange of data. The Division adopted the International Association of Industrial Accident Boards and Commissions (IAIABC) national standard for proof of coverage and claims reporting and developed a proprietary electronic reporting system to collect medical data. Proof of coverage (POC) information is thoroughly edited and compared to prior policy information before it is processed and loaded to the Division's internal coverage database. For example, electronic filings relating to endorsements must be effective on or after the effective date of a policy or prior to the policy cancellation date or the filings are rejected. During FY 2008-2009, 714,821 Proof of Coverage filings were accepted by the Division. As of 6/30/09, 374,350 workers' compensation policies were in effect. **Graphic 1** shows the volume of Proof of Coverage filings received during FY 2008-2009.

Graphic 1

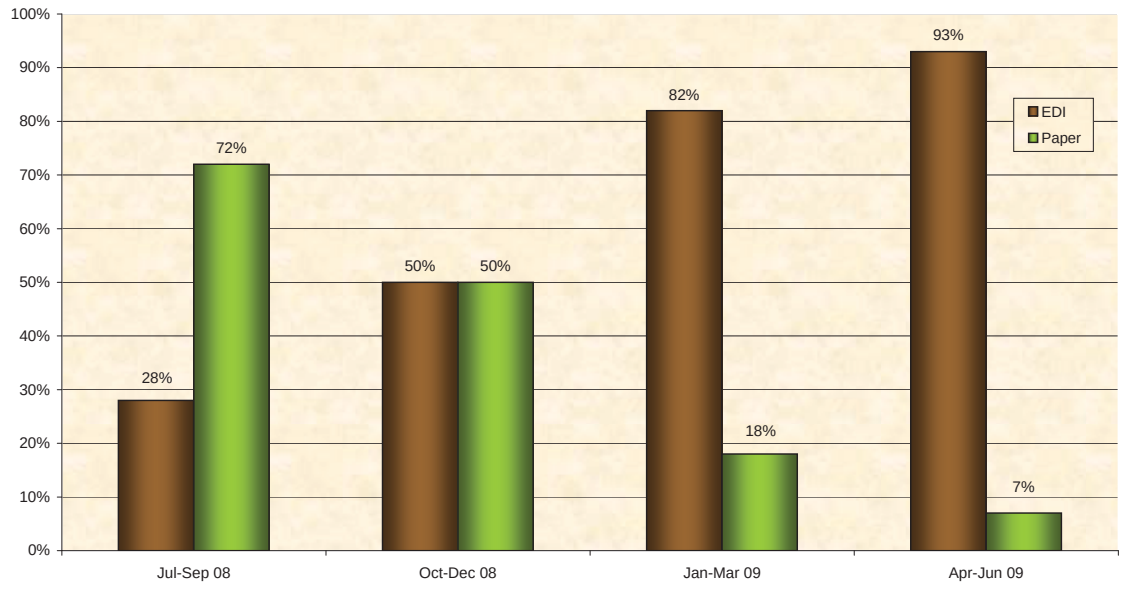


Source: DWC Proof of Coverage Database as of 7/1/09

The second mandated electronic initiative required the submission of all medical billings received from health care providers, pharmacists, hospitals and ambulatory surgical centers. This phase has been fully operational since April, 2005.

The third and final mandated electronic initiative required electronic submission of all indemnity claim data. During June, 2009, 94.6% of all claim data were submitted electronically by trading partners. **Graphic 2** *below* illustrates the increase in the acceptance of electronic claim filings during FY 08-09.

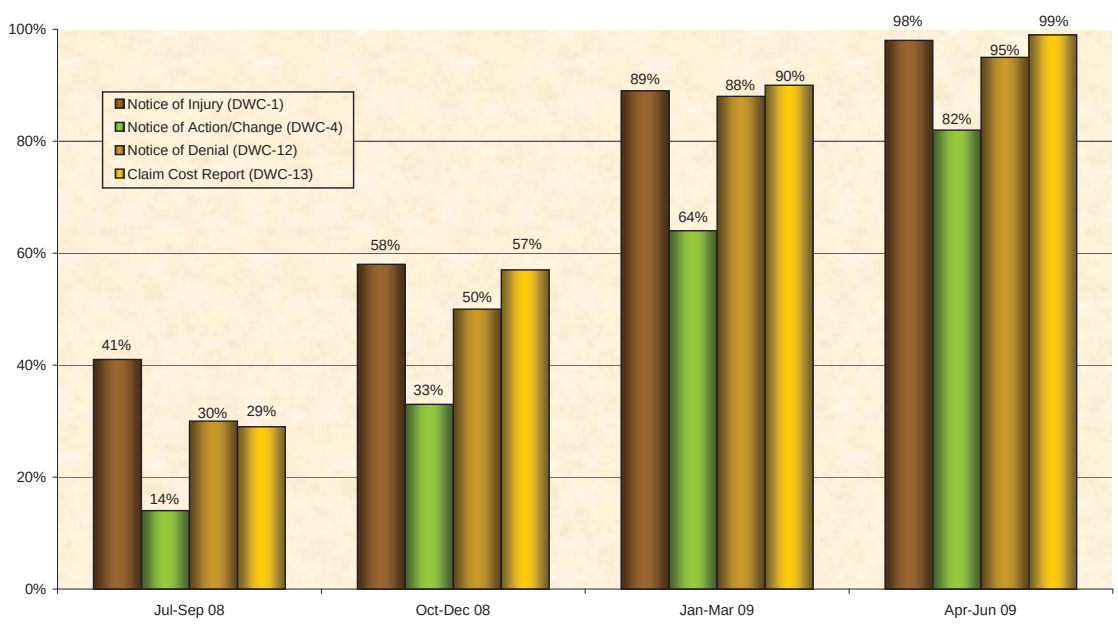
Graphic 2



*DWC-1, DWC-4, DWC-12, DWC-13 forms or electronic equivalents
Source: Bureau of Data Quality and Collection as of 7/1/09

Under the Claims EDI program, insurers are held accountable for timely submission of required claims data as well as the content of the information submitted. If an insurer attempts to report a new claim with inaccurate data or without all of the required information, the report will be rejected and the insurer will not be credited with timely filing unless the EDI filing is corrected and resubmitted within the required filing timeframe. If an insurer previously reported a claim under a particular identifier (i.e., date of accident or social security number) and filed the next report with a different identifier, the subsequent report(s) would be rejected because the filings do not match. Under the EDI process, reports are not considered filed until they are corrected, resubmitted and have successfully passed all structural and quality edits with the Division. The Division has seen a substantial increase in the quality of data that is reported electronically. **Graphic 3** *below* illustrates the electronic acceptance of claims data by form type.

Graphic 3



Source: Bureau of Data Quality and Collection as of 7/1/09

Data Collection, Use and Access

This section enumerates the data submitted to the Division, both electronically and on paper, depicting how the Division uses the data to help administer the workers' compensation system and how external parties can access the data. It is important to note that the Division also uses data extensively to respond to inquiries from legislators and policymakers. Data submitted to meet statutory requirements are included as are data that are collected to perform numerous Division business processes.

Proof of Coverage Data

Workers' Compensation Policy Information

Data: Workers' compensation insurance policy proof of coverage information is collected and includes data regarding certificates of insurance, endorsements, reinstatements, cancellations and non-renewals which include information about the policyholder, inception and cancellation dates and changes in coverage.

DWC-250 Notice of Election to be Exempt

Data: Corporate officers or members of a limited liability company engaged in the construction industry submit this form to obtain a Certificate of Election to be Exempt. The data includes, among other information, the scope of business or trade, licensure information and coverage information.

DWC-250R Revocation of Election to be Exempt

Data: An exemption-holder seeking to voluntarily revoke a Certificate of Election to be Exempt submits this form which includes, among other information, the scope of

business or trade, employer information and coverage information.

DWC-251 Notice of Election of Coverage

Data: A sole proprietor or partner that is seeking an election to be covered under an existing workers' compensation policy submits this form which includes, but is not limited to, information about the business entity by whom the applicant is employed and workers' compensation insurance policy coverage for that business entity.

DWC-251R Revocation of Election of Coverage

Data: A sole proprietor or partner submits this form to voluntarily revoke an election of coverage under an existing workers' compensation policy. The data includes information about the sole proprietor or partner, the business entity and the insurer providing the workers' compensation coverage.

Use of Proof of Coverage Data:

- The Bureau of Compliance uses this information as an investigative tool to verify if an employer has a valid workers' compensation policy and also when performing job site investigations; to determine if an individual is eligible to obtain a Certificate of Election to be Exempt; to approve a request to voluntarily revoke a Certificate of Election to be Exempt; to approve a request submitted by a sole proprietor or partner to be covered under an existing workers' compensation policy; and to approve a voluntary request to revoke an election of coverage.
- The Bureau of Data Quality and Collection uses these data to populate databases to reflect dates of employer coverage and cancellation, the name of the insurer responsible for losses during a particular policy period and also to produce requested employer loss runs.
- The Bureau of Employee Assistance and Ombudsman uses these data to determine whether coverage exists for an employee who has been injured on the job.

Access to Proof of Coverage Data:

- Interested parties can search the Proof of Coverage database available on the Division's website (http://www.myfloridacfo.com/WC) to determine if an employer has workers' compensation coverage for a particular policy period; the date of coverage inception; date of cancellation, if any; and the policy number. Exemption and election (to be covered) information can also be viewed in this database. During FY 08-09, more than 32,000 users accessed this data per month.
- Interested parties can access the Compliance Stop-Work Order Database which is available on the Division's website (http://www.myfloridacfo.com/WC) and includes information about employers that have been issued a Stop-Work Order, including whether the employer was released from the Stop-Work Order or whether the employer has defaulted under its obligations under a Periodic Payment Agreement.
- Using the Construction Policy Tracking Database,(http://myfloridacfo.com/WCAPPS/Contractor/logon.asp) general contractors can register on the Division's website to receive automatic email notification about changes to the workers' compensation coverage status for any contractors they use. As of 6/30/09, 6,650 general contractors were registered for this notification.
- Interested parties may request a downloadable report through the Division's website that contains a list of employers in Florida whose workers' compensation insurance policies are either due to expire within a month and year selected or become effective within a month and year selected. Data can also be accessed through public record and subpoena requests.

Medical Data

DWC-9 Health Care Provider Claim Form

Data: Data such as charge and payment data, diagnosis and procedure codes and bill adjudication information are collected for treatment rendered by health care providers, ambulatory surgical center facilities and pharmaceuticals dispensed by physicians.

DWC-10 Statement of Charges for Drugs & Medical Supplies

Data: Data such as charge and payment data are collected for drug, medical supplies and durable medical equipment dispensed by pharmacists and medical supply companies. The National Drug Code number is collected for all prescription and over-the-counter pharmaceutical items.

DWC-11 Dental Claim Form

Data: Data such as billing and payment data, diagnosis and procedure codes and bill adjudication information are collected for workers' compensation related treatment rendered by dentists.

DWC-90 Hospital Billing Form

Data: Data such as facility charge and payment data, diagnosis, length of stay, revenue and procedure codes and bill adjudication information are collected about facility treatment.

Use of Medical Data:

- The Bureau of Monitoring and Audit uses these data to determine the timeliness of provider payments and timeliness of medical bill filing with the Division.
- The Bureau of Monitoring and Audit uses aggregate data to identify which insurers and/or claims-handling entities have a pattern or practice of not paying providers timely or filing reports timely with the Division.
- The Bureau of Data Quality and Collection uses these data to determine what procedure codes will be included in the Healthcare Provider and Hospital Reimbursement Manuals, provide data to the Three-Member Panel, conduct research and determine health care costs to the workers' compensation system.
- The Bureau of Data Quality and Collection uses ambulatory surgical center data to establish maximum reimbursement allowances.
- The Office of Medical Services uses this data to resolve reimbursement disputes.

Access to Medical Data:

- Insurers and claims-handling entities can electronically view their aggregate timely filing and payment information through the Centralized Performance System.
- Aggregate medical diagnosis, charge and reimbursement data are provided in the Division's annual report.
- The Division distributes monthly Submitter Medical Filing Report Cards to every entity that submits medical bills. These report cards compare the timely filing performance for each submitter compared to all submitters as a group and also contain a summary of the previous month and six-month medical bill reporting history. Additionally, the Division issues bi-monthly reports to each submitter listing all outstanding uncorrected rejected medical bills.
- Data may be accessed through subpoena requests and in aggregate form pursuant to a public record request.

Claims Data

First Report of Injury or Illness/ Electronic Form Equivalent

Data: Insurers or claims-handling entities submit data about work-related injuries and illnesses such as the date of accident, accident description, cause and nature of accident, biographical information about the injured worker, information about the insurer and employer and disability information. The insurer is obligated by law to provide a copy to the injured employee.

Notice of Action/Change/ Electronic Form Equivalent

Data: Insurers or claims-handling entities submit data to report a change of condition such as reinstatement or suspension of indemnity benefits, date of maximum medical improvement, permanent impairment rating, completion of a settlement, changes to the average weekly wage or compensation rate, acceptance/ adjudication of permanent total disability status, changes/corrections to the North American Industrial Classification System Codes and Risk Class Codes or changes/corrections in the injured workers' demographic information. The insurer is obligated by law to provide a copy to the injured employee.

Notice of Denial/ Electronic Form Equivalent

Data: Insurers or claims-handling entities submit data to report a partial or total denial of indemnity benefits which includes the type of benefit denied, effective date, reason for denial and insurer identification. The insurer is obligated by law to provide a copy to the injured employee.

Claim Cost Report/
Electronic Form Equivalent

Data: Insurers or claims-handling entities submit data on a cumulative basis that provides medical and indemnity financial expenditures for lost-time cases and time periods for payment of indemnity benefits.

Use of Claims Data:

- The Bureau of Employee Assistance and Ombudsman (EAO) uses First Report of Injury or Illness data as a trigger to contact injured workers within two days of the Division's receipt of the First Report of Injury or Illness data to provide the injured worker with benefit entitlement information, answer questions or concerns about the workers' compensation system and advise injured workers about services available to them through EAO.
- EAO also uses these data to research and investigate injured workers' concerns or disputes about medical treatment or payment of indemnity benefits.
- Notice of Denial data are used by EAO to determine if the claims-handling entity has submitted appropriate documentation to support the denial of benefits in accordance with Chapter 440, F.S.
- The Bureau of Monitoring and Audit uses these data to determine the timeliness of injury reporting and timeliness and accuracy of initial indemnity benefit payments.
- The Bureau of Monitoring and Audit also uses these data during audits to determine if appropriate and timely indemnity benefits have been paid, validate information filed with the Division and determine that all required forms or their electronic equivalents have been filed with the Division.
- The Bureau of Monitoring and Audit uses aggregate First Report of Injury or Illness data to identify insurers that may need further monitoring via on-site audits.
- The Bureau of Data Quality and Collection establishes lost-time injury cases in Division databases based on First Report of Injury or Illness data submitted by claims-handling entities.
- The Bureau of Monitoring and Audit, Permanent Total Section uses Notice of Action/Change data to verify that the correct weekly compensation rate has been used for benefit payment, confirm the accuracy of annual cost of living adjustments to permanent total supplemental benefit payments and to suspend Division-paid permanent total supplemental benefits upon notification of settlement or death.
- The Bureau of Monitoring and Audit, Permanent Total Section also uses Claims Cost Report data to determine the accuracy of permanent total payments to injured employees.

Access to Claims Data:

- Aggregate claim information is provided in the Division's annual report and posted to the Division's website.
- Potential employers can query the Claims Database available on the Division's website by entering a potential employee's name and social security number to view accident data on an individual claim basis.
- Interested parties can also access the Database of Statistical Reports Based on Claims Data available on the Division's website to generate statistical reports from accident records selected by county, year of injury, nature of injury, or other claim characteristics with output consisting of aggregated data by year of injury for the number of injuries, total benefits and average benefits for each category.
- Interested parties can access a list of lost-time injuries from 1990 to date as reported to the Division regarding particular employers based on the employer's federal employer identification number from the Workers' Compensation Employer Loss Run Database which is available on the Division's website.
- Insurers and claims-handling entities can electronically view their aggregate timely filing and initial indemnity payment information through the Centralized Performance System.
- Claims-handling entities can view their electronically submitted claims data in the Claims EDI Warehouse, including Report Cards which are available to every trading partner that submits claims data. These report cards provide an accounting of filings accepted and rejected for each trading partner and compared to all trading partners as a group. Additionally, the Claims EDI Data Warehouse contains trading partner listings that identify uncorrected rejected First Report of Injury or Illness and Claim Cost filings.
- Data may be accessed through public record and subpoena requests.

Medical Dispute Resolution and Medical Certification

3160-0023 Petition for Resolution of Reimbursement Dispute

Data: Health care providers submit these data to dispute the reimbursement amount or lack of reimbursement by a carrier for services rendered to an injured employee.

3160-0024 Carrier Response to Petition for Resolution of Reimbursement Dispute

Data: Carriers file these data to respond to the Petition for Resolution of Reimbursement Dispute that has been submitted by a provider.

3160-0020 Health Care Provider Application for Certification

Data: Health care providers file these data to apply for certification in the Florida workers' compensation system.

3160-0021 Expert Medical Advisor Application and Contract for Certification

Data: Health care providers file these data to apply for certification as an expert medical advisor (EMA) in the Florida workers' compensation system.

Use of Medical Dispute Resolution and Medical Certification Data:

- The Office of Medical Services uses Petition for Resolution of Reimbursement Dispute data to determine if the provider was reimbursed correctly and to track the number and frequency of disputes, the number and type of providers utilizing the dispute process and to identify pattern and practice issues relating to reimbursement disputes between providers and carriers.
- The Office of Medical Services uses Carrier Response to Petition for Resolution of Reimbursement Dispute data to track carrier response within the dispute resolution process and to collect data from carriers to substantiate the disallowed or adjusted reimbursement that the provider is contesting.
- The Office of Medical Services uses Health Care Provider and Expert Medical Advisor Applications for Certification data to determine if applicants qualify for certification.
- Information about certified applicants is included in the Expert Medical Advisor Directory which is used by Judges of Compensation Claims and the Division to identify specialists able to provide expert opinions or peer review services to resolve issues related to physician services or reimbursement and utilization disputes.
- The Office of Medical Services uses these data to target specialty areas for EMA recruitment.
- The Office of Medical Services uses these data to monitor the certification status of EMAs so they can contact EMAs 90 days prior to certification expiration to request reapplication.

Access to Medical Dispute Resolution and Medical Certification Data:

- Aggregate reimbursement dispute determination data and dismissal information by type of provider are included in the Division's annual report which is posted to the Division's website.
- Aggregate carrier response data are utilized within the Office of Medical Services to evaluate the need for more extensive investigation of health care providers and to identify potential pattern and practice violation issues for referral to the Bureau of Monitoring and Audit.
- Interested parties can query the Health Care Provider and Expert Medical Provider Databases available on the Division's website which contains the names, addresses, telephone numbers and specialty types for all Division certified health care providers and Expert Medical Providers.

Self-Insurance Data

SI-5 Payroll Report

Data: Individual self-insurers submit these data annually to report their payroll and employee job classifications.

SI-17 Loss Data Report

Data: Individual self-insurers submit data for three years of outstanding claims, loss payments and reserve amounts.

Use of Self-Insurance Data:

- The Self-Insurance Section of the Bureau of Monitoring and Audit uses Payroll Report data to calculate the manual premium and ultimately calculate the experience modification factor for individual self-insurers.
- The Assessments Unit uses the experience modification factor to calculate and determine the individual self-insurer's assessments for the Special Disability Trust Fund and the Workers' Compensation Administration Trust Fund.

Access to Self-Insurance Data:

- Pursuant to s. 440.515, F.S., these data are confidential and exempt from the provisions of Chapter 119, F.S.

Data Mining and Validation

To ensure that the Division meets its responsibilities for financial accountability, the Division has undertaken additional initiatives to verify benefits are paid to only eligible individuals and to validate data. These initiatives include:

DOC Incarceration Report: The Division obtains a monthly list from the Department of Corrections of incarcerated individuals to determine the continued statutory eligibility of injured workers to receive permanent total supplemental benefits paid by the Division since the Division would discontinue payment of permanent total supplemental benefits of an injured worker who became incarcerated and had no dependents.

Bureau of Vital Statistics: The Division obtains a monthly list from the Florida Department of Health which contains the names of injured workers who have become deceased. The Bureau of Monitoring and Audit, Permanent Total Section would discontinue Division payment of permanent total supplemental benefits for names on this list.

Out-of-State Death Report: The Division contracts with a private vendor to whom a list is sent monthly of permanently and totally disabled workers who live out of state to determine if the workers are deceased and have no dependents who are eligible for permanent total supplemental benefits.

JCC Settlement Report: The Division obtains a monthly report from the Division of Administrative Hearings which contains the names of any injured workers who have settled their workers' compensation claims. The Bureau of Monitoring and Audit, Permanent Total Section uses this information to cease payment of Division paid permanent total supplemental benefits for injured workers no longer eligible for those benefits.

Request For Social Security Disability Benefit Information (DWC-14): When permanently and totally disabled workers become eligible for Division paid permanent total supplemental benefits, the Division asks that they request that information about their social security benefits be sent to the Division by the Social Security Administration. The Bureau of Monitoring and Audit, Permanent Total Section uses the information to calculate the correct social security offset applicable to permanent total supplemental benefit payments.

Employee Earnings Report (DWC-19): Annually, the Division requests that permanently and totally disabled workers who are receiving permanent total supplemental benefits from the Division complete and submit this form. The Bureau of Monitoring and Audit, Permanent Total Section uses the data submitted to ensure that the injured worker is not earning income which would require a reduction or cessation of the supplemental benefit.

Permanent Total Offset Worksheet (DWC-33): This form is filed by the insurer upon request by the Division. The Bureau of Monitoring and Audit, Permanent Total Section uses the worksheet to validate the amount of the permanent total offset and to ensure the injured worker is receiving the appropriate amount of permanent total benefits.

Permanent Total Supplemental Worksheet (DWC-35): This form is filed by the insurer upon request by the Division. The Bureau of Monitoring and Audit, Permanent Total Section uses the data to validate the accuracy of the insurer's permanent total supplemental benefit calculation and payments to the injured worker.

Carrier and Self-Insurance Fund Quarterly Premium Reports: Carriers and self-insurance funds file these reports detailing their assessable premiums and assessment computation for the Special Disability Trust Fund and Workers' Compensation Administration Trust Fund. The Assessments Unit validates the accurate calculation of carrier and self-insurance fund assessments through the reconciliation of the reported premiums with the premiums reported to the Office of Insurance Regulation and the National Association of Insurance Commissioners.

Social Security Administration: The Division implemented additional processes to ensure the validity of the data taken from the First Report of Injury/Illness filed via electronic means or by paper form by partnering with the Social Security Administration. This allows the Division to validate the correct social security number (SSN) and date of birth on file with the Social Security Administration against the SSN and date of birth reported to the Division on filed claims. As a result, duplicate claims are being eliminated from the Division's database and excluded from statistical analysis/research. Claim information for multiple accidents is being properly recorded under the correct SSN and date of accident. This enables the Division to maintain more accurate information and correctly produce all claim records for a particular SSN when responding to public record and subpoena requests.

Department of State, Division of Corporations: The Division compares the information on all new businesses registered in Florida on a monthly basis to the Division of Workers' Compensation's proof of coverage data to identify businesses who have not yet reported proof of coverage information to the Division.

External Data Mining

As a result of efficiencies gained through evolving technology instituted by the Division, workers' compensation data have also become sought-after by other government agencies. These data are being utilized to enhance the business functions of other government agencies and provide opportunities to strengthen State government's statutory performance. Examples include:

Department of Revenue, Child Support Enforcement Office: The Division sends a monthly download of injured worker indemnity payment data and list of settled cases. These data are cross matched to child enforcement data to identify opportunities to secure monies for child support payments that are in arrears and other information is used to locate delinquent parents, thus allowing the Department of Revenue to proactively collect past due monies for Florida's children.

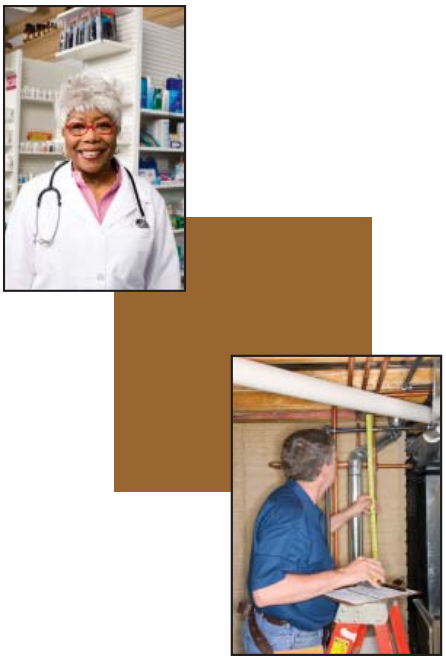
University of South Florida Monthly Claims Extract: The Division sends a monthly electronic injury data file that contains information about injured workers, their employers and accident descriptions. These injury data are used by the University of South Florida Consultation Program in the College of Public Health to determine where to focus safety efforts to prevent injuries, what types of employers could best use their services, what type of training might be needed to help prevent accidents and to track accident trends.

Juvenile Claims Extract: The Division sends a monthly electronic injury data file to the Department of Business and Professional Regulation, Child Labor Office so they can investigate injuries by workers 17 years old or younger to determine compliance with hour limitations. Their investigations look at the type of job performed, accident description and employer information.

Center for Medicare/Medicaid Services (CMS) Monthly Claims Report: The Division sends a monthly download of injury data to CMS who uses this data to identify cases where Medicare should be the secondary payor.

Data Research

As part of the Division's continuing commitment to utilize its data in ways that will be meaningful both internally and to our stakeholders and policymakers, the Bureau of Data Quality and Collection has begun analyzing the impact of the extensive changes to the workers' compensation statute mandated in 2003. The research being performed draws on the extensive data collected by the Division that will result in a series of topically focused research briefs.



BUREAU OF COMPLIANCE

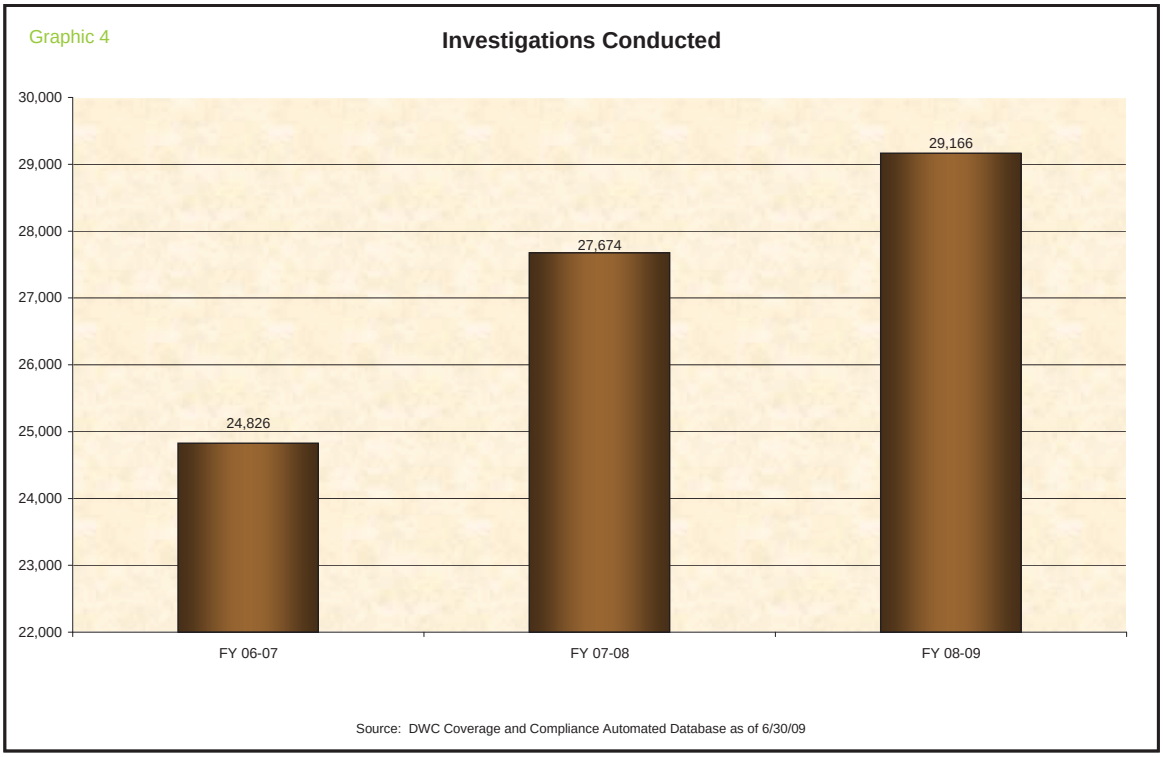
The Bureau of Compliance is responsible for ensuring that employers comply with their statutory obligations to obtain appropriate workers' compensation insurance coverage for their employees. Ensuring that employers adhere to workers' compensation coverage requirements results in coverage for employees that were previously without coverage due to non-compliance; ensures that covered employees with work-related injuries receive all statutorily required benefits; levels the playing field for all employers who are bidding jobs; and adds premium dollars to the system that were previously evaded due to non-compliance. The Bureau accomplishes its mission through enforcement investigations, management of the exemption process and education of employers.

The Bureau of Compliance conducts investigations to determine employer compliance and assesses penalties against employers who fail to meet their statutory obligations. The Bureau also reviews and processes applications from eligible employers seeking to utilize the exemption provisions of the Workers' Compensation Law. The Bureau participates in employer conferences and conducts workshops to educate employers, contractors and other stakeholders about workers' compensation coverage and compliance requirements.

Through its enforcement and investigative efforts in FY 2008-2009 the Bureau:

- Conducted 29,166 investigations. **Graphic 4** *below* shows the volume of investigations performed during the last three fiscal years. Investigations are physical on-site inspections of an employer's job-site or business location conducted to determine employer compliance with the workers' compensation coverage requirements.

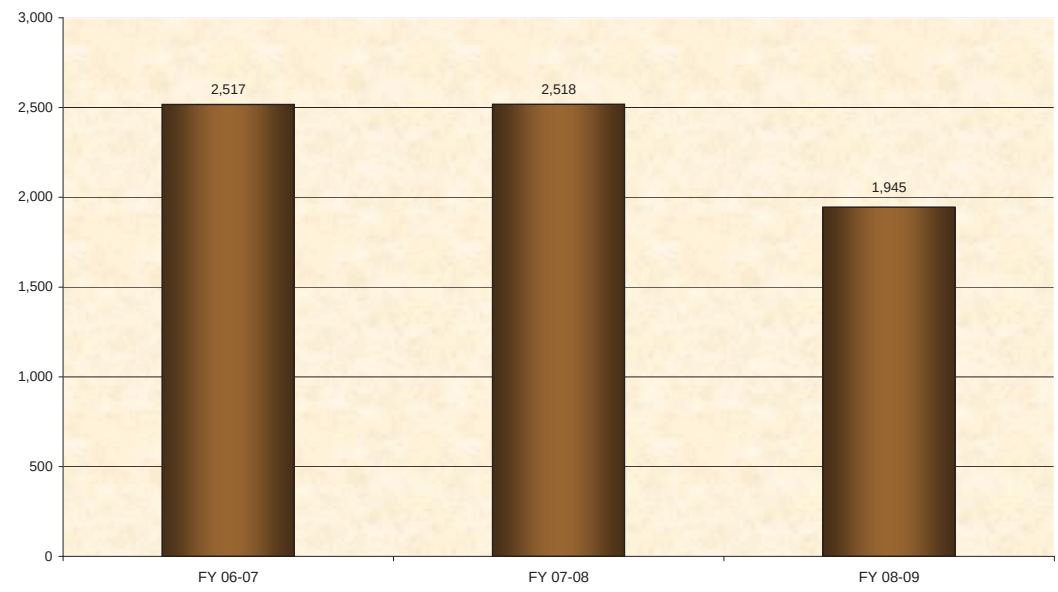
Graphic 4



Source: DWC Coverage and Compliance Automated Database as of 6/30/09

- Issued 1,945 Stop-Work Orders as illustrated by **Graphic 5**. Stop-Work Orders are issued when it is determined that an employer has failed to comply with the coverage requirements of Chapter 440, F.S. Stop-Work Orders require the employer to cease business operations and the Order remains in effect until the Division issues an Order Releasing the Stop-Work Order. Stronger compliance standards and resultant penalties, the provision of comprehensive statewide employer education programs and fewer employers in business due to the economic downturn may have contributed to a decrease in the issuance of Stop-Work Orders during FY 2008-2009.

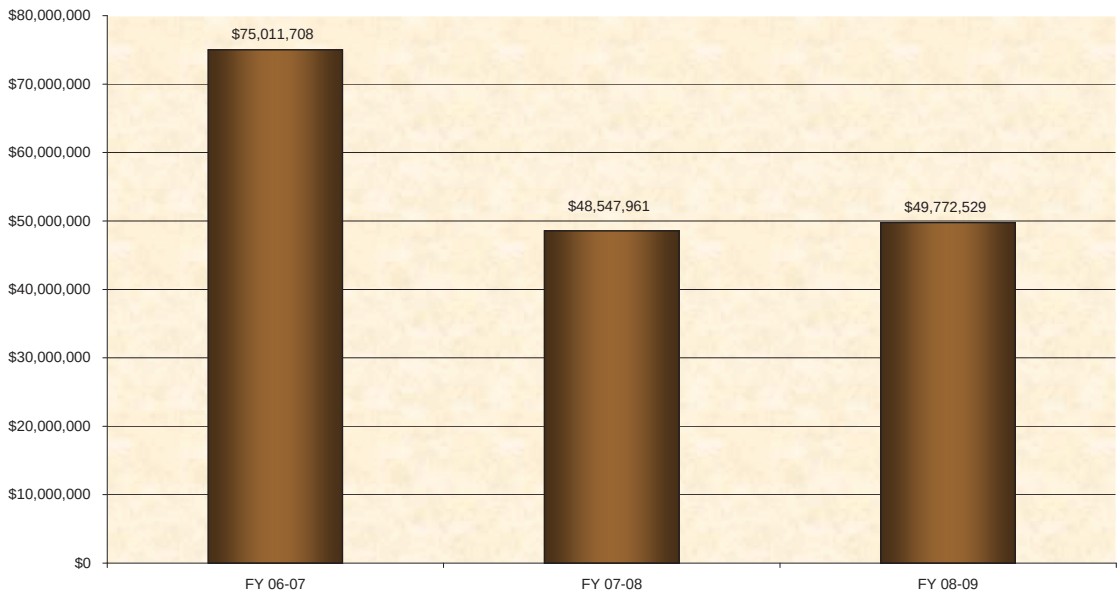
Graphic 5



Source: DWC Coverage and Compliance Automated Database as of 6/30/09

- Assessed $49,772,529 in penalties as illustrated by **Graphic 6** *below*. Assessed penalties are equal to 1.5 times what the employer would have paid in workers' compensation insurance premiums for all periods of non-compliance during the preceding three-year period or $1000, whichever is greater. In order to come into compliance with the coverage requirements, employer must obtain coverage, based on the current number of employees, which may be different than the number of historical employees, upon which the penalty was based.

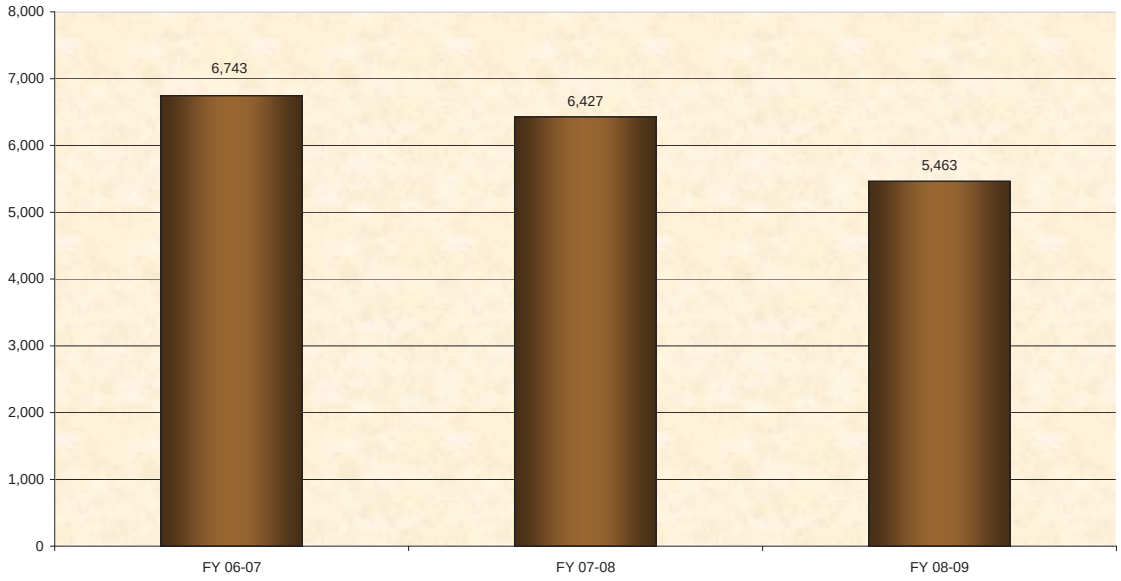
Graphic 6



Source: DWC Coverage and Compliance Automated Database as of 6/30/09

- Caused 5,463 new employees to be covered under the Workers' Compensation Law. **Graphic 7** shows the number of employees covered as a direct result of the Bureau's intervention.

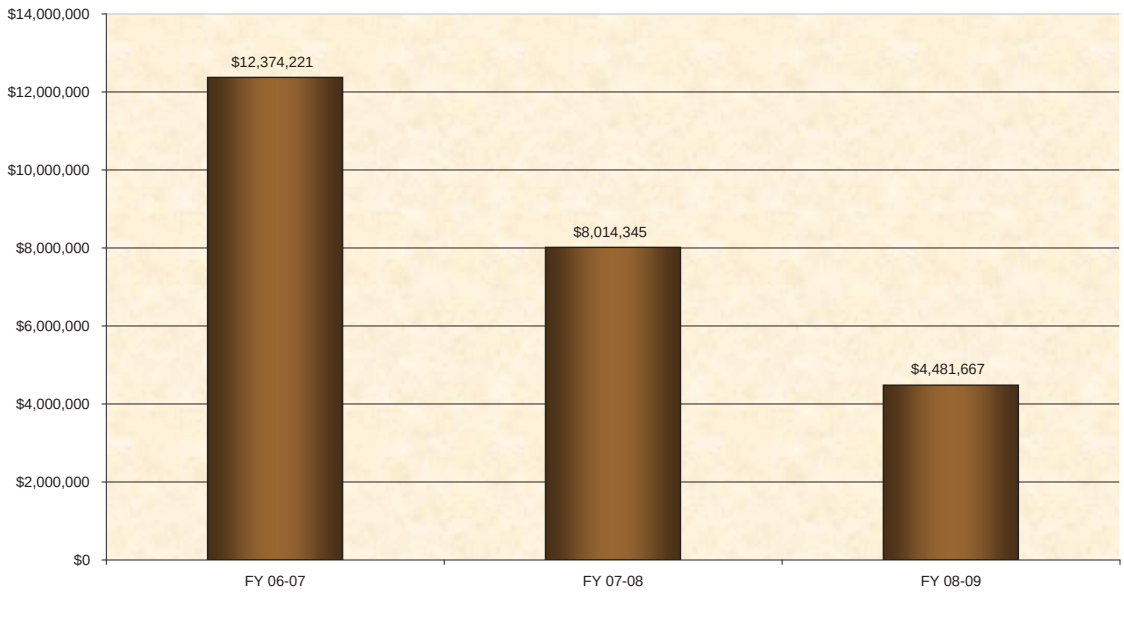
Graphic 7



Source: DWC Coverage and Compliance Automated Database as of 6/30/09

- Caused $4,481,667 to be added to the premium base that had been previously evaded as illustrated in **Graphic 8** *below*. The continued effectiveness of compliance investigations is somewhat masked by the fact that during the last six years, the workers' compensation rates have decreased on average by over 60% due to major statutory reforms in 2003. This rate reduction also resulted in reduced workers' compensation insurance premiums.

Graphic 8

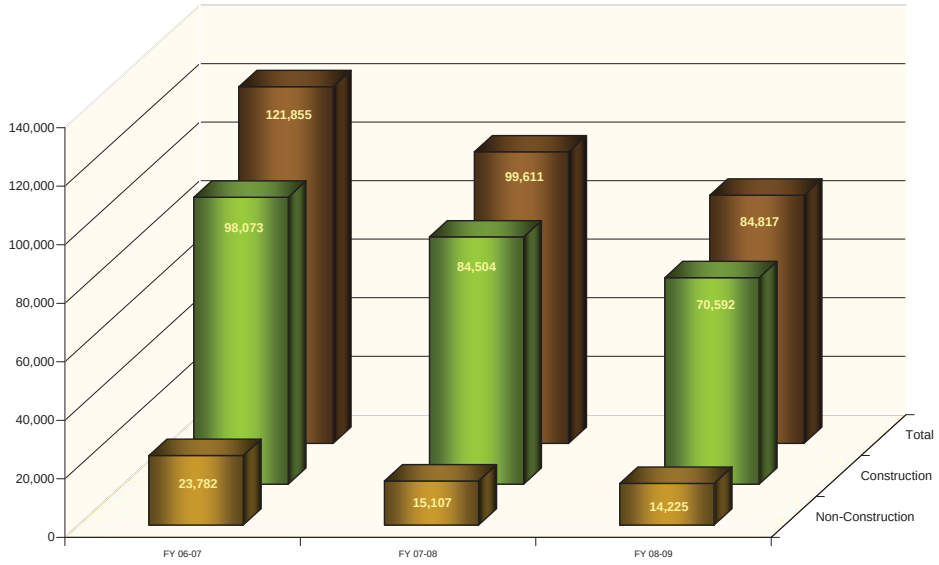


Source: DWC Coverage and Compliance Automated Database as of 6/30/09

- Processed 70,592 construction industry exemption applications and 14,225 non-construction industry exemption applications as illustrated by **Graphic 9**. As of June 30, 2009 there were 332,334 active construction exemptions which expire every two years. The 798,462 active non-construction exemptions do not expire, pursuant to Chapter 440.

