Biennial Report

Presented January 2017

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INTRODUCTION

The Legislature enacted Senate Bill 108 in 2002 and included a charge to the Three-Member Panel, section 440.13(12)(e), F.S., to assess the adequacy of medical reimbursement, access to care, and other aspects of health care delivery in Florida's workers' compensation system. Beginning in 2003 and biennially thereafter, the Three-Member Panel has presented, to the Speaker of the House of Representatives and to the President of the Senate, a report on ways to improve the Florida workers' compensation health care delivery system. Over the years, the reports have offered recommendations in a number of areas where regulatory efficiencies might be realized and where impediments to cost containment and access to care could be abated or eliminated.

The 2017 Three-Member Panel Biennial Report provides a status on the recommendations contained in previous reports. Each of those reports can be accessed via the Division of Workers' Compensation website at www.myfloridacfo.com/Division/wc. The 2011, 2013, and 2015 reports address a variety of public policy issues, from changing the reimbursement methodology for hospital services and repackaged drugs to electronic medical billing, eliminating certification requirements for health care providers to treat workers' compensation patients, and exempting the reimbursement manuals from legislative rule ratification. Several legislative and regulatory solutions have been implemented that have taken into account the Panel's recommendations and position statements.

The 2017 Biennial Report also contains sections on emerging issues identified by the Division of Workers' Compensation or by the stakeholders themselves. Subject areas in this section include:

- Drug Formulary in Workers' Compensation;
- Facility (Hospital and Ambulatory Surgical Center) Reimbursement; and
- Medical Authorization

Exhibit 1 provides a list of survey questions and initial responses, which fulfills the requirements in section 440.13(12)(e), F.S. whereby the Three-Member Panel is to collect data and survey stakeholders to determine the state of the workers' compensation benefit delivery system.

STATUS ON PREVIOUS RECOMMENDATIONS

1. Section 440.13(12)(a), F.S., states that the Three-Member Panel shall annually adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. Section 440.13(12), F.S., also contains explicit provisions that dictate the amount of reimbursement payable to various health care providers.

   The Division of Workers' Compensation (Division) presents recommendations to the Three-Member Panel on reimbursement and policy changes to the Health Care Provider Reimbursement Manual, Hospital Reimbursement Manual, and the Ambulatory Surgical Center Reimbursement Manual. The Three-Member Panel receives public comment on the proposed changes and either adopts the recommendations, amends the recommendations, or does not accept them. The Three-Member Panel's recommendations are implemented within each respective reimbursement manual. The Division undertakes administrative rulemaking in order to formally adopt each manual. The opportunity for public comment is extensive beginning with Three-Member Panel meetings and continues through the Division's rulemaking process.

   In 2010, the Legislature enacted changes to Chapter 120, the Administrative Procedure Act. These changes require each state agency to submit for legislative ratification any rule that meets one or more of the following criteria:

   1. The rule is likely to have an adverse impact on economic growth, private sector job creation or employment, or private sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule;

   2. The rule is likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule; or

   3. The rule is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

Florida has a $3.64 billion workers' compensation marketplace, impacting hundreds of thousands of employers, thousands of health care providers, and hundreds of insurance companies licensed to write workers' compensation insurance. Consequently, annually updating the reimbursement amounts to be consistent with the law is likely to meet the third criteria because of the scope and reach the reimbursement manuals have on the parties within the system.

In an effort to balance the competing aspects of the Administrative Procedure Act and s. 440.13(12), F.S., the Division of Workers' Compensation has taken the position that the rules incorporating the reimbursement manuals are subject to legislative ratification despite the statutory authority given to the Three-Member Panel to determine maximum reimbursement allowances and despite the explicit provisions that dictate the amount of reimbursement payable to various health care providers contained in s. 440.13(12), F.S. The 2016 Editions of the Hospital Reimbursement Manual and the Ambulatory Surgical Center Reimbursement Manual have been adopted, but are not yet in effect as they are subject to ratification during the 2017 Legislative Session.

The Three-Member Panel recommended that the reimbursement manuals become exempt from the legislative ratification requirements of Chapter 120, F.S. Statutory authority is provided to the Three-Member Panel in section 440.13(12), F.S., to establish maximum reimbursement allowances and contains specific provisions on reimbursement amounts that are payable to health care providers.

Status: HB 1013 and SB 1060 were introduced during the 2015 Legislative Session to exempt maximum reimbursement allowances and manuals approved by the Three-Member Panel from legislative ratification. Neither bill passed their respective chambers.