Graphic 9

Exemption Applications Processed

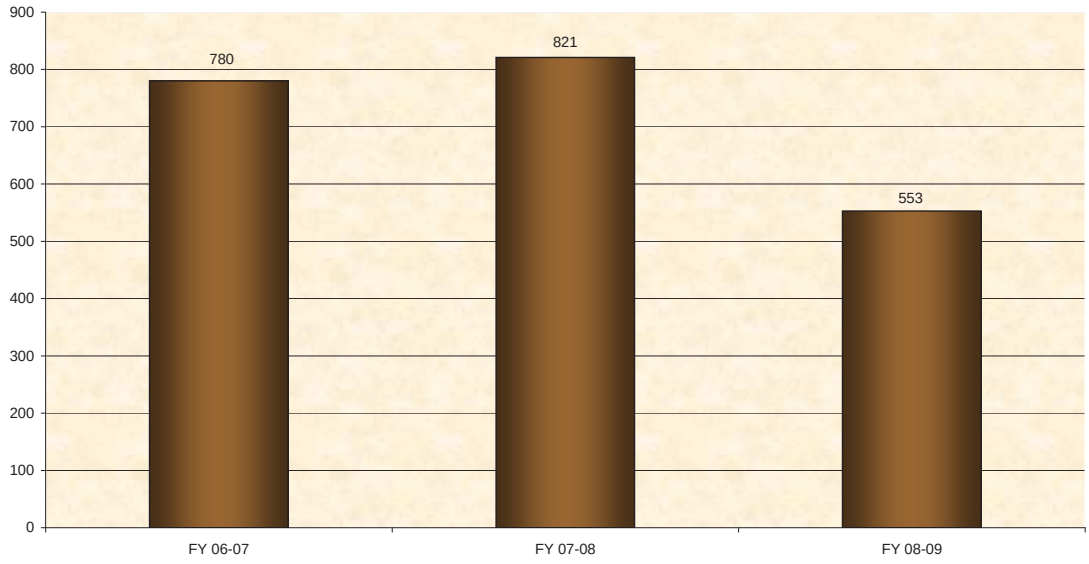


Source: DWC Coverage and Compliance Automated Database as of 6/30/09

Section 440.107(7)(a), F.S., authorizes the Division to conditionally release an employer from a Stop-Work Order upon a finding that the employer has complied with statutory coverage requirements and has agreed to remit periodic penalty payments pursuant to a payment agreement schedule. An employer is required to make an initial down payment that equals at least 10% of the total assessed penalty or $1,000, whichever is greater. Under Rule 69L-6.025, F.A.C., an employer has to make 12, 24, 36, 48, or 60 equal monthly payments to pay the remaining penalty. The penalty collection rate for employers who have entered into a periodic payment plan is two times more than those employers who elect to pay their penalty in full. The number of periodic payment agreements entered into by employers that have been conditionally released from Stop-Work Orders is illustrated in **Graphic 10** *below*.

Graphic 10

Periodic Payment Agreements Entered Into By Employers

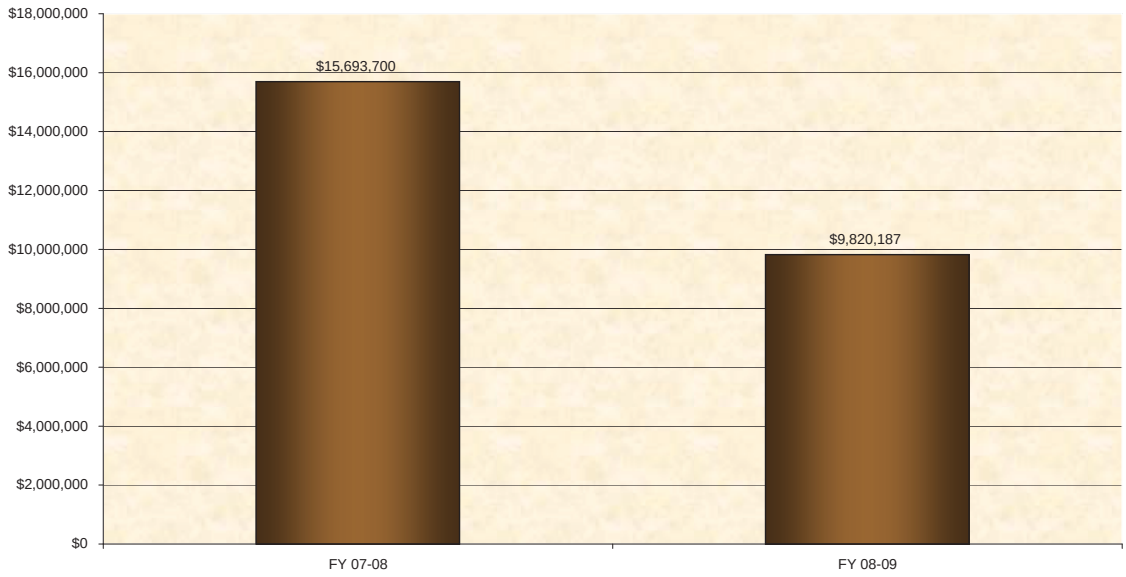


Source: DWC Coverage and Compliance Automated Database as of 6/30/09

- **Graphic 11** *below* illustrates the total penalties assessed against employers who entered into periodic payment agreements.

Graphic 11

Penalties Assessed in Periodic Payment Agreements



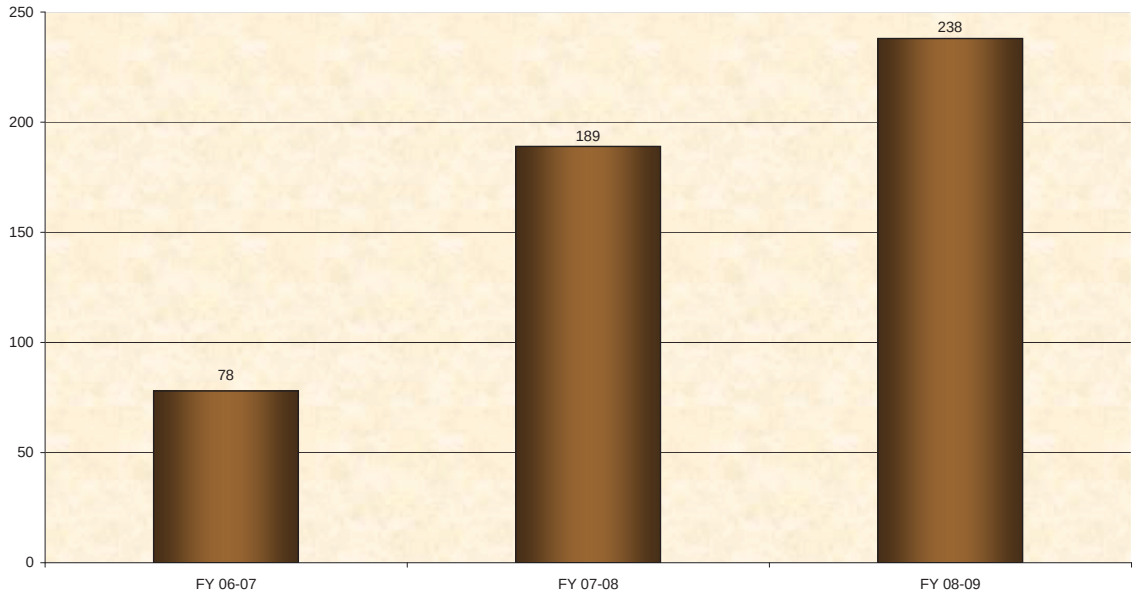
Source: DWC Coverage and Compliance Automated Database as of 6/30/09

The Division is authorized by administrative rule to assess a penalty against an employer who failed to secure the payment of workers' compensation on the date an investigation commences, but came into compliance prior to the issuance of a Stop-Work Order.

The next four graphics pertain to Orders of Penalty Assessment for cases where the employer obtained coverage which made the issuance of a Stop-Work Order unnecessary. During FY 2008-2009, 238 employers were issued an Order of Penalty Assessment as illustrated in **Graphic 12** with assessed penalties totaling $5,062,112, as illustrated in **Graphic 13**. **Graphic 14** illustrates the total number of new employees covered and the amount of insurance premium generated is illustrated in **Graphic 15**.

Graphic 12

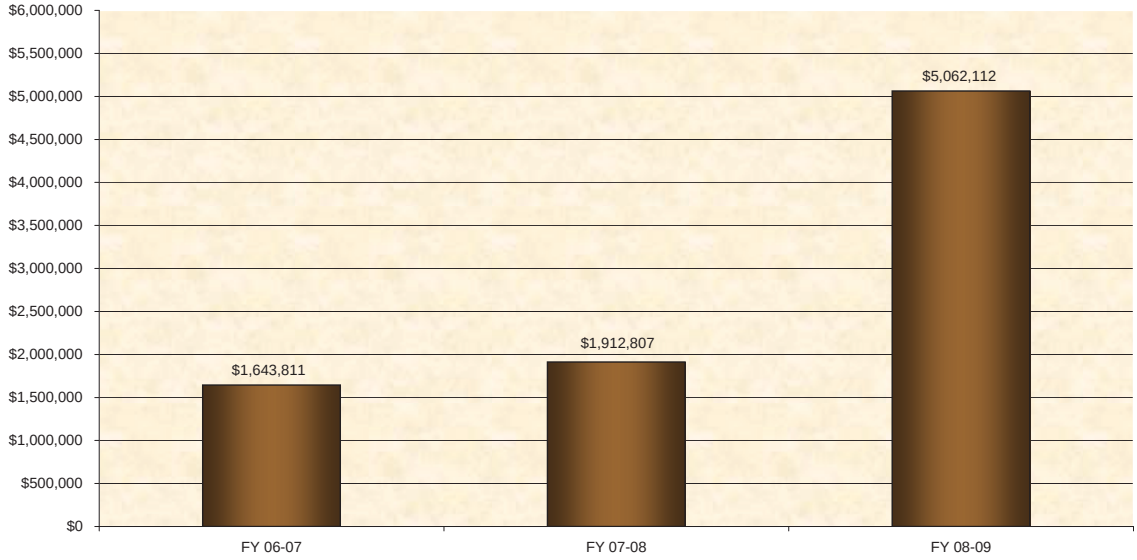
Orders of Penalty Assessment Issued



Source: DWC Coverage and Compliance Automated Database as of 6/30/09

Graphic 13

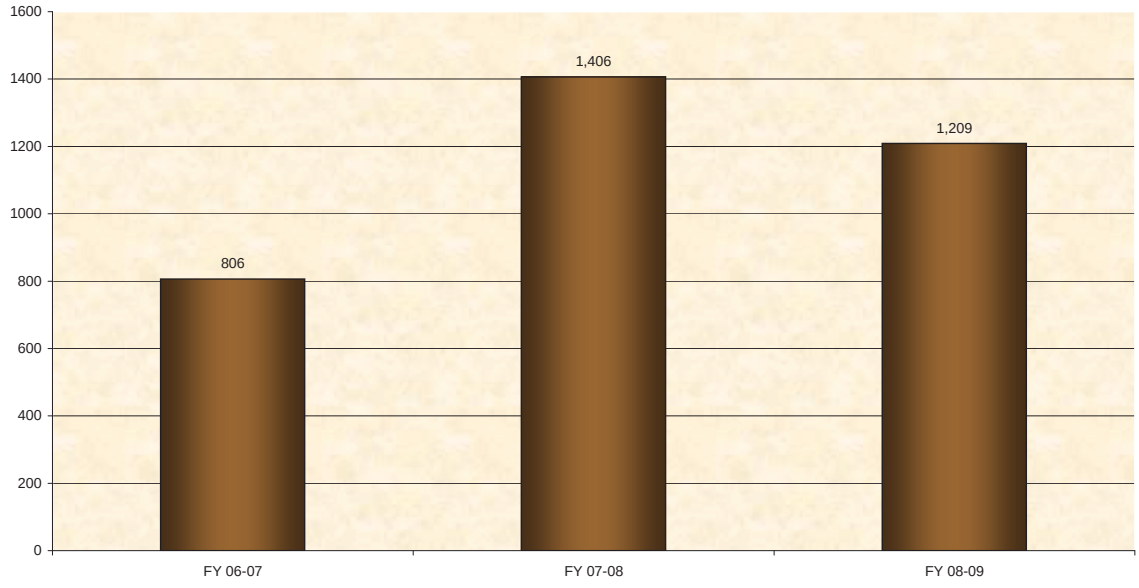
Total Penalties Resulting From Orders of Penalty Assessment



Source: DWC Coverage and Compliance Automated Database as of 6/30/09

Graphic 14

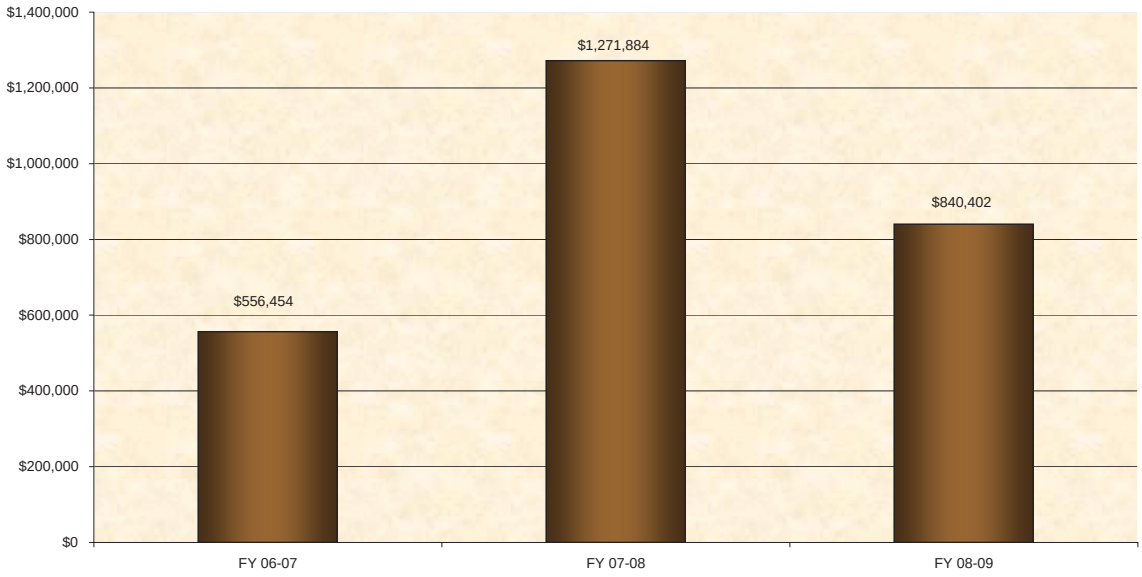
New Employees Covered Based Upon Orders of Penalty Assessment



Source: DWC Coverage and Compliance Automated Database as of 6/30/09

Graphic 15

Insurance Premium Resulting From Orders of Penalty Assessment



Source: DWC Coverage and Compliance Automated Database as of 6/30/09

New Initiatives

Expansion of Employer Education Campaign

During FY 2008-2009, the Bureau of Compliance continued its emphasis on educating employers and helping them understand their statutory obligations under the Workers' Compensation Law by partnering with the U.S. Department of Labor, Office of Safety and Health Administration (OSHA) to provide employers with information related to both workers' compensation and workplace safety. The Bureau obtained licensure to provide instruction and continuing education credits for training on workers' compensation and workplace safety to employers who are licensed by the Department of Business and Professional Regulation, the Department of Financial Services, Bureau of Fire Prevention and the Florida Water Well Administration.

The Bureau conducted 66 education seminars in 20 cities throughout the state, providing education to 1,798 business owners, licensed contractors, employers and stakeholders who attended those workshops. The education seminars were conducted in both English and Spanish to ensure the information was accessible to all interested stakeholders.

Non-Compliance Referral Database

Since its inception, the Bureau of Compliance has investigated referrals about employers that allegedly failed to provide workers' compensation coverage. During FY 2008-2009, the Bureau investigated 1,305 referrals alleging employer non-compliance. Previously, the method by which referrals were received was cumbersome and labor intensive, with a limited ability to provide a response to the person making the referral. During FY 2008-2009, the Bureau designed and implemented an electronic referral tracking database to increase responsiveness and provide real-time feedback to the person making the referral.

A referral can be submitted electronically by accessing the Non-Compliance Referral Database on the Division's website. The person making the referral has the option to submit the referral anonymously or to provide an email address to receive electronic notification on the status and outcome of the referral. However, even if an email address is not provided, the referring person has the ability to track the status and outcome of the referral by entering into the database the confirmation number that is provided upon

electronic submission of the referral. The electronic referral tracking database will enable the Bureau to receive referrals in a more timely manner which will streamline the process to initiate investigations earlier and provide real-time feedback to the person who made the referral.

Use of Internal and External Data to Promote Compliance

The Bureau of Compliance has implemented two new data mining initiatives to help identify a higher percentage of non-compliant employers. The Bureau began partnering with the Department of State, Division of Corporations, to obtain data related to new businesses being registered. The data is matched against the Division's proof of coverage records to identify those employers that have not reported workers' compensation policy information. The second initiative consists of a separate analysis of the Division's proof of coverage records to identify employers whose workers' compensation policies have been cancelled or expired and have not reported subsequent coverage information to the Division. This initiative enables the Bureau to utilize internal resources, employer correspondence and tracking mechanisms to identify potential non-compliant employers and initiate employer investigations.

Historically, many non-compliant employers have complied with the workers' compensation coverage requirements as a result of enforcement action by the Division. This initiative will allow the Division to measure the number of employers that obtain coverage in response to the Division's correspondence, making it unnecessary to initiate formal enforcement activities.

Payment Receipting System

The Bureau of Compliance, in conjunction with the Department of Financial Services, Division of Administration and the Division of Information Systems, has implemented changes to enable our financial recordkeeping to more efficiently account for all monies received by the Bureau and to ensure prompt deposit. This process eliminated double-keying of receipts information and provides a daily electronic fiscal reconciliation. This stronger internal control ensures that all revenue received within the Bureau is receipted, processed and deposited according to established procedures and guidelines.

COMPLIANCE
CASE SUMMARIES

The Bureau received a public tip regarding a company that employs 35 individuals who travel to Florida Wal-Mart stores to assemble bicycles for display and sale. A Business Records Request was issued and served on the employer to determine compliance with workers' compensation coverage requirements. The investigation revealed the employer was out of compliance; however, the employer obtained a valid workers' compensation policy prior to the issuance of a Stop-Work Order. A subsequent Business Records Request was issued and served on the employer for penalty calculation purposes. The employer was issued and served an Order of Penalty Assessment in the amount of $81,355. The employer came into compliance by obtaining a workers' compensation policy covering 35 employees, which generated $52,539 in premium dollars and by entering into a Periodic Payment Agreement

While conducting a routine investigation of a restaurant in Orlando, an Investigator observed approximately eight employees working. The owner was contacted regarding their workers' compensation coverage. The owner stated he had a workers' compensation policy and he was on his way to his office to retrieve it. A Business Records Request was issued to the employer for purposes of determining compliance with the workers' compensation coverage requirements. The owner responded to the Business Records Request several days later by providing a workers' compensation policy that had been obtained after the date of the site visit. The employer was served an Order of Penalty Assessment in the amount of $32,500. The newly obtained workers' compensation policy covered 14 employees, which generated $8,296 in premium dollars. The employer came into compliance by entering into a Periodic Payment Agreement.

While conducting routine investigations in the Pensacola area, an Investigator conducted a site visit to a picture framing business. An investigation revealed that the business had three separate locations with a total of nine employees and no workers' compensation coverage. A Stop-Work Order for failure to secure coverage and a Business Records Request were issued to the employer. A penalty was assessed in the amount of $47,863. The employer came into compliance by obtaining a workers' compensation policy covering nine employees, which generated $6,127 in premium dollars and entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

While working as a part of an inter-jurisdictional enforcement team with local municipal and county building code investigators in Palm Beach County, an Investigator observed three workers renovating a building. Information obtained on the job site indicated the employer had secured workers' compensation coverage through an employee leasing company. However, contact with the employee leasing company revealed that the three workers were not reported on the employee leasing payroll. A Stop-Work Order for failure to secure coverage and a Business Records Request were served on the employer. A penalty was assessed in the amount of $35,000. The employer came into compliance by adding the workers to the employee leasing contract, which generated $3,510 in premium dollars and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

Based on a public complaint in Hillsborough County, a site visit was conducted and eleven workers were observed installing cement blocks at a three-story hotel under construction. The investigation revealed that the employer's workers' compensation policy had been canceled 40 days prior. A Stop-Work Order for failure to secure coverage and a Business Records Request were issued to the employer. A penalty was assessed in the amount of $56,509. The employer came into compliance by purchasing a new workers' compensation policy, which generated $9,078 in premium dollars and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

While conducting routine investigations in Broward County, an Investigator observed two daycare centers operating in close proximity to each other. Investigations of both centers were initiated to determine compliance with the workers' compensation coverage requirements. The investigations revealed that both daycare centers were operating in violation of the Workers' Compensation Law. Stop-Work Orders for failure to secure coverage and Business Records Requests were issued to the daycare centers. A penalty was assessed against the first center in the amount of $20,000. The employer came into compliance by obtaining a workers' compensation policy covering 16 employees, which generated $4,789 in premium dollars and by entering into a Periodic Payment Agreement. A penalty was assessed against the second center in the amount of $32,000. That employer came into compliance by obtaining a workers' compensation policy for seven employees, which generated $2,486 in premium dollars and by entering into a Periodic Payment Agreement. The Stop-Work Orders were conditionally released.

While conducting routine investigations in Jacksonville, an Investigator conducted a site visit at a construction drywall company. The Investigator observed 17 employees on-site and only two were legally documented U.S. citizens. The investigation revealed the employer had a workers' compensation policy with a reported payroll of $60,000. A Stop-Work Order for underreporting and concealing payroll and a Business Records Request were issued to the employer. Subsequent to the site visit and after the issuance of the Stop-Work Order, the employer attempted to increase the payroll from $60,000 to $400,000 in an effort to avoid being cited for the non-compliance violation. Coincidentally, the day after the Stop-Work Order was issued, another Investigator conducting routine investigations in St. Augustine, came across a different job being completed by the same employer and found four additional undocumented workers. The total employees identified for the employer on both job sites were 21.

A Business Records Request was issued to general contractors that had hired the employer and records revealed that the general contractors had paid the employer in excess of $2 million for services provided. The employer failed to provide all of the requested business records and an imputed payroll was calculated using the statewide average weekly wage multiplied by 1.5. A penalty was assessed in the amount of $61,815. The employer came into compliance by terminating the undocumented workers, adding 27 employees to his workers' compensation policy, which generated $55,370 in premium dollars and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

The Bureau initiated an investigation in Escambia County after a public complaint was levied by a local county code enforcement office alleging an employer was working without workers' compensation coverage. The Investigator observed a number of workers preparing to load several aerial trucks for sign installation. The employer stated the workers were independent contractors, although none of the workers owned their own companies or had a Certificate of Election to be Exempt. The investigation revealed that the workers were employees and the employer did not have a valid workers' compensation policy. A Stop-Work Order for failure to secure coverage and a Business Records Request were issued to the employer. The penalty was assessed at $11,140. The employer came into compliance by reducing the number of employees below the statutory threshold and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

Approximately two years later, the employer defaulted on the Periodic Payment Agreement and the Stop-Work Order was reinstated. Two months later, the employer was found working in violation of the reinstated Stop-Work Order. A referral was made to the Division of Insurance Fraud, Bureau of Workers' Compensation Fraud and the employer was assessed an additional penalty in the amount of $12,000 for working in violation of the Stop-Work Order. Six months later, the employer was found working in violation of the Stop-Work Order a second time. The employer was assessed a third penalty in the amount of $121,000. Two additional months later, the employer was found working in violation of the Stop-Work Order a third time. The employer was assessed an additional penalty in the amount of $50,000. The Division of Insurance Fraud arrested the employer for knowingly violating the Stop-Work Order. The total amount of penalties assessed against the employer for working in violation of the Stop-Work Order was $183,000.

Pursuant to a court order, the employer submitted a payment of $18,000 toward the assessed penalty. The remaining balance is currently outstanding and the employer is awaiting criminal sentencing for insurance fraud.

While conducting routine investigations in Sarasota County, an Investigator observed four employees working in a restaurant. A Business Records Request was issued to the employer for purposes of determining compliance with the workers' compensation coverage requirements. The business records revealed a total of 19 employees. However, the current employer had purchased the restaurant from another owner and failed to secure workers' compensation coverage. A Stop-Work Order for failure to secure coverage and a Business Records Request were issued to the employer. A penalty was assessed in the amount of $17,000. The employer came into compliance by purchasing a workers' compensation policy covering 19 employees, which generated $5,270 in premium dollars and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

The Bureau received a tip that a resort hotel was operating without workers' compensation coverage. An investigation confirmed the employer employed eight individuals, but did not have workers' compensation coverage. A Stop-Work Order for failure to secure coverage and a Business Records Request were issued to the employer. A review of the business records revealed the hotel had been in operation for 10 years without securing workers' compensation coverage while employing at least seven employees during that timeframe. A penalty was assessed in the amount of $42,330. The employer came into compliance by obtaining a workers' compensation policy covering seven employees, which generated $6,658 of premium dollars and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

While conducting routine investigations at a job site in the Orlando area, an Investigator discovered two workers performing tile installation. The investigation revealed the owner had elected to be exempt from obtaining workers' compensation coverage, but had failed to secure workers' compensation coverage for his employees. A Stop-Work Order for failure to secure coverage and a Business Records Request were issued to the employer. A review of the business records revealed additional uninsured employees. A penalty was assessed in the amount of $15,000. The employer came into compliance by reducing the number of employees below the statutory threshold and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released. The two uninsured employees established their own corporation and obtained Certificates of Election to be Exempt.

Based on a public complaint, the Bureau initiated an investigation of a security company that supplies armed and unarmed security officers to government agencies, residential developments and business establishments in a large metropolitan area in Miami-Dade County. The complaint alleged the employer was operating without workers' compensation coverage.

The investigation revealed that the employer had secured workers' compensation coverage through an employee leasing company. However, contact with the employee leasing company revealed that the employer's leasing contract only covered 25 security officers. The employer employed an additional 15 security officers that were not listed on the leasing contract. A Stop-Work Order for failure to secure coverage and a Business Records Request were issued to the employer. A review of the employer's business records revealed that the company employed approximately 136 security officers. The penalty was calculated in the amount of $65,720. The employer came into compliance by adding all employees to the employee leasing contract, which generated $84,839 in premium dollars and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

Through a joint investigative effort, the Bureau of Compliance and the Bureau of Workers' Compensation Fraud (Division of Insurance Fraud) were successful in getting the owner of the company criminally charged by the State Attorney's Office for failure to provide workers' compensation coverage, insurance fraud and underreporting. The owner entered into a plea agreement which resulted in a sentence of ten years probation and a fine of $291,299.

While conducting routine investigations in Hillsborough County, an Investigator observed 13 workers performing masonry work at a residence under new construction. The investigation revealed the employer had secured workers' compensation coverage through an employee leasing company. The employee leasing company reported that 63 employees were currently covered through the leasing contract; however, the 13 workers performing masonry work were not included on the employee leasing payroll. A Stop-Work Order for failure to secure coverage and a Business Records Request were issued to the employer. The employer was assessed a penalty in the amount of $261,114. The employer came into compliance by reducing the number of employees below the statutory threshold and by entering into a Periodic Payment Agreement. The Stop-Work Order was conditionally released.

BUREAU OF MONITORING AND AUDIT

The Bureau of Monitoring and Audit is responsible for accountability and enforcement to ensure that insurers meet their statutory obligations or are penalized according to statutory requirements. Its responsibilities include ensuring that benefits are paid timely and accurately to injured workers and that medical bills and all required forms are filed timely and accurately with the Division. The Bureau also verifies that self-insurers have sufficient resources to pay outstanding liabilities.

The completion of the electronic mandate for reporting of data resulted in major changes in the work processes within the Bureau. Data on insurers and self-insurers can be aggregated and analyzed in many ways to identify trends and concerns regarding claims-handling patterns and practices. The past year was one of transition in the Bureau and included the following business process changes:

- The Audit Section began validating the accuracy of indemnity and medical information filed via EDI which allows auditors to identify data reporting issues, inaccuracies and reporting failures.
- The Permanent Total (PT) Section began receiving electronic reports regarding each insurer/self-insurer's changes in the amount of permanent total benefits paid to injured workers, which allows them to identify documents which have not been filed or were filed late and to more rapidly respond to changes in permanent total benefit eligibility such as death or incarceration.
- The Penalty Section received complete and accurate data for evaluation and assessment of penalties as a result of electronic reporting of the First Report of Injury or Illness. This has resulted in a more efficient and accurate assessment of fines, penalties and interest to the industry.

The Bureau achieves its mission for accountability and enforcement by organizing staff into four sections: Audit Section, Penalty Section, Permanent Total Section and Self-Insurance Section.

Audit Section

The Audit Section collects information and data from all areas of the Division to monitor and evaluate the performance of insurers, self-insurers, self-insurance funds and claims-handling entities. One example is the information and data received from the Centralized Performance System (CPS) regarding timely form and medical bill filings and timeliness of medical bill payments and initial indemnity payments. In addition, information and data are received from the Bureau of Employee Assistance and Ombudsman Office (EAO) regarding requests for assistance and/or complaints from injured workers. The information and data received from the various areas of the Division play an integral role in determining which regulated entities will be audited in the coming year.

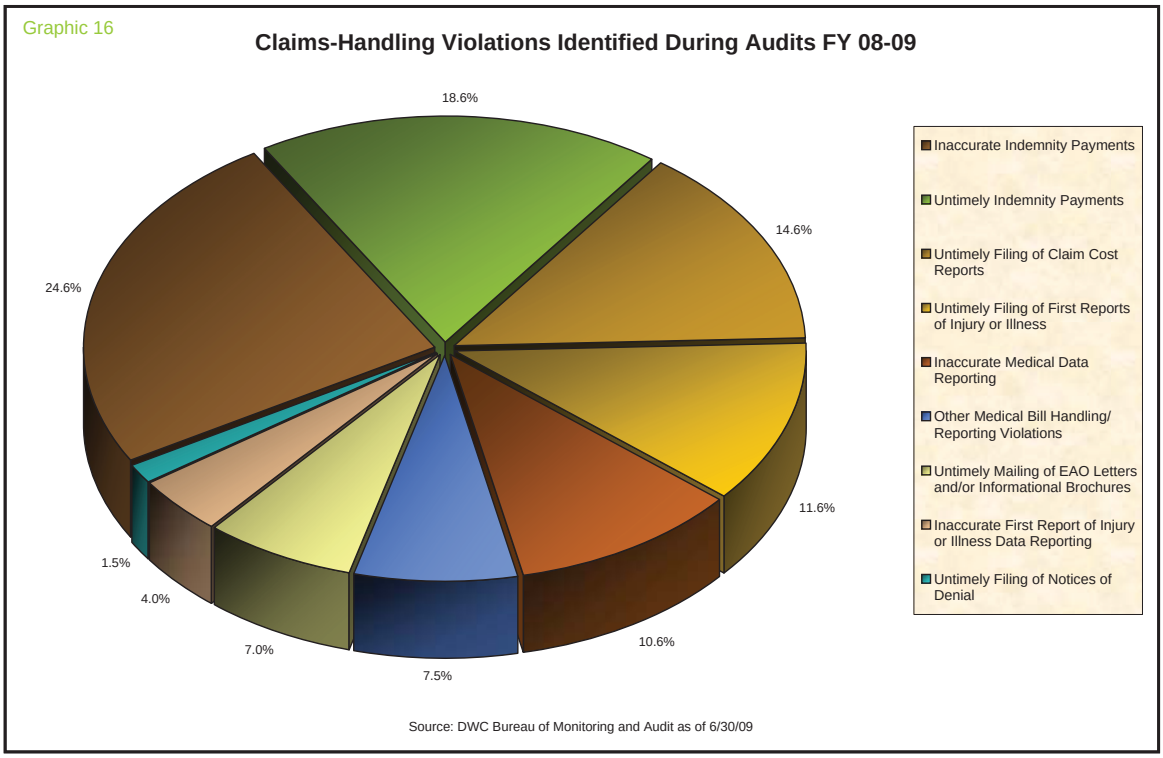
Since mandated electronic filing of medical and claim data was implemented, the Audit Section has expanded its focus on the validation of the accuracy of data filed with the Division. This validation activity is conducted to identify reporting errors and inaccuracies on medical bill and electronic First Report of Injury or Illness data.

The Audit Section conducts audits of insurers, self-insurers and self-insurance funds to identify claims-handling violations of administrative rule and/or statute. **Graphic 16** illustrates the claims-handling violations identified during audits conducted in FY 2008-2009. Claims-handling violations include, but are not limited to:

- Untimely and/or inaccurate payment of benefits to injured workers;
- Untimely mailing of Employee Assistance Office letters or informational brochures to injured workers;
- Untimely filing and/or payment of medical bills;
- Untimely and/or inaccurate filing of required reports; and
- Non-compliance with Orders of Judges of Compensation Claims.

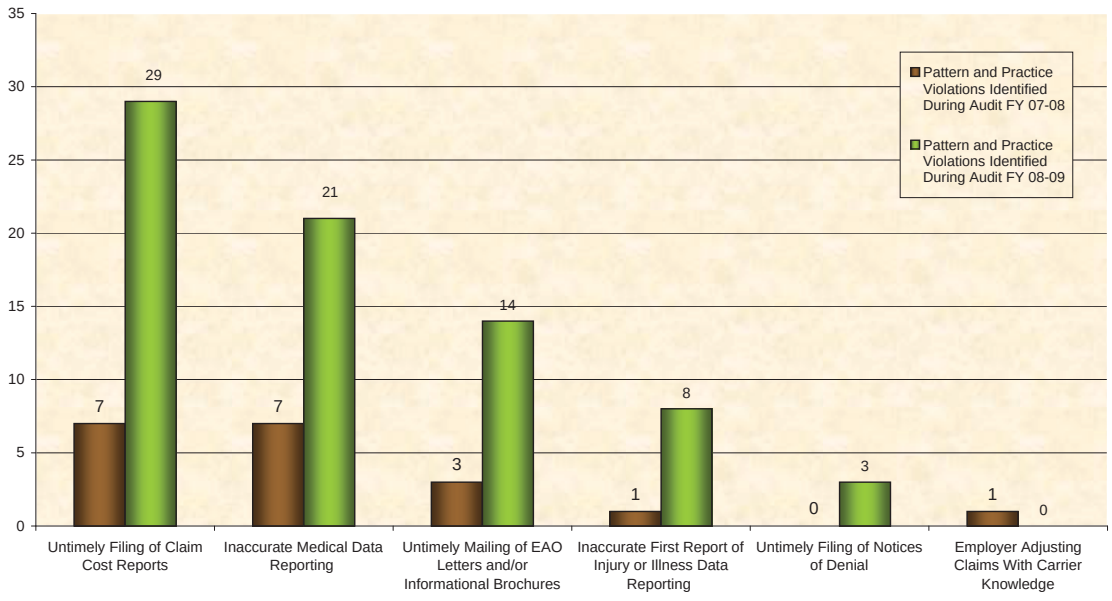
The Audit Section identifies and addresses poor claims-handling patterns and practices such as unreasonable delay in claims processing or timeliness and accuracy of payments and reports. **Graphic 17** illustrates the types of pattern and practice violations identified during audits.

Graphic 16



Source: DWC Bureau of Monitoring and Audit as of 6/30/09

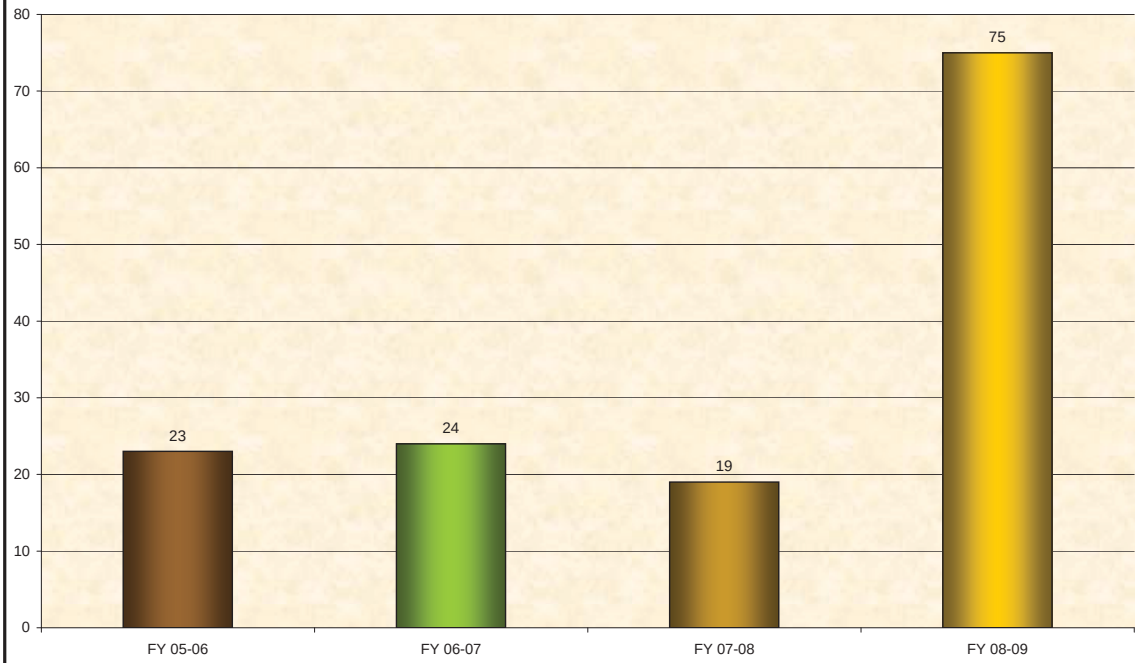
Graphic 17



Source: DWC Bureau of Monitoring and Audit on-site audits as of 06/30/09

Graphic 18 compares the number of pattern and practice violations identified during audits during the last four fiscal years. The combination of identifying additional areas that constitute pattern and practice violations, a significant increase in the number of audits performed and the actual performance of insurers account for the substantial increase in the number of violations indentified during FY 2008-2009.

Graphic 18



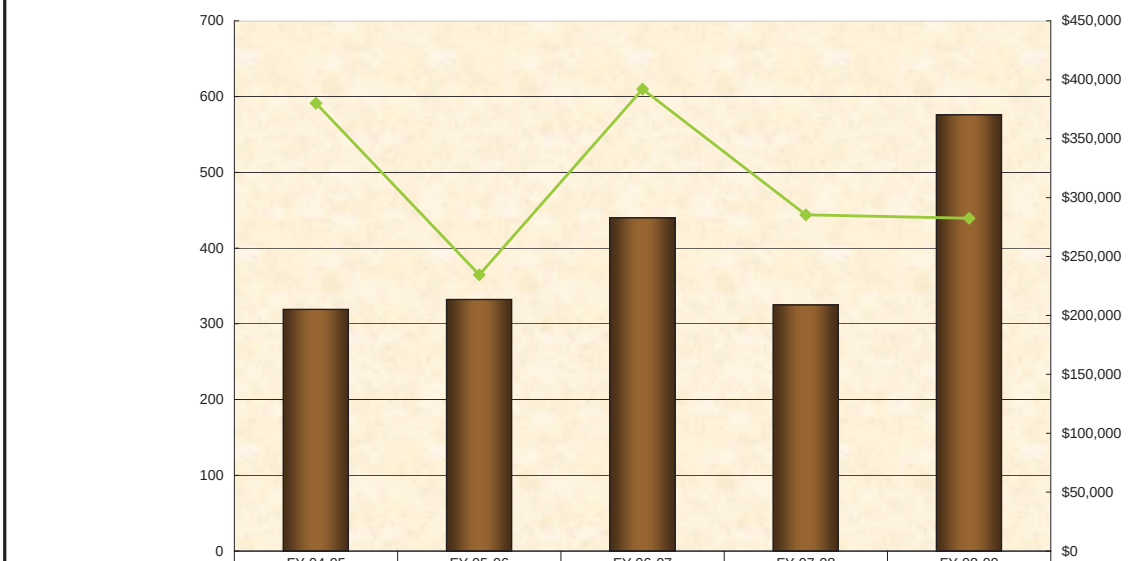
Source: DWC Bureau of Monitoring and Audit as of 06/30/09

During FY 2008-2009, the Audit Section:

- Audited 5,891 insurer claim files and completed 49 on-site insurer audits. Insurer claim files contain all records, medical reports and benefit information relative to a particular worker's injury or illness.

- Reviewed 24,309 indemnity payments for accuracy and timeliness and identified 576 claim files with underpayments. The identification of these underpayments resulted in the additional payment of $170,644 in indemnity benefits and $111,815 in penalties and interest, for a total of $282,459 paid to injured workers. **Graphic 19** *below* illustrates the number of underpayments identified and total amount of indemnity benefits and penalties and interest paid to injured workers as a result of audits conducted during the last five fiscal years.

Graphic 19



	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09
Number of Underpayments	319	332	440	325	576
Amount Paid	$379,948	$234,421	$392,003	$285,402	$282,459

Source: DWC Bureau of Monitoring and Audit as of 6/30/09

- Verified that 87.7% of the required informational brochures and employee notification letters were mailed timely to injured workers pursuant to s. 440.185, F.S.

- Verified the accuracy and/or timeliness of 11,458 claim forms required to be filed with the Division.

- Reviewed 13,703 medical bills and 645 electronic First Reports of Injury or Illness Reports for filing and accuracy in data submitted to the Division.

- Identified 75 pattern and practice violations during 49 audits for failure to meet statutory claims-handling requirements. Specific violations are as follows:

    - Twenty-nine violations for failure to timely file Claim Cost Reports with the Division;
    - Twenty-one violations for failure to report accurate medical data to the Division;
    - Fourteen violations for untimely mailing of the Important Workers' Compensation Information for Florida's Workers and/or the Informacion Importante de Seguro de Indemnizacion por Accidentes de Trabajadores de la Florida or the informational employee notification letter to injured workers;
    - Eight violations for failure to report accurate data on First Reports of Injury or Illness filed with the Division; and
    - Three violations for failure to timely file Notices of Denial with the Division.

- Assessed $313,950 in penalties for audits conducted during FY 2008-2009 as follows:

    - $110,150 for untimely indemnity payment performance that fell below the required 95% standard;
    - $16,300 for untimely filing of First Reports of Injury or Illness; and
    - $187,500 for 75 pattern and practice violations.

Penalty Section

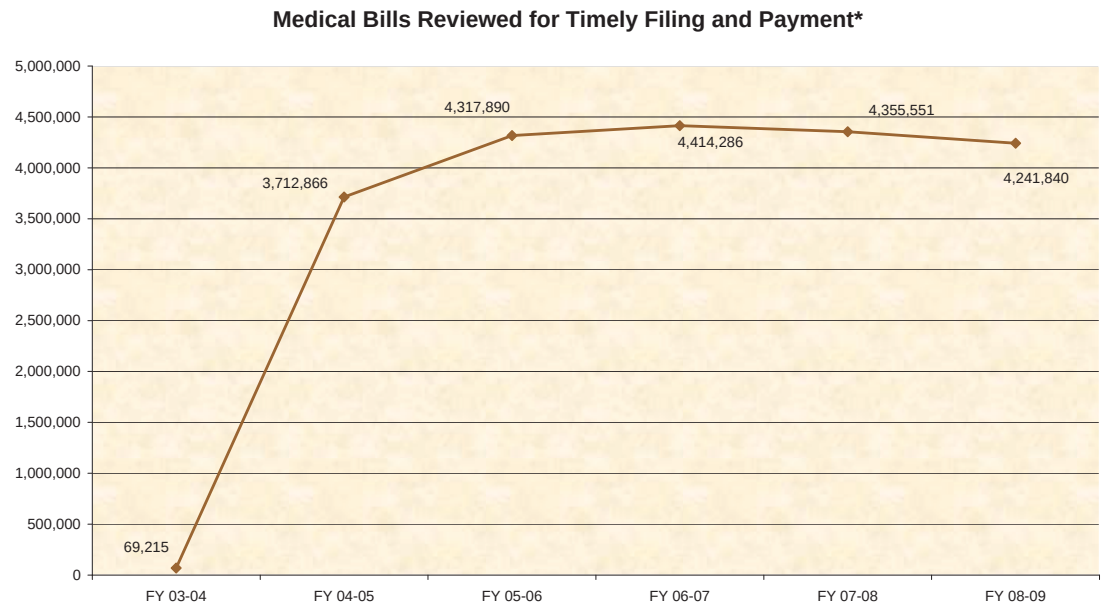
The Penalty Section is responsible for monitoring and evaluating insurer performance regarding the timely payment and accuracy of initial indemnity benefit payments and timely payment of medical bills. The Section also ensures that First Reports of Injury or Illness and all medical bills are filed timely with the Division. The Penalty Section monitors insurer performance on these measures through the Centralized Performance System (CPS).

As an interactive web-based system, CPS provides insurers and claims-handling entities with the ability to review and respond to their performance information in real-time. The system has two components: a medical module and an indemnity module. Both modules provide stakeholders with the ability to monitor their claim performance and compare their company's performance to the industry. The CPS system also plays a key role in identifying insurers or other claims-handling entities with poor performance that may require further monitoring or examination.

Medical Module

Since November, 2004, the CPS medical module has permitted the Division to electronically evaluate insurer performance on a monthly basis for timely filing and payment of medical bills. Medical bills must be paid, disallowed or denied within 45 calendar days of the date the bill is received. Medical bills must be filed with the Division within 45 calendar days of the date the bill is paid, disallowed or denied. Monthly bill payment information is reviewed and payment and filing performance penalties are assessed. The CPS also electronically tracks penalty payments, communications between the Division and regulated entities and proof of payment by the insurers. **Graphic 20** reflects the total number of medical bills submitted annually over time.

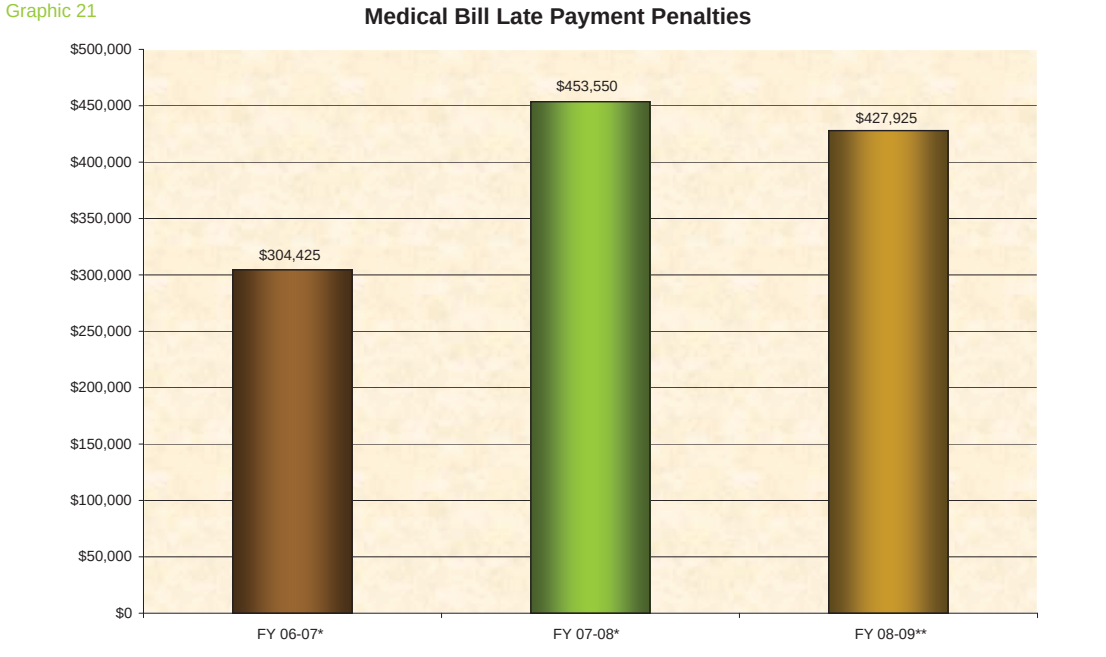
Graphic 20



Source: DWC Centralized Performance System as of 6/30/09
* This graphic may not reflect current data since real-time updates occur in the system as new data is received.

The Division is statutorily required to impose penalties for late payments, disallowances or denials of medical, hospital, pharmacy or dental bills that do not meet a minimum standard of 95% timely performance. Specifically, the carrier is required to pay a $25 penalty to the Workers' Compensation Administration Trust Fund for each bill below the 95% timely performance standard for all bills that do meet a 90% timely standard and a $50 penalty for each bill below a 90% timely performance standard. **Graphic 21** *below* illustrates the penalties assessed for late payment of medical bills for the past three fiscal years.

Graphic 21

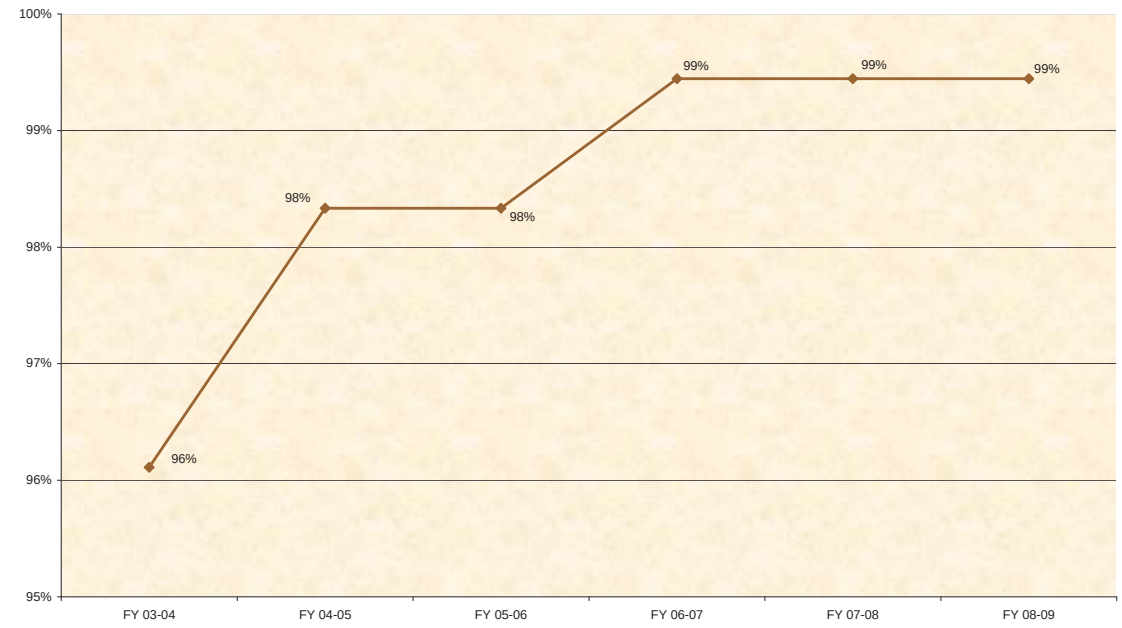


Source: DWC Centralized Performance System as of 6/30/09
* Penalty amounts have been updated to reflect recalculations based on current claims dispositions.
** These are preliminary penalty amounts that will be updated if penalties are recalculated to reflect different claims dispositions.

Graphic 22 illustrates timely medical bill payment performance. During FY 2003-2004, medical bills were manually evaluated for timely bill payment. At that time the industry average for timely payment

was 96%. Since the inception of electronic reporting of medical billing data in 2004 and the increased enforcement through CPS, the industry timely payment percentage has increased to 99%.

Graphic 22



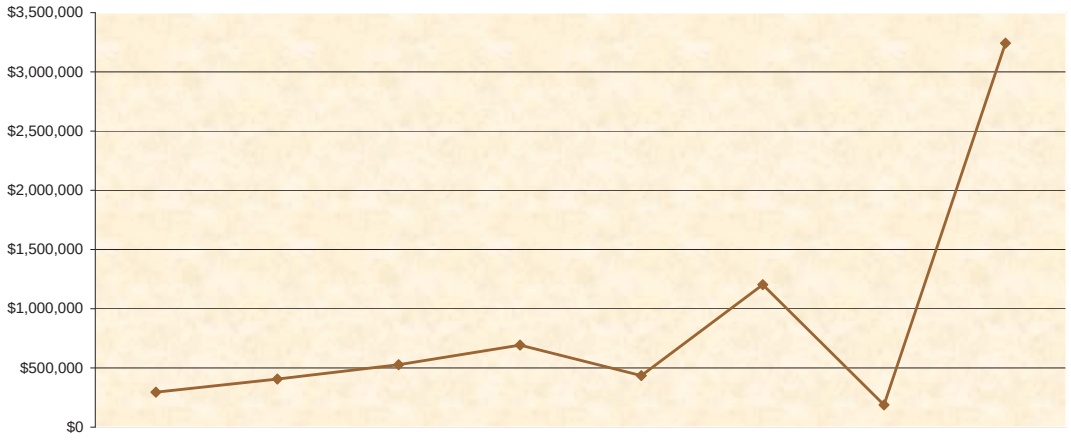
Source: DWC Centralized Performance System as of 6/30/09
*This graphic may not reflect current data since real-time updates occur in the system as new data is received.

In accordance with Rule 69L-7.602, F.A.C., insurers are required to report all medical bills timely. Insurers that fail to submit a minimum of 95% of all medical bills timely are subject to an administrative fine. Each untimely filed medical bill which falls below the 95% requirement is subject to penalties according to the following schedule:

- 1 – 30 calendar days late $5.00;
- 31 – 60 calendar days late $10.00;
- 61 – 90 calendar days late $25.00; and
- 91 or more calendar days late $100.00.

Graphic 23 *below* illustrates the quarterly penalties assessed for late filing of medical bills since July, 2007. The most recent quarter's penalties are considered preliminary until the insurer dispute process has been completed.

Graphic 23



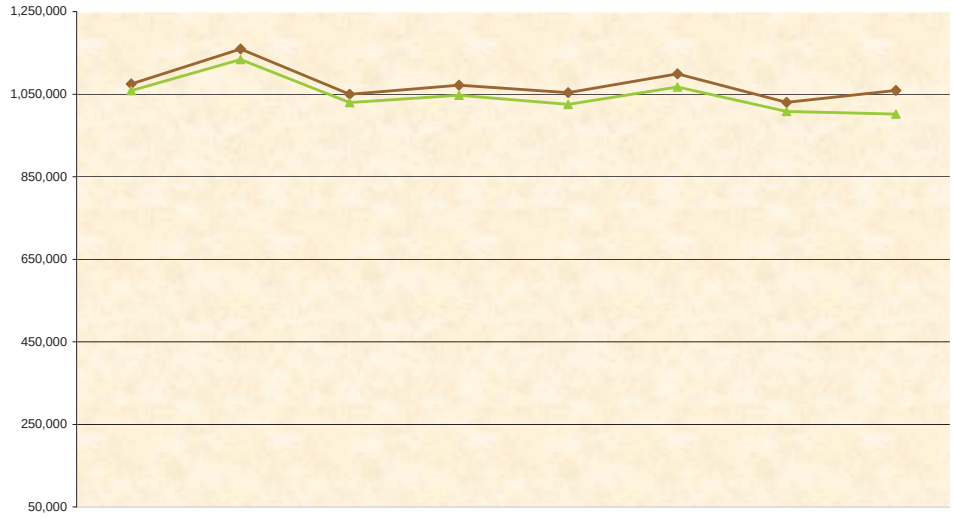
Quarter Ending Sept-07 *	Quarter Ending Dec-07 *	Quarter Ending Mar-08 *	Quarter Ending Jun-08 *	Quarter Ending Sept-08*	Quarter Ending Dec-08 *	Quarter Ending Mar-09 *	Quarter Ending Jun-09 *
$295,850	$406,340	$526,505	$692,475	$434,545	$1,202,515	$188,400	$3,241,710

Source: DWC Centralized Performance System as of 6/30/09
* Penalty amounts have been updated to reflect recalculations based on current claims dispositions.
** These are preliminary penalty amounts that will be updated if penalties are recalculated to reflect different claims dispositions.

Graphic 24 *below* compares the total number of medical bills filed to the total number of medical bills filed timely during the last two fiscal years.

Graphic 24

Timely Medical Bill Filing*



	Quarter Ending Sept-07	Quarter Ending Dec-07	Quarter Ending Mar-08	Quarter Ending Jun-08	Quarter Ending Sep-08	Quarter Ending Dec-08	Quarter Ending Mar-09	Quarter Ending Jun-09
Total Number of Bills Filed	1,074,769	1,159,273	1,049,666	1,071,843	1,053,490	1,099,018	1,030,110	1,059,222
Compliance Percentage	99%	97%	99%	97%	97%	97%	97%	97%
Total Number of Bills Filed Timely	1,058,702	1,133,734	1,029,741	1,047,077	1,025,252	1,067,218	1,007,918	1,001,978

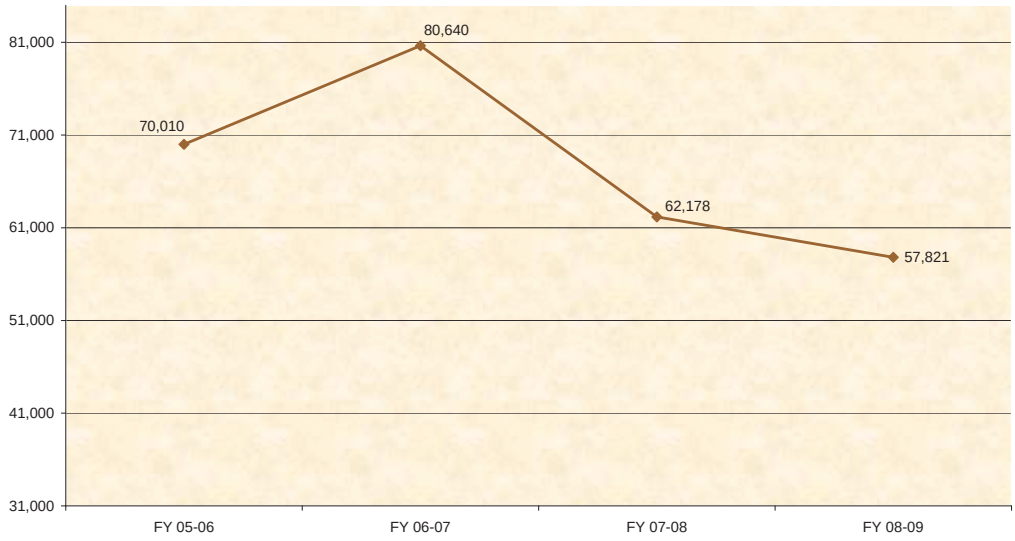
Source: DWC Centralized Performance System as of 6/30/09
*This graphic may not reflect current data since real-time updates occur in the system as new data is received.

Indemnity Module

The CPS indemnity module was implemented during June, 2005 for electronic evaluation of insurer performance for timely filing First Reports of Injury or Illness and timely payment of initial installments of indemnity benefits due to the injured worker. Prior to this implementation, the Division manually reviewed approximately 17% (13,000) of all filed First Reports of Injury or Illness per year. Subsequent to the implementation of this module, the Division was able to electronically review all forms submitted. **Graphic 25** *below* illustrates the changes in the volume of First Reports of Injury or Illness reviewed since the implementation of the indemnity module.

Graphic 25

First Reports of Injury or Illness Reviewed*

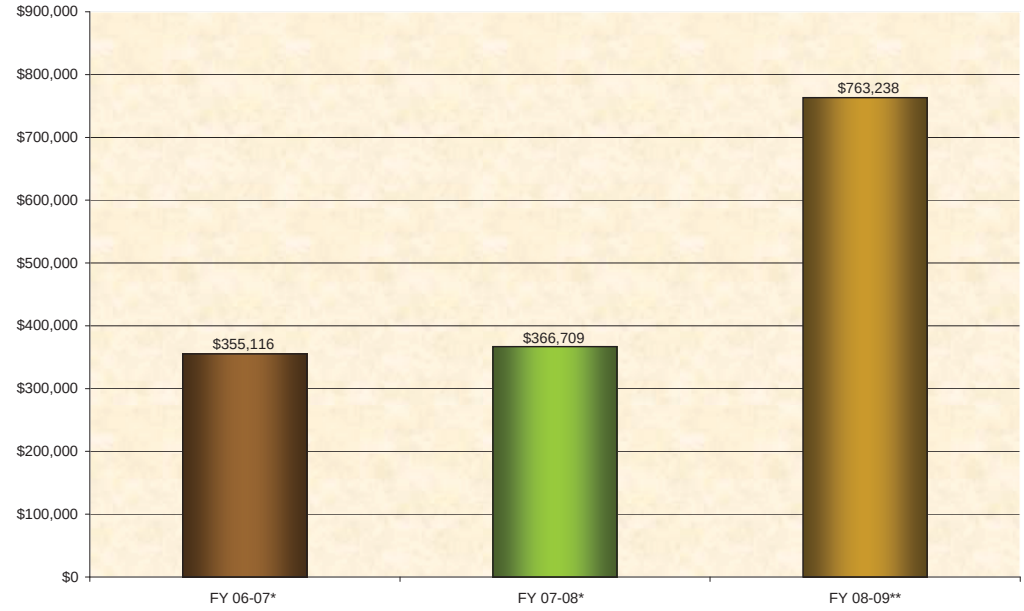


Source: DWC Centralized Performance System as of 6/30/09
* This graphic may not reflect current data since real-time updates occur in the system as new data is received.

The First Report of Injury or Illness is evaluated to determine if the initial indemnity benefit was paid timely. If not, the insurer must pay penalties and interest to the injured worker. **Graphic 26** *below* illustrates the penalties and interest awarded to injured workers over the past three fiscal years as a result of the CPS analysis regarding timely payment of initial indemnity benefits.

Graphic 26

Insurer Penalties and Interest on Late Initial Indemnity Benefit Payments

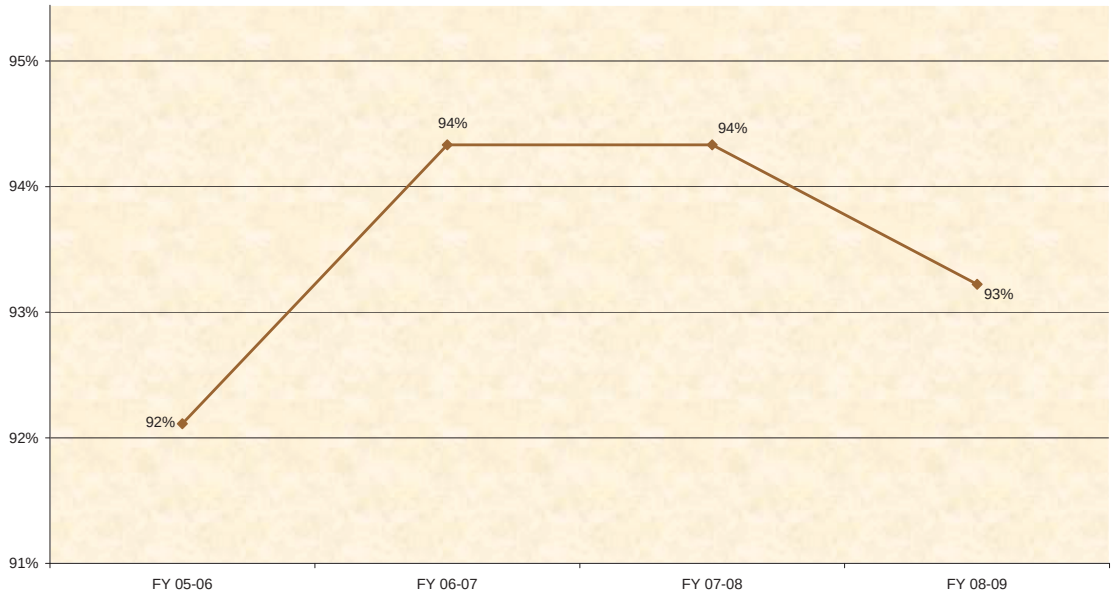


Source: DWC Centralized Performance System as of 6/30/09
* Penalty amounts have been updated to reflect recalculations based on current claims dispositions.
** These are preliminary penalty amounts that will be updated if penalties are recalculated to reflect different claims dispositions.

Graphics 27 and 28 illustrate insurer performance for timely payment of initial indemnity benefits over time. There was a slight decrease in the industry timely payment percentages from FY 2007-2008 to FY 2008-2009.

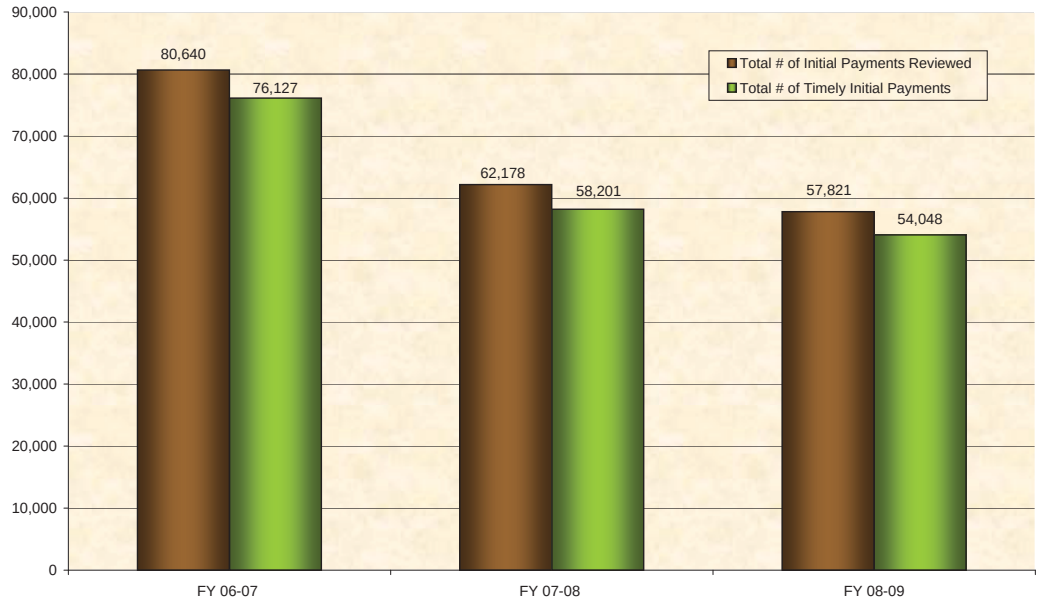
Graphic 27

Timely Initial Indemnity Benefit Payments*



Source: DWC Centralized Performance System as of 6/30/09
*This graphic may not reflect current data since real-time updates occur in the system as new data is received.

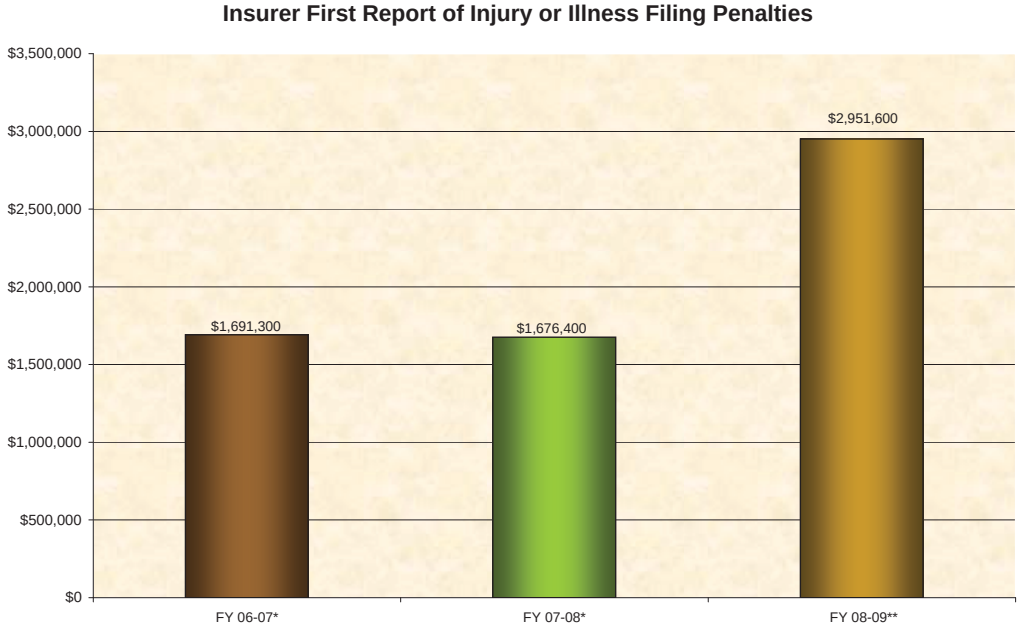
Graphic 28



Source: DWC Centralized Performance System as of 6/30/09
* This graphic may not reflect current data since real-time updates occur in the system as new data is received.

Insurers are also penalized for failure to timely file First Reports of Injury or Illness. **Graphic 29** *below* illustrates the penalties assessed to insurers for late filing of First Reports of Injury or Illness.

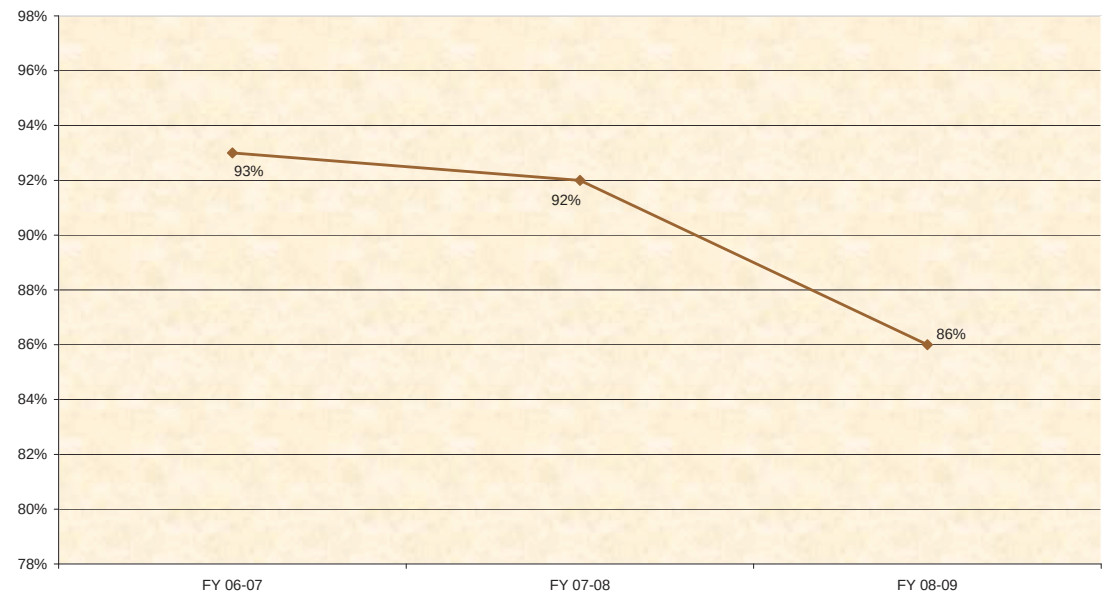
Graphic 29



Source: DWC Centralized Performance System as of 6/30/09
* Penalty amounts have been updated to reflect recalculations based on current claims dispositions.
** These are preliminary penalty amounts that will be updated if penalties are recalculated to reflect different claims dispositions.

Graphic 30 *below* represents timely filing percentages of the industry over the past three fiscal years.

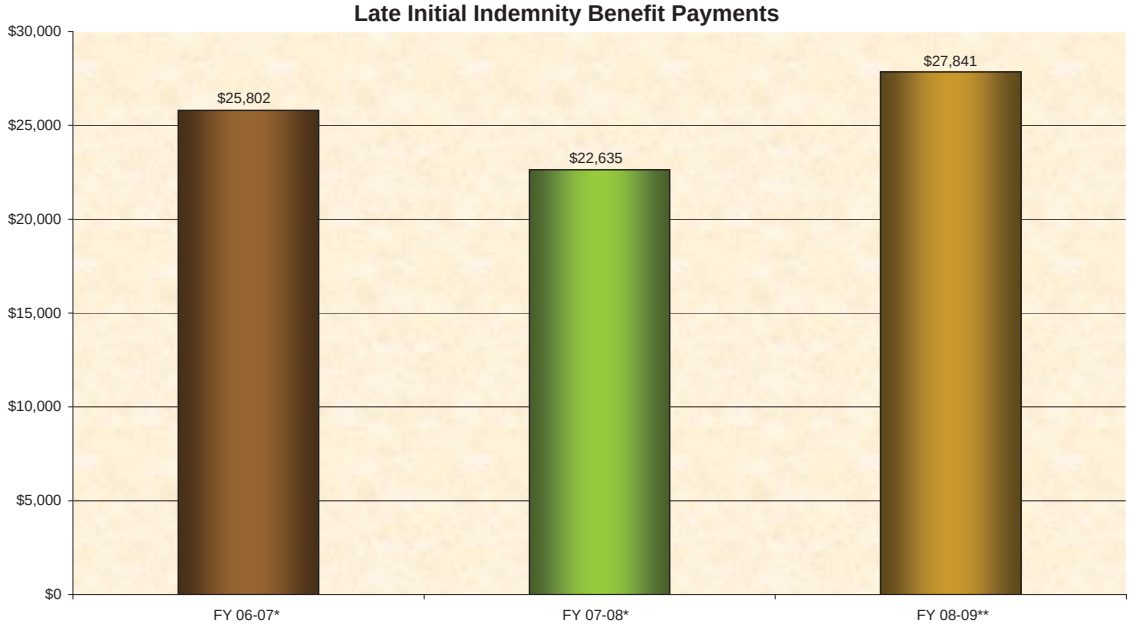
Graphic 30



Source: DWC Centralized Performance System as of 6/30/09
* This graphic may not reflect current data since real-time updates occur in the system as new data is received.

Employers are responsible for timely reporting the injury or illness to their insurer in accordance with ss. 440.20 and 440.185(9), F.S. and Rule 69L-3, F.A.C. Employers are required to pay penalties and interest to the injured worker if they are responsible for the late payment of indemnity benefits. Penalties and interest assessed to employers for causing the late payment of the initial indemnity benefit are illustrated in **Graphic 31** *below*. Employers are also penalized for reporting an injury or illness late to the insurer. **Graphic 32** reflects the total penalties issued to employers for the late reporting of injuries or illnesses.

Graphic 31



Source: DWC Centralized Performance System as of 6/30/09
* Penalty amounts have been updated to reflect recalculations based on current claims dispositions.
** These are preliminary penalty amounts that will be updated if penalties are recalculated to reflect different claims dispositions.

Graphic 32

Source: DWC Centralized Performance System as of 6/30/09
* Penalty amounts have been updated to reflect recalculations based on current claims dispositions.
** These are preliminary penalty amounts that will be updated if penalties are recalculated to reflect different claims dispositions.

During FY 2008-2009, the Penalty Section:

- Evaluated and monitored the accuracy and timeliness of 57,821 First Reports of Injury or Illness filed by employers, insurers and claims-handling entities through CPS. This evaluation resulted in a combined total of $791,079 for penalties assessed against employers and insurers due to late payments and a combined total of $3,103,600 for assessed penalties due to late filings.

- Evaluated and monitored insurer performance for timely disposition and timely filing of medical bills through CPS. 4,241,840 medical bills were evaluated for compliance with the Division's timely disposition and timely filing standards and resulted in $427,925 in late disposition assessed penalties and $5,067,170 in late filing assessed penalties.

Permanent Total Section

The PT Section determines the accuracy and timeliness of permanent total and permanent total supplemental benefit payments to injured workers through audits of claims data submitted to the Division by insurers and on-site audits of insurers and claims-handling entities.

The Division is required to pay permanent total supplemental benefits to all permanently and totally disabled workers who were injured prior to July 1, 1984. During FY 2008-2009, the PT Section calculated, approved and processed supplemental benefits for 1,737 claims, totaling $20,290,890. In addition, the PT Section verifies the calculation of social security offsets and permanent total benefits due to these injured workers. The PT Section also verifies ongoing eligibility for the continued receipt of permanent total supplemental benefits by reviewing the following resources:

- List of deceased persons provided by the Department of Health, Bureau of Vital Statistics;
- Out-of-state list of deceased persons provided by a private vendor;
- Department of Corrections inmate records;
- Judges of Compensation Claims data; and
- Employee Earnings Reports.

Graphic 33 represents the permanent total supplemental benefits paid to injured workers by the Division over the past nine years.

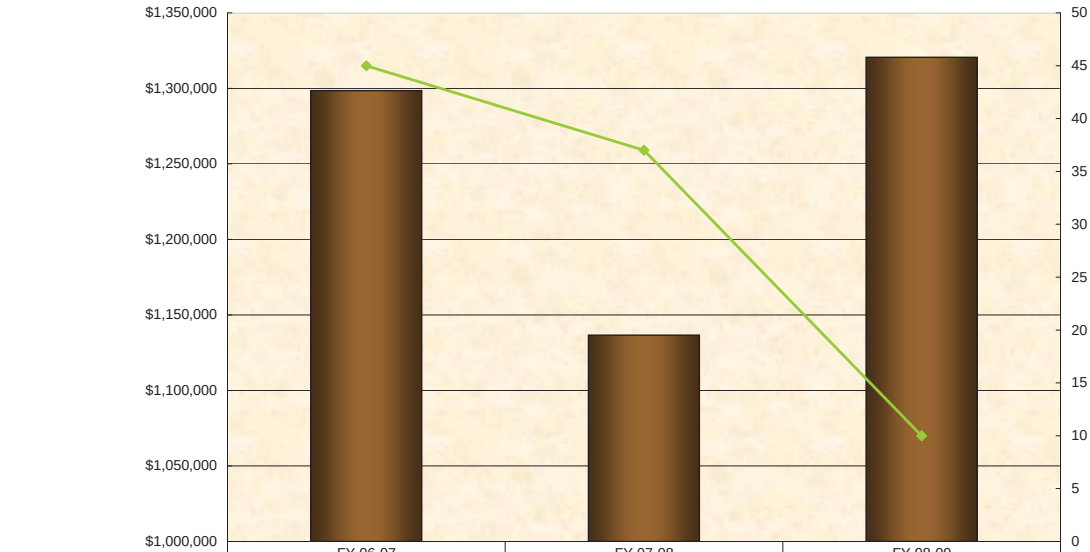
Graphic 33

Permanent Total Supplemental Benefits Paid to Injured Workers by the Division

Source: DWC Bureau of Monitoring and Audit as of 6/30/09

Graphic 34

Permanent Total Benefit Underpayments Identified Through Desk Audits



	FY 06-07	FY 07-08	FY 08-09
Amount of Underpayments	$1,298,510	$1,136,665	$1,320,516
Underpayments Found	45	37	10

Source: DWC Bureau of Monitoring and Audit as of 6/30/09

The PT Section handles requests for assistance and dispute resolution concerning PT benefits by determining the correct benefit and payment amounts due. The PT Section also partners with the Special Disability Trust Fund (SDTF) and the Audit Section to ensure injured workers are receiving appropriate permanent total benefits. When discrepancies are noted by the SDTF during the processing of reimbursement requests or by the Audit Section during insurer audits, the discrepancies are referred to the PT section for resolution of payment and benefit issues.

During FY 2008-2009, the Permanent Total Section:

- Audited 15,470 claim documents filed by insurers with the Division to ensure the payment of accurate permanent total and permanent total supplemental benefits;

- Calculated and approved payment of $20,290,890 in permanent total supplemental benefits to 1,737 eligible injured workers.
- Determined and authorized reimbursement payments to injured workers in the amount of $1,320,516 due to underpayments by insurers as shown in **Graphic 34**.

PERMANENT TOTAL SECTION SUCCESS STORIES

An injured worker was accepted as permanently and totally disabled in February 1989, after he received an electrical shock and burns to his body in a work related accident in December 1985. During a recent desk audit by the Permanent Total Unit, it was determined that the claimant had not received permanent total supplemental benefits from the insurer since 1992. After the insurer was notified of the past due benefits, the injured worker was paid $392,131 in back benefits and bi-weekly permanent total supplemental benefit payments were resumed in the amount of $737 for this 80 year old injured worker.

As a result of a review and analysis of a SDTF reimbursement claim, a case file was referred to the PT Section to determine if the injured worker had received the appropriate benefits. The worker was injured on June 5, 1986 and was determined to be permanently and totally disabled on June 19, 1986. When the injured worker turned 62, on March 5, 2001, the insurer improperly discontinued paying PT supplemental benefits. The Specialist contacted the insurer and advised that the insurer was not properly applying case law and that injured workers who were injured prior to July 1, 1990, received supplemental benefits until death. After further investigation, the Permanent Total Specialist discovered that during the time the insurer had not paid permanent total supplemental benefits, they had been incorrectly paying benefits at a higher weekly compensation rate than was justified. The PT Specialist concluded that the injured worker was due $140,273 in past permanent total supplemental benefit payments, penalties and interest, but the insurer was entitled to a credit of $15,857. This resulted in the insurer owing and paying the injured worker an additional $124,416 in past due benefits.

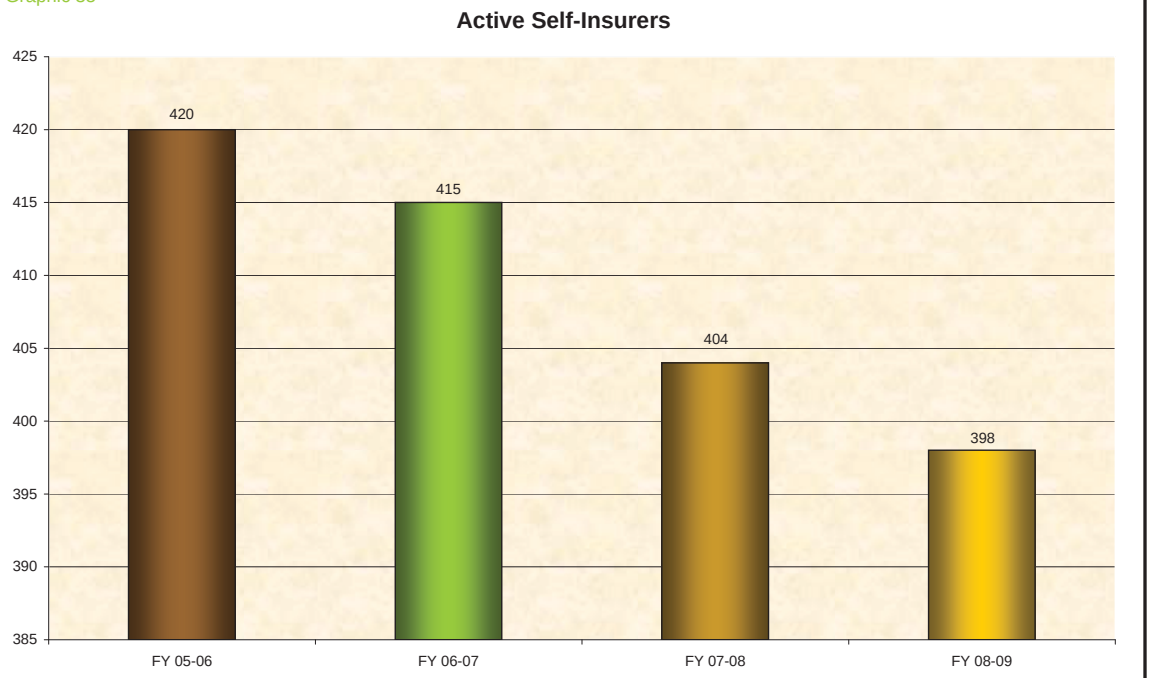
During a review of an annual Claim Cost Report, a Permanent Total Specialist noted that there was no information regarding payment of permanent total supplemental benefits for the injured worker. The worker had been injured on July 19, 1995, at age 65, when she fell over an open file cabinet drawer and sustained contusions and multiple injuries to her body. On October 16, 1995, she was accepted as permanently and totally disabled. The Specialist contacted the insurer who concurred with the Division's determination of the underpayment and sent the injured worker a check for $144,123, which included past due benefits, penalties and interest.

The PT Section audited a file on an 83 year old who had been injured in 1988 in an automobile accident and suffered broken ribs, lacerations and contusions to his arms and legs. The injured worker was accepted as permanently and totally disabled in November, 1991. The Insurance Specialist determined that the injured worker had not been paid permanent total supplemental benefits from November 15, 1991, through August 10, 2007. The injured worker was contacted and advised of the $295,697 due and owing to him. After review of the Division's findings, the insurer sent a check to the injured worker for the full amount.

Self-Insurance Section

The Self-Insurance Section is responsible for approving self-insurance programs for governmental and private companies that have met statutory requirements and demonstrated the required financial strength to fund their workers' compensation liabilities. **Graphic 35** *below* shows the number of active self-insurers over the last four fiscal years.

Graphic 35



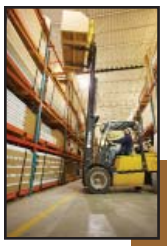
Source: DWC Bureau of Monitoring and Audit as of 06/30/09

The Self-Insurance Section contracts with the Florida Self-Insurance Guaranty Association (FSIGA) to review financial statements and actuarial reports of self-insurers to ensure their financial stability and ability to pay current and future workers' compensation liabilities. FSIGA makes recommendations to the Division to request modification of security deposits when needed and grant the self-insurance privilege. Further, FSIGA collects and examines self-insurers' financial statements and payroll, loss data and outstanding liabilities reports and forwards them to the Division.