2. The Panel recommended that the Legislature consider amending section 440.13(12)(c), F.S., to create a new reimbursement benchmark that reduces the financial disparity between repackaged and non-repackaged drugs; provides a reasonable and standardized level of reimbursement to those parties that dispense prescription drugs; and minimizes future reimbursement disputes related to prescription drugs. Absent a legislative solution, the Panel recommended that the Division of Workers' Compensation explore regulatory options to achieve these goals.

Status: Senate Bill 662 became law on July 1, 2013. The bill was a compromise between employer/insurer interests and the advocates of physician dispensing of prescription drugs. The law provides that reimbursement for relabeled or repackaged drugs is 112.5% of the average wholesale price set by the original manufacturer of the underlying drug dispensed by the practitioner, based upon the manufacturer's average wholesale price published in the Medi-Span Master Drug Database as of the date of dispensing.

- **Medical data reported to the Division of Workers' Compensation reflect the following payment changes from 2011-2015.**
    - **The total payments for physician-dispensed repackaged drugs decreased 73% from $52,591,981 in 2011 to $14,375,182 in 2015. The total payments for pharmacy-dispensed repackaged drugs decreased 65% from $1,071,147 to $370,523. The total payments for all repackaged drugs decreased 73% or $38,917,423 from $53,663,128 to $14,745,705. (Exhibit 2)**
    - **The total for physician-dispensed non-repackaged drugs increased 626% from $6,197,831 to $44,999,772 while pharmacy-dispensed non-repackaged drugs total payments increased from $123,845,908 to $128,134,730. The total payments for all non-repackaged drugs increased 33% or $43,090,764 from $130,043,739 to $173,134,502. (Exhibit 3)**
    - **The total payments for all drugs dispensed by physicians and pharmacies increased 2% or $4,173,341 from $183,706,866 to $187,880,207.**
    - **The total number of repackaged drug prescriptions dispensed by pharmacies decreased 28% from 8,976 to 6,471 and from 357,573 to 78,910 for physicians, representing a 78% decrease. (Exhibit 4)**

Another positive result of the law change is the effect it has had on the number of petitions for reimbursement disputes submitted by physicians. The Division of Workers' Compensation is responsible for resolving reimbursement disputes between health care providers and insurers. In FY 11-12, physicians submitted 12,460 reimbursement disputes, mostly related to repackaged drugs. In FY 15-16, the number of petitions dropped to 3,601, which represents a 71% decrease.

3. Remove the statutory mandate in s. 440.13(12)(a), F.S., that requires reimbursement for outpatient hospital services to be based on a percent of "usual and customary charges" and fix the reimbursement amounts to 120% or 140% of Medicare's payments under its Outpatient Prospective Payment System; or, in the alternative;
4. Define the term "usual and customary charge" – so that all stakeholders are aware of its intended meaning and when it is to be used in determining reimbursement for medically necessary treatment, care and attendance provided in an outpatient hospital setting.

5. Remove the statutory mandate in s. 440.13(12)(a), F.S. that requires reimbursement for inpatient hospital services to be based on per diem rates and fix the reimbursement amounts to 120% or 140% of Medicare's payments under its Inpatient Prospective Payment System.

Status for Recommendations 3, 4, and 5: The Legislature has taken no action on these recommendations. However, the Three-Member Panel in conjunction with the Division of Workers' Compensation have engaged in regulatory activities involving the Hospital Reimbursement Manual and changes to the reimbursement amounts for inpatient and outpatient services.

The 2014 Edition of the Florida Hospital Reimbursement Manual became effective on January 1, 2015 and replaced the 2006 edition. NCCI estimated that the cumulative effect of the changes to the inpatient and outpatient reimbursement amounts resulted in an overall cost savings of -0.8% or $26 million. The 2016 edition has been adopted, but is not effective, since it is subject to legislative ratification. NCCI estimates that the new reimbursement amounts for inpatient and outpatient services will increase costs 2.2% or $80 million.

A summary of the most significant changes in the 2016 Edition of the Hospital Reimbursement Manual are listed below.

Inpatient services are reimbursed based on per-diem rates, which includes a Stop-Loss Reimbursement threshold.