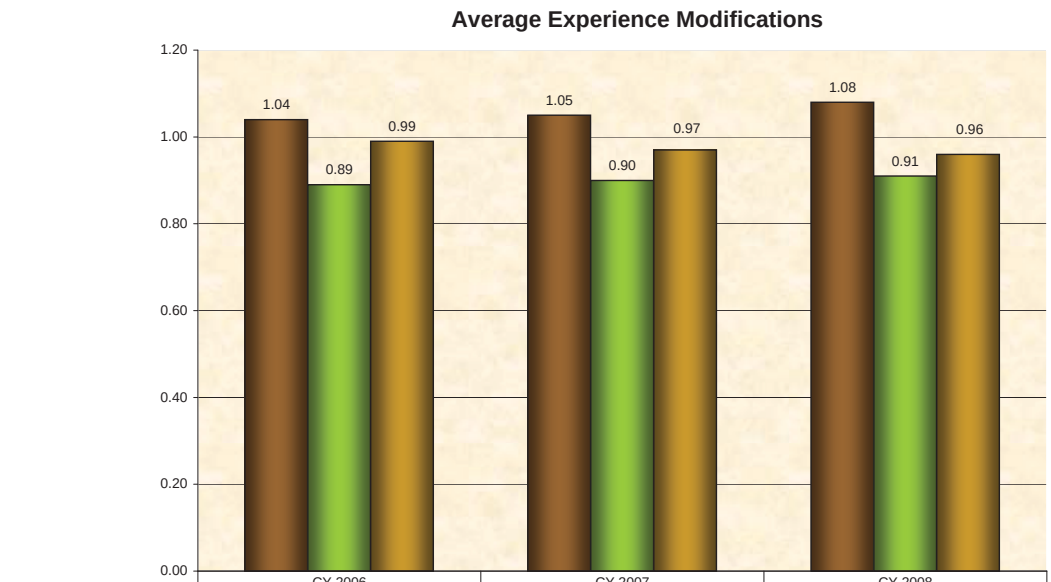
The Self-Insurance Section performs on-site audits of self-insurers' payroll information to ensure that payrolls and employee classifications are correctly reported since this data is used to determine the amount of each insurer's assessment to be paid to the Workers' Compensation Administration Trust Fund and the Special Disability Trust Fund. Upon receipt of loss and payroll data from self-insurers, the Self-Insurance Section promulgates individual experience modification factors for each self-insurer. The experience modification factor is also used by the Assessment Unit to calculate each self-insurer's annual assessments.

Workers' compensation premiums are calculated using the experience modification factor. The experience modification factor reflects an entity's loss experience for the past three years. The lower the factor is, the lower the premium. **Graphic 36** shows the average experience modification among governmental self-insurers, private self-insurers and commercial insurers over the last three years.

The Self-Insurance Section certifies service companies that meet statutory requirements to provide adjusting, loss control and rehabilitation services to self-insurers. The Self-Insurance Section monitors the performance of service companies and each entity must annually apply for recertification. **Graphic 37** shows the change over time in the number of certified service companies.



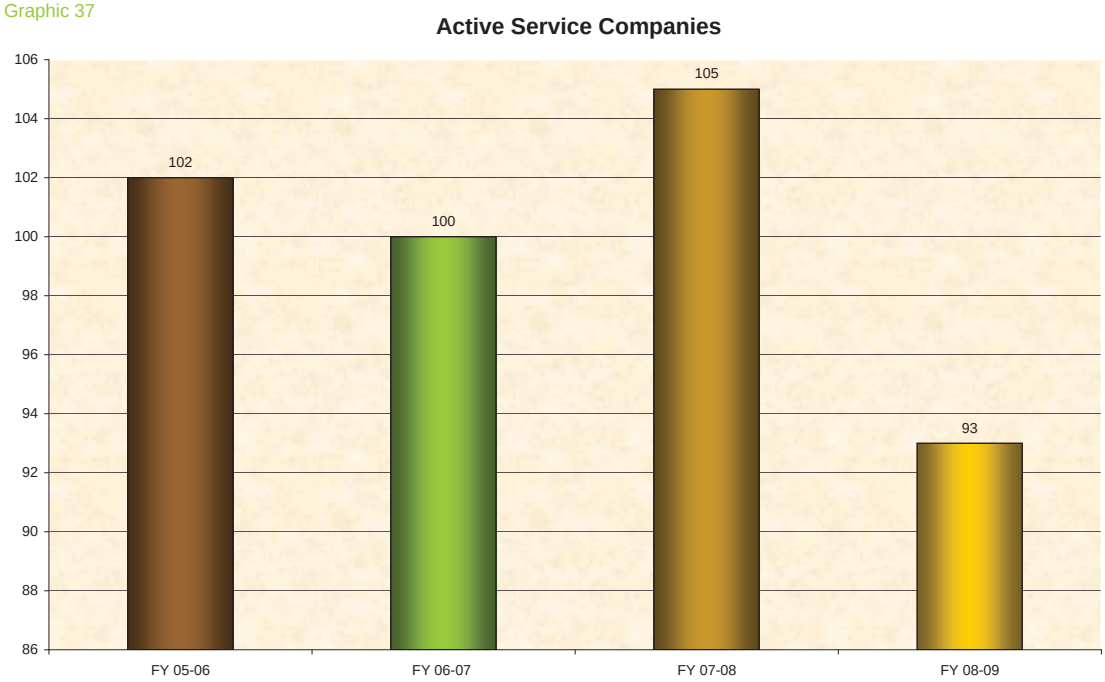
Graphic 36



	CY 2006	CY 2007	CY 2008
Governmental Self-Insurers	1.04	1.05	1.08
Private Self-Insurers	0.89	0.90	0.91
Commercial Insurers	0.99	0.97	0.96

Source: DWC Bureau of Monitoring & Audit and NCCI's database as of 12/31/08

Graphic 37



Source: DWC Bureau of Monitoring and Audit as of 06/30/09

During FY 2008-2009, the Self-Insurance Section:

- Promulgated 398 experience modification factors for active self-insurers;
- Approved nine new service companies and recertified 84;
- Approved 11 new self-insurance entities; and
- Audited payroll records of 21 self-insurers and 33,322 payroll records. The audits resulted in the reporting of an additional $23,069,553 in payroll dollars and the over reporting of $1,107,891 in manual premium for assessment purposes.

SELF-INSURANCE SECTION
SUCCESS STORIES

While conducting a payroll/premium audit of a government self-insurer, an error was identified in the computer software used by the self-insurer to generate payroll reports. The auditor advised the self-insurer that due to this error, the quarterly payroll report and the Division payroll report did not reconcile, resulting in over reported payroll of $1,756,147. Also, the manual premium was reduced by $525,375, because of numerous employee misclassifications. This reduction reduced the amount of the employer's SDTF and WCATF assessments and provided the employer with an assessment credit.

During a self-insured employer payroll/premium audit, it was determined that the employer had reported his payroll to the Division for the calendar year rather than the fiscal year, as required. This resulted in the employer's quarterly report not reconciling with the payroll report. When the auditor reconciled the reports, it was determined that the employer had over reported his total payroll by $1.9 million. The auditor also corrected the misclassification of numerous employees, which resulted in a reduction of $1.2 million in the self-insurer's workers' compensation manual premium. This reduced the amount of the self-insurer's assessment for the SDTF and the WCATF and entitled the self-insurer to a credit on future assessments.

The payroll of a self-insurer was reviewed during a payroll/premium audit and it was determined that the self-insurer had not included the payroll totals for all subsidiaries listed under its workers' compensation program. As a result, the self-insurer had under reported its payroll in the amount of $32,901,218. The additional payroll and reclassification of employees increased the self-insurer's manual premium by $168,155. As a consequence, the self-insurer owed additional assessment amounts for the SDTF and WCATF.

BUREAU OF DATA QUALITY AND COLLECTION

The Bureau of Data Quality and Collection (DQC) is responsible for collecting workers' compensation claims, medical, and proof of coverage data; ensuring data quality; organizing data to provide real-time feedback to data submitters; and maintaining accurate and readily accessible information for all workers' compensation stakeholders. As the central information collection point for workers' compensation information sent to the Division, DQC facilitates the distribution of this data to other areas of the Division. Other DQC responsibilities include research and analysis of data collected by the Division and publication of research studies.

DQC accomplishes its mission by:

- Ensuring the quality of information submitted to the Division concerning injured workers' claim filings, medical services billings and employers' proof of coverage status through systematic and organized collection, editing and analysis of these data.
- Developing and implementing Rule 69L-56, F.A.C., to establish filing requirements and procedures for proper reporting of electronic First Reports of Injury or Illness, Subsequent Reports of Injury, including Notices of Action/Change, Periodic Claim Cost Reports, Notices of Denial, Changes in Claims Administration Report and Proof of Coverage (POC) filings, using national Electronic Data Interchange (EDI) standardized file formats.
- Providing "real time" filing results to EDI submitters via an electronic acknowledgement for all electronic medical, claims and proof of coverage data submissions.
- Training, facilitating and supervising the transition process from paper to electronic submission of required reports.
- Providing performance feedback to EDI claims and medical submitters regarding the status of their electronic submissions, including feedback about an individual submitter's current performance levels and their performance compared to all other submitters.
- Serving as the repository for workers' compensation paper records that are archived using electronic imaging technology.
- Processing and complying with public record and subpoena requests.
- Conducting research and periodically issuing research briefs.

FY 2008-2009 Accomplishments

- Received 4,221,599 medical records from claims handling entities (CHEs) comprised of bills from health care providers including physicians, hospitals, ambulatory surgical centers, pharmacies, therapists and dentists. One hundred percent of all medical reports have been filed electronically with the Division since FY 2005-2006. The total number of accepted records stored in the Division's Medical Data Warehouse exceeded over 44.7 million as of June 30, 2009.
- Received and processed 714,821 electronic Proof of Coverage (POC) transactions.
- Received and processed a combined total of 64,177 electronic First Reports of Injury or Illness, 69,007 Notices of Action/ Change, 24,721 (total or partial) Notices of Denial, and 150,185 Claim Cost Reports, for a total of 308,090 electronic filings.
- Received and processed a combined total of 28,550 paper First Reports of Injury or Illness, 79,220 Notices of Action/Change, 13,854 (total or partial) Notices of Denial, and 92,708 Claim Cost Reports for a total of 214,332 paper filings.
- Received and processed 4,043 subpoenas for record production and 3,701 public records requests.
- Published a research brief on the impact of compensability changes in the 2003 Workers' Compensation Reform (Senate Bill 50-A).
- Provided claim administrators with one two-day training class on the R3 Claims EDI reporting standard and requirements, bringing the total attendance for all six training classes provided over the last three years to 573 members of the claims-handling industry.

Ensuring Data Quality through Electronic Collection and System Edits

As part of the move to a paperless system, the Bureau implemented standardized methods for the electronic submission of workers' compensation proof of coverage, claims and medical data. The Division adopted the International Association of Industrial Accident Boards & Commissions (IAIABC) national standard for claims and proof of coverage reporting and developed a proprietary electronic reporting system to collect medical data. These efforts moved the Division into a real-time business environment that has permitted the Division to enhance its regulatory oversight of claims-handling practices and increase efficiency.

One of the main goals of electronic data collection is to increase the integrity of the data submitted to and used throughout the Division to conduct day-to-day responsibilities. As the central point of data collection for the Division, the Bureau has instituted thousands of program edits to ensure the quality of the data. Electronic filings are edited for the presence of required data fields and the validity of specified data elements. These edits ensure that the data have been inspected and validated and prevent the acceptance of EDI filings that are missing critical data elements or contain incorrect information. If an EDI submitter attempts to report information that is incomplete or inaccurate, the electronic submission will be rejected. Only those transactions that pass structural and business edits are uploaded to the Division's claims, proof of coverage and medical databases, thus ensuring greater reliability of collected data. EDI submitters can review all system acknowledgement results that identify data that have failed edits. Timely filings are only acknowledged after a rejected EDI submission is corrected, resubmitted, and successfully passes all structural and quality edits within the filing timeframe required by the applicable administrative rule.

The Bureau has developed proprietary business edits and national standardized edits to make certain data are of the highest quality. An example of a proprietary edit is the 'duplicate check' edit that each medical bill undergoes upon submission to the Division. This edit compares each medical bill submitted to the previously accepted medical bills in the medical data warehouse, to determine if that bill data has been previously submitted. When duplicates are detected, the current submission is rejected. An example of a national edit is the requirement that data be submitted in the proper sequence; i.e., a Claim Cost Report cannot be submitted prior to the First Report of Injury or Illness. The system automatically blocks the receipt and collection of data submitted out of order.

Claims Electronic Data Interchange (EDI) Release 3 Progress Update

The Bureau of Data Quality and Collection began its implementation of claims data collection using the IAIABC national standard Claims EDI Release 3 formats in March, 2008. As of July, 2009, 1,093 insurers, represented by 156 trading partners, had achieved full EDI implementation.

In addition to receiving data in a more technologically efficient manner through EDI, the Division has also increased the quality of data collected. Rejected EDI filings are being re-filed more quickly because the notification that one or more EDI filings were not accepted is sent to the submitter the morning after submission. Error messages provide information for proper correction and re-submission. The EDI process results in more data being available earlier to the Division for responding to employee, employer and insurer requests for information and assistance. For example, during the last five years, a paper First Report of Injury or Illness that took the Division an average of 10 days to image, index and manually enter data is now being processed the same day the electronic form equivalent is accepted by the Division. This improvement enables EAO the ability to contact injured workers sooner to offer assistance.

The exchange of electronic claims information between CHEs and the Division has also improved feedback to submitters. The EDI data warehouse provides the claim administrator with a user-friendly view of their electronic transactions and acknowledgement outcomes via a secure database available on the Division's website. The database allows CHEs to identify filings that have been rejected, but not yet corrected and resubmitted; filings for which non-fatal errors generated by the Division's program edits remain uncorrected; and to access various reports that allow each claims-handling entity to assess its filing performance.

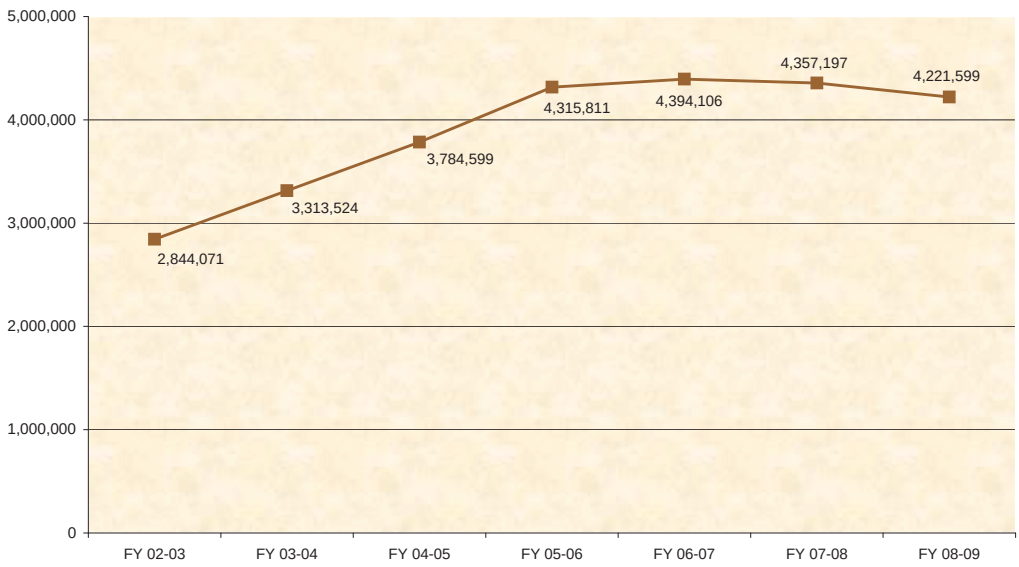
Medical Data EDI Update

The Bureau's Medical Data System (MDS) received, processed and accepted over 4.2 million medical bills during FY 2008-2009. This volume has held steady for the past four fiscal years. The processing performance of MDS averages two to three medical bills per second, while simultaneously applying hundreds of structural and quality edits to each medical bill received.

Analysis to detect inaccurate medical data is on-going and has led to the development and implementation of additional quality edits. For example, the Division determined that when data submitters received paper medical billings, they must enter that information into an electronic system to be able to submit the data to the Division electronically. This manual entry was found to result in some extensive charge and/or reimbursement data errors. To reduce these errors, an edit was developed to compare the relationship between charge and reimbursement data to identify those cases needing further investigation.

Graphic 38 *below* illustrates the volume of medical bills accepted in electronic form over time.

Graphic 38



Source: DWC Medical Data Warehouse as of 7/1/09

Each medical bill record submitted to the Division is required to meet specific data requirements to ensure accuracy and completeness of the data. If a record is rejected, the submitter must successfully re-submit corrected data within 45 days of the date the bill was adjudicated in order to meet administrative rule requirements. **Graphic 39** illustrates the submitters' performance for initial filing acceptance of medical bills. Due to the implementation of more sophisticated quality edits over the past two fiscal years, initial medical bill acceptance has slightly declined.

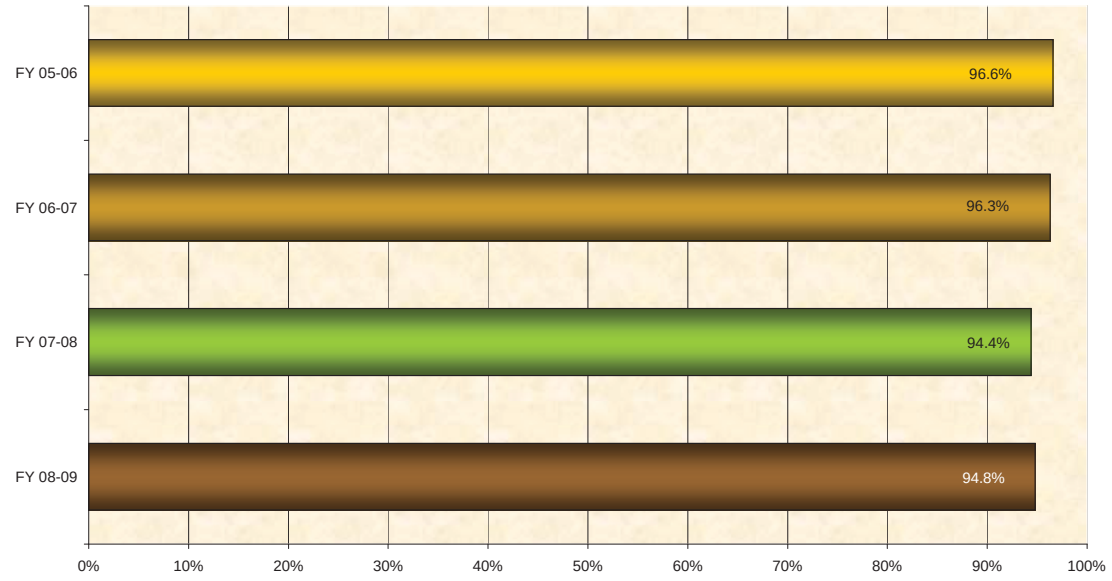
In order to improve the rate of initial medical bill acceptance, the Division generates monthly report cards for all submitters that detail their respective reasons for initial bill rejection. The report card also compares the performance of each submitter to the performance of all submitters. **Graphic 40** illustrates the top five reasons for medical bill record rejection over the past four fiscal years.

Administrative Rule Amended in FY 2008-2009

Rule 69L-56, F.A.C.; Electronic Data Interchange (EDI) Requirements for Proof of Coverage (POC) and Claims (Non-Medical), was amended to specify insurer requirements for reporting proof of coverage information to the Division to identify a professional employer organization or employee leasing company and its client companies. The rule incorporated by reference, the revised IAIABC EDI Implementation Guides for POC and Claims, as well as a revised Florida POC Implementation Manual which contained a new requirement to report total payroll and number of employees. The rule also added a new definition for the meaning of "Cancellation/Non-Renewal Effective Date" and clarified that the employer address must not be substituted for the employee address when filing an electronic First Report of Injury or Illness with the Division.

Graphic 39

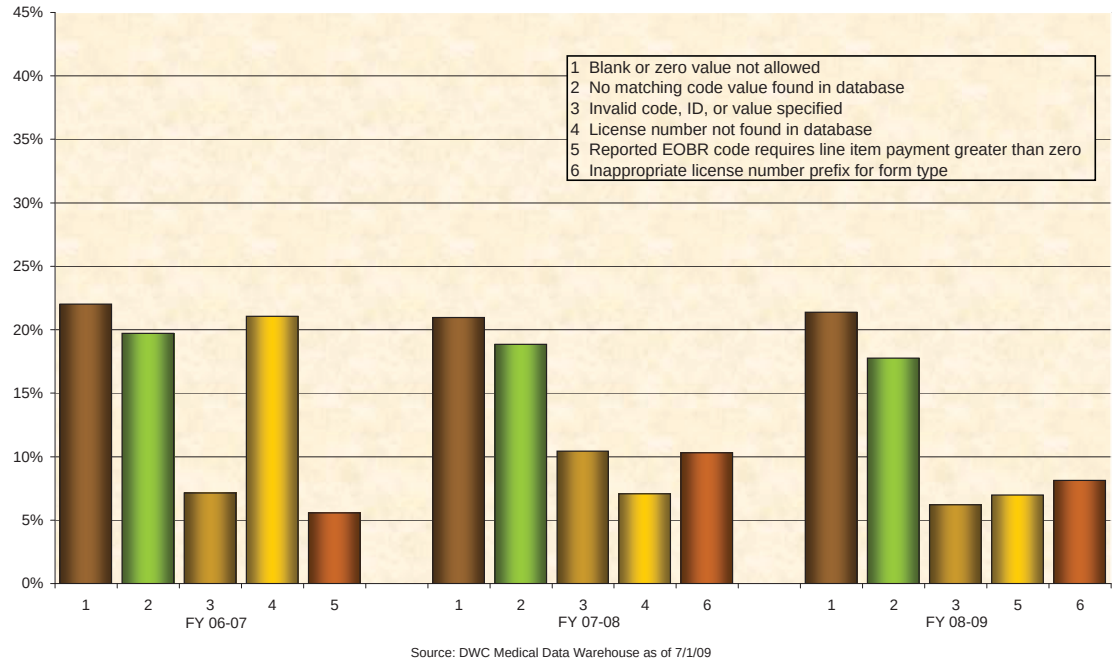
Original Medical Bill Acceptance Performance
(DWC-9, DWC-10, DWC-11, DWC-90)



Source: DWC Medical Data Warehouse as of 7/1/09

Graphic 40

Top Five Rejection Reasons for Medical Bills
(DWC-9, DWC-10, DWC-11, DWC-90)



Source: DWC Medical Data Warehouse as of 7/1/09

BUREAU OF EMPLOYEE ASSISTANCE AND OMBUDSMAN OFFICE

The Employee Assistance and Ombudsman Office (EAO) is responsible for facilitating the self-executing features of the Workers' Compensation Law by:

- Initiating contact with injured employees to discuss their rights and responsibilities and advising them of services available through EAO;
- Educating and disseminating information to all system participants;
- Assisting system participants in fulfilling their statutory responsibilities;
- Resolving disputes without undue expense, costly litigation or delay in the provision of benefits; and
- Reviewing claims in which injured workers' benefits have been denied, stopped or suspended.

To effectively fulfill these charges, EAO utilizes a team structure. This approach allows each team to focus on specific statutory responsibilities. This focus also permits EAO to contact a larger proportion of injured workers, educate a greater number of system stakeholders and ultimately provide more assistance. Further, each team can collect more data about its functions, permitting a more comprehensive analysis of the workers' compensation system.

First Report of Injury Team

Utilizing Division data, the First Report of Injury Team identifies injured workers who have lost more than seven days of work due to job related injuries. Within two business days of the Division's receipt of a First Report of Injury or Illness, the Team initiates contact with injured workers to discuss their rights and responsibilities under the Workers' Compensation Law, educate them about the Workers' Compensation System and advise them of EAO's services.

The First Report of Injury Team's outreach efforts assist injured workers by clarifying their understanding of the workers' compensation system. Initial telephone contact with injured workers also allows the Team the opportunity to answer questions about the workers' compensation system and immediately address any concerns about medical or indemnity benefits.

During FY 2008-2009, the Team personally contacted 25,271 injured workers by telephone. If the Team was unable to reach an injured worker, contact was attempted with the injured worker's employer. The Team made personal telephone contact with 12,238 employers to inquire about the status of the injured worker's claim and to advise the employers about EAO's services. While EAO succeeded in contacting 94% of injured workers and/or employers, there were 2,593 claims in which the Team was unable to reach either party by telephone. In addition to educating injured workers by telephone, EAO mailed letters to 40,102 injured workers to advise them of EAO's services and offer assistance.

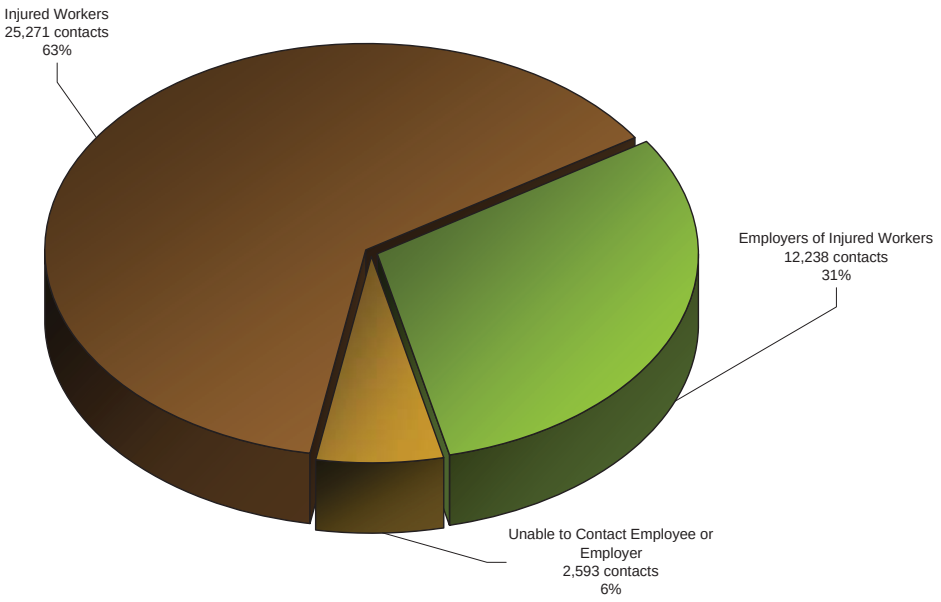
Graphic 41 illustrates injured worker and employer contacts by the First Report of Injury Team. **Graphic 42** illustrates that the injured worker contact rate has steadily increased during the past four fiscal years. The increased contact success rate is attributable to the creation of a team solely to perform this function.

Injured Worker Helpline Team

The Injured Worker Helpline Team's primary responsibility is to educate and provide assistance to system participants who call the Division's toll-free telephone line. The Team answers general questions about the workers' compensation system as well as specific inquiries posed by injured workers about their claims. The Team also facilitates the resolution of minor disputes on behalf of injured workers. During FY 2008-2009, the Team provided workers' compensation educational information and assistance to 72,719 system participants, including 8,232 Spanish-speaking callers.

Graphic 41

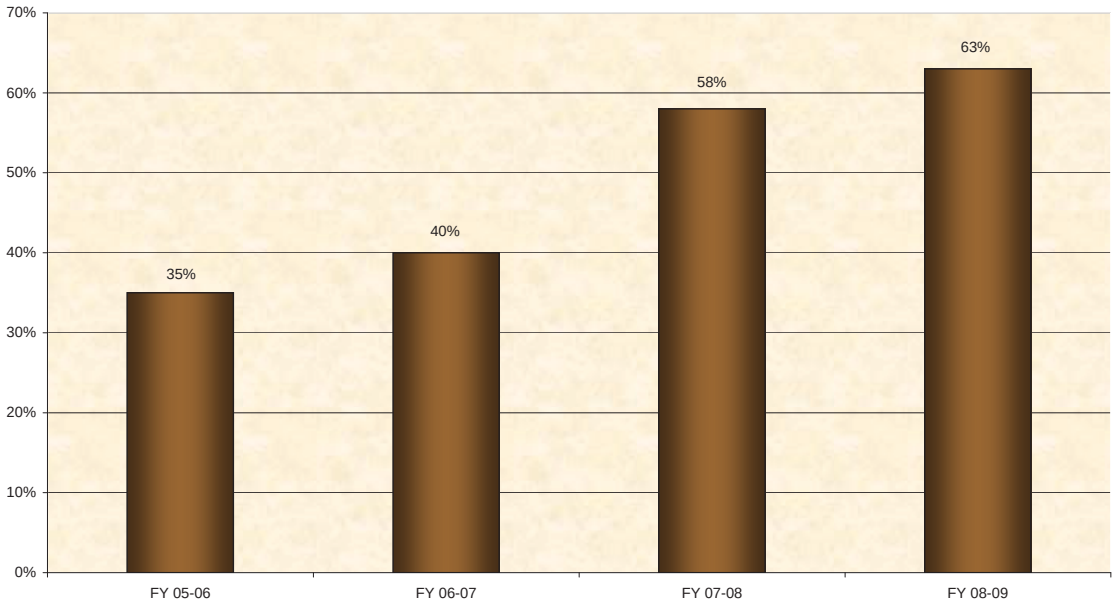
First Report of Injury Team - Injured Worker & Employer Contacts FY 08-09



Source: DWC Integrated Database as of 6/30/09

Graphic 42

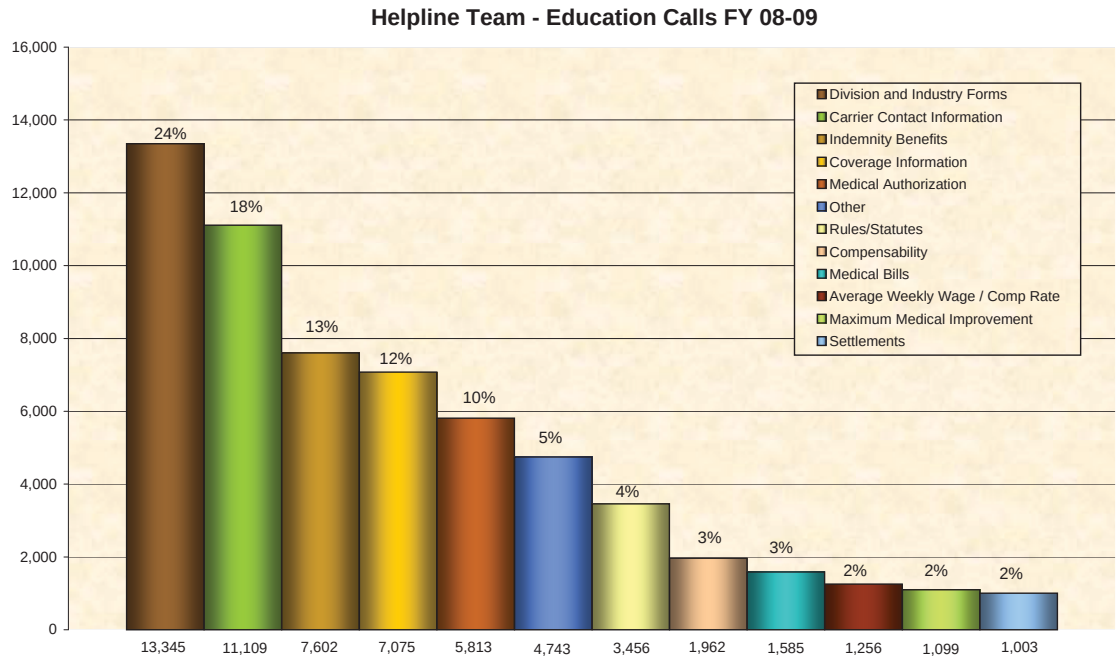
First Report of Injury Team - Injured Worker Contact Rate



Source: DWC Integrated Database as of 6/30/09

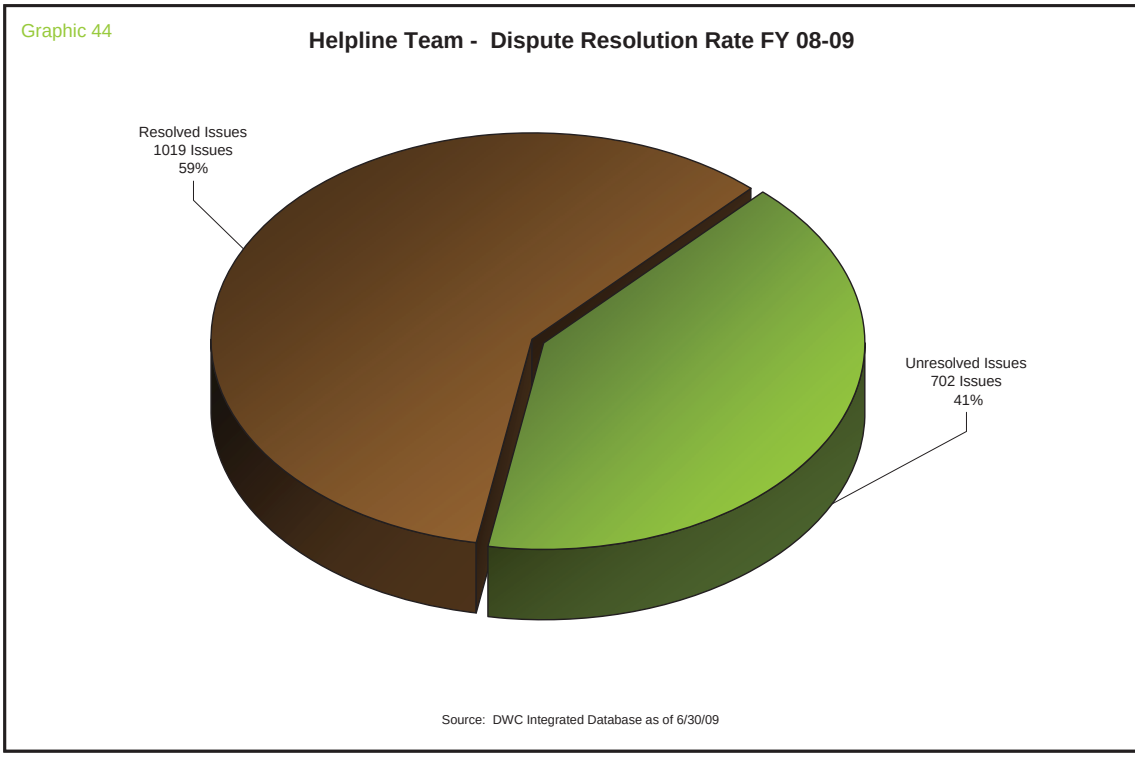
Graphic 43 *below* illustrates the volume of educational inquiries by topic addressed by the Injured Worker Helpline Team.

Graphic 43



During FY 2008-2009, the Helpline Team resolved 1,019 disputes out of 1,721 disputes filed with the Division and prevented another 6,647 potential disputes by providing in-depth case specific information and education to injured workers. **Graphic 44** *below* illustrates the dispute resolution rate for the Injured Worker Helpline Team.

Graphic 44



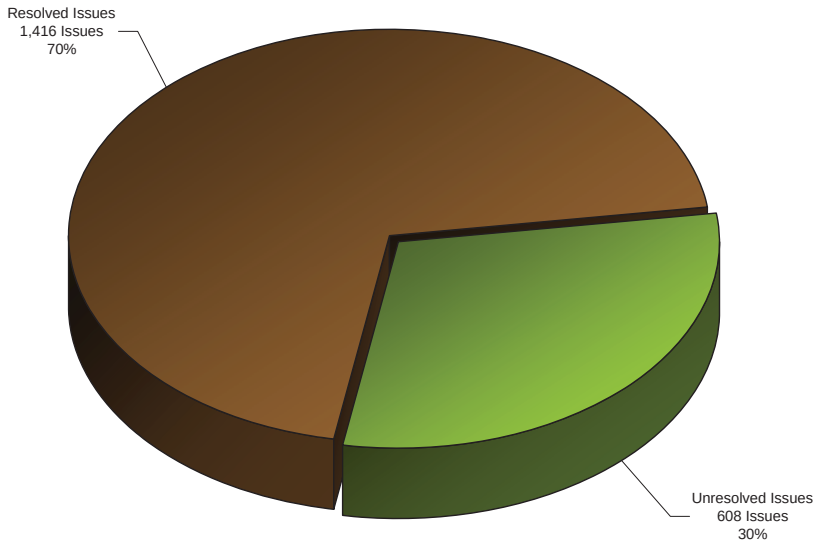
Ombudsman Team

The Ombudsman Team assists injured workers in resolving complex and contentious disputes by conducting fact finding reviews, promoting open communication between parties and advising them of their statutory responsibilities. During FY 2008-2009, the Ombudsman Team resolved 1,416 disputes out of 2,024 disputes filed with the Division and prevented another 1,585 potential disputes by educating injured workers and providing them with in-depth case specific information. Of the 1,416 disputes resolved, 329 were disputes from injured workers regarding unpaid medical bills. The amount charged for the unpaid medical treatment was $3,936,298.

Graphic 45 *below* illustrates the resolution rate for the Ombudsman Team for all of the issues addressed.

Graphic 45

Ombudsman Dispute Resolution Rate FY 08-09

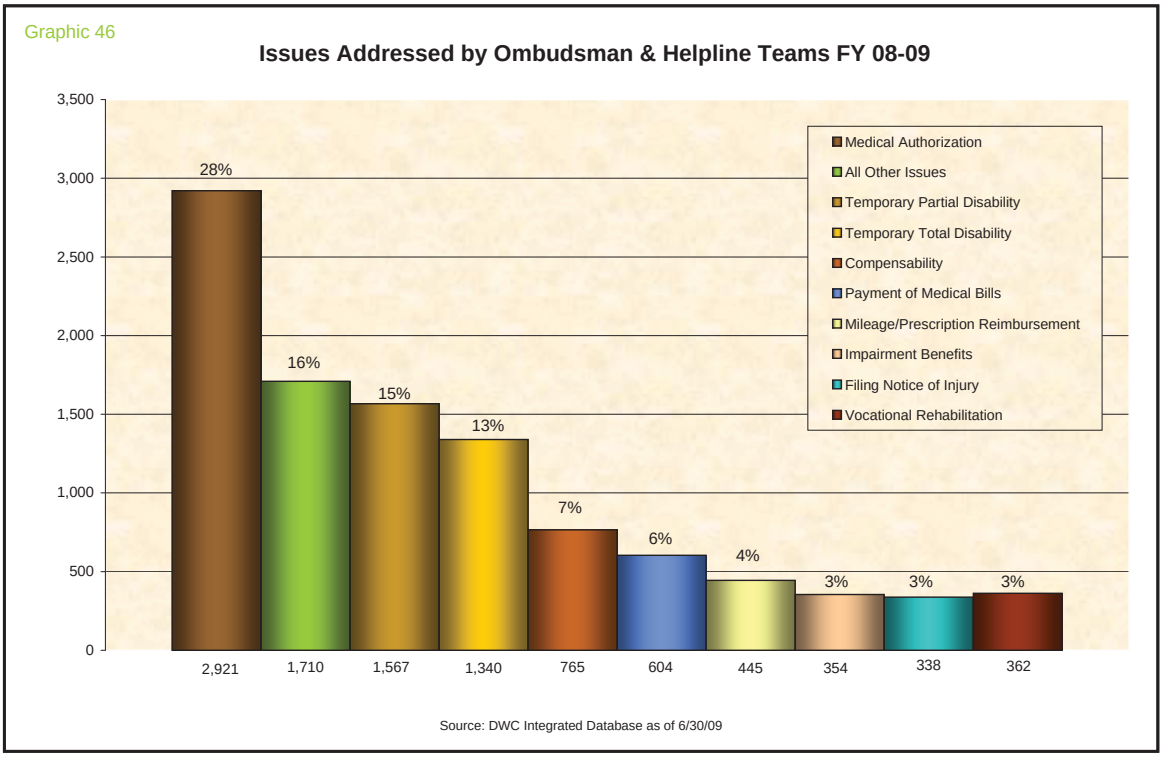


Source: DWC Integrated Database as of 6/30/09

The Division has expanded its efforts to communicate with injured workers via email using the Division's website. This tool permits Ombudsmen the ability to actively communicate with injured workers as questions arise during the development of their claims. Electronic communications such as web inquiries are expected to become a more significant tool in the workers' compensation education and assistance process in the future. During FY 2008-2009, 967 responses were provided to email requests by the Ombudsman Team.

Injured workers requested assistance or information concerning medical authorization issues more than any other issue in FY 2008-2009. Requests for orthopedic services, physical therapy, surgery, MRI/CT scan and pain management are the medical authorization issues for which assistance was requested most frequently. **Graphic 46** illustrates the types of issues addressed by the Ombudsman and the Injured Worker Helpline Teams. These Teams secured $645,803 in indemnity benefits for injured workers and obtained 879 authorizations for medical treatment on their behalf.

Graphic 46



Source: DWC Integrated Database as of 6/30/09

Early Intervention Team

The Early Intervention Team proactively focuses on workers who have suffered serious injuries that may result in prolonged treatment and protracted recovery periods. By establishing and maintaining on-going communication with these injured workers, the Team is able to communicate with insurers and facilitate the prompt provision of benefits throughout the life of the claim. During FY 2008-2009, the Team provided continuous case management for 253 injured workers.

Additionally, upon receipt of a notice that a work related injury has resulted in death, the Team immediately initiates contact with family members to advise that they may be eligible for benefits pursuant to the Workers' Compensation Law and offer assistance. During FY 2008-2009, the Team managed 324 death claims.

Customer Service Team

The Customer Service Team educates and assists employers with questions regarding workers' compensation coverage, exemptions from coverage and drug-free workplace and safety programs. The Team also receives calls from persons reporting employer non-compliance. When compliance violations are reported, those inquiries are referred to the Bureau of Compliance for appropriate review. During FY 2008-2009, the call volume for the Customer Service Team was 121,494.

Graphic 47 illustrates the volume of educational calls handled by topic by the Customer Service Team. In addition, this Team educates and assists health care providers who have questions relating to reimbursement issues and provides information relating to health care provider applications, statutorily required forms and administrative rules regarding the provisions of s. 440.13, F.S. The Team also responds to email inquiries sent to workers.medservice@myfloridacfo.com. During FY 2008-2009, the Team received and responded to 471 email inquiries.

Graphic 48 shows the monthly call volume for the Customer Service Team.

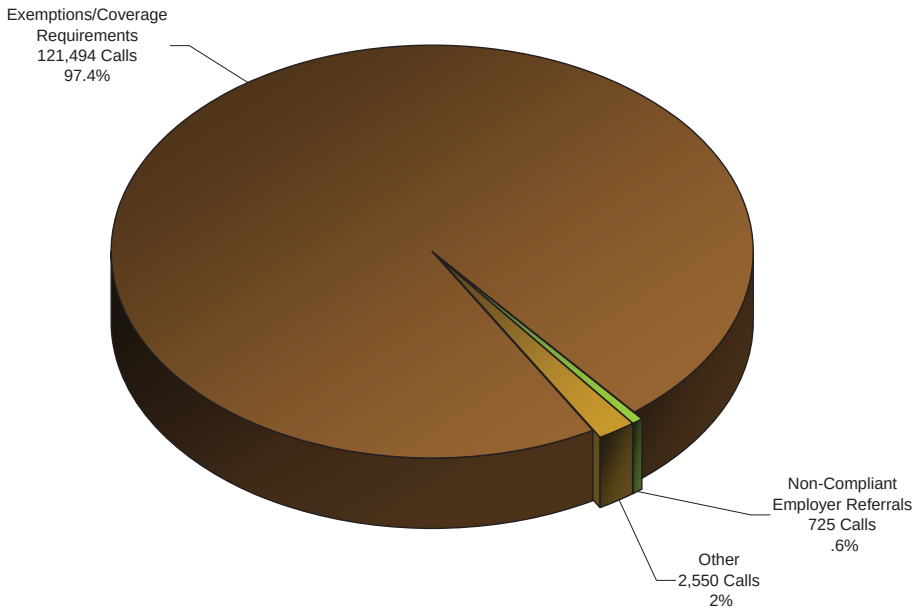
Denials Team

During FY 2008-2009, the Denials Team reviewed 37,173 Notices of Denial filed with the Division to ensure compliance with the Workers' Compensation Law. Team members contacted insurers for clarification regarding appropriateness, reasonableness and specific details of the denial. This review also permits the Division to monitor and analyze the denial trends of the industry.