- **The $3,850.33 per-diem rate for a surgical stay in a trauma center increases to $4,216.00.**
- **The $2,313.69 per-diem rate for a non-surgical stay in a trauma center increases to $2,534.00.**
- **The $3,849.16 per-diem rate for a surgical stay in an acute care hospital increases to $4,215.00.**
- **The $2,283.40 per-diem rate for a non-surgical stay in an acute care hospital increases to $2,501.00.**
- **The stop-loss threshold amount increases from $59,891.34 to $65,587.00.**

The methodology for calculating a "usual and customary charge" for reimbursing hospital outpatient services is consistent with 2014 edition. This "usual and customary charge" methodology is summarized below.

- **18 months of hospital outpatient charge data is used.**
- **A minimum of 40 bills per procedure are used to calculate a statewide average charge per qualifying procedure.**

- **The statewide average charge per qualifying procedure is then discounted by 25% or 40% depending on whether the procedure was associated with a scheduled surgery. By law, hospital outpatient surgical procedures are reimbursed at 60% of charges, while all other hospital outpatient procedures are reimbursed 75% of charges.**
- **The discounted statewide average charge per qualifying procedure is then modified by a Medicare geographic wage adjustment factor based upon the location of the service to attain the Maximum Reimbursement Allowance (MRA) per qualifying procedure.**
- **Procedures not subject to an MRA are reimbursed 60% or 75% of the hospital's charges.**
- **The number of procedures subject to an MRA at 60% of usual and customary charges is 132.**
- **The number of procedures subject to an MRA at 75% of usual and customary charges is 344.**

6. Eliminate the health care provider certification process performed by the Division. The criterion for certification would then become the standards used by Florida's Department of Health declaring all practitioners who are currently in good standing regarding their licensure to practice in their respective discipline and specialty as eligible to be authorized by carriers and to receive reimbursement for services rendered.

   Status: House Bill 553 became law on July 1, 2013. One of the provisions in the bill eliminated the health care provider certification process performed by the Division of Workers' Compensation.

7. Amend section 440.13(7), F.S., to allow providers 45 days from receipt of a notice of disallowance or adjustment of payment to file a petition; allow carriers 30 days from receipt of a provider's petition to respond to the petition; and allow the Department 120 days from receipt of all documentation to issue a determination.

   Status: House Bill 553 increased the reimbursement dispute process timelines for health care providers, carriers, and the Division of Workers' Compensation, which reflected the Three-Member Panel's recommendation.

8. Electronic Medical Billing (E-billing)
   It is the Panel's recommendation that the Division continue its current practice of permitting health care providers to electronically submit medical bills to insurers, provided the insurer agrees to accept the submission of electronic medical bills. In addition, the Panel recommended that the Division develop an action plan with the goal of determining whether to mandate electronic billing no later than 2015.

Status: The Division of Workers' Compensation held a public meeting on April 1, 2014 to solicit input from stakeholders about the advantages and disadvantages of mandating electronic medical billing between the health care provider and the insurer. Comments from the meeting suggest that E-billing continues to grow in Florida. Although there was general agreement that E-billing may lead to quicker payments to providers and reduce administrative costs compared to issuing and processing paper bills, pursuing a mandate and implementing a "one-size fits all" approach may prove to be the least effective method to expand the use of E-billing. Unless providers and insurers specifically request the Division to mandate a standardized E-billing requirement, the Division of Workers' Compensation should continue to promote mutually-agreeable E-billing practices between the provider and the insurer.

9. Practice Parameters and Protocols of Treatment
   The Panel recommends that the Legislature give serious consideration to repealing section 440.13(15), Florida Statutes, and replacing it with an alternative that effectively translates the mandates of section 440.13(16), Florida Statutes, (Standards of Care) into meaningful treatment guidelines.

   As a foundation for the above recommendation, the Panel recommends that the Legislature conduct or commission an analysis of the various types and sources of available practice guidelines to determine which is most appropriate for Florida and determine how it should be developed and implemented.

   Status: The Legislature has taken no action on this recommendation.

10. The Florida Uniform Permanent Impairment Rating Schedule
    It is the Panel's recommendation that the Legislature consider authorizing an interim study to determine whether to retain, update, amend, or replace the Florida Uniform Impairment Rating Schedule.

    Status: The Legislature has taken no action on this recommendation.

    Note: For items 9 and 10, the Division held a public meeting August 26, 2015, to solicit feedback from stakeholders about establishing one specific set of practice guidelines for treating workers' compensation patients. The attendees generally agreed on the benefits of using practice guidelines. However, there was less consensus for mandating only using one set of guidelines. In addition, the Division received comments about the need to update the Florida Uniform Permanent Impairment Rating Schedule to better align the assignment of impairment ratings with the advances in medical treatment.