Denied claims include total denials (both indemnity and medical benefits) and partial denials (for which a portion of the indemnity or medical benefits were denied). **Graphics 49 and 50** illustrate the reasons claims were totally or partially denied.

Graphic 47

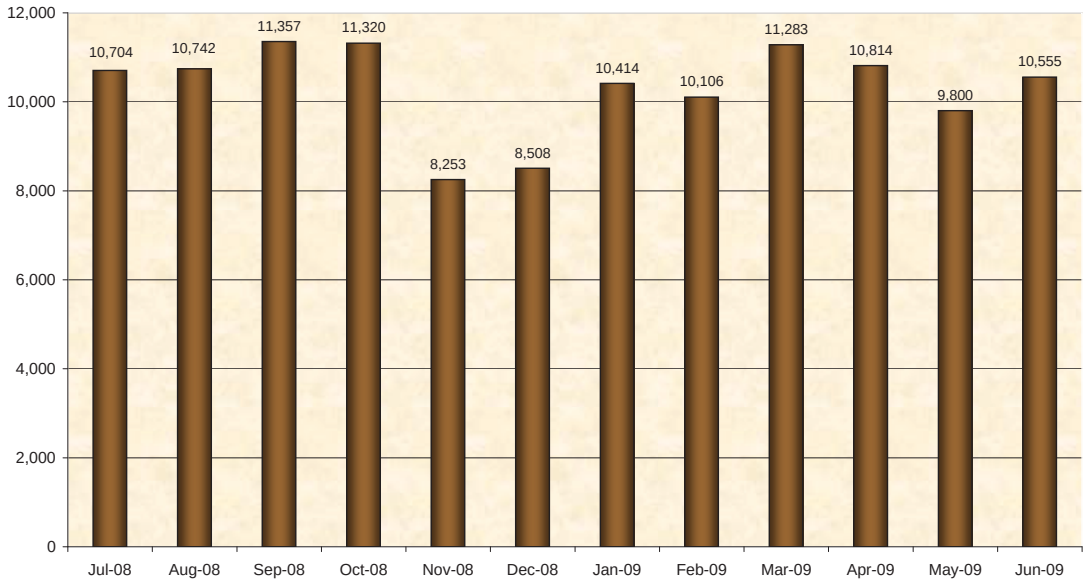
Customer Service Calls FY 08-09



Source: Employee Assistance & Ombudsman Office as of 6/30/09

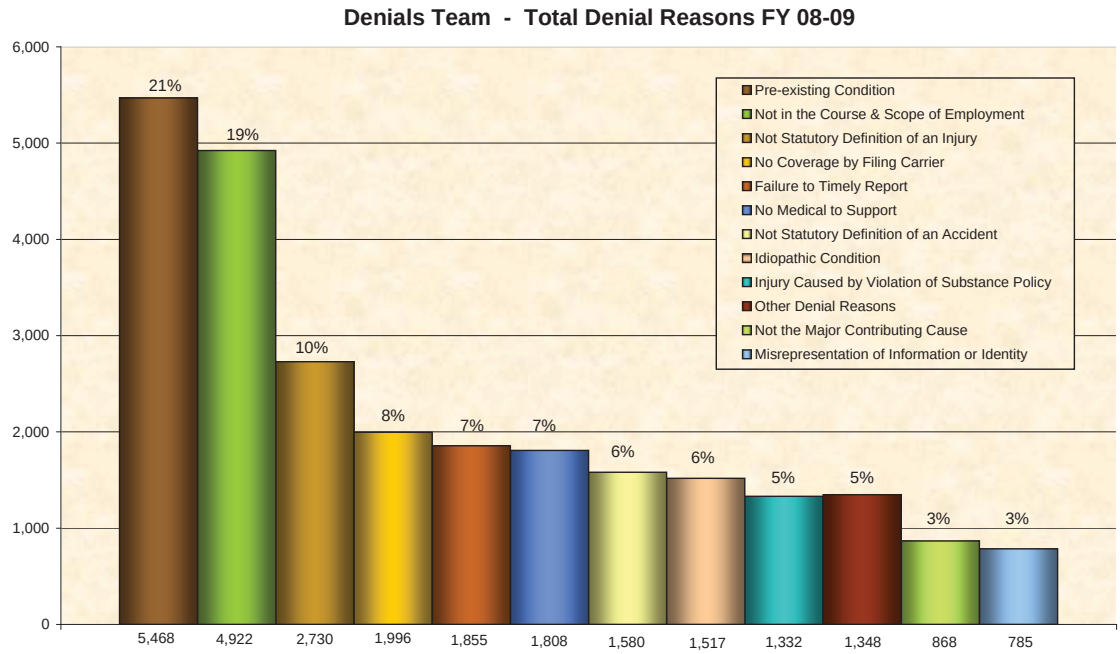
Graphic 48

Customer Service Call Volume FY 08-09



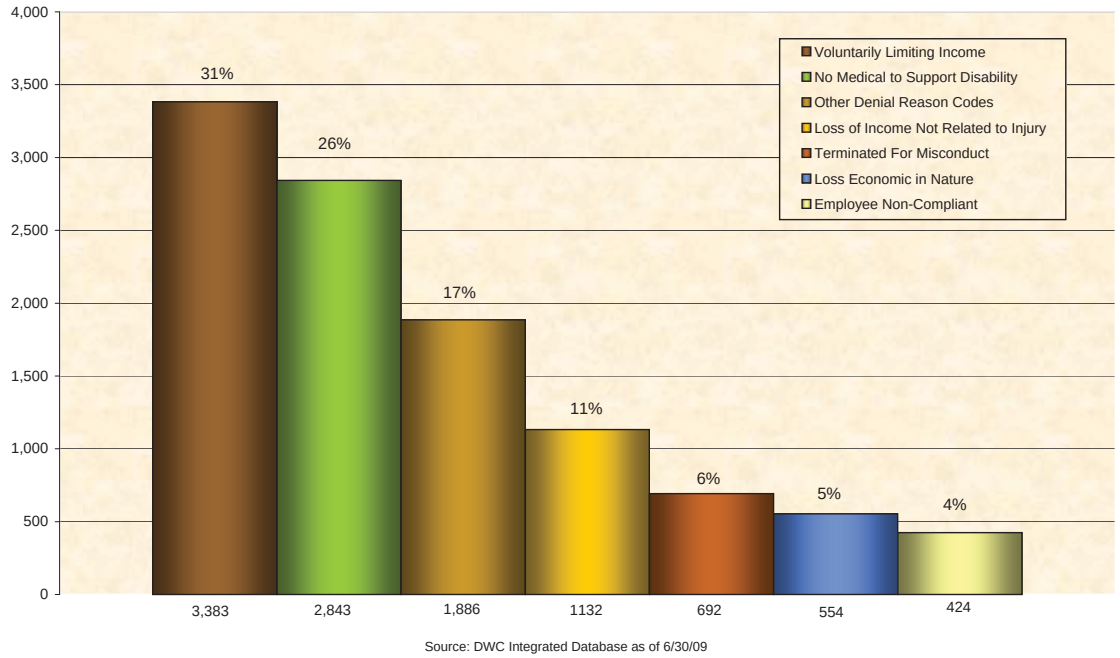
Source: Employee Assistance & Ombudsman Office as of 6/30/09

Graphic 49



Source: DWC Integrated Database as of 6/30/09

Graphic 50



Source: DWC Integrated Database as of 6/30/09

EAO SUCCESS STORIES

A 66 year old paramedic, who was injured after exposure to chlorine gas in 1989, telephoned EAO in January, 2009 for assistance. He had just received his monthly permanent total (PT) disability payment and found that the payment was one-third less than usual. The Ombudsman assigned to investigate this matter contacted the insurance adjuster who said that the injured worker had been overpaid for nearly three years in the amount of $65,279.36. Therefore, the injured worker's PT benefit payments were to be reduced until all of the monies had been recouped. After reviewing applicable Florida Statutes and administrative rules, the Ombudsman determined that the injured worker was entitled to all of the PT benefits the carrier had been originally paying, based on the date of his accident. The Ombudsman shared this information with the adjuster, who agreed to reinstate the injured worker's PT disability payments retroactive to the day they were improperly reduced.

A 51 year old injured worker was in imminent danger of losing his home to foreclosure when he telephoned EAO in January, 2009 for assistance. While working as a tree trimmer in 2004, the injured worker had suffered a compound fracture to his elbow after falling 16 feet from a ladder on his first day on the job. Since the injured worker had not yet completed payroll documentation, there was a question about whether there was an employee/employer relationship. In an effort to resolve the issue, the worker petitioned the court for a remedy. After a lengthy appeals process, the injured worker ultimately prevailed. A settlement agreement was reached in December, 2008, but at the time the injured worker contacted EAO, nearly a month had passed and the injured worker reported that he had not received his settlement payment and that calls to his attorney had gone unanswered. After speaking with the injured worker, the Ombudsman contacted the claims adjuster, attorney for the defendant and the injured worker's attorney to determine the status of the settlement payment. As a result of the Ombudsman's intervention, the settlement payment was issued to the injured worker within two days of EAO's receipt of the injured worker's request for assistance.

A 58 year old construction crew leader was struck by a vehicle in June, 1988 and sustained a fractured neck, which left him a quadriplegic. He copied the Division of Workers' Compensation on a letter he mailed to his insurance adjuster during October, 2008 that voiced numerous concerns even though he was receiving permanent total disability benefits. The injured worker requested: repair or replacement of a nine year old van; repair/replacement of the hydraulic lift on the van; repair or replacement of his wheelchair; replacement of his rehabilitation exercise equipment; authorization for annual evaluations at a local Spinal Injury Center; authorization of a lawn service and an explanation why the carrier's defense counsel was involved in the approval of his ongoing medical care. The injured worker was especially concerned about the repairs to his van because the van was his only means of mobility and independence.

The EAO Ombudsman contacted the insurance adjuster to discuss the injured workers' concerns and received a response to all of the eight concerns within two days. The adjuster reported that a replacement wheelchair had been ordered with expected delivery within two weeks; quotes for the van repairs, including the hydraulic lift, as well as the cost of replacing the van, had been requested; and the adjuster had already received quotes for the repair or replacement of the rehabilitation exercise equipment. The adjuster advised the Ombudsman that the injured worker's settlement agreement provided only for biannual evaluations at the local spinal injury center and stipulated that the carrier would not be responsible for lawn care. Finally, the adjuster advised that the injured worker's treating physician had not submitted required medical records to the carrier, so the defense counsel met with the physician to ascertain the status of the claim, not because he was involved in the approval of medical care.

When the Ombudsman checked with the injured worker the following week, it was confirmed that the van was repaired. The Ombudsman later assisted the injured worker in getting the claimant's new wheelchair adjusted and obtained payment for past due attendant care benefits.

OFFICE OF MEDICAL SERVICES

On July 1, 2008, the Office of Medical Services (OMS) was transferred from the Agency for Health Care Administration (AHCA) to the Division under a Type II transfer to continue the administration of its four programs pursuant to s. 440.13, F.S.: certification of health care providers; certification of Expert Medical Advisers; determination of whether any health care provider has engaged in a pattern or practice of overutilization or a violation of the Workers' Compensation Law or administrative rules; and resolution of reimbursement and utilization disputes concerning medical services. This transfer facilitated the essential working relationship between OMS and the Bureau of Data Quality and Collection (DQC), as the two areas collaborate extensively. This collaboration was to refine the Medical Billing, Filing and Reporting Rule for health care providers and insurers to ensure that valid and reliable medical data will be available for mandated provider oversight initiatives and cost analyses for the administrative support of the Three-Member Panel in its annual adoption of schedules of maximum reimbursement allowances.

The Office of Medical Services played a significant part in the Division's role to identify and recommend to the Three-Member Panel an appropriate method for calculating "usual and customary charges," which is the statutory methodology mandated for reimbursement of hospital outpatient care. The impetus for this project was Florida's First District Court of Appeals ruling in 2007 against AHCA in a medical reimbursement dispute involving the interpretation of the term "usual and customary charges" [One Beacon Insurance v. Agency for Health Care Administration, 958 So.2d 1127, 32 FLW D1578 (Fla. App. 1 Dist.)]. The Court found that it was the Legislature's intent to eliminate calculation of "usual and customary charges" based on the fees of any one provider in favor of calculating the charges based on the average fees of all providers in a specified geographic area.

In order to comply with the Court's decision, the Division contracted with a consultant to identify and recommend to the Three-Member Panel a hospital payment methodology that would meet the legislative and judicial standards for computing "usual and customary charges". The consultant issued a report and recommended to the Division that the Three-Member Panel adopt Medicare's Hospital Outpatient Prospective Payment System methodology (which includes geographic considerations in establishing reimbursement amounts) in conjunction with appropriate payment adjustment factors, in order to determine reimbursement levels for outpatient hospital services.

The Three-Member Panel adopted the consultant's recommendation at its November 20, 2008, public meeting. As a result, OMS drafted the Florida Workers' Compensation Reimbursement Manual for Hospitals, 2009 Edition (Rule 69L-7.501,F.A.C.), which incorporates Medicare's Hospital Outpatient Prospective Payment System methodology which is undergoing the administrative rule development process.

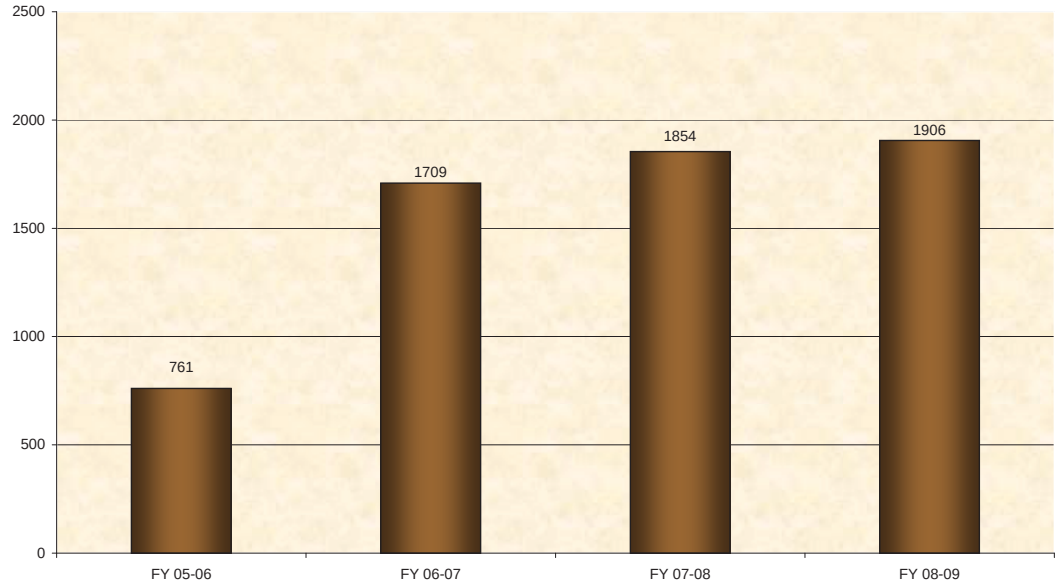
This proposed change in the hospital outpatient reimbursement methodology requires that additional data be collected by the Division for hospital outpatient bills and reimbursement information. To that end, OMS and DQC worked together to revise portions of the billing rule, the hospital billing form completion instructions and the Florida Medical EDI Implementation Guide.

During FY 2008-2009, OMS also published the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2008 Edition, which became effective February, 2009. This manual incorporates the 2008 Medicare fee schedule and the National Correct Coding Initiative edits from the Centers for Medicare and Medicaid Services for additional cost containment. These edits enable providers and insurers to identify which procedure codes should not be reimbursed when billed in certain combinations because the codes are considered part of another billed procedure or are mutually exclusive.

The following graphics provide a snapshot of the medical reimbursement dispute process. In these graphics, disputes are classified according to provider type, whether the decision rendered is a Determination or Dismissal and the reason for the Determination or Dismissal. **Graphic 51** illustrates the total number of Petitions for Resolution of Reimbursement Dispute received during each of the last four fiscal years. As the graph indicates, the number of petitions submitted has increased annually resulting in a 150% increase from the number of petitions submitted in FY 2005-2006 to those submitted in FY 2008-2009.

Graphic 51

Petitions for Reimbursement Dispute Resolution Submitted, FY 08-09

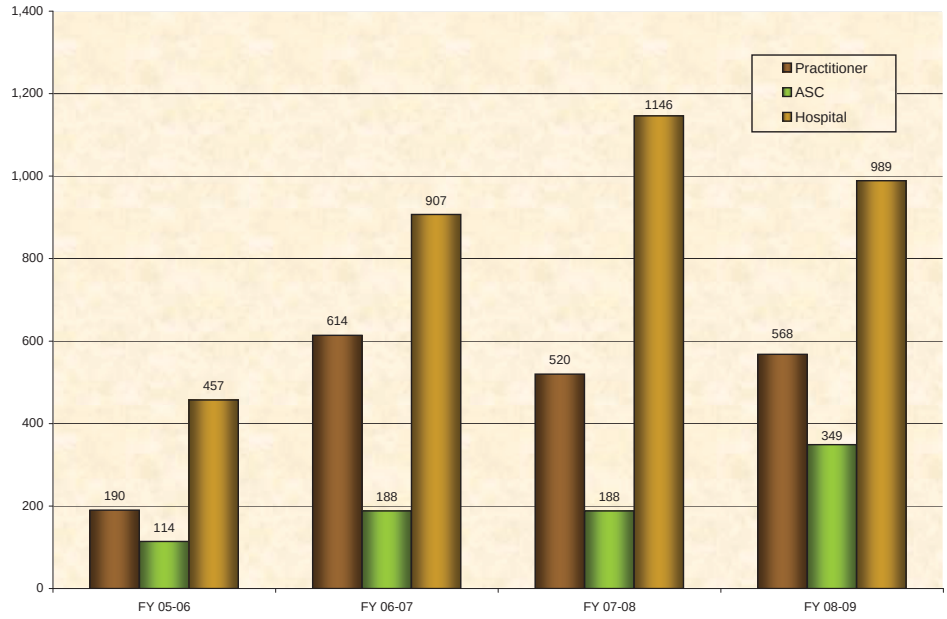


Source: DWC Automated Reemployment and Medical Information Systems Database as of 6/30/09

Graphic 52 *below* illustrates the distribution of Petitions for Resolution of Reimbursement Dispute received during each of the last four fiscal years by provider type. The number of petitions received from hospitals increased by 116% from FY 2005-2006 to FY 2008-2009. The number of hospital petitions submitted exceeds the combined number of petitions submitted by ambulatory surgical centers and practitioners (including physicians and other recognized providers rendering services under the supervision or prescription of a physician) during each of the four fiscal years cited.

Graphic 52

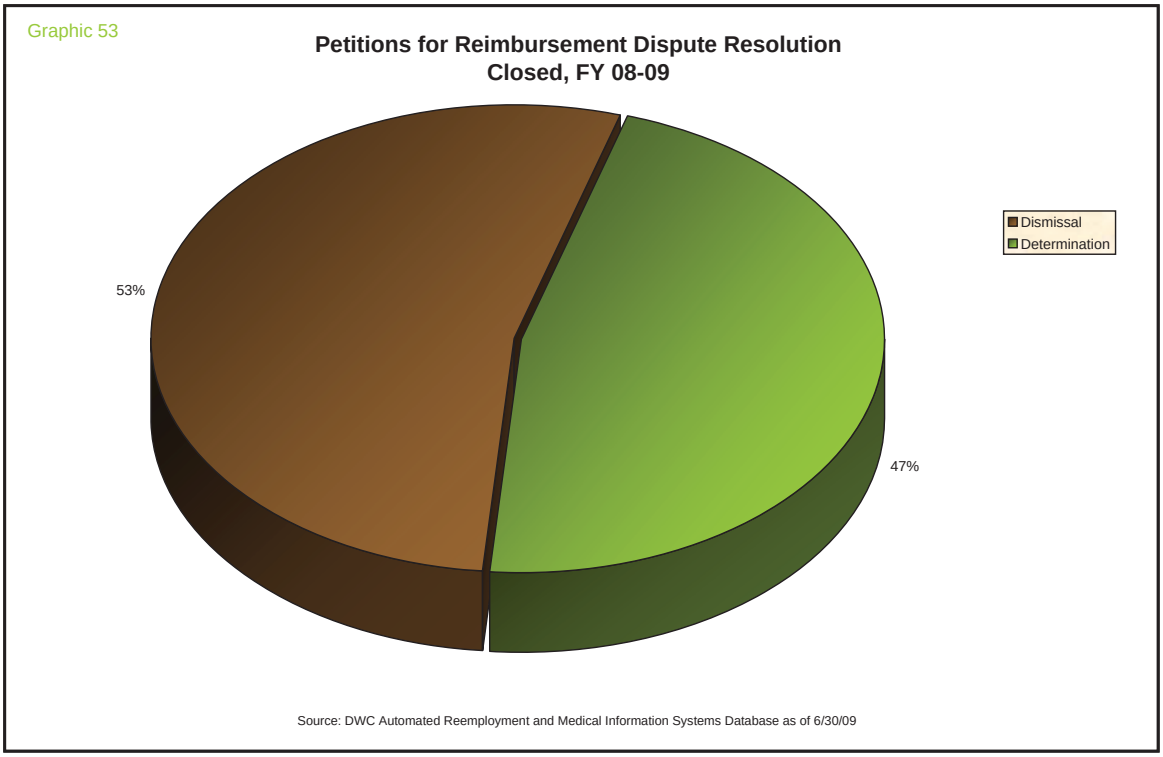
Petitions for Reimbursement Dispute Resolution Submitted by Provider Type, FY 08-09



Source: DWC Automated Reemployment and Medical Information Systems Database as of 6/30/09

Graphic 53 *below* illustrates the distribution of Petitions for Resolution of Reimbursement Dispute closed during FY 2008-2009. Out of 1,687 petitions, OMS issued 899 Dismissals and 788 Determinations.

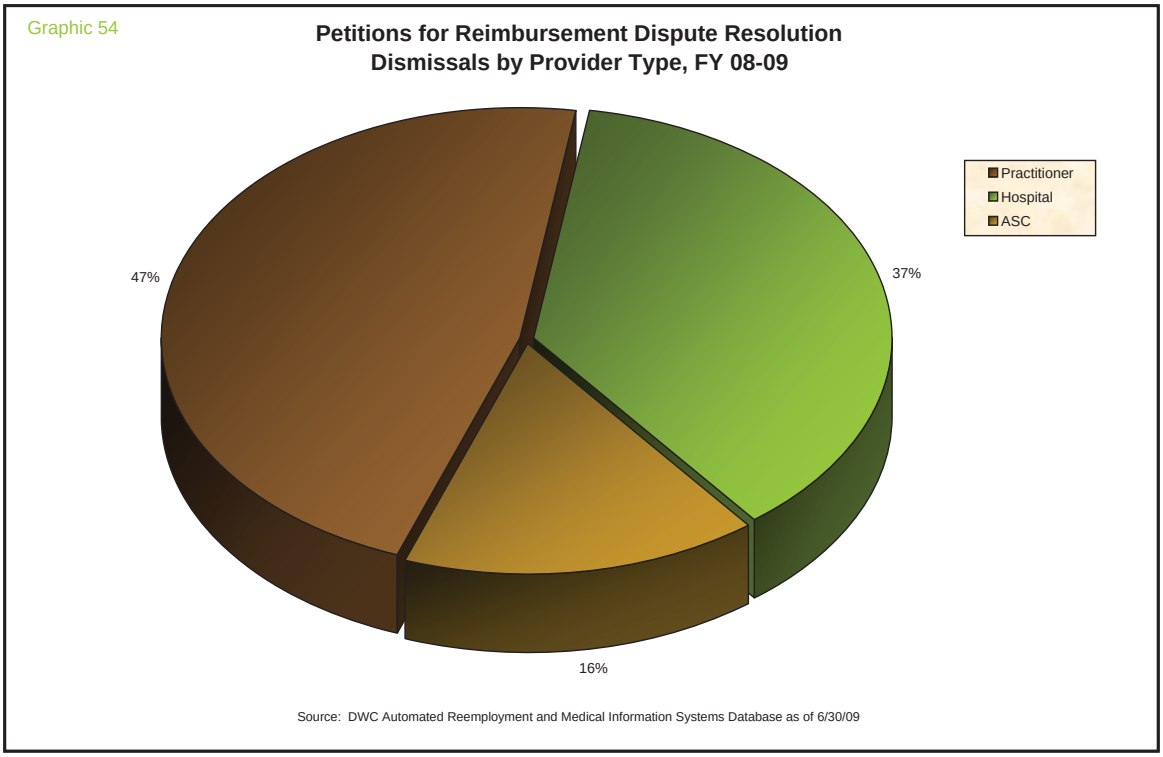
Graphic 53



Graphic 54 *below* illustrates the distribution of Petitions for Resolution of Reimbursement Dispute for which a Dismissal was issued by provider type.

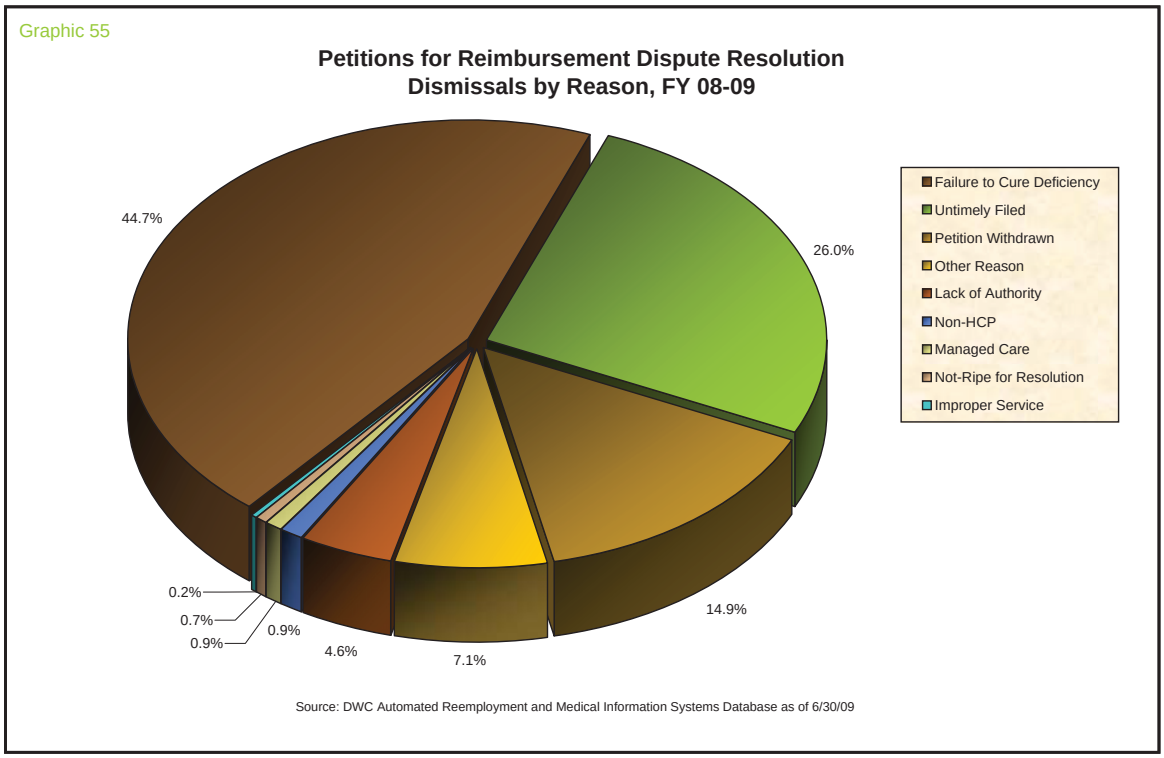
Of the 899 petitions that were dismissed, 421 were submitted by Practitioners, 332 were submitted by hospitals and 146 were submitted by ASCs.

Graphic 54



Graphic 55 *below* illustrates the distribution of Petition for Resolution of Reimbursement Dispute dismissals. A petition is dismissed as untimely filed if it was submitted more than 30 days after receipt of the Explanation of Bill Review (EOBR). A petition must be served on the entity listed on the EOBR or it is dismissed for improper service. If an incomplete petition is received, the petitioner is sent a Notice of Deficiency and given 10 days to cure the deficiency. If not cured within 10 days or if the response does not address the deficiency, the petition is dismissed for failure to cure the deficiency. Incomplete responses to a Notice of Deficiency are dismissed for failure to cure the deficiency. If a petition received is not within OMS' scope of authority, i.e., the claim is not covered by Florida's Workers' Compensation Law, the petition is dismissed for lack of authority. Services rendered under a managed care arrangement are not contestable under s. 440.13(7), F.S. and are dismissed. Petitions filed by a party that does not meet the statutory definition of a health care provider are dismissed for lack of standing and are recorded as Non-HCP. Petitioners may withdraw petitions prior to OMS issuing a determination or dismissal and those petitions are dismissed as petition withdrawn. Petitions submitted without an EOBR or documentation of payment by the carrier are dismissed as not-ripe for resolution. Finally, petitions that are dismissed under the other reason category are submissions that, for various reasons, cannot be resolved under s. 440.13(7), F.S. Of the 899 petitions dismissed during FY 2008-2009, 402 were for Failure to Cure Deficiency; 234 for Untimely Filed; 134 for Petition Withdrawn; 64 for Other Reason; 41 for Lack of Authority; 8 for Non-HCP; 8 for Managed Care; 6 for Not-Ripe for Resolution; and 2 for Improper Service.

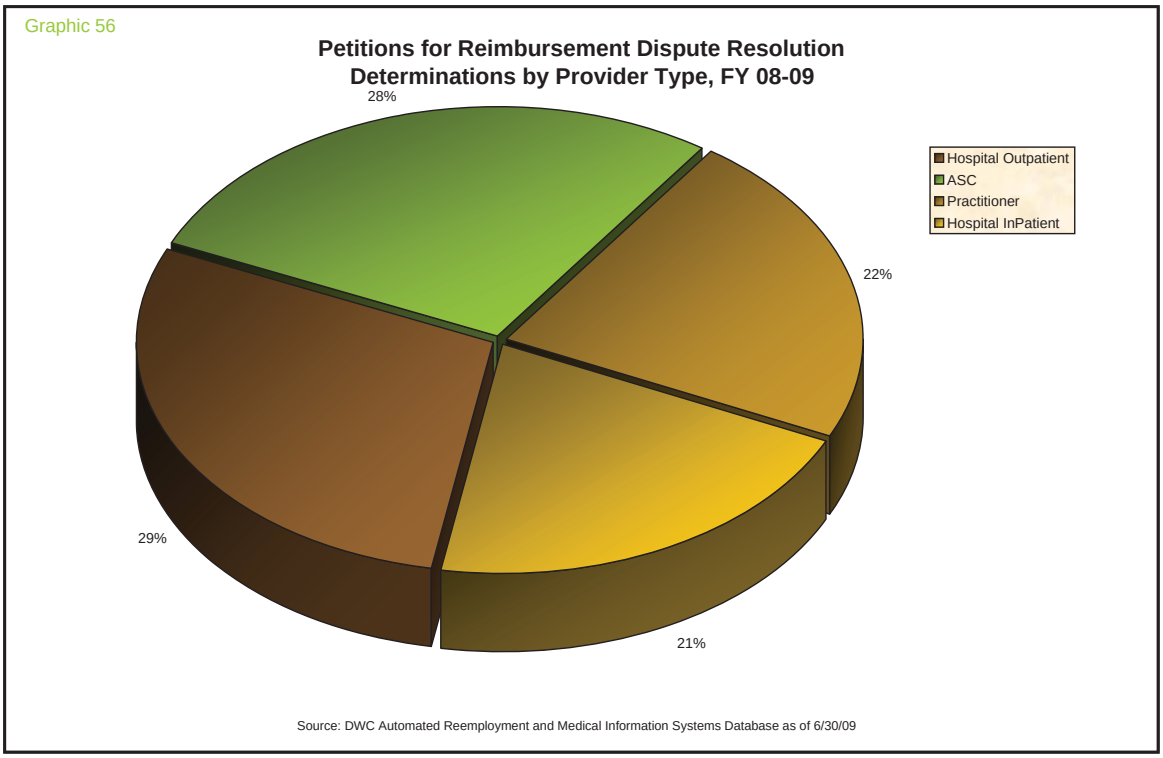
Graphic 55



Source: DWC Automated Reemployment and Medical Information Systems Database as of 6/30/09

Graphic 56 *below* illustrates the Petitions for Resolution of Reimbursement Dispute for which a Determination was issued during FY 2008-2009 by provider type.

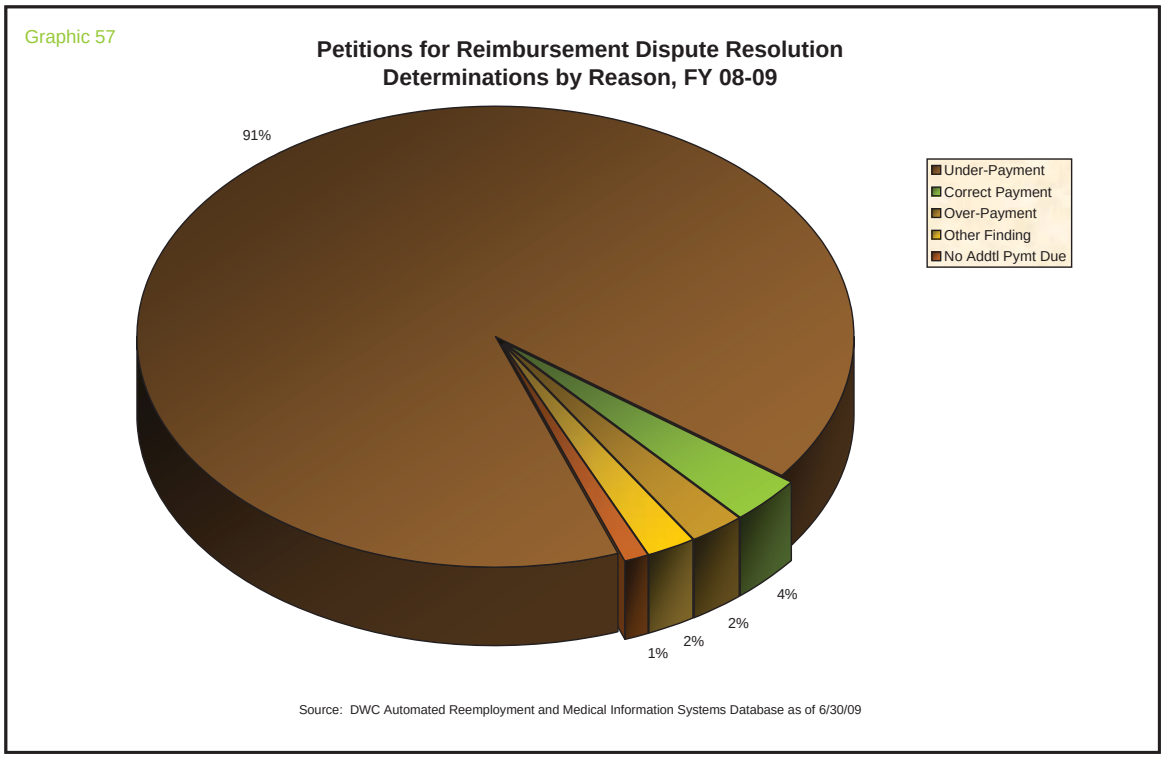
Graphic 56



Source: DWC Automated Reemployment and Medical Information Systems Database as of 6/30/09

Graphic 57 *below* illustrates the Petitions for Resolution of Reimbursement Dispute for which a Determination was issued, by determination reason.

Graphic 57



Source: DWC Automated Reemployment and Medical Information Systems Database as of 6/30/09

During the FY 2008-2009, OMS received 14 referrals and completed investigations on eight of those referrals alleging overutilization or other violations of Chapter 440, F.S. or related rules by health care providers. The physician specialty types referred for review included one physician licensed by the Board of Dentistry and nine physicians licensed by the Board of Medical Examiners. The remaining four referrals included two hospitals, one ASC and one clinical laboratory.

Each referral evaluation included information from one or more of the following sources:

- Review of the documentation submitted with the referral;
- Review of services rendered according to the carrier's paid claims data filed with the Division;
- Review of medical records documenting the services rendered and billed by the health care provider; and
- The opinion of an Expert Medical Advisor (EMA) to determine whether the medical records substantiated a pattern or practice of overutilization or other Standards of Care or billing violations under Chapter 440, F.S.

The following table provides a summary of the investigations closed by OMS during FY 2008-2009 and the Division's findings.

Referring Party	Allegation	Cases	Finding/Agency Action
Insurer	Standard of Care Violation	4	Insurer failed to substantiate allegation. Division issued insurer education letter regarding responsibility for utilization review.
Insurer	Improperly Billing Injured Employee	1	Provider erred in billing injured employee; business office record established as self-pay claim. Division issued provider education letter regarding the inappropriateness of billing an injured employee.
Insurer	Overpayment	2	Insurer failed to substantiate allegation. Division issued education letter regarding insurer bill review responsibilities.
Department of Health	Improperly Billing Injured Employee	1	Provider billed injured employee for services for a non-compensable condition rendered when treating compensable condition; no violation. However, provider voluntarily submitted proof of refund to injured employee. DOH notified of disposition of case.
Total		8	

OFFICE OF SPECIAL DISABILITY TRUST FUND

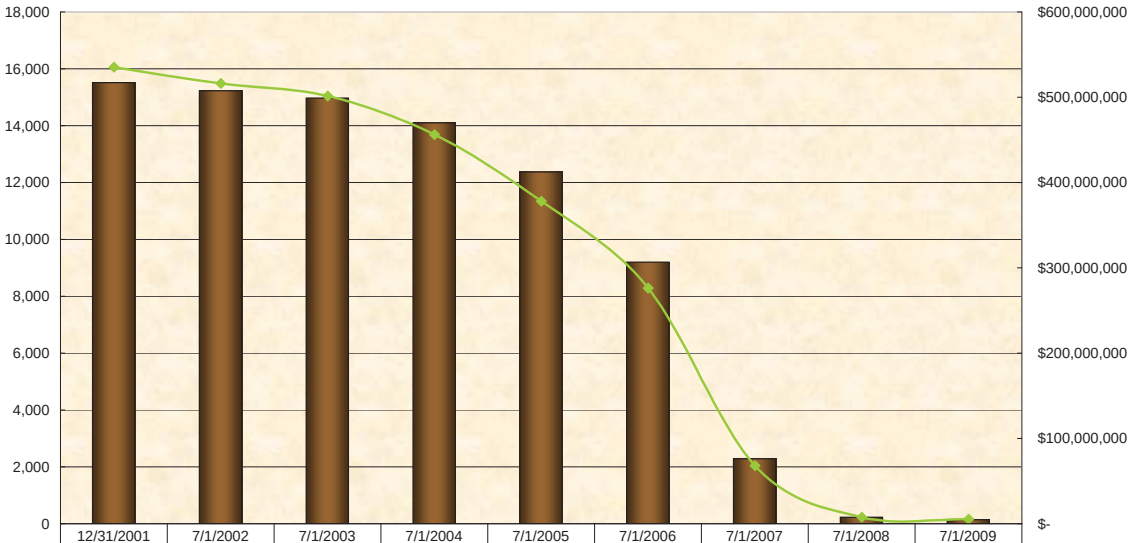
The Special Disability Trust Fund (SDTF) was established in 1955 to encourage employers to hire people with pre-existing permanent impairments by reimbursing excess costs if new work-related injuries occur subsequent to hiring and result in an additional permanent impairment. The cost of the SDTF, including reimbursements to employers and claims administration, is funded through assessments on workers' compensation premiums written by insurers and the amount of premium calculated by the Division for self-insured employers. The SDTF was "prospectively abolished" in 1997 and has transitioned to a "run-off" of eligible claims. However, assessments continue to be collected as statutorily required.

The assessment rate for the SDTF is set by a statutory formula. Section 440.49(9)(b)2., F.S., requires that the annual assessment be calculated so that, when combined with the balance in the fund on June 30 of the current fiscal year which is in excess of $100,000, the amount produced is equal to the average of the sum of disbursements from the fund during the immediate past three calendar years and twice the disbursements of the most recent calendar year. However, the assessment is not permitted to exceed 4.52%. The assessment has been limited to this cap every year since the cap was first enacted in 1994.

Prior to 2002, the value of approved Reimbursement Requests exceeded the revenue produced by the capped assessment. The result was a backlog of approved Reimbursement Requests awaiting payment. The backlog reached over 15,000 approved reimbursements and was valued in excess of $535 million in FY 2001-2002. As of March, 2008, the SDTF had eliminated the backlog of approved Reimbursement Requests awaiting payment. During FY 2008-2009, the SDTF paid reimbursements as the Reimbursement Requests were approved and cleared for payment. Beginning with the peak as of 12/31/01 and continuing with the balances at the end of each subsequent fiscal year, **Graphic 58** *below* illustrates the reduction in both the value and number of approved reimbursements awaiting payment as of each date specified.

Graphic 58

Approved Reimbursement Requests Awaiting Payment



	12/31/2001	7/1/2002	7/1/2003	7/1/2004	7/1/2005	7/1/2006	7/1/2007	7/1/2008	7/1/2009
	15,511	15,222	14,971	14,097	12,371	9,195	2,290	228	144
	$535,014,362	$516,041,216	$501,408,751	$456,094,024	$378,307,156	$276,386,454	$67,900,522	$7,850,812	$5,013,235

Source: Special Disability Trust Fund as of 7/1/09

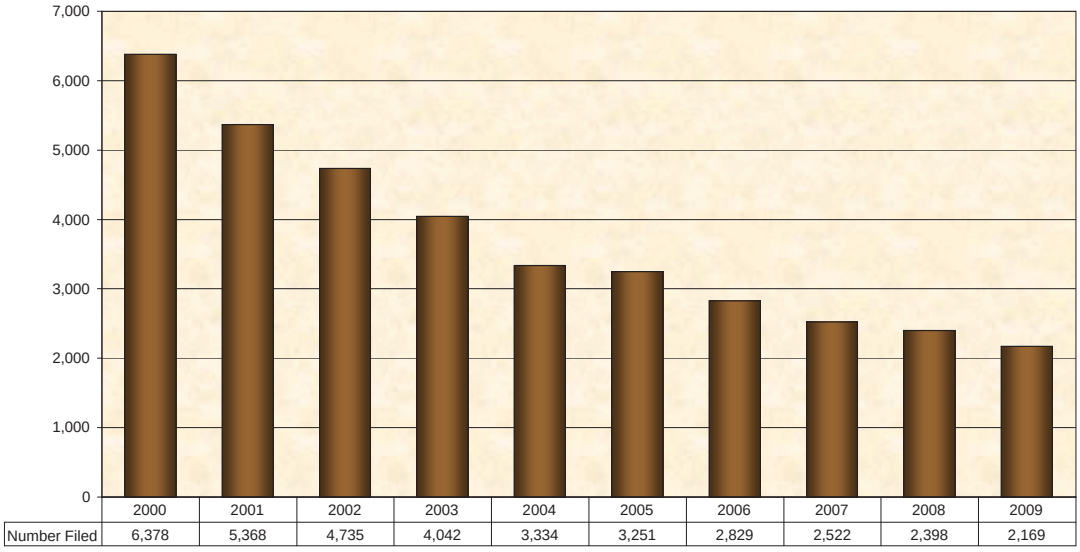
The assessment rate formula was designed to produce increasing revenues to support the growth in reimbursement levels that the SDTF had historically experienced. The present statutory formula requires an assessment of approximately 250% of the prior year's disbursements. This formula was based on expected growth in the SDTF, but the Fund is now in run-off and a surplus of this magnitude is no longer needed. To avoid maintenance of excessive surplus, the Division proposed a legislative change in 2008 and again in 2009 to revise the assessment formula.

The Division advocated the adoption of a new statutory assessment formula that would require the SDTF to maintain a balance equal to only 125% of the average amount approved in the three most recent calendar years instead of the current 250%. Under the proposed assessment formula, any excess revenue from a given year would continue to be considered in the computation of the next annual assessment rate. While the proposed assessment formula has not yet been adopted, the Division will continue to promote this change so that only a reasonable amount of surplus is maintained in the SDTF.

The number of Reimbursement Requests filed per year has steadily declined since FY 1999-2000. Reimbursement Requests decreased from 6,378 filed during FY 1999-2000 to 2,169 filed during FY 2008-2009. This is a reduction of nearly 66% during this period. **Graphic 59** *below* shows the reduction in Reimbursement Requests filed over time.

Graphic 59

Reimbursement Requests Filed by Fiscal Year

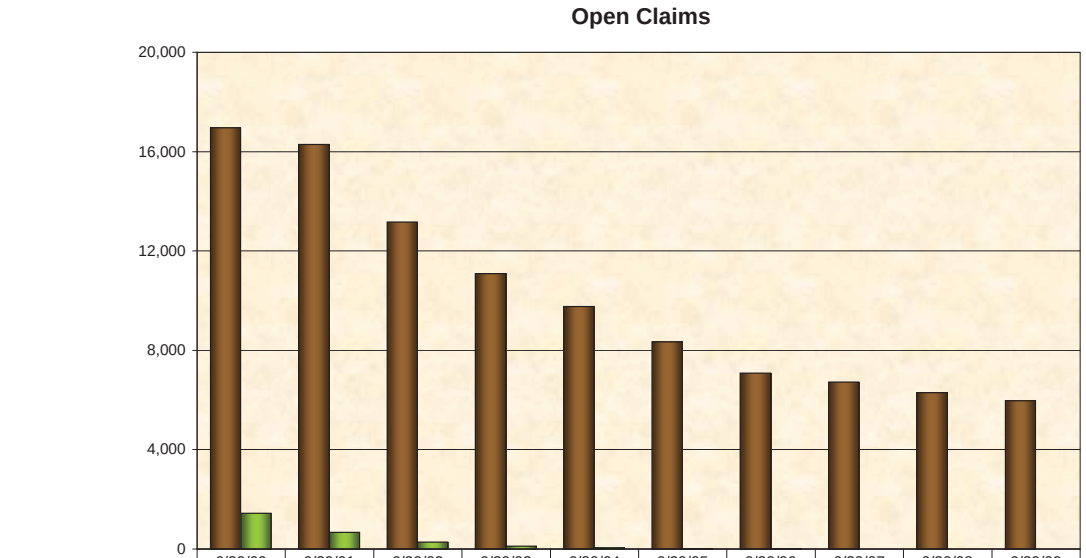


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Number Filed	6,378	5,368	4,735	4,042	3,334	3,251	2,829	2,522	2,398	2,169

Source: Special Disability Trust Fund as of 7/1/09

In addition to the continuing decline in the number of Reimbursement Requests being filed, the number of open claims and new Proofs of Claim has also continued to decline. The Proof of Claim is an initial filing that triggers an eligibility determination on a brand new claim against the SDTF. The number of Proof of Claim filings has become negligible with only three filed in FY 2008-2009. **Graphic 60** *below* illustrates the number of open claims and Proof of Claims filed over time.

Graphic 60



	6/30/00	6/30/01	6/30/02	6/30/03	6/30/04	6/30/05	6/30/06	6/30/07	6/30/08	6/30/09
Number of Open Claims	16,961	16,286	13,171	11,088	9,761	8,342	7,073	6,714	6,304	5,965
Number of Proofs Filed	1,443	666	282	115	45	13	9	6	5	3

Source: Special Disability Trust Fund as of 7/1/09

ASSESSMENTS AND FUNDING

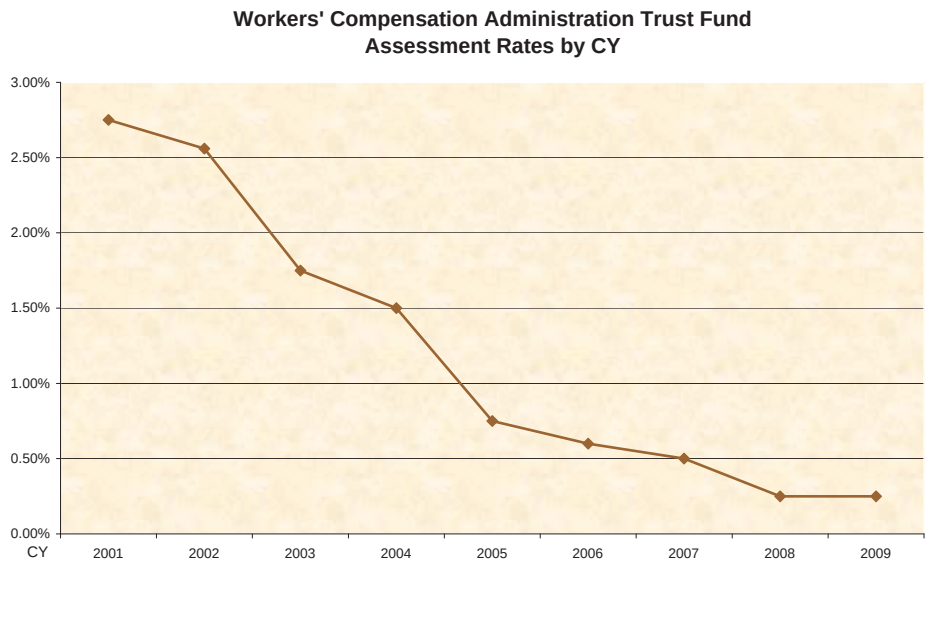
The Division is responsible for administering the Workers' Compensation Administration Trust Fund (WCATF) and the Special Disability Trust Fund (SDTF). The WCATF is partially funded through annual assessments on workers' compensation premiums and is used to fund the administration of the Workers' Compensation System. The WCATF is supplemented by the collection of fines, penalties, fees, investment earnings and other miscellaneous revenue sources. The SDTF is primarily funded through an annual assessment on premiums, but is used to reimburse employers and their carriers for eligible second injury claims. The SDTF is supplemented by investment income and the collection of fees.

The Workers' Compensation Administration Trust Fund

Annually, the Division issues an assessment rate order, signed by the Chief Financial Officer which sets the assessment rate for the following calendar year. The WCATF is the source of funding for the expenses of the administration of the Workers' Compensation System. Any excess revenue or deficit from a given year is considered in the computation of the next annual assessment rate analysis. Among the expenses funded through this source are administrative expenses of the Division, including the payment of permanent total disability supplemental benefits to eligible injured workers with dates of accident preceding July 1, 1984, the expenses of the Office of the Judges of Compensation Claims and a portion of the expenses of the First District Court of Appeals, the Agency for Health Care Administration, the Department of Education, the Division of Insurance Fraud and the Department of Business and Professional Regulation. Additionally, the Legislature appropriated $35 million dollars from the WCATF to the General Revenue Fund during the 2009 Special Session A. This transfer of funds was completed during FY 2008-2009.

Since January 1, 2001, the WCATF assessment rate has been capped at 2.75% of net premiums, including the deductible premium discount of the policy and the non-deductible amount. From 2001 to 2008, the WCATF assessment rate declined from 2.75% to 0.25%; a decrease of approximately 91% during the period. For calendar year 2009, the WCATF assessment rate was unchanged at 0.25%. **Graphic 61** *below* illustrates the decline in the WCATF assessment rate since 2001.

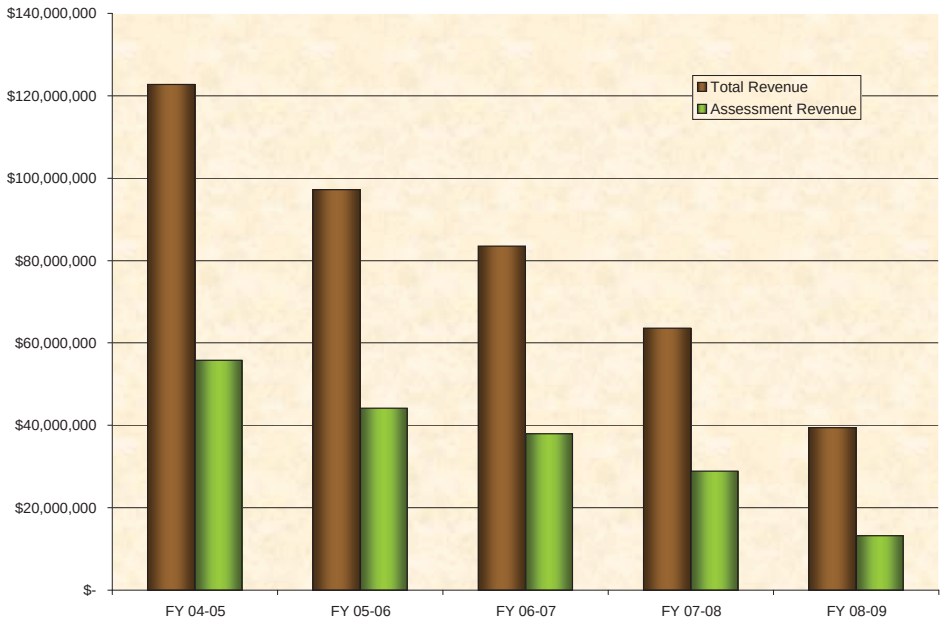
Graphic 61



Source: DWC Assessments Unit as of 6/26/09

Graphic 62 *below* summarizes WCATF total revenue and assessment revenue over the last five fiscal years. Several factors have contributed to the decline in WCATF revenue including reduced assessment rates, a reduced assessment base, and lower investment revenues due to reduced investment balances. Penalty revenue for the fiscal year increased from the prior fiscal year.

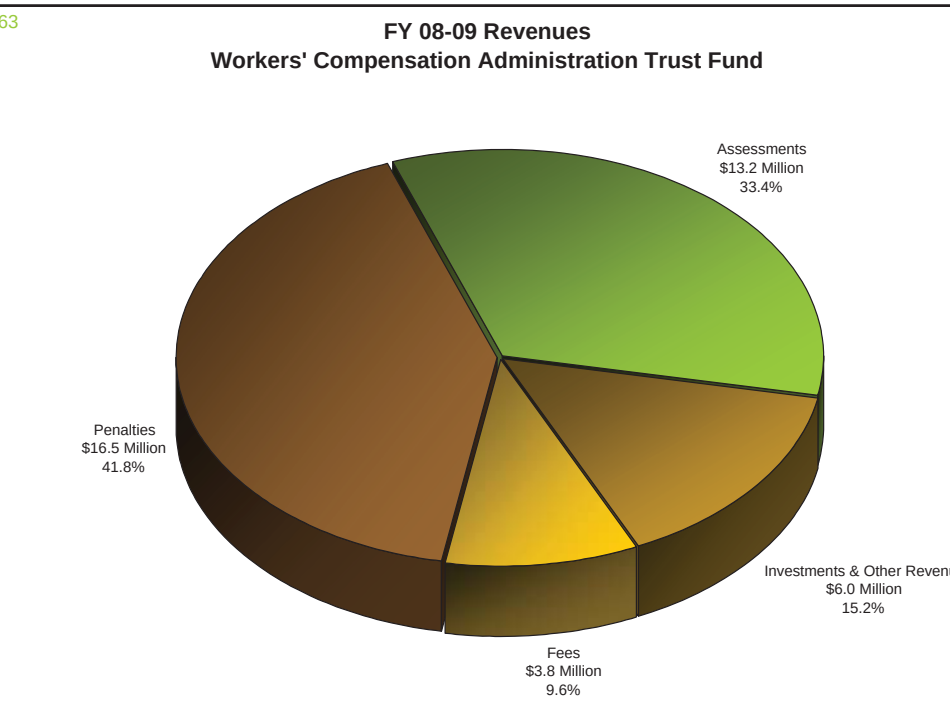
Graphic 62



Source: Department of Financial Services, Revenue Processing Unit and Division of Treasury, as of 7/23/09

Graphics 63 and 64 illustrate the breakout of total revenues and disbursements for the WCATF during FY 2008-2009.

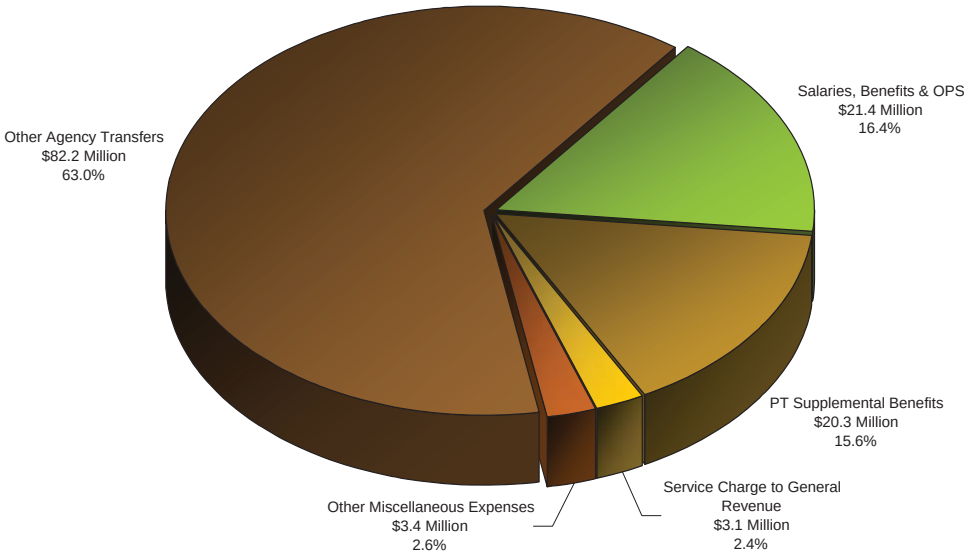
Graphic 63



Source: Department of Financial Services, Revenue Processing Unit and Division of Treasury, as of 7/23/09

Graphic 64

FY 08-09 Disbursements
Workers' Compensation Administration Trust Fund



Source: Florida Accounting Information Resource (FLAIR) Database as of 7/23/09

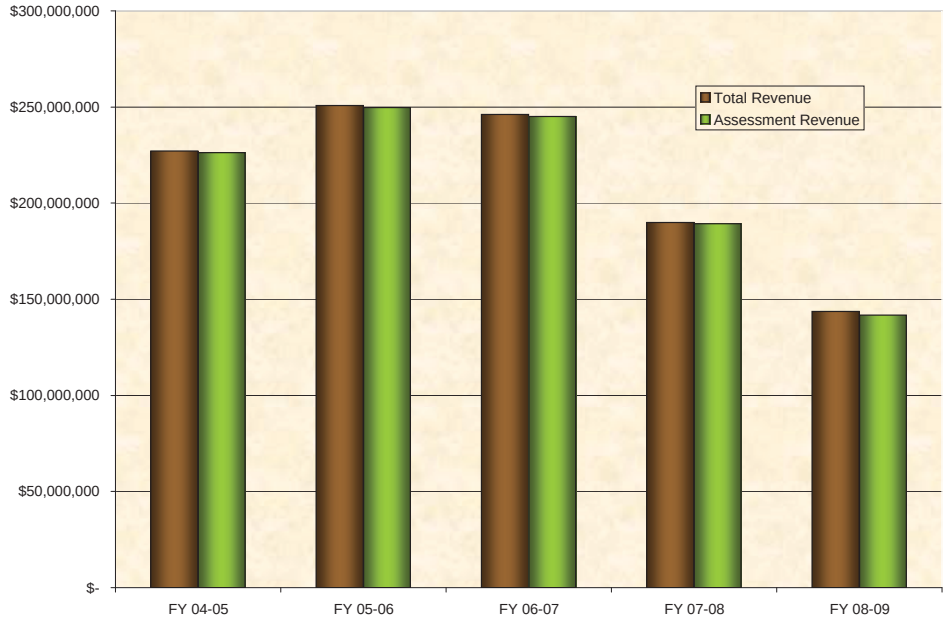
The Special Disability Trust Fund

The SDTF assessment rate is set annually according to statutory formula and the assessment rate order is issued annually at the same time as the WCATF assessment rate order. However, the SDTF assessment rate is effective on a fiscal year basis on the July 1st following the rate order.

Since 1994, the SDTF assessment rate has been capped at 4.52%. The assessment has been levied at the 4.52% cap each year since 1994. The statutory formula considers any excess revenue or deficit from a given year in the following year's assessment rate computation. **Graphic 65** *below* summarizes SDTF total revenue and assessment revenue over the last five fiscal years.

Graphic 65

Special Disability Trust Fund
Revenues by Fiscal Year

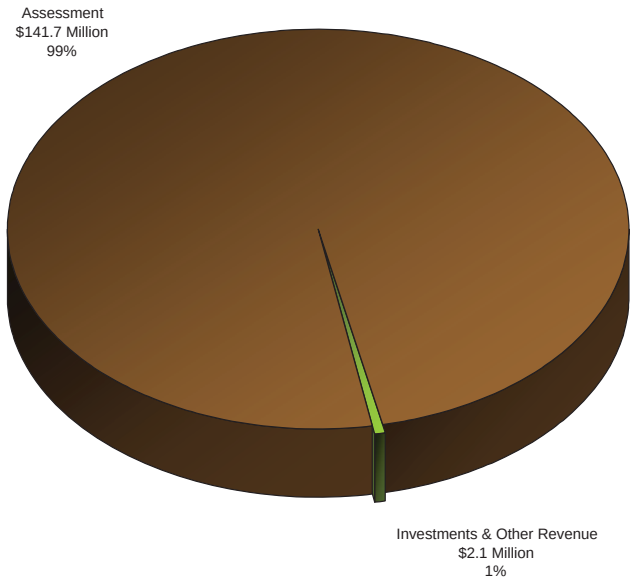


Source: Department of Financial Services, Revenue Processing Unit and Division of Treasury, as of 7/23/09

The SDTF assessment supports the reimbursements paid to employers and their carriers on eligible claims against the SDTF, for the excess costs related to second injuries to their employees for dates of accident on or before December 31, 1997. The only other expenses paid from the SDTF are administrative expenses associated with the operation of the SDTF. **Graphics 66 and 67** *below* illustrate the breakout of total revenues and disbursements for the SDTF during FY 2008-2009.

Graphic 66

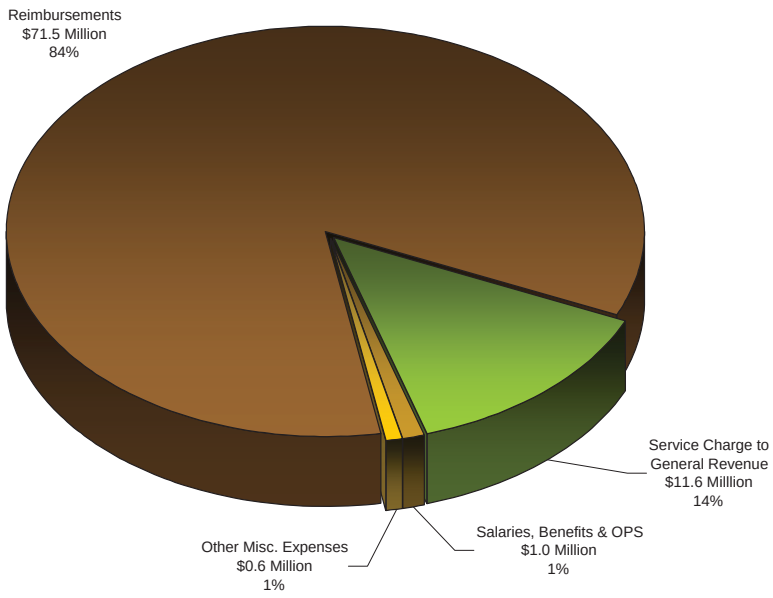
FY 08-09 Revenues
Special Disability Trust Fund



Source: Department of Financial Services, Revenue Processing Unit and Division of Treasury, as of 7/23/09

Graphic 67

FY 08-09 Disbursements
Special Disability Trust Fund



Source: Florida Accounting Information Resource (FLAIR), as of 7/23/09

CLAIMS DATA

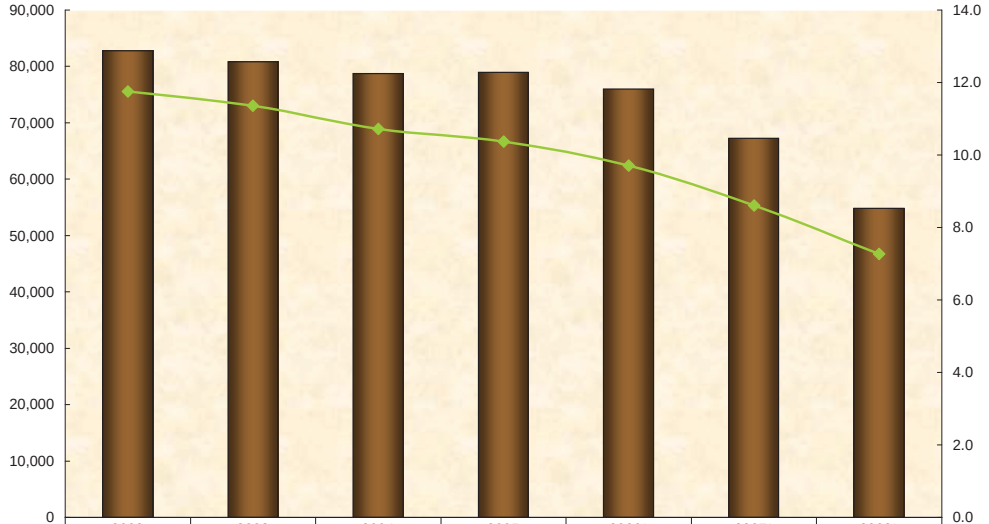
Frequency and Rate of Lost-Time Claims

The frequency of lost-time claims decreased by less than 4,000 between 2002 and 2005. Total claims for 2005 represent a 4.6% decline below the 2002 total and a slight increase (.3%) from the total for 2004. Injury years after 2005 are preliminary in that claim frequencies will increase as additional accidents develop into lost-time cases. Consequently, injury years after 2005 should not be interpreted as indicative of substantive trends. Preliminary reporting associated with these years is noted by an asterisk in the graphics below.

Graphic 68 *below* provides the frequency of lost-time cases since 2002 along with the case rate per 1,000 employees. Employment comprises Florida employees excluding federal government workers as reported in the 2008 Statewide Quarterly Census of Employment and Wages Program of the Agency for Workforce Innovation. In contrast to the decline in lost-time case frequencies, the case rate per 1,000 employees has dropped more markedly: The rate for 2005 (10.4) is 88.2% of the rate for 2002 (11.8), largely reflecting the growth of Florida employment during that period.

Graphic 68

Lost-Time Cases and Lost-Time Case Rate



	2002	2003	2004	2005	2006*	2007*	2008*
# of Lost-Time Cases	82,747	80,823	78,707	78,947	75,959	67,238	54,797
Rate per 1,000 Employees	11.8	11.4	10.7	10.4	9.7	8.6	7.3

*Preliminary data

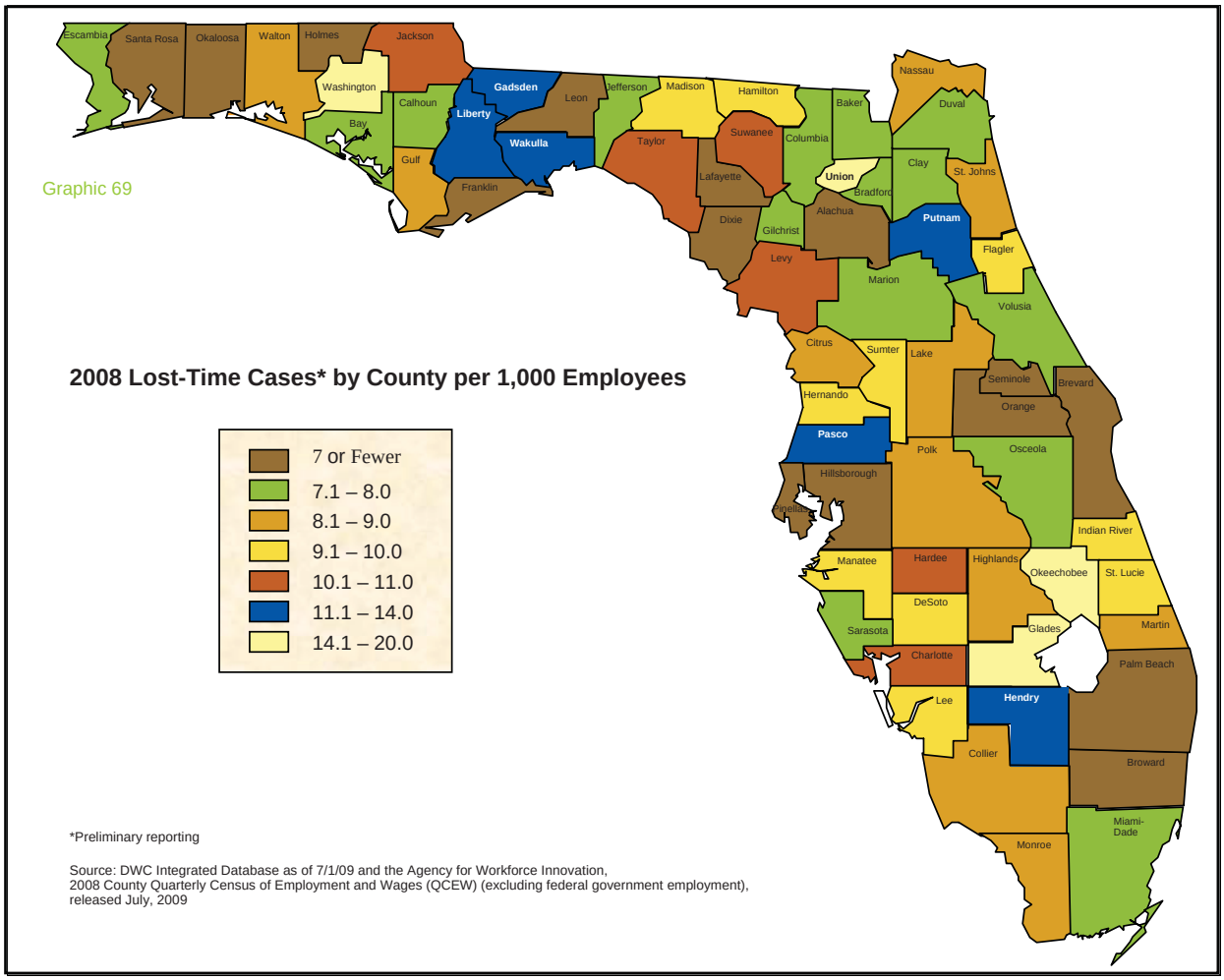
Note: Employment comprises persons covered under the Unemployment Insurance Tax Law, excluding federal government employees.

Source: DWC Integrated Database as of 7/1/09 and the Agency for Workforce Innovation, 2002 - 2008 Statewide Quarterly Census of Employment and Wages (QCEW) (excluding federal government employment) released July, 2009

Geographic Distribution of Lost-Time Cases

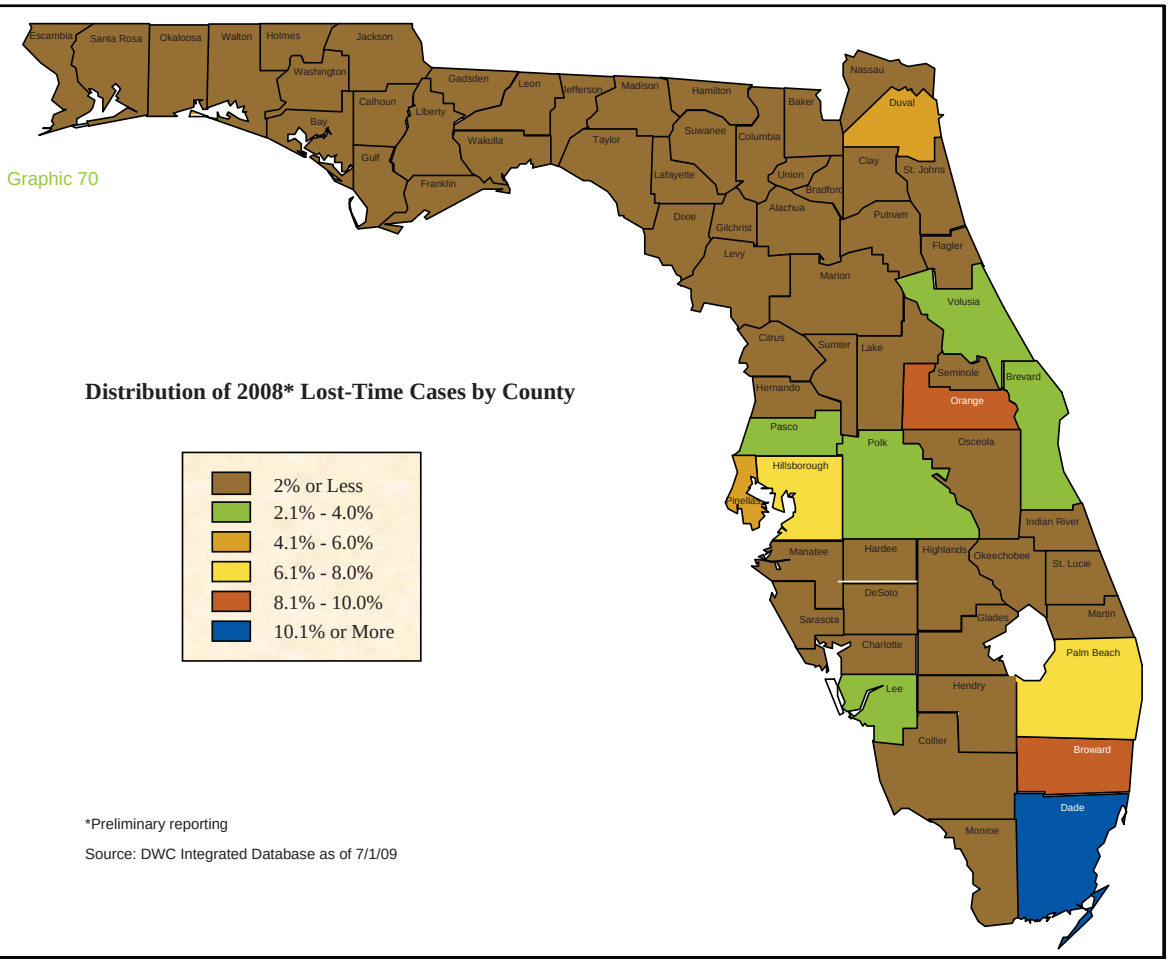
During 2008, the rate of lost-time claims per 1,000 employees varied considerably throughout Florida, ranging from 5.1 in Leon County to 17.0 in Union County. **Graphic 69** displays each county by lost-time case-rate levels for Florida employment excluding federal government workers. Numerous counties in Florida with the largest concentrations of employment had lost-time rates below the statewide rate of 7.5 per 1,000 employed. Duval, Pinellas, Hillsborough, Orange, Palm Beach and Broward Counties all exemplify this pattern. Conversely, the four counties with the highest rates of lost-time injuries, Washington, Glades, Okeechobee and Union, have a comparatively small labor force. Lost-time case rates in these four counties topped 15 per 1,000 employees. With the exception of Pasco and Charlotte Counties, all 16 counties with lost-time rates exceeding 10 per 1,000 employees had a labor force that averaged less than 19,000 during 2008.

Graphic 69



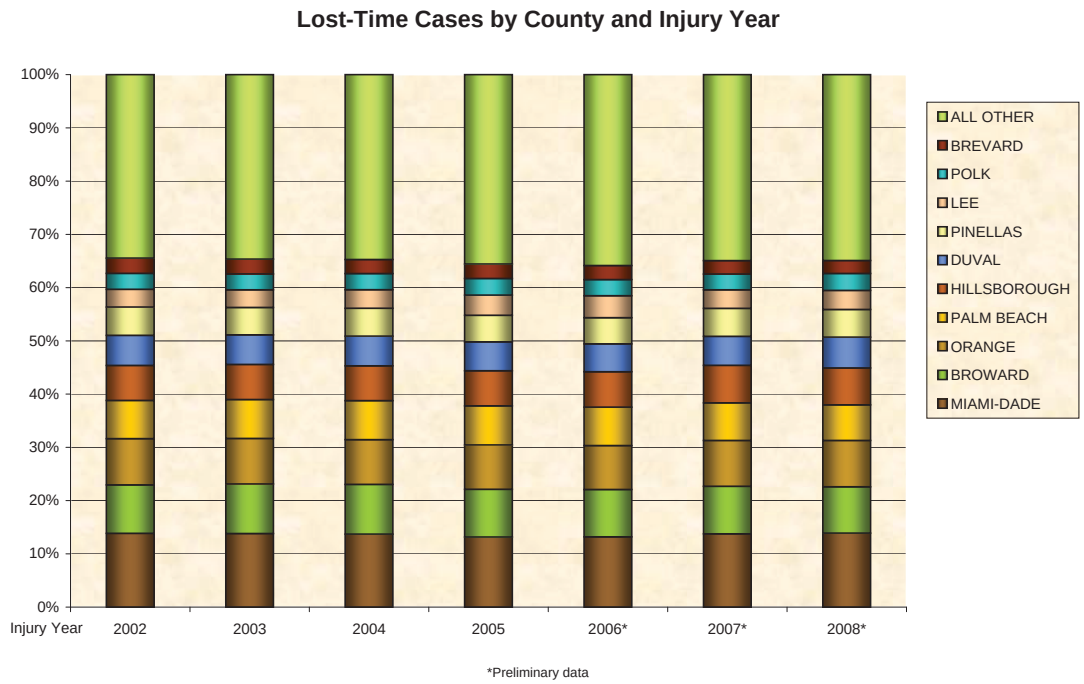
Graphic 70 displays the geographic concentration of 2008 lost-time cases. Cases tend to cluster in counties most concentrated in population and workforce. Miami-Dade County, the most populous county, had the largest share of lost-time cases, 13.9% of the statewide total. Of the 12 counties with the largest number of persons employed, only one, Seminole, did not have a share of lost-time cases that exceeded two percent. The 10 counties having the largest concentrations of lost-time cases accounted for almost two-thirds (65.1%) of the statewide total in 2008.

Graphic 70



Historical patterns in the geographic distribution of lost-time cases since 2002 are illustrated in **Graphic 71** *below*. County shares of cases have generally remained stable throughout the period. In each injury year, the three leading counties, Miami-Dade, Orange and Broward, reported almost one-third of the statewide total, only slightly less than the combined shares of the 57 counties grouped as "all other." Throughout the period shown, the leading 10 counties consistently accounted for almost two-thirds of the statewide total.

Graphic 71

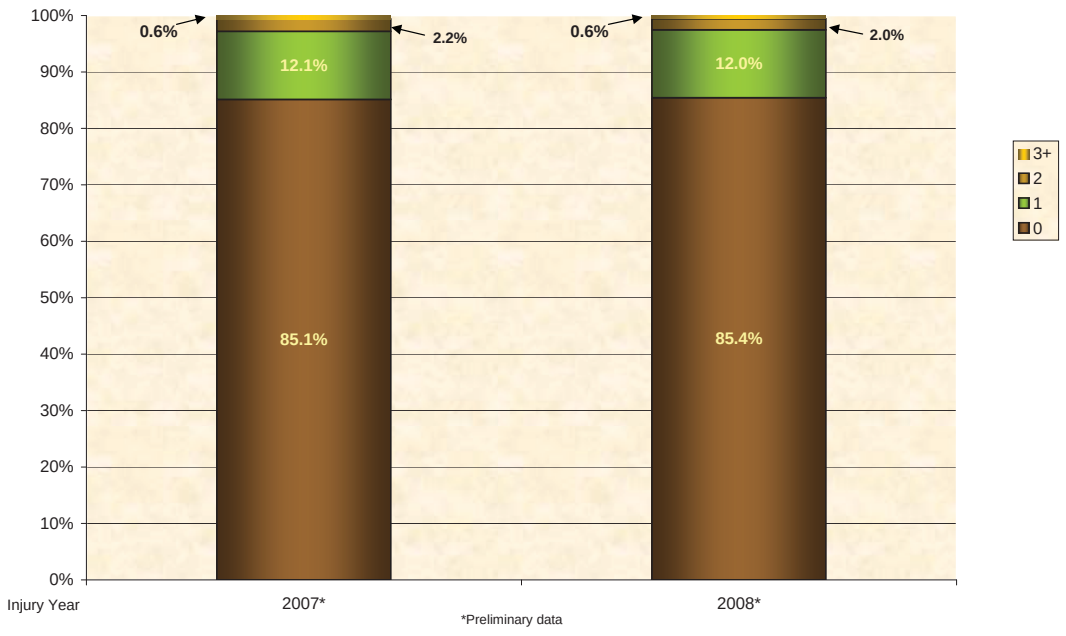


Prior Claims

The vast majority of injured workers with a lost-time claim have not reported a lost-time injury within the previous five years. **Graphic 72** *below* displays this pattern for 2007 and 2008. For both years, over 85% of workers filing a lost-time claim have no prior claim within five calendar years. Of the remainder, 12% have a single prior claim, while fewer than three percent have multiple prior claims.

Graphic 72

Prior Lost-Time Claims within Five Years Among Injured Workers with Lost-Time Claims



*Preliminary data

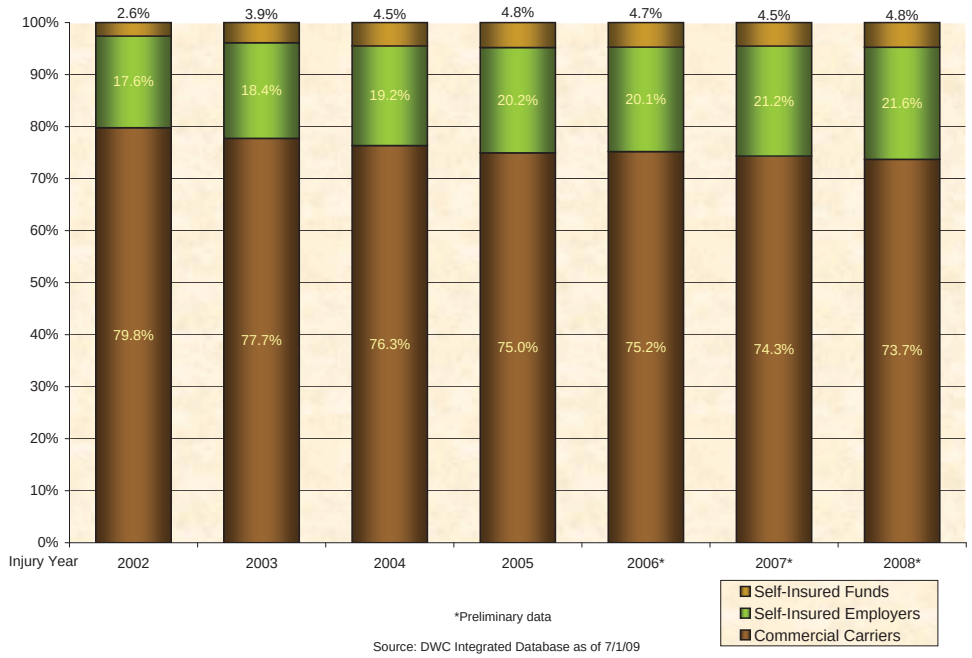
Source: DWC Integrated Database as of 7/1/09

Carrier Type

The type of carrier reporting lost-time claims provides an indirect and approximate indicator of the workers' compensation insurance market. Three types of carriers dominate that market: commercial carriers, self-insured employers and self-insured funds. **Graphic 73** displays the respective carrier shares of lost-time claims from 2002 through 2008. Claim shares for self-insured employers increased from 2002 to 2005 and have remained steady since then. Claims for self-insured funds increased slightly over that same period. Claim shares for commercial carriers had a small, but steady decline. This graphich includes lost-time claim counts, without regard to changes in market share for these groups.