DRUG FORMULARY IN WORKERS' COMPENSATION

A drug formulary, or preferred drug list, is a continually updated list of medications and related products supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health. The primary purpose of the formulary is to encourage the use of safe, effective and most affordable medications.

Utilization and the cost of prescription drugs in states' workers' compensation systems continues to be a hotly debated topic. The National Council on Compensation Insurance (NCCI) and the Workers' Compensation Research Institute (WCRI) have published over 30 state and national research reports on this subject during the last five years.

In addition, the Division of Workers' Compensation has detected a rise in the use and cost of compound drugs, as reflected in Exhibit 5. The Federal Drug Administration (FDA) defines compounding as "a practice in which a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient." Compound drugs are not FDA-approved, meaning that FDA does not verify the safety, or effectiveness of compounded drugs.

Workers' compensation stakeholders understand the importance of striking the right balance between reducing prescription drug costs and providing a drug regiment appropriate for the injured worker's condition(s). These goals should not be mutually exclusive of one another. Policymakers have established drug formularies in several states to help achieve these goals.

The Florida Division of Workers' Compensation is a member of the International Association of Industrial Boards and Commissions (IAIABC). The IAIABC is a not-for-profit association representing most of the government agencies charged with the administration of workers' compensation systems throughout the United States, Canada, and other nations and territories, as well as other workers' compensation professionals in the private sector. Its mission is to advance the efficiency and effectiveness of workers' compensation systems throughout the world.

In April, 2016, the IAIABC published "*A Discussion on the Use of a Formulary in Workers' Compensation*." This report provides Florida's stakeholders and policymakers with a framework of how a formulary works, and developing and implementing a formula. It also contains insights from states that have established drug formularies within their respective jurisdictions. The full report can be found in Exhibit 6.

Recommendation: The Panel recommends the Legislature grant the Division of Workers' Compensation specific rule authority to establish a drug formulary, as long as such formulary is generally accepted by Florida's employers, insurers, health care providers, and injured worker advocates; provides reasonable assurance in reducing or mitigating prescription drug costs; and ensures appropriate and effective treatment is provided to injured workers.

FACILITY REIMBURSEMENT

At its April 20, 2016 meeting, the Three-Member Panel requested the Division of Workers' Compensation to conduct a review of other states' methods for reimbursing outpatient services. The methods fall into four general categories:

- Fixed fee amount per service
- Percentage of the facility's billed charges
- Percentage of a usual and customary charge or prevailing rate
- Outpatient Prospective Payment System (% of Medicare or state-specific)

An inventory of hospital outpatient fees is contained in WCRI's publication, "Workers' Compensation Medical Cost Containment: A National Inventory, 2015". A section of that report detailing each state's reimbursement method is listed in Exhibit 7. No method is predominant, and states with the same method apply different adjustment factors to determine the final payment amount.

Florida law requires charges for hospital outpatient care be reimbursed at 75% of usual and customary charges and at 60% of charges for scheduled surgeries, or an agreed-upon contract price. As described earlier in this report and in the 2013 Biennial Report, the 2014 Edition of the Hospital Reimbursement Manual, which became effective on January 1, 2015, incorporated a methodology for calculating usual and customary charges that established maximum reimbursement allowances (MRAs) for eligible procedures. The Three-Member Panel adopted the same methodology for the 2016 Edition of the Hospital Reimbursement Manual.

Preliminary data from the Division and WCRI show a slowdown in the growth of outpatient payments since the adoption of Florida's MRAs for usual and customary charges. According to Division data, the average hospital outpatient bill payment increased 23% from 2012-2014. In 2015, the average payment declined 3% (Exhibit 8). For a common knee surgery, WCRI estimates a 39% lower payment, and for a shoulder surgery; the average payment may decrease 22% (Exhibit 9). The downward results are likely to be a one-time occurrence and reflect a new baseline for hospital outpatient payments. Future payments will most likely increase since hospital charges tend to increase from year-to-year. This predicted outcome is reflected in the 2016 Edition of the Hospital Reimbursement Manual. According to NCCI, overall hospital outpatient payments are expected to increase 17.5%, which equates to an increase of 2.2% in overall system costs (Exhibit 10).

Outpatient procedures performed in Ambulatory Surgical Centers (ASC) are reimbursed similar to payments for hospital outpatient services. Prior to January 1, 2016, ASC payments were calculated using 70% of the median state-wide charge to establish MRAs for certain eligible procedures. An ASC was reimbursed 70% of its billed charges for those procedures that did not have a corresponding MRA. For the ASC Reimbursement Manual that became effective on January 1, 2016, the Three-Member Panel modified the MRA calculation by reducing the payment adjustment factor from 70% to 60%. Procedures with no corresponding MRA are now reimbursed 60% of the ASC's billed charges, instead of 70%. The number of procedures subject to an MRA also significantly increased from 29 to 90. These changes resulted in an estimated 2.8% reduction in payments to ASCs.

Since ASC reimbursements are also based upon charges, ASC payment amounts are expected to increase. In fact, the 2016 Edition of the ASC Reimbursement Manual is estimated to increase ASC payments by 10.1%, which equates to an increase of 0.6% in overall system costs (Appendix 11); and, consequently is also subject to legislative ratification.

Approximately two-thirds of charges are covered under maximum reimbursement allowances. Thus, the establishment of maximum reimbursement allowances for certain hospital outpatient and ASC procedures helps reduce the growth of payments. However, a mechanism or process does not currently exist for a carrier to ensure the reasonableness of a hospital's or an ASC's charge for a procedure that does not have a corresponding maximum reimbursement allowance.

Recommendation: Absent the Legislature repealing the current charge-based reimbursement statute and replacing it with one based upon Medicare's Outpatient Prospective Payment System, as recommended by the Three-Member Panel, the Legislature should consider the following amendments to s. 440.13(7), F.S.:

- **For reimbursement disputes for procedures that do not have an MRA, allow the hospital or ASC to provide evidence substantiating its charge is reasonable and meets the criteria in s. 440.13(12)(d)1-4; allow the carrier to provide evidence substantiating its reimbursement is reasonable and meets the criteria in s. 440.13(12)(d)1-4; and require the department to issue a determination reflecting a range of reimbursement amounts for the disputed procedure that the parties can use to resolve the dispute.**

Regulatory Recommendation: If the Legislature does not address the charge-based reimbursement methodology, the Division of Workers' Compensation should develop a process for evaluating and determining whether the charge for a procedure that does not have an MRA is reasonable; and whether such process could be enacted through the administrative rule process for the 2017 Editions of the Hospital Reimbursement Manual and Ambulatory Surgical Center Reimbursement Manual.

MEDICAL AUTHORIZATION

Medical authorization continues to be an integral component of an efficient and self-executing workers' compensation system. The request for authorization and the timely decision to authorize or not to authorize, have a direct impact on the injured worker's medical care and treatment, the length of time the injured worker is out of work, whether the injured worker hires an attorney, health care provider participation in the workers' compensation system, and the cost of the claim. Streamlining the medical authorization process may lead to better patient outcomes, less litigation, increased health care provider participation, and less administrative costs for the health care provider and carrier.

S. 440.13(3), F.S., describes the current authorization procedures under Florida's workers' compensation system. Highlights include:

- A health care provider must receive authorization from a carrier before providing treatment.
- For emergency care, a health care provider must notify the carrier by the close of the third business day after care has been provided. If the injured worker is admitted to a medical facility, the provider must notify the carrier within 24 hours of initial treatment.
- When an authorized health care provider requests a referral, the carrier must respond, by telephone or in writing, to the referral request by the close of the third business day after receipt of the request. Failure to respond within this timeframe results in the carrier consenting to the medical necessity of the treatment.
- Prior authorization is required for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other specialty services identified by department rule. For these services, carriers must respond within 10 days to a written request for authorization.
- Carriers are required to adopt procedures for receiving, reviewing, documenting, and responding to requests for authorization.

The authorization statutes do not provide a definitive answer as to whether the service will be authorized and when. The statutes consistently require the carrier to "respond" to a request for authorization. The term "respond" is not defined in statute, and thus is subject to various degrees of interpretation, which can lead to confusion and inconsistency.

Exhibits 12 and 13 contain injured worker contact data from the Division of Workers' Compensation. The data reveal that medical authorization is one of the most frequent issues and disputes raised by injured workers. The Division provides on-going education and assistance to injured workers so they better understand the authorization process. The Division successfully resolved 95% of medical authorization disputes during the informal resolution dispute process for FY 2015-2016, which is consistent with previous years. This high resolution rate is primarily attributed to the Division creating an unbiased and open dialogue between the injured worker and the carrier, and the willingness of both parties to cooperate to resolve the issue.