Graphic 73

Distribution of Lost-Time Cases by Insurer Type and Injury Year



*Preliminary data

Source: DWC Integrated Database as of 7/1/09

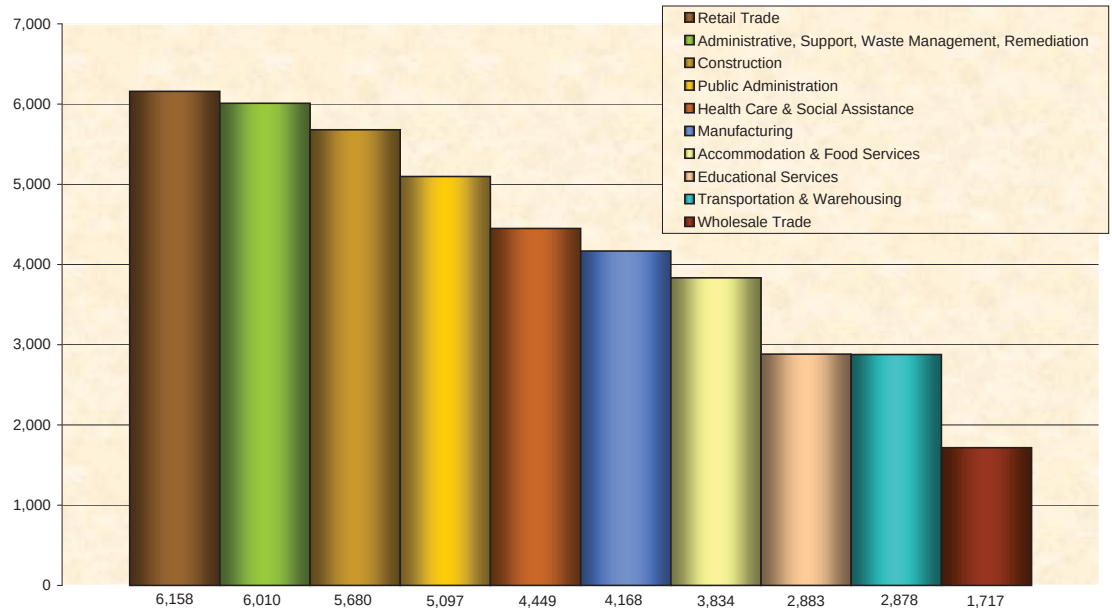
Industry Type

Graphic 74 *below* provides the frequency of 2008 lost-time cases for the top ten industry classifications, based on the North American Industry Classification System (NAICS). These classifications were reported on 92.9% of First Reports of Injury or Illness.

Retail Trade, with 6,158 lost-time cases, leads among the industry groups, followed by Administrative, Support, Waste Management and Remediation (6,010 cases) and Construction (5,680 cases). These three industry classifications account for more than a third (35.1%) of all 2008 lost-time cases reporting a classification code. Public Administration (5,097 cases) and Health Care and Social Assistance (4,449 cases) complete the top five, which cumulatively represent nearly 53.8% of cases with a reported industry code. Together, the top ten industry groups account for over 84% of all 2008 lost-time cases reporting an industry classification code.

Graphic 74

Top Ten Industrial Classifications for 2008* Lost-Time Cases



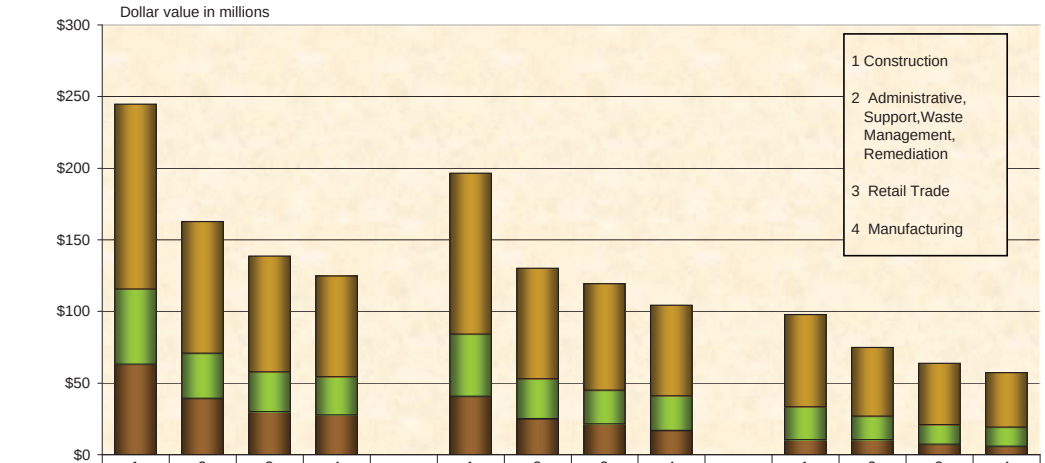
*Preliminary data

Source: DWC Integrated Database as of 7/1/09

Graphic 75 *below* displays the relative distribution of indemnity, medical and settlement costs for the past three injury years by industrial classification for the four leading classifications. These benefit costs illustrate claim development and reflect benefits paid on each injury year's cases reported, as of June 30, 2009. Construction, which has the highest benefit cost among the classifications, has the smallest relative share of medical costs and the largest relative share of indemnity and settlement costs combined over the three-year period. However, the relative proportions for all classifications will likely change as the claims mature.

Graphic 75

Benefit Costs for the Top Four Industrial Classifications by Injury Year



	2006*				2007*				2008*			
	1	2	3	4	1	2	3	4	1	2	3	4
Medical	$129.3	$92.2	$81.0	$70.8	$112.6	$77.5	$74.7	$63.5	$64.6	$48.3	$43.1	$38.1
Indemnity	$52.6	$31.5	$27.7	$26.6	$43.3	$27.9	$23.6	$23.9	$22.9	$16.3	$13.6	$13.3
Settlement	$62.9	$39.0	$29.8	$27.5	$40.5	$24.9	$21.1	$16.8	$10.3	$10.3	$7.1	$5.7

*Preliminary data

Source: DWC Integrated Database as of 7/1/09

NATURE, CAUSE AND BODY LOCATION OF WORKPLACE INJURIES

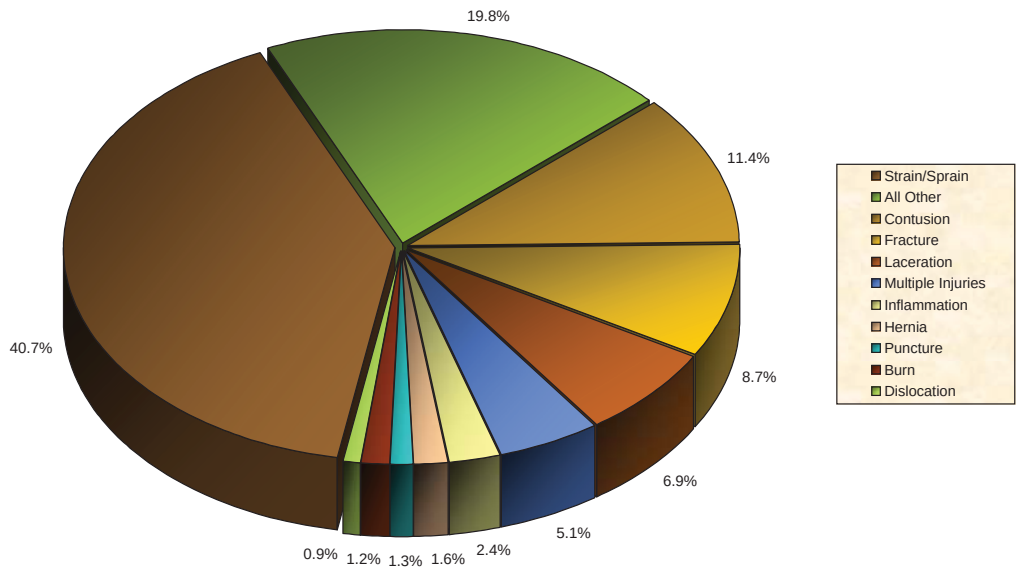
Nature of Injury

A few types of workplace injuries typically account for the majority of lost-time claims. **Graphic 76** *below* illustrates the distribution of 2008 lost-time injuries by their general nature as reported by the employer. Strains and Sprains jointly account for 40.7% of all cases. Contusion (11.4%), Fracture (8.7%) and Laceration (6.9%) combine with Strain and Sprain to account for over two-thirds (67.6%) of all 2008 lost-time cases.

Graphic 77 provides some historical perspective on the consistency of injuries that underlie lost-time claims as reported by the employer. For each of the years shown, Strains and Sprains account for 40%-42% of lost-time cases, while Contusions account for about 11%. Other injuries exhibit similar consistencies throughout the period, with Fractures, Lacerations and Multiple Injuries showing a slight increase over time.

Graphic 76

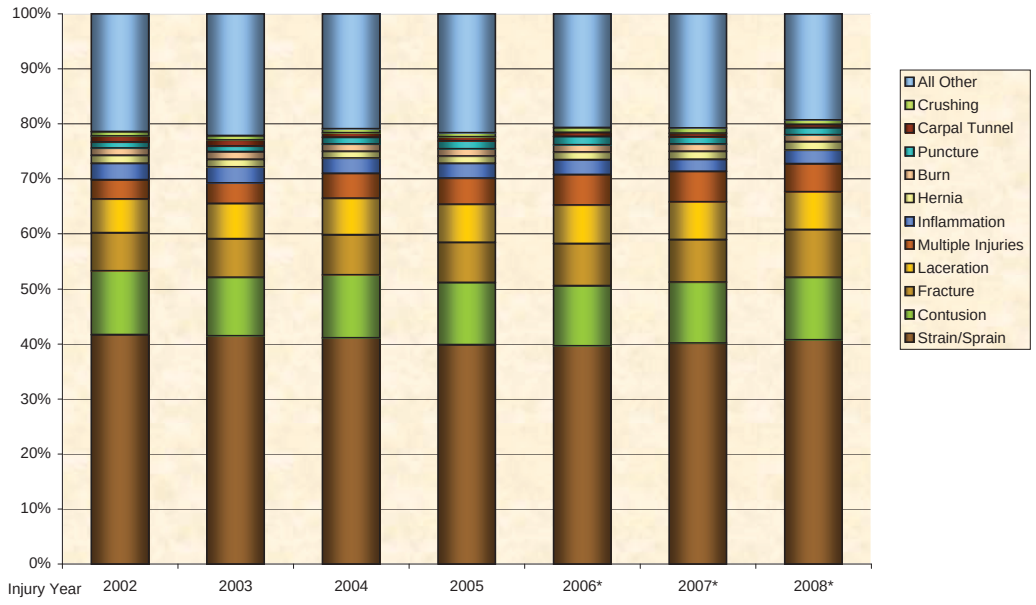
2008* Lost-Time Cases by Nature of Injury



*Preliminary reporting
Source: DWC Integrated Database as of 7/1/09

Graphic 77

Lost-Time Cases by Nature of Injury and Injury Year



*Preliminary data

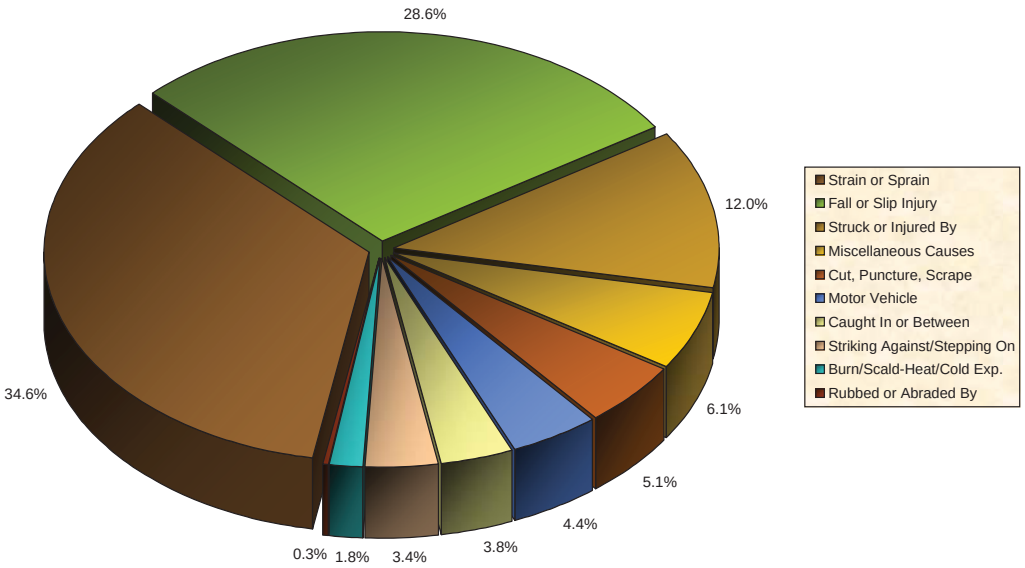
Source: DWC Integrated Database as of 7/1/09

Cause of Injury

Three-quarters of injuries leading to lost-time claims in 2008 were the result of three basic causes: Strain or Sprain (34.6%), Fall or Slip (28.6%) and Struck or Injured by (12.0%). **Graphic 78** *below* illustrates the distribution of causes of injury for 2008 lost-time cases as reported by the employer on the First Report of Injury or Illness.

Graphic 78

2008* Lost-Time Cases by Cause of Injury



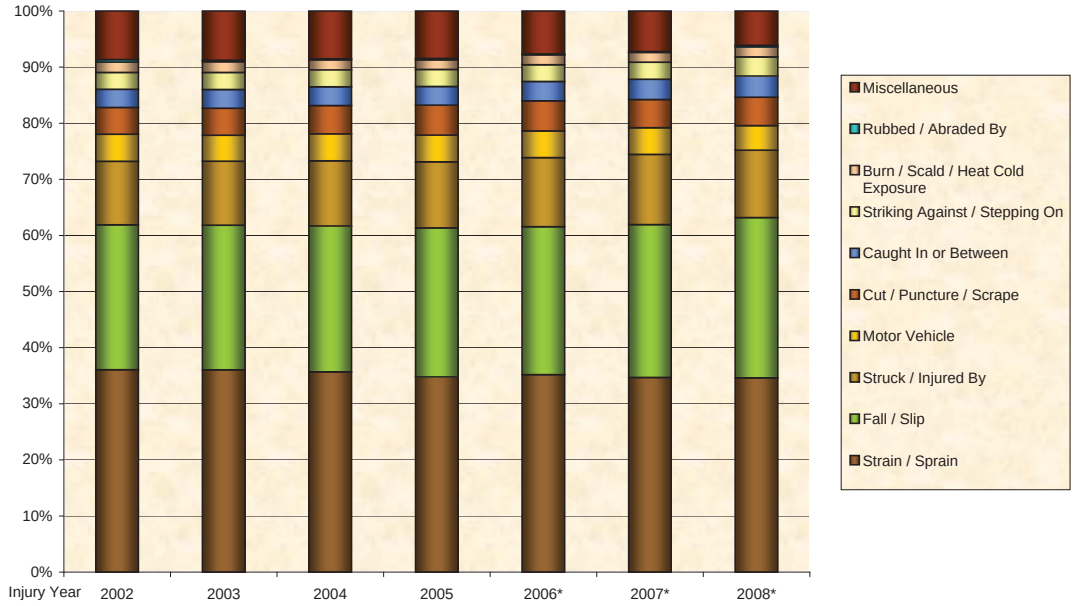
*Preliminary reporting

Source: DWC Integrated Database as of 7/1/09

Graphic 79 *below* displays the relative proportions for causes of injury for lost-time claims since 2002. Throughout the period shown, little variation in the cause of injury is evident for injury years with mature data. The only cause of injury with a decline exceeding one percentage point between 2002 and 2005 is Strain or Sprain, which decreased 1.3 percentage points.

Graphic 79

Lost-Time Cases by Cause of Injury and Injury Year



*Preliminary data

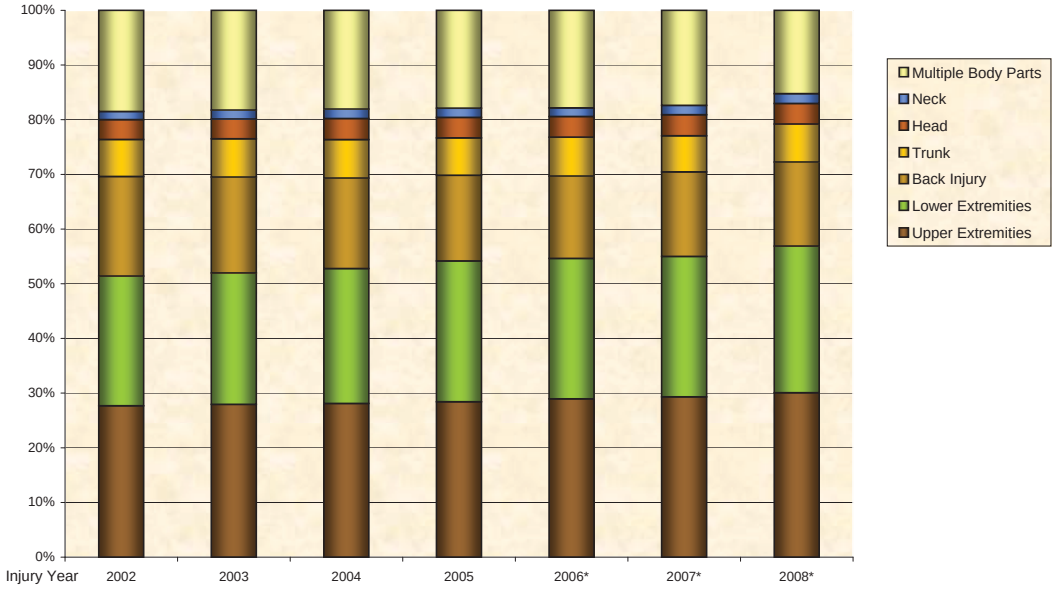
Source: DWC Integrated Database as of 7/1/09

Body Location of Injury

The relative distribution of lost-time cases by injured body part since 2002 is shown in **Graphic 80** *below*. The injured body part is reported by the employer and may not correspond to the health care provider's diagnosis. During the period with mature data, relative frequencies for Lower Extremities increased by 2.1 percentage points, while Back injuries declined by 2.5 percentage points. The distribution of other injured body parts has remained relatively stable since 2002.

Graphic 80

Lost-Time Cases by Injured Body Part and Injury Year



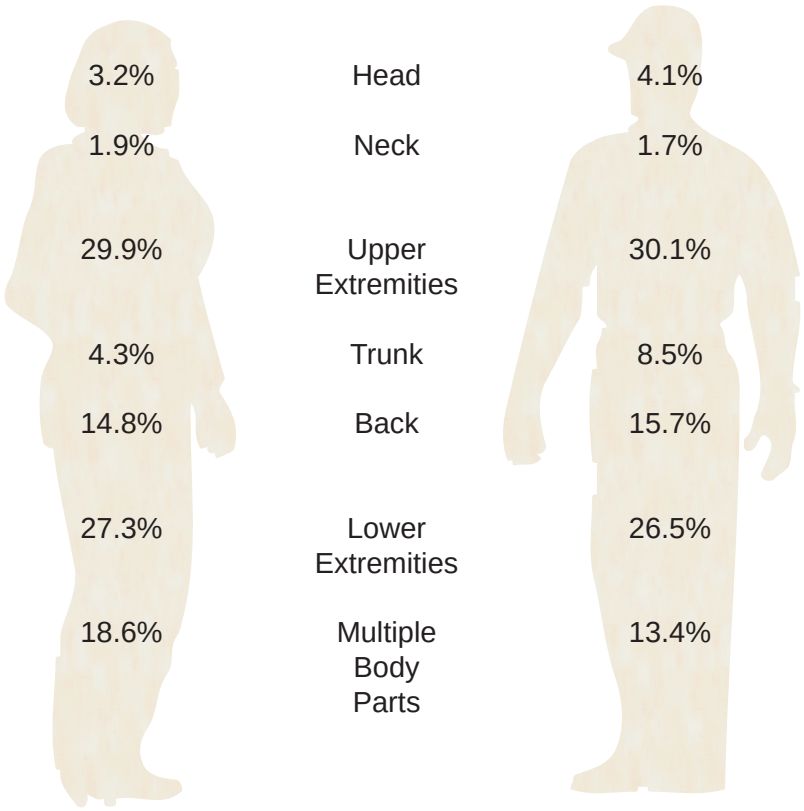
*Preliminary data

Source: DWC Integrated Database as of 7/1/2009

Gender differences associated with body location of 2008 lost-time injuries are illustrated *below* in **Graphic 81**. For Upper Extremities, Lower Extremities, Head and Neck injuries, gender differences in relative frequency are minimal, within a percentage point. Only three body locations of injury exhibited more pronounced gender differences: Back, Trunk, and Multiple Body Parts. Nearly nine percent (8.5%) of lost-time injuries sustained by men involved the Trunk, compared to 4.3% of injuries to women. Conversely, women were more likely than men to sustain Multiple Body Part injuries, 18.6% versus 13.4%, and Back injuries, 14.8% versus 15.7%.

Injury Body Location by Gender for 2008 Lost -Time Cases

Graphic 81



3.2%	Head	4.1%
1.9%	Neck	1.7%
29.9%	Upper Extremities	30.1%
4.3%	Trunk	8.5%
14.8%	Back	15.7%
27.3%	Lower Extremities	26.5%
18.6%	Multiple Body Parts	13.4%

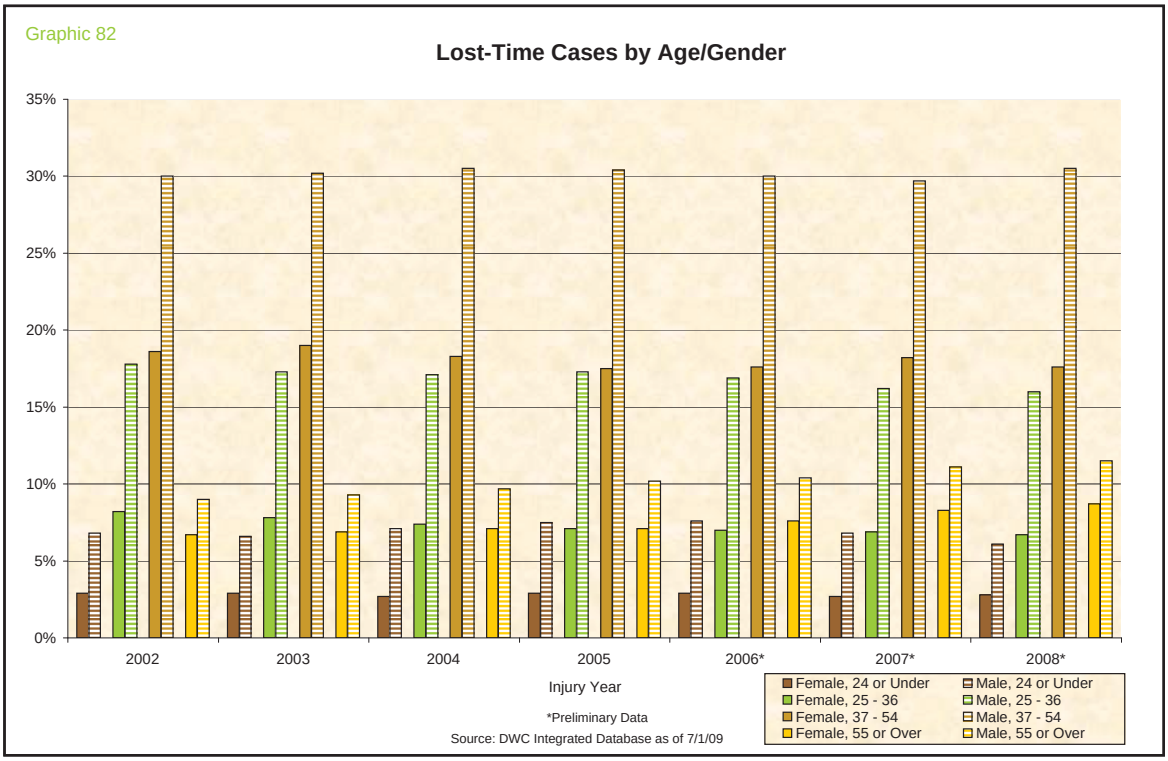
Source: DWC Intergrated Database as of 07/07/2009

Gender and Age

Considered by gender alone, lost-time cases typically reflect close to a two-to-one ratio of men to women with men sustaining 64.1% of lost-time injuries and women sustaining 35.9%. Analysis by combined gender and age groups, illustrated in **Graphic 82** *below*, helps to further characterize the lost-time population. Males aged 37-54 at the time of injury constitute the single largest demographic group. Since 2002, this group has comprised about 30% of lost-time cases in each injury year. Beginning in 2002, females aged 37-54 constitute the second largest demographic segment of the lost-time population and the largest demographic group among women with lost-time injuries representing 18%-19% of all lost-time cases.

Males aged 25-36 constitute the third largest demographic segment of the lost-time population, comprising 16%-18% of cases annually. Together, males aged 25-36 and 37-54 constitute nearly half of the lost-time population. About two-thirds of lost-time cases annually consist of males 25-36, males 37-54 and females 37-54. Among the remaining one-third of the population, slight trends of growth have occurred since 2002 for both males and females 55 and older. The median age for persons with lost-time injuries has increased somewhat each year, from 41 in 2002 to 44 years of age in 2008.

Graphic 82



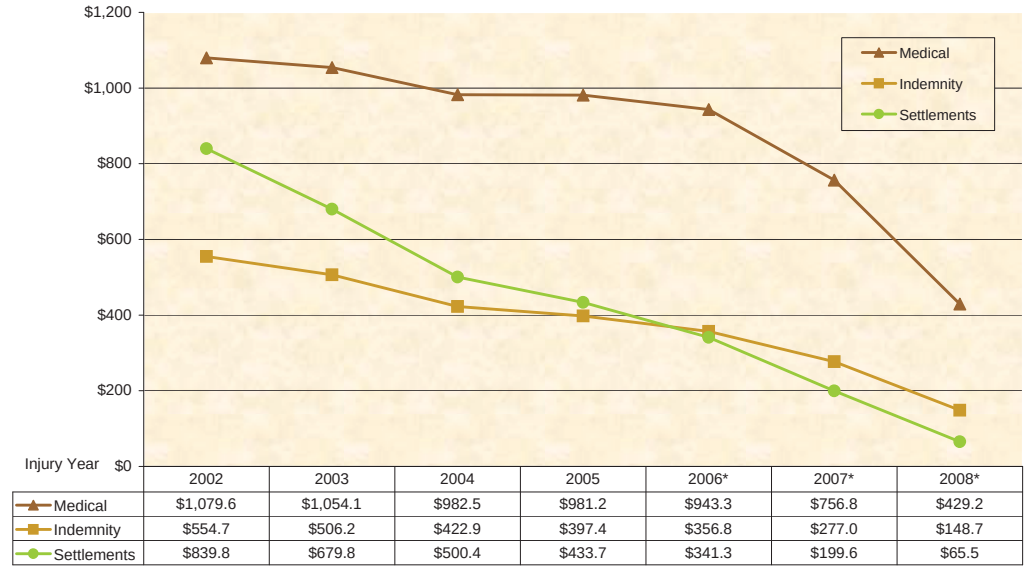
BENEFITS PAID

For all covered employees, the workers' compensation system provides all medically necessary remedial treatment, care and attendance as the nature of the injury or the process of recovery may require. In addition, workers losing time from work due to their injury may receive indemnity benefits to replace a portion of wages lost due to the injury. Injured workers may receive some or all medical and/or indemnity benefits in a lump-sum settlement of their claim.

Graphic 83 *below* shows total amounts paid for indemnity benefits, medical benefits and settlements by injury year since 2002. Payment amounts relate only to lost-time cases and are unadjusted for inflation. The decreasing payment amounts for injury years with immature data reflect a lack of development and any decreases that may be caused by a reduction in severity will not be known for several more years. There was significant transition in 2008 as claim cost data collection moved from annual paper and EDI filings to EDI semi-annual filings. At the same time, insurers were no longer required to submit medical payment information on claim cost filings, but submitted individual medical bill charge and payment data to the Division. Since this year's data is comprised of both paper and EDI filings, too much weight should not be placed on claim cost proportional differences between medical and indemnity benefits. As we transition to 100% EDI filings over the next year, any anomalies due to the timing of reports filed should disappear.

Graphic 83

Cumulative Medical, Indemnity, and Settlement Costs for Lost-Time Cases by Injury Year



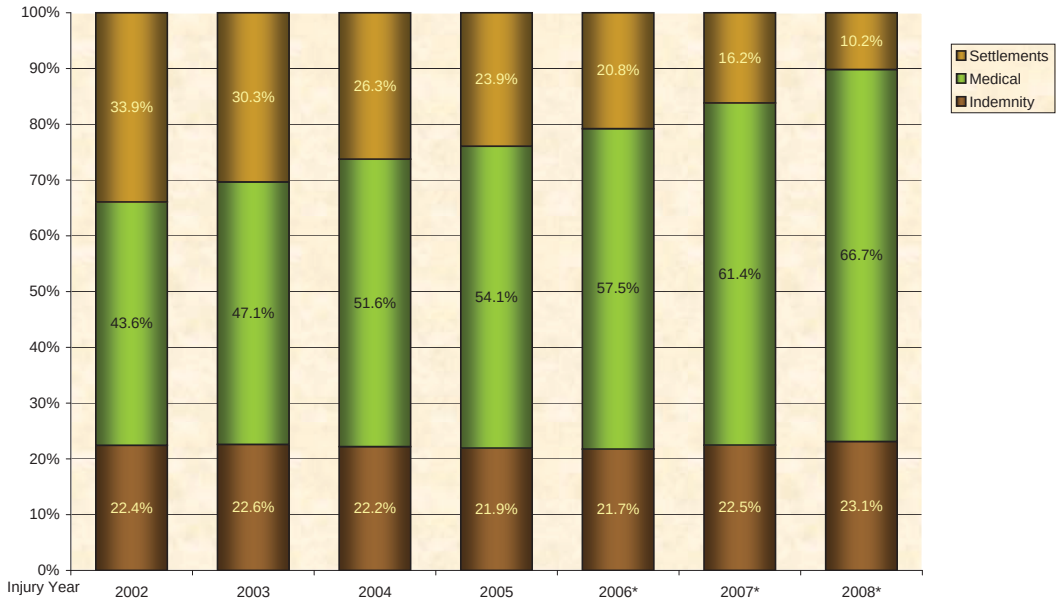
Injury Year	2002	2003	2004	2005	2006*	2007*	2008*
Medical	$1,079.6	$1,054.1	$982.5	$981.2	$943.3	$756.8	$429.2
Indemnity	$554.7	$506.2	$422.9	$397.4	$356.8	$277.0	$148.7
Settlements	$839.8	$679.8	$500.4	$433.7	$341.3	$199.6	$65.5

*Preliminary data
Source: DWC Integrated Database and Medical Data Warehouse as of 7/1/09

Graphic 84 shows the relative distribution of benefit payments for lost-time cases by payment type. For 2002 through 2008, the share of medical benefits grows larger each year, rising over 23 percentage points during the period, while settlement payments declined by more than 23 percentage points. However, the proportionate shares of the payment categories change significantly over time as the claims mature and more cases are settled. Medical costs are proportionately highest and settlement costs lowest in the most recent injury year, with relative medical costs decreasing and relative settlement costs increasing for each year of claim maturity. In the years with preliminary data, this pattern largely illustrates the difference in timing between settlements and medical services; the latter tend to be more immediate following an injury. The same issues raised above regarding the transition to EDI claim cost filings apply to this graphic.

Graphic 84

Distribution of Indemnity, Medical, and Settlement Costs for Lost-Time Cases by Injury Year



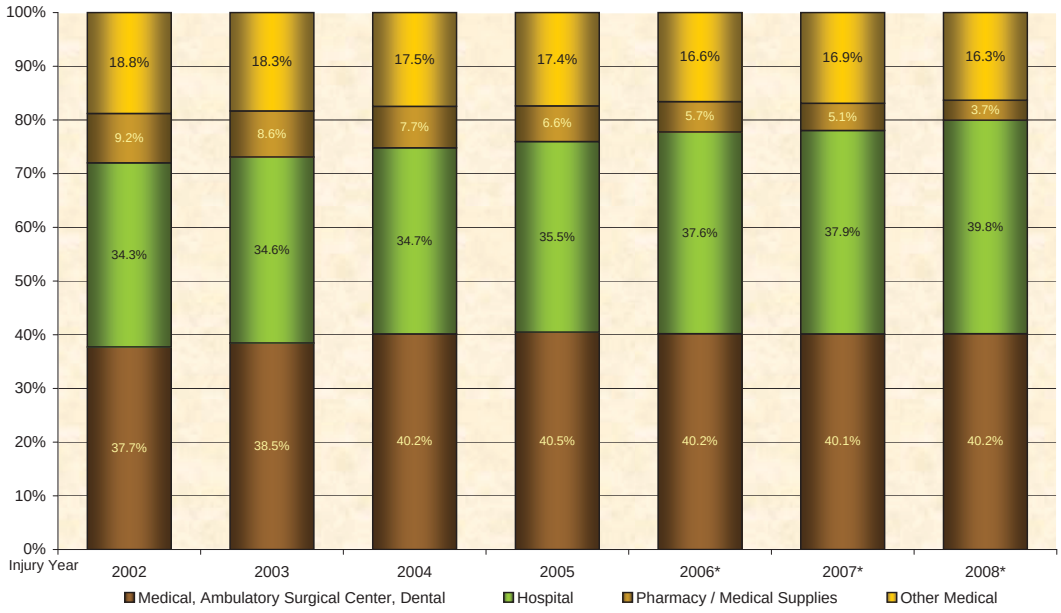
*Preliminary data

Source: DWC Integrated Database and Medical Data Warehouse as of 7/1/09

Graphic 85 *below* displays the relative proportion of different cost components. Four components are shown: medical, ambulatory surgical centers and dental (combined), hospital, pharmacy and medical supplies (combined) and an "other" category which comprises medical transportation, home attendant care, skilled nursing care, rehabilitation and miscellaneous medical. This is another view of the data shown in **Graphic 84** *above* and further demonstrates how the proportionate costs change as injuries mature. (It should be noted that medical costs include prescription drugs dispensed by a health care provider and pharmacy costs include prescription drugs dispensed only by a pharmacy.)

Graphic 85

Distribution of Medical Costs for Lost-Time Cases by Injury Year



*Preliminary data

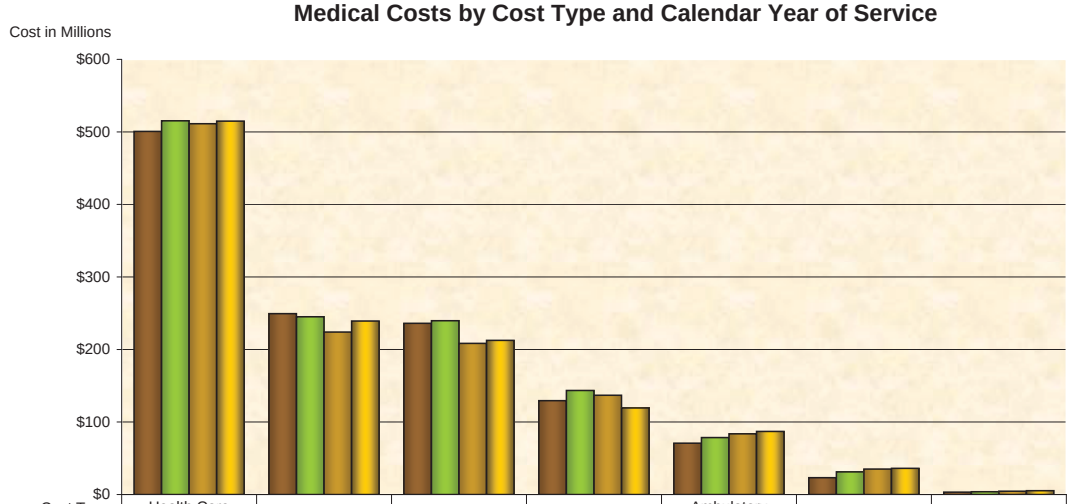
Source: DWC Integrated Database and Medical Data Warehouse as of 7/1/09

Graphics 83 and 85 pertain only to lost-time cases. In the remainder of this section, the focus shifts to include medical costs for both lost-time and medical only cases, with analysis based on data obtained from medical bills submitted to the Division rather than Claim Cost Reports. Because these bills do not contain some of the miscellaneous medical costs reported for lost-time cases (such as home attendant care or medical transportation), "other" medical costs are not included in the graphics that follow. One further difference in the graphics that follow is that, with the exception of **Graphics 93 and 94**, cost information is aggregated by the calendar year the treatment was provided rather than by the calendar year in which the injury occurred.

Graphic 86 *below* displays total payments for seven medical categories during the past four calendar years. The relative standing of payment amounts is consistent over the period. Health care provider payments lead the payment categories, followed by hospital outpatient and hospital inpatient payments, pharmacy payments, ambulatory surgical center payments, medical supply payments and dental payments. Totaling more than $500 million each year and representing 41%-42% of total annual costs, health care provider payments exceeded the total annual inpatient and outpatient hospital payments. Together, payments to health care providers and hospitals were close to $1 billion dollars each year and accounted for nearly 78%-81% of total annual costs. Total payments for all categories were consistently above $1.2 billion each year. Because of delayed carrier reporting, disputes regarding some medical bills and adjustments of previously reported bills, payment totals may change somewhat over time.

Graphic 86

Medical Costs by Cost Type and Calendar Year of Service



Cost Type	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Pharmacy	Ambulatory Surgical Center	Medical Supplies	Dental
2005	$500.7	$249.4	$236.0	$129.4	$70.8	$23.2	$3.3
2006	$515.3	$245.1	$239.6	$143.5	$78.6	$31.2	$3.9
2007	$511.2	$224.0	$208.5	$136.9	$83.7	$35.1	$4.6
2008	$514.8	$239.2	$212.6	$119.4	$87.0	$36.2	$5.3

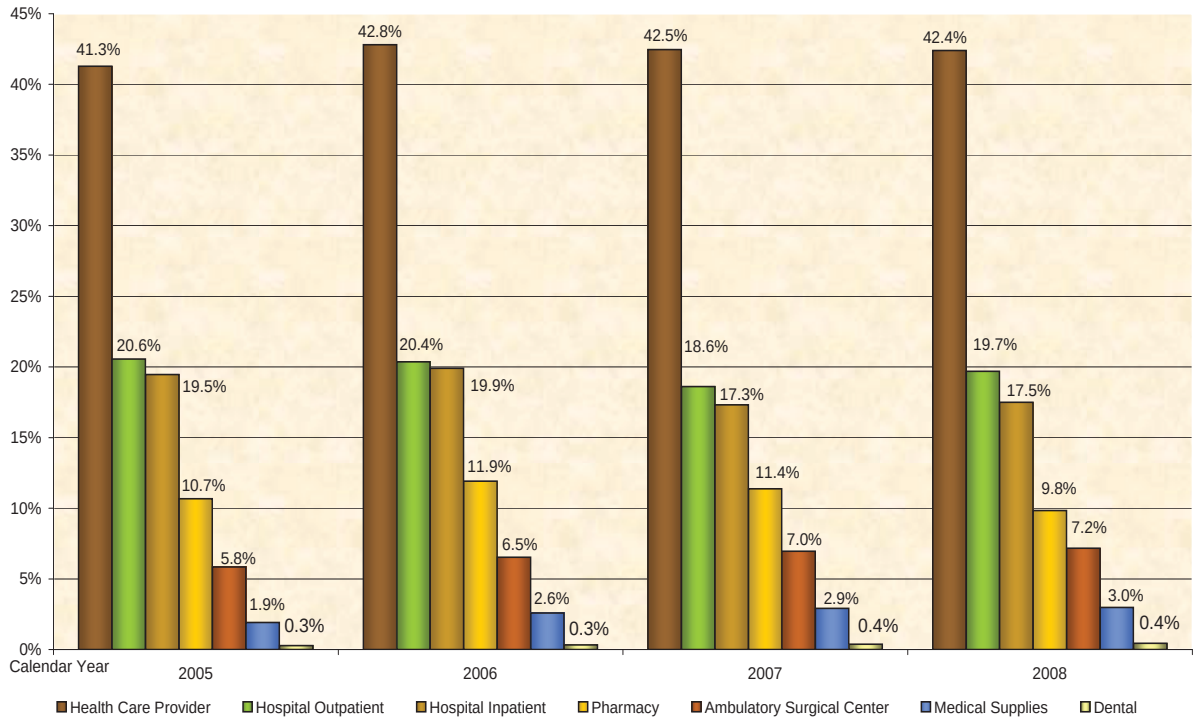
Source: DWC Medical Data Warehouse as of 7/1/09

Graphic 87 displays the relative proportions of medical costs reported in **Graphic 86**. The dominance of health care provider, hospital outpatient and hospital inpatient payments is apparent. Pharmacy costs increased in both dollar volume and relative share in 2006 and declined in both respects in 2007 and 2008. Pharmacy costs only include those prescription drugs dispensed by a pharmacy and not those dispensed by a health care provider.

Graphic 88 shows the interval between the date medical treatment was provided and the date of accident. In each year shown, more than two-thirds of all medical services were provided for dates of accident within a year of the treatment date. Another eight to nine percent of the medical services represent dates of accident preceding the medical treatment by between one and two years. When combined, more than three-quarters of the medical treatment during the last four calendar years represent injuries that occurred within two years of medical treatment provided. The remaining one quarter stem from accidents preceding medical treatment by more than two years, with 13%-16% representing accidents preceding medical treatment by more than five years. Analysis of the interval between medical treatment and injury illustrates the protracted nature of many injuries and the extent to which more severe injuries remain a significant cost factor in the workers' compensation system for many years.

Graphic 87

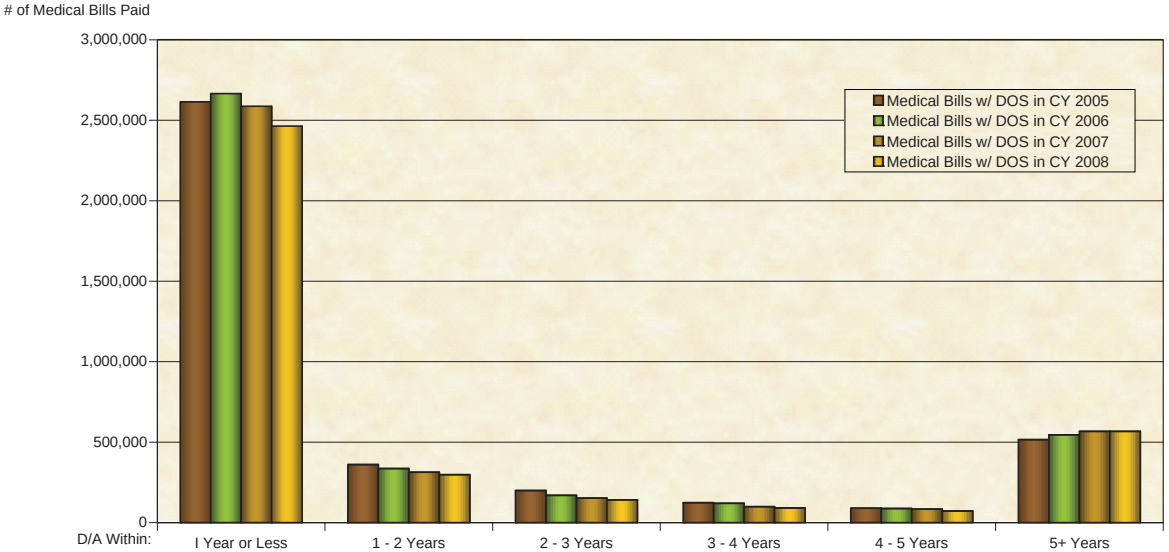
Distribution of Medical Costs by Calendar Year of Service



Source: DWC Medical Data Warehouse as of 7/1/09

Graphic 88

Correlation between Medical Bill Date of Service and Date of Accident



CY of Service	1 Yr or Less	1 - 2 Years	2 - 3 Years	3 - 4 Years	4 - 5 Years	5+ Years
2005	67.0%	9.2%	5.1%	3.2%	2.3%	13.2%
2006	67.9%	8.6%	4.3%	3.1%	2.2%	13.9%
2007	68.0%	8.2%	4.0%	2.6%	2.2%	14.9%
2008	67.8%	8.2%	3.9%	2.5%	2.0%	15.6%

Source: DWC Medical Data Warehouse as of 7/1/09

The next four graphics are a related series that offers two perspectives on hospital revenue codes. Separately for inpatient and outpatient codes, the graphics display the frequency of revenue codes and the percent of total bills having a revenue code in a particular category. The graphics pertaining to frequency aggregated medical bills containing one or more instances of a revenue code. The graphics pertaining to percent show what percentage of bills contained one or more revenue codes from that category.