The Division evaluated Petition for Benefits (PFB) data from the Office of the Judges of Compensation Claims. Exhibit 14 details the five most frequent issues listed on a Petition for Benefits between May 2015 and November 2016. Requests for attorney fees and medical authorization exchange the top spot and far outpace the remaining three most frequent issues. The Division further analyzed the data by examining Petition for Benefits filed in 2015, where medical authorization was at issue. Exhibit 15 shows the number of medical authorization issues filed on PFBs within 28 weeks of the date of accident. The Division excluded any PFB for medical authorization if compensability was also listed as an issue on the same petition. The data show a substantial number of petitions are filed within four weeks of the date of accident and then gradually decline over time.

The Three-Member Panel supports a medical authorization structure, which ensures workers' compensation patients are appropriately treated in a timely manner. Despite having an entire section of the workers' compensation law devoted to medical authorization, the data seem to reflect yet unidentified and unresolved behavioral, educational, communication, and statutory and regulatory hurdles working against a more streamlined, patient-centered, and less litigious medical authorization process.

Recommendation: The Three-Member Panel recommends the Legislature amend section 440.13(3)(d), F.S., to clarify the term "respond" as that term does not definitively obligate carriers to render a decision on a request for authorization in a consistent manner.

Recommendation: The Three-Member Panel recommends the Legislature consider modifying a carrier's 3-day and 10-day "response" deadline, to more specifically align with requested medical treatment and a physician's use of treatment guidelines.

Recommendation: The Three-Member Panel recommends the Legislature require any Petition For Benefits, listing medical authorization as an issue, to be filed no sooner than 30 days after the date of accident; unless, the carrier has denied the compensability of the claim or has denied the request for medical authorization.

Regulatory Recommendation: The Three-Member Panel recommends the Division of Workers' Compensation hold a public meeting(s) to solicit input from stakeholders to determine if the DWC-25 – Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form is still meeting the treatment and authorization goals for health care providers and carriers.

EXHIBIT 1 - SURVEY

The Division sent a survey to a portion its stakeholders on November 18, 2016. The survey was available for 12 business days for those stakeholders who had signed up to receive E-Mail notifications from the Division.

The Division sent the survey to 4,468 potential respondents, and received 447 responses.

The percentage of the respondents who answered a question is based upon the total responses for the survey.

Each question's percentage of selected choices represents a percentage of the total responses for that question and not a percentage of total responses for the survey.

Survey Questions with Results

1. What industry group do you represent?

   99.78% of the respondents answered this question.

   Health Care Provider was the answer that the most respondents chose for this question.

Employer	Carrier/TPA	Attorney - Injured Employee	Attorney - Employer/Carrier	**Health Care Provider**	Health Care Facility	Other
117	51	33	5	**189**	10	41
26.2%	11.4%	7.4%	1.1%	**42.4%**	2.2%	9.2%

2. How many years of experience do you have in workers' compensation?

   99.33% of the respondents answered this question.

   >15 was the answer that the most respondents chose for this question.

< 3	3-5	6-10	11-15	**> 15**
28	18	35	41	**322**
6.31%	4.05%	7.88%	9.23%	**72.52%**

3. Florida's workers' compensation system is striking the right balance between providing benefits to the injured worker, while keeping costs under control.

   99.11% of the respondents answered this question.

   Strongly Disagree was the answer that the most respondents chose for this question.

Strongly Agree	Agree	No Opinion	Disagree	**Strongly Disagree**
27	79	45	115	**177**
6.09%	17.83%	10.16%	25.96%	**39.95%**

4. Florida's workers' compensation system is: (check all that apply)

   97.32% of the respondents answered this question.

   Complex was the answer that the most respondents chose for this question.

Fair to all parties	Outdated	Litigious	Self-executing	**Complex**	Over-regulated	Dynamic	Other
45	162	171	57	**177**	152	11	76
5.29%	19.04%	20.09%	6.70%	**20.80%**	17.86%	1.29%	8.93%

5. The system for the adjudication of workers' compensation claim disputes in Florida is:

   97.09% of the respondents answered this question.

   Pro Employer was the answer that the most respondents chose for this question.

Pro Employer	Neutral	Pro Employee
189	126	119
43.55%	29.03%	27.42%

6. Are Florida's indemnity benefits too high, too low or about right?

   88.14% of the respondents answered this question.