Graphics 89 and 90 provide revenue code frequencies. Although the volume of paid bills is much higher for outpatient codes, eight of the top ten inpatient and outpatient codes are identical, differing only in frequency rank order. Some differences among the top ten codes reflect services most typically associated with a specific place of delivery, i.e., inpatient bills most frequently include Room and Board, while the most frequent outpatient code is for Emergency Room.

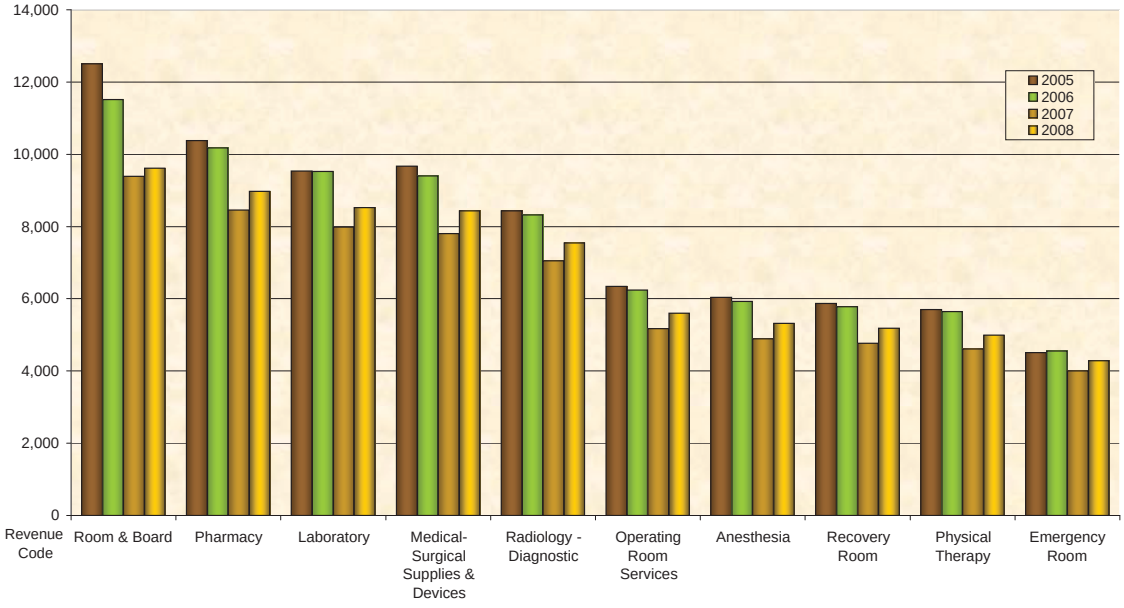
For nine of the top 10 inpatient code groups, the frequency of codes decreased in 2006 and 2007 and then increased for 2008. As a percent of total bills, Room and Board was fairly consistent at between 96% and 98% for all four years. The percentages for other inpatient codes shown in the graphic, with the exception of Physical Therapy, increased annually from 2006-2008. **Graphic 91** displays the leading 10 inpatient codes as a percent of all paid inpatient bills.

For hospital outpatient codes, there is much greater disparity in code frequency than among inpatient codes. While the leading outpatient code, Emergency Room, peaked at 119,160 for services in 2005, the tenth ranked code, Recovery Room, peaked at 15,668 for the same year. Eight of the top 10 outpatient codes sustained consistent annual decline in frequencies from 2006-2008, while two (Treatment/Observation Room and Clinic) exhibited small, annual growth. As a percent of hospital outpatient bills, Treatment/Observation Room sustained consistent annual growth, despite its downward turn in code frequency in 2008.

Graphic 92 illustrates the leading outpatient codes as a percent of all bills. Additionally, when viewing outpatient billing frequency, it should be noted that a change from year to year may be more reflective of a change in claim frequency and/or number of bills received rather than a decline in the frequency in service or severity of injuries.

Graphic 89

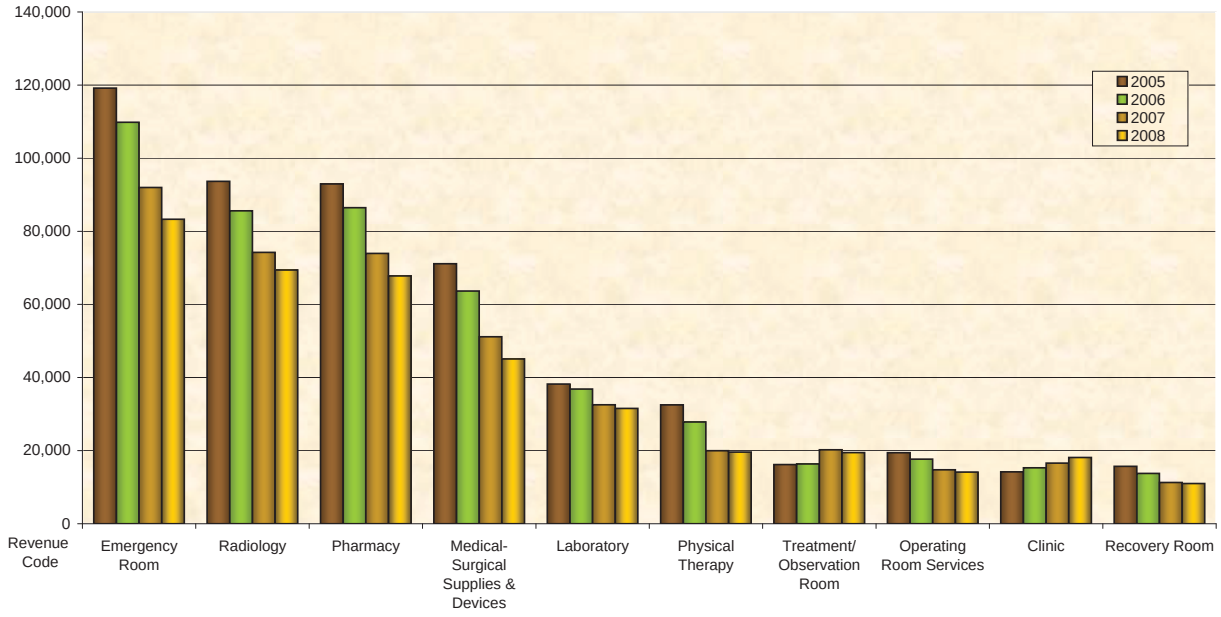
Billing Frequency of Hospital Inpatient Revenue Codes by Calendar Year of Service*



*Only the 10 most frequently billed revenue codes are included. Room and Board includes Subacute Care, Intensive Care, and Coronary Care.
Source: DWC Medical Data Warehouse as of 7/1/09

Graphic 90

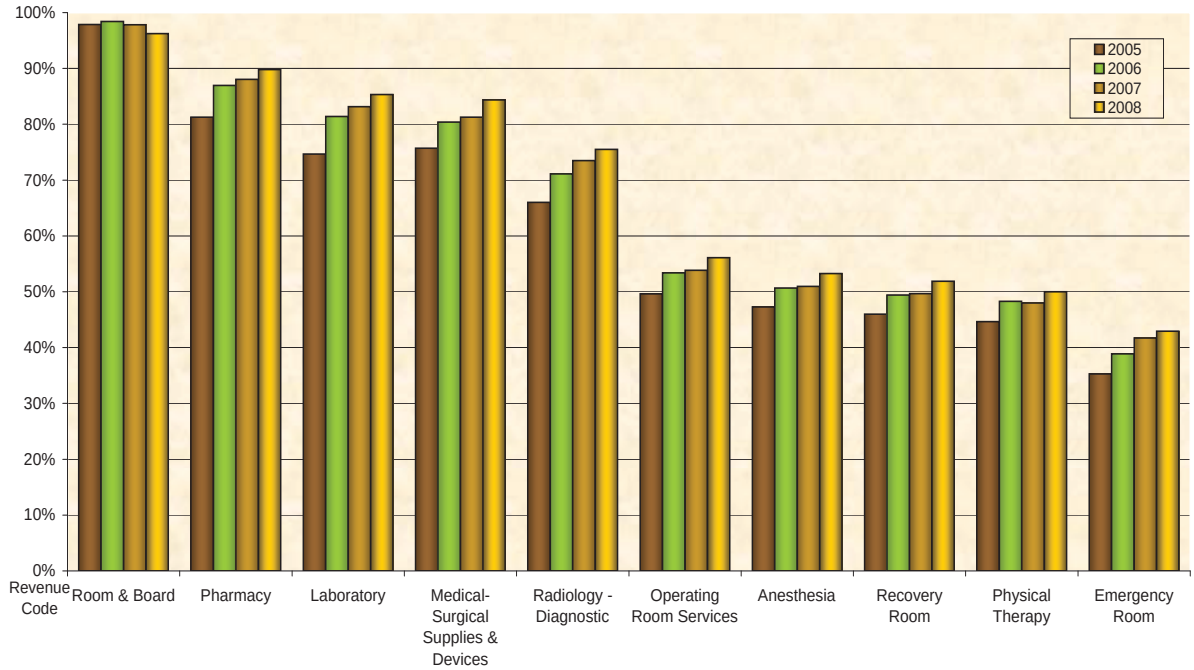
Billing Frequency of Hospital Outpatient Revenue Codes by Calendar Year of Service*



*Only the 10 most frequently billed revenue codes are included.
Source: DWC Medical Data Warehouse as of 7/1/09

Graphic 91

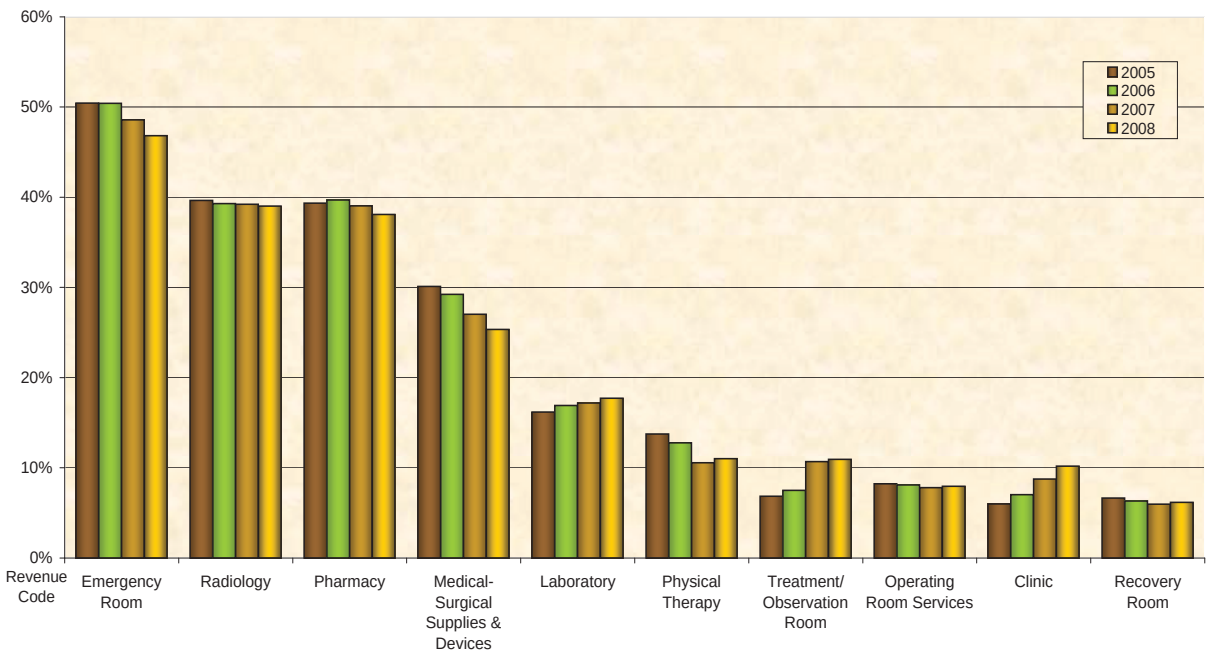
Percent of Hospital Inpatient Bills with Top 10 Revenue Codes by Calendar Year of Service



Note: Room & Board includes Subacute Care, Intensive Care, and Coronary Care.
Source: DWC Medical Data Warehouse as of 7/1/09

Graphic 92

Percent of Hospital Outpatient Bills with Top 10 Revenue Codes by Calendar Year of Service



Source: DWC Medical Data Warehouse as of 7/1/09

Graphic 93 displays medical payments grouped in seven different categories by year of injury for the last four years. Payment totals are limited to services provided within six months of injury and are further restricted to medical bills submitted to the Division by June 30 of the year following the injury year. These analytic restrictions allow a comparison of annual medical costs that is not affected by differences in the age of a claim.

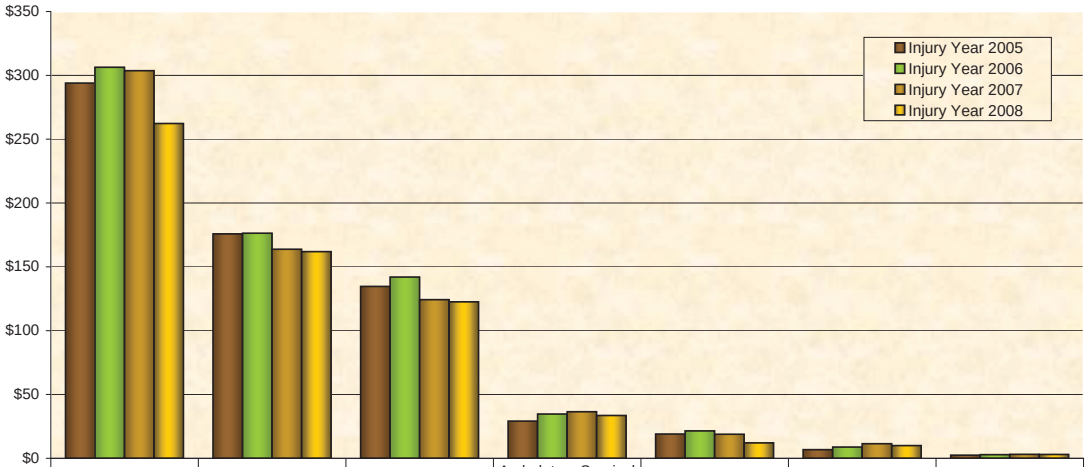
In the largest payment category for payments to Health Care Providers, the amount paid increased in 2006 and declined in 2007 and 2008. Hospital Outpatient and Hospital Inpatient payments also increased in 2006 and then declined in 2007 and 2008 with the steepest decline occurring in 2007. By contrast, Ambulatory Surgical Center payments rose in 2006 and 2007 with a small decrease in 2008. Medical Supply and Dental payments rose in 2006 and 2007 before declining slightly in 2008. Overall, total medical payments for 2008 fell nearly nine percent from the 2007 total. It is unclear whether this decrease reflects the decline in the frequency of injury cases, change in the utilization of medical services, or a decline in the severity of injuries.

Graphic 94 displays medical payments grouped in seven different categories by year of injury from 2005 through 2007 based on services provided within 12 months of injury. Payment totals are further restricted to medical bills submitted to the Division by June 30 of the second year following the injury year. Comparison of this graphic with the preceding one provides an indication of the impact of case development on payment trends for injury years 2005 through 2007. At 12 months maturity, there is substantially less variation for 2006 and 2007 in total payments for hospital outpatient services and somewhat less variation for hospital inpatient for 2006 and 2007 compared to data maturity of six months.

Graphic 93

Total Medical Paid for Services Provided within Six Months of Injury

Paid in Millions



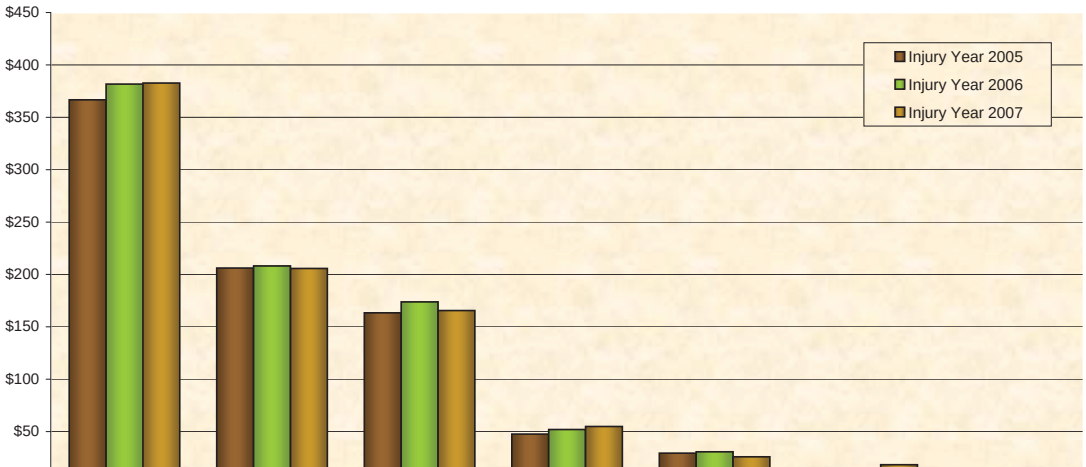
	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental
Injury Year 2005	$293.9	$175.8	$134.7	$29.1	$19.1	$6.8	$2.4
Injury Year 2006	$306.3	$176.3	$142.0	$34.7	$21.4	$8.8	$2.8
Injury Year 2007	$303.7	$163.8	$124.3	$36.5	$18.8	$11.4	$3.1
Injury Year 2008	$262.3	$161.9	$122.6	$33.5	$12.1	$10.0	$3.0

Source: DWC Medical Data Warehouse as of 7/1/09

Graphic 94

Total Medical Paid for Services Provided within 12 Months of Injury

Paid in Millions



	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental
Injury Year 2005	$366.6	$206.1	$163.4	$47.7	$29.4	$12.0	$3.0
Injury Year 2006	$381.7	$208.1	$173.8	$52.0	$30.7	$15.0	$3.8
Injury Year 2007	$382.7	$205.7	$165.6	$54.9	$26.0	$18.4	$4.0

Source: DWC Medical Data Warehouse as of 7/1/09

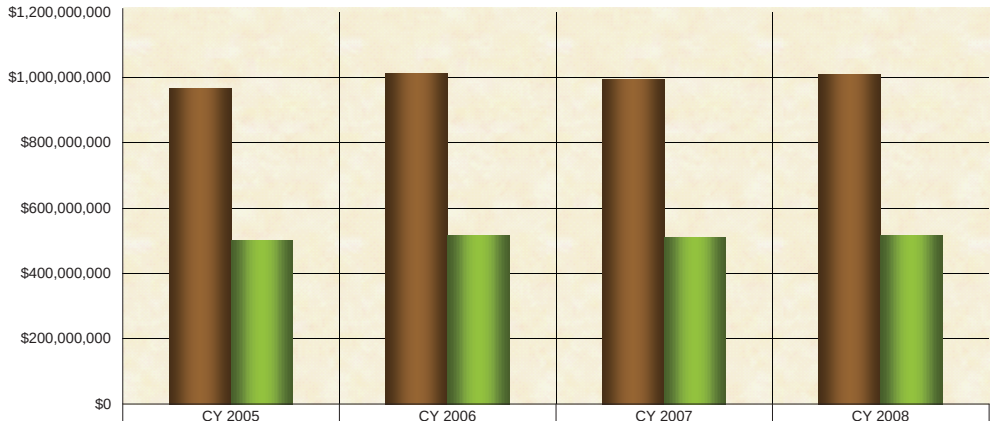
MEDICAL BILLING DATA

Graphics 95 through 99 display total charges and payments for five types of health care providers. Information provided in these graphics was obtained from medical bills for both medical only and lost-time cases. For health care provider services, ambulatory surgical center services, dental services and pharmacy purchases, charges and payments are reported by calendar year of service, with additional information on the total annual number of paid bills and the average charged and paid amounts per date of service, for a particular date of accident and provider. It should be noted that pharmacy charge data was not required to be reported to the Division until April 7, 2006. In order to report average pharmacy charge and payment data for 2006, 87,672 bills, (representing 10.2% of the paid 2006 bills), were excluded from this graphic because they lacked charge data. Using the bills without charge information would have improperly deflated the average amount charged per date of service compared to the amounts paid. For inpatient and outpatient hospital services, charges and payments are also reported by year of service, but average charged and paid amounts are calculated per bill. The graphics include four calendar years of data (2005 – 2008) except for pharmacy bills, for which the Division has complete data only for the three most recent years.

What is consistent among all medical providers is an annual increase in average charged and paid amounts, with the sole exception of the average paid amount for 2008 hospital inpatient services, which declined slightly. It should be noted that the Hospital Reimbursement Manual effective October 1, 2007, changed the reimbursement methodology for inpatient hospital bills containing implants, which reduced the number of bills that exceeded stop-loss provisions. Dental services, with increases of 13.5% and 13.9%, respectively, for service years 2007 and 2008, had the largest relative sustained growth in average amounts paid, but comprised the smallest total cost among the major service categories. For average charged amounts, ambulatory surgical centers exceeded all other providers in sustained relative growth, with respective annual increases of 14.4%, 14.6%, and 15.1% for 2006-2008.

Graphic 95

Total Charges and Total Paid for Health Care Provider Services by CY of Service



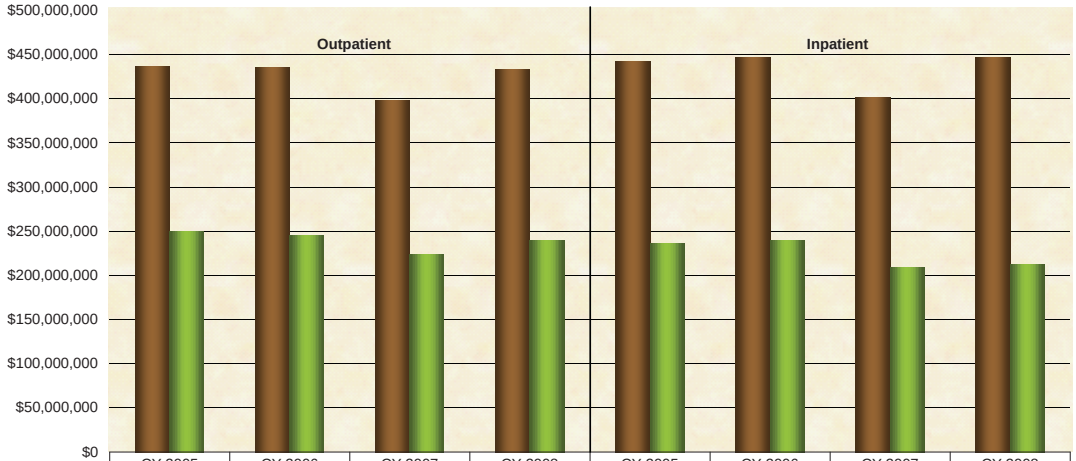
	CY 2005	CY 2006	CY 2007	CY 2008
Charges	$965,419,216	$1,013,971,226	$994,682,239	$1,008,941,503
Paid	$500,702,773	$515,301,177	$511,245,131	$514,821,239
Total Bills Paid	2,721,016	2,719,337	2,687,176	2,617,803
Total Dates of Service*	3,086,872	3,040,006	2,919,855	2,801,879
Avg Charge per DOS*	$313	$334	$341	$360
Avg Paid per DOS*	$162	$170	$175	$184

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

Source: DWC Medical Data Warehouse as of 7/1/2009

Graphic 96

Total Charges and Total Paid By Hospital Bill Type and CY of Service

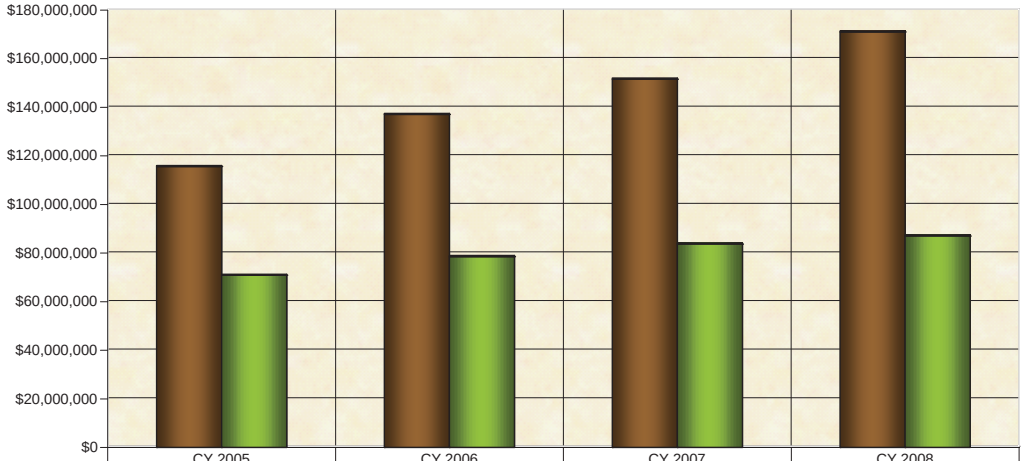


	Outpatient				Inpatient			
	CY 2005	CY 2006	CY 2007	CY 2008	CY 2005	CY 2006	CY 2007	CY 2008
Charges	$435,984,171	$435,106,632	$397,628,891	$433,250,997	$441,911,362	$445,993,265	$401,265,538	$446,407,274
Paid	$249,435,174	$245,099,271	$223,997,879	$239,225,383	$236,018,732	$239,616,207	$208,478,297	$212,606,297
Total Bills	236,260	217,828	189,303	177,903	12,774	11,698	9,600	9,991
Avg Charge / Bill	$1,845	$1,997	$2,100	$2,435	$34,595	$38,126	$41,798	$44,681
Avg Paid / Bill	$1,056	$1,125	$1,183	$1,345	$18,476	$20,484	$21,716	$21,280

Note: Only bills with payment amount > $0 are included.
Source: DWC Medical Data Warehouse as of 7/1/09

Graphic 97

Total Charges and Total Paid for Ambulatory Surgical Services by CY of Service

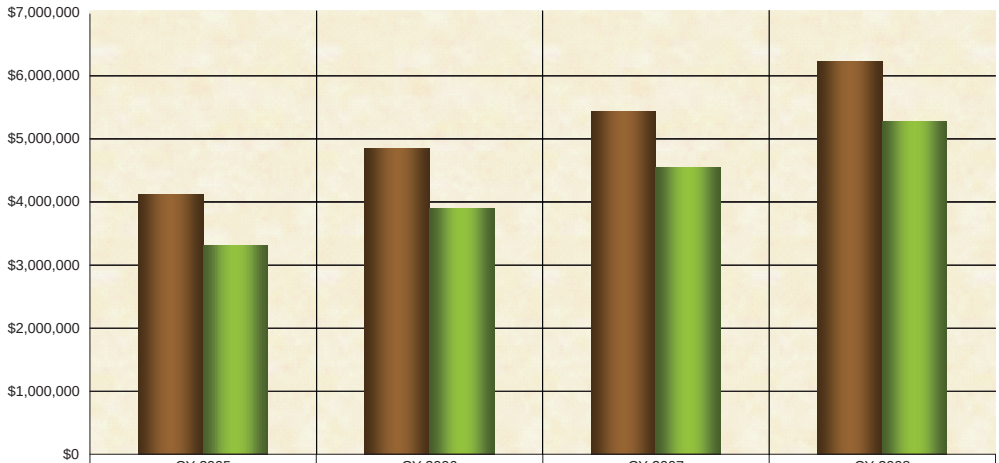


	CY 2005	CY 2006	CY 2007	CY 2008
Charges	$115,559,728	$137,028,493	$151,546,685	$170,953,571
Paid	$70,835,099	$78,552,197	$83,698,177	$86,982,429
Total Bills Paid	25,125	26,717	26,725	26,314
Total Dates of Service*	24,230	25,106	24,233	23,758
Avg Charge per DOS*	$4,769	$5,458	$6,254	$7,196
Avg Paid per DOS*	$2,923	$3,129	$3,454	$3,661

*Only bills with payment amount > $0 are included.
Source: DWC Medical Data Warehouse as of 7/1/2009

Graphic 98

Total Charges and Total Paid for Dental Services by CY of Service



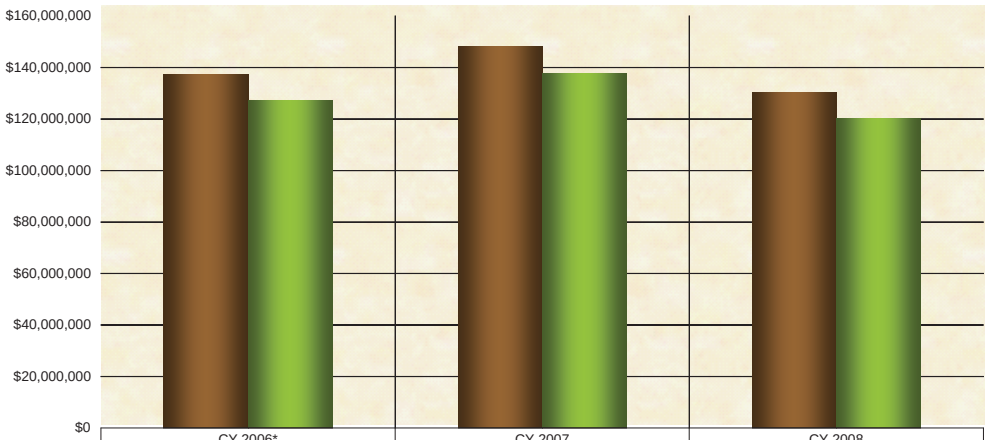
	CY 2005	CY 2006	CY 2007	CY 2008
Charges	$4,120,506	$4,853,963	$5,428,779	$6,228,254
Paid	$3,304,548	$3,894,997	$4,551,656	$5,269,616
Total Bills Paid	3,871	4,381	4,666	4,620
Total Dates of Service*	3,693	4,242	4,369	4,443
Avg Charge per DOS*	$1,116	$1,144	$1,243	$1,402
Avg Paid per DOS*	$895	$918	$1,042	$1,186

*Only bills with payment amount > $0 are included.

Source: DWC Medical Data Warehouse as of 7/1/2009

Graphic 99

Total Charges and Total Paid for Pharmacy Bills by CY of Service



	CY 2006*	CY 2007	CY 2008
Charges	$137,235,059	$148,202,197	$130,248,541
Paid	$127,039,422	$137,507,675	$120,045,142
Total Bills Paid	768,342	795,184	704,050
Total Dates of Service*	772,414	767,779	654,878
Avg Charge per DOS*	$178	$193	$199
Avg Paid per DOS*	$164	$179	$183

*10.2% of the paid pharmacy bills (87,672 bills) were excluded from this analysis because they do not contain charge data, which was not required by the Division until 4/7/06.
**Only dates of service with payment amount > $0 are included for drugs dispensed by a pharmacy.

Source: DWC Medical Data Warehouse as of 7/1/2009

DIVISION OF WORKERS' COMPENSATION WEBSITE

The Division of Workers' Compensation website home page is located at: http://myfloridacfo.com/WC and was designed to provide direct information access for all of the stakeholders in the Workers' Compensation System. On average, the Division's home page is visited more than 60,000 times per month. Division databases are accessed more than 32,000 times per month and the Statutes, Rules and Forms page is visited more than 27,000 times per month. A revised homepage has been implemented which organizes many items of interest by each stakeholder group with tabs for Employer, Insurer, Injured Employee and Health Care Provider.

The sections on databases; statutes, rules and forms; and information and frequently asked questions are essentially unchanged. Below is a list and description of pages within the Division's website, grouped by stakeholder. In addition, a description of databases, statutory and rule information and publications are provided.

Injured Workers:

1. **EAO Answer:** This icon allows injured workers to send an email to the Bureau of Employee Assistance and Ombudsman with questions, complaints, or requests for assistance. Click on the "Injured Employee" tab on the Division's home page and then click on the Email Us icon.

   Injured employees may also contact the Employee Assistance Office by telephone at: (800) 342-1741.

2. **Report Suspected Non-Compliance:** Click on the Report Suspected Workers' Comp Non-Compliance icon on the Division's home page.

3. **An Online Tutorial:** Click on the "Injured Employee" tab on the Division's home page, click on "Education and Information" and then click on "Injured Worker Workshop."

4. **Injured Worker FAQs:** Click on "Information and FAQs" on the Division's home page and then click on "Injured Worker FAQs."

5. **Benefit Delivery Process:** Click on "Information and FAQs" on the Division's home page and then click on "Benefit Delivery Process."

6. **Informational Brochure for Employees (English and Spanish):** Click on the "Injured Employee" tab on the Division's home page, click on "Education and Information" and then click on "Injured Worker Brochure."

Employers/Contractors:

1. **Employer FAQs:** Click on "Information and FAQs" on the Division's home page and then click on "Employer FAQs."

2. **Key Coverage and Exemption Eligibility Requirements:** Click on "Information and FAQs" on the Division's home page and then click on "Key Coverage and Exemption Eligibility Requirements."

3. **Proof of Coverage Database:** Click on the Proof of Coverage DATABASE Exemptions icon on the Division's home page.

4. **Claims Database:** Click on “Databases” on the Division’s home page and then click on “Claims Database.”

5. **Online Penalty Payment Service:** Click on the  icon on the Division’s home page.

6. **Construction Policy Tracking Database:** Click on “Databases” on the Division’s home page and then click on “Construction Policy Tracking Database.”

7. **Online Exemption Application:** Click on the  icon on the Division’s home page.

8. **Stock Certificate template for Construction Exemption Applicants:** Click on the “Employer” tab on the Division’s home page and then click on the  icon.

9. **Informational Brochure for Employers (English and Spanish):** Click on “Publications” on the Division’s home page and then click on “Important Workers’ Compensation Information for Florida’s Employers.”

10. **Safety Information:** Click on “Information and FAQs” from the Division’s home page and then click on “Safety Information.”

11. **Employer Education Seminars:** Click on the “Employer” tab on the Division’s home page and then click on “Educational Outreach/ Resources.”

12. **Workers.CompService@myfloridaCFO.com:** Employers and contractors may submit email inquiries regarding workers’ compensation insurance coverage requirements and exemption eligibility criteria as defined by law to this email address.

Insurers/Claim-Handling Entities:

1. **Claims Database:** Click on “Databases” on the Division’s home page and then click on “Claims Database.”

2. **Centralized Performance System (CPS) Database Tutorial:** Click on the “Insurer” tab on the Division’s home page, click on “Insurers” and then click on “CPS Tutorial.”

3. **Division EDI Claims Data Warehouse:** Click on “Database” on the Division’s home page and then click on “DWC Claims EDI Data Warehouse.”

4. **Special Disability Trust Fund Rules for Reimbursement and Reimbursement Request Form:** Click on the “Statutes, Rules & Forms” on the Division’s home page and then click on the “69L-10” tab.

Health Care Providers:

1. **Expert Medical Provider Recruitment:** Click on the “Health Care Provider” tab on the Division’s home page, then click on the  icon.

2. **Florida Workers’ Compensation Uniform Medical Treatment /Status Report Form, DFS-F2-DWC-25 in Word Format savable as a Word template:** Click on “Statutes, Rules & Forms” on the Division home page, click on the “69L-7” tab and then scroll down to the fourth link.

3. **Medical, Medical Provider, Managed Care Arrangement FAQs:** Click on “Information and FAQs” on the Division’s home page and then “Medical, Medical Provider, Managed Care Arrangement FAQs.”

4. **Health Care Provider Reimbursement Manual Menu:** Click on the “Publications & Reimbursement Manuals” on the Division’s home page, click “Florida Workers’ Compensation Health Care Provider Reimbursement Manual, 2008 Edition” and then you must accept the license agreement before you can reach the links for the Reimbursement Manual. This page permits access to the complete Florida Workers’ Compensation Health Care Provider Reimbursement Manual as well as text files of the Schedule of Maximum Reimbursement Allowances and Reimbursement Manuals for Hospitals and Ambulatory Surgical Centers.

Workers’ Compensation Databases:

The following includes a list and description of the various databases that are maintained to provide interested parties with direct access to information that is routinely utilized by various stakeholders.

1. The **Insurer/Claim Administrator Database** contains addresses and contact information for claims administrators, self-insurers and third party administrators approved to handle workers’ compensation claims of injured workers in the State of Florida.

2. **Insurers licensed to do business in the State of Florida:** This link to the Office of Insurance Regulation can provide names, business

addresses and identifying information for companies/entities doing business in Florida.

3. The **Proof of Coverage Database** provides information regarding workers' compensation coverage and exemptions from workers' compensation.

4. The **Construction Policy Tracking Database** allows general contractors to register on the Division's website to receive automatic email notification about changes to the workers' compensation coverage status for any contractors they use.

5. The **Non-Compliance Referral Database** is used to report an employer you suspect has failed to secure workers' compensation insurance coverage for all of its employees. Other options for reporting non-compliant employers are provided.

6. The **Provider Databases** contain the names, addresses, telephone numbers and specialty types for all Division certified health care providers and Expert Medical Providers.

7. The **Claims Database** contains workers' compensation accident data on an individual claim basis. Information relating to personal financial or health information has been redacted from the database in compliance with ss. 440.125 and 626.9651, F.S. and Rule 69J-128.025, F.A.C.

8. **Statistical Reports Based on Claims Data** can be generated from the end-of-month claims file and may be requested based on a variety of search options. Output consists of aggregated data by year of injury for: the number of injuries, total benefits (including indemnity, medical and settlement payments) and average benefits for each category.

9. **WC Policy Search Page:** Allows a user to obtain a customized downloadable list of employers in the State of Florida whose workers' compensation insurance policies are either due to expire within the month and year selected or become effective within the month and year selected.

10. **Employer Loss Run Report:** Allows a user to obtain a list of lost-time injuries reported to the Division of Workers' Compensation for an employer since 1990.

11. The **Compliance Stop-Work Order Database** lists employers that have been issued a Stop-Work Order based upon a determination that an employer has failed to secure the payment of compensation and reflects the date the Stop-Work Order was served, released and/or reinstated.

12. The **DWC Claims EDI Data Warehouse** contains workers' compensation records for which an EDI First Report of Injury (FROI), Subsequent Report of Injury (SROI), or Electronic Supplement to the First Report of Injury (8th Day of Disability information) has been electronically reported to the Division since 10/1/2000. Claims EDI Trading Partners may view specific transactions/data elements in the manner and format received by the Division to aid in the reconciliation of filing errors.

Florida Workers' Compensation Statutes:

Workers' Compensation Law, Chapter 440, Florida Statutes: Click on "Statutes, Rules & Forms" on the Division's home page and then click on "Chapter 440."

Information and FAQs:

Informational Memoranda/Bulletins: Click on "Informational Memoranda" on the Division's home page.

Rules and Forms:

1. **Rule 69L of the Florida Administrative Code:** Click on the "Statutes, Rules & Forms" on the Division's home page to see forms related to each chapter of the 69L Rule (Worker's Compensation) of the Florida Administrative Code.

2. **Division Forms:** Click on the "Statutes, Rules & Forms" on the Division's home page and then click on the tab for the specified rule.

Publications and Manuals:

Click on the "Publications and Reimbursement Manuals" on the Division's home page. This page provides direct access to many reports issued over the last nine years on subjects pertinent to the business of the Division of Workers' Compensation including:

- Three Member Panel Reports;
- Joint Reports of the Bureau of Workers' Compensation Fraud and Bureau of Compliance;
- Division Annual Reports;
- Medical Reimbursement Manuals; and
- Employer's Guide to a Drug-Free Workplace.

DIVISION OF WORKERS' COMPENSATION CONTACTS

Director's Office:
850-413-1600
Tanner Holloman, Director
Andrew Sabolic, Assistant Director

Bureau of Employee Assistance:
850-413-1610
Pam Macon, Bureau Chief

Bureau of Compliance:
850-413-1609
Tasha Carter, Bureau Chief

Bureau of Monitoring and Audit:
850-413-1608
Robin Ippolito, Bureau Chief

Bureau of Data Quality and Collection:
850-413-1711
Don Davis, Bureau Chief

Office of Special Disability Trust Fund:
850-413-1604
Eric Lloyd, Manager

Office of Assessments:
850-413-1644
Evelyn Vlasak, Assessments Coordinator

Office of Medical Services;
850-413-1944
Eric Lloyd, Program Administrator

Hotlines:

Reporting Deaths: 800-219-8953

Compliance Fraud Referral Hotline: 800-742-2214

Employee Assistance Office Hotline: 800-342-1741

Customer Service Center: 850-413-1601

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Robert Lambert (District Supervisor)

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Fax 904-353-2101

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Bureau of Compliance
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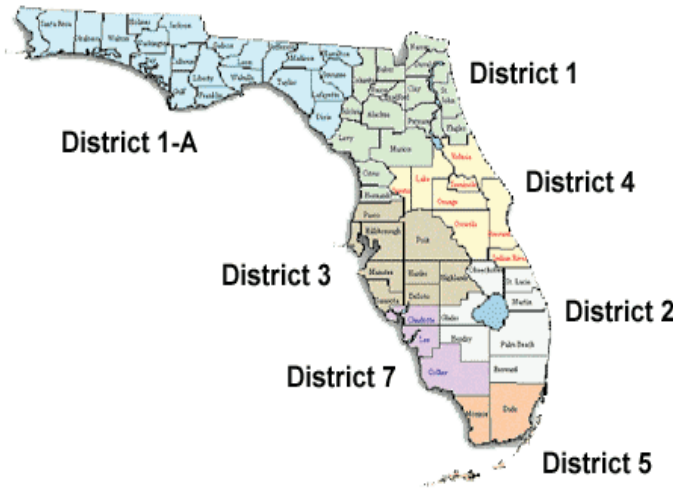
Ocala, FL 34470
Tel 352-401-5350
Fax 352-401-5344



St. Augustine

Bureau of Compliance
2200 A1A South
St. Augustine, FL 32080
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Fax 904-461-5087

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Fax 850-922-1028

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Fax 850-833-7435

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Fax 850-747-5426

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Fax 727-816-1970

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Fax 813-233-3742

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Fax 941-378-6318

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Fax 386-226-7883

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Tel 407-835-4406
Fax 407-999-5570

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Tavares, FL 32778
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Fax 352-343-9616

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Fax 239-461-4090

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List of Graphics