   Just Right was the answer that the most respondents chose for this question.

Too High	**Just Right**	Too Low
65	**187**	142
16.50%	**47.46%**	36.04%

7. Florida's workers' compensation medical benefit system is striking the right balance between providing access to quality medical care and medical cost containment.

98.21% of the respondents answered this question.

Strongly Disagree was the answer that the most respondents chose for this question.

Strongly Agree	Agree	No Opinion	Disagree	**Strongly Disagree**
12	97	55	112	**163**
2.73%	22.10%	12.53%	25.51%	**37.13%**

8. Are Florida's medical reimbursement amounts too high, too low or about right?

8a. For physicians

92.39% of the respondents answered this question.

Too Low was the answer that the most respondents chose for this question.

Too High	Just Right	**Too Low**
47	148	**218**
11.38%	35.84%	**52.78%**

8b. For hospitals

78.97% of the respondents answered this question.

Just Right was the answer that the most respondents chose for this question.

Too High	**Just Right**	Too Low
139	**161**	53
39.38%	**45.61%**	15.01%

8c. For ambulatory surgical centers

76.73% of the respondents answered this question.

Just Right was the answer that the most respondents chose for this question.

Too High	**Just Right**	Too Low
102	**177**	64
29.74%	**51.60%**	18.66%

8d. For prescription drugs

78.52% of the respondents answered this question.

Just Right was the answer that the most respondents chose for this question.

Too High	**Just Right**	Too Low
119	**178**	119
33.90%	**50.71%**	33.90%

8e. For attendant care

77.85% of the respondents answered this question.

Just Right was the answer that the most respondents chose for this question.

Too High	**Just Right**	Too Low
64	**192**	92
18.39%	**55.17%**	26.44%

9. Is overutilization a major medical cost driver in Florida's workers' compensation system?

95.08% of the respondents answered this question.

Agree was the answer that the most respondents chose for this question.

Strongly Agree	**Agree**	No Opinion	Disagree	Strongly Disagree
57	**115**	94	102	57
13.41%	**27.06%**	22.12%	24.00%	13.41%

10. In Florida, carriers/TPAs timely authorize medical treatment.

95.75% of the respondents answered this question.

Agree was the answer that the most respondents chose for this question.

Strongly Agree	**Agree**	No Opinion	Disagree	Strongly Disagree
25	**124**	62	102	115
5.84%	**28.97%**	14.49%	23.83%	26.87%

11. Is access to Specialty Care limited in Florida?

11a. For Neurology

94.18% of the respondents answered this question.

No Opinion was the answer that the most respondents chose for this question.

Strongly Agree	Agree	**No Opinion**	Disagree	Strongly Disagree
69	121	**146**	73	12
16.39%	28.74%	**34.68%**	17.34%	2.85%

11b. For Neurosurgery

92.62% of the respondents answered this question.

No Opinion was the answer that the most respondents chose for this question.

Strongly Agree	Agree	**No Opinion**	Disagree	Strongly Disagree
55	95	**185**	67	12
13.29%	22.95%	**44.69%**	16.18%	2.90%

11c. For Orthopedic

90.60% of the respondents answered this question.

No Opinion was the answer that the most respondents chose for this question.

Strongly Agree	Agree	**No Opinion**	Disagree	Strongly Disagree
41	85	**134**	114	31
10.12%	20.99%	**33.09%**	28.15%	7.65%

11d. For Orthopedic Surgery

92.84% of the respondents answered this question.

No Opinion was the answer that the most respondents chose for this question.

Strongly Agree	Agree	**No Opinion**	Disagree	Strongly Disagree
51	88	**138**	109	29
12.29%	21.20%	**33.25%**	26.27%	6.99%

11e. For General Surgery

91.50% of the respondents answered this question.

No Opinion was the answer that the most respondents chose for this question.

Strongly Agree	Agree	**No Opinion**	Disagree	Strongly Disagree
36	80	**192**	85	16
8.80%	19.56%	**46.94%**	20.78%	3.91%

11f. For Pain Management

90.83% of the respondents answered this question.

No Opinion was the answer that the most respondents chose for this question.

Strongly Agree	Agree	**No Opinion**	Disagree	Strongly Disagree
55	73	**134**	100	44
13.55%	17.98%	**33.00%**	24.63%	10.84%

12. In Florida, carriers and health care providers collaborate to provide the best medical care for injured workers.

96.64% of the respondents answered this question.

Strongly Disagree was the answer that the most respondents chose for this question.

Strongly Agree	Agree	**No Opinion**	Disagree	**Strongly Disagree**
19	103	64	119	**127**
4.40%	23.84%	14.81%	27.55%	**29.40%**

EXHIBIT 2 - PHARMACY VS. PHYSICIAN REPACKAGED DRUG PAYMENTS

DWC Annual Accomplishments Report 2016 Ed.

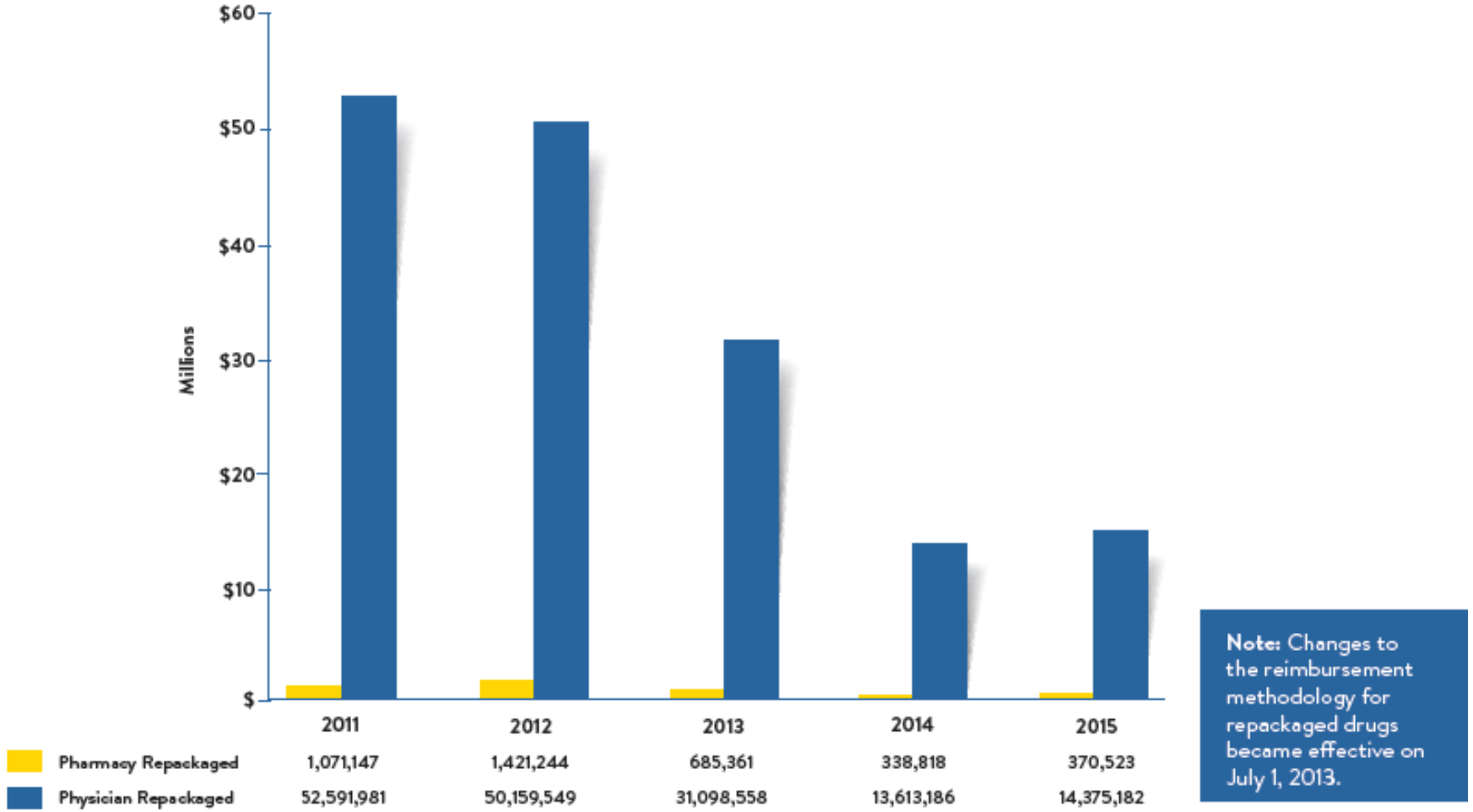


EXHIBIT 3 - PHARMACY VS. PHYSICIAN NONREPACKAGED DRUG PAYMENTS

DWC Annual Accomplishments Report 2016 Ed.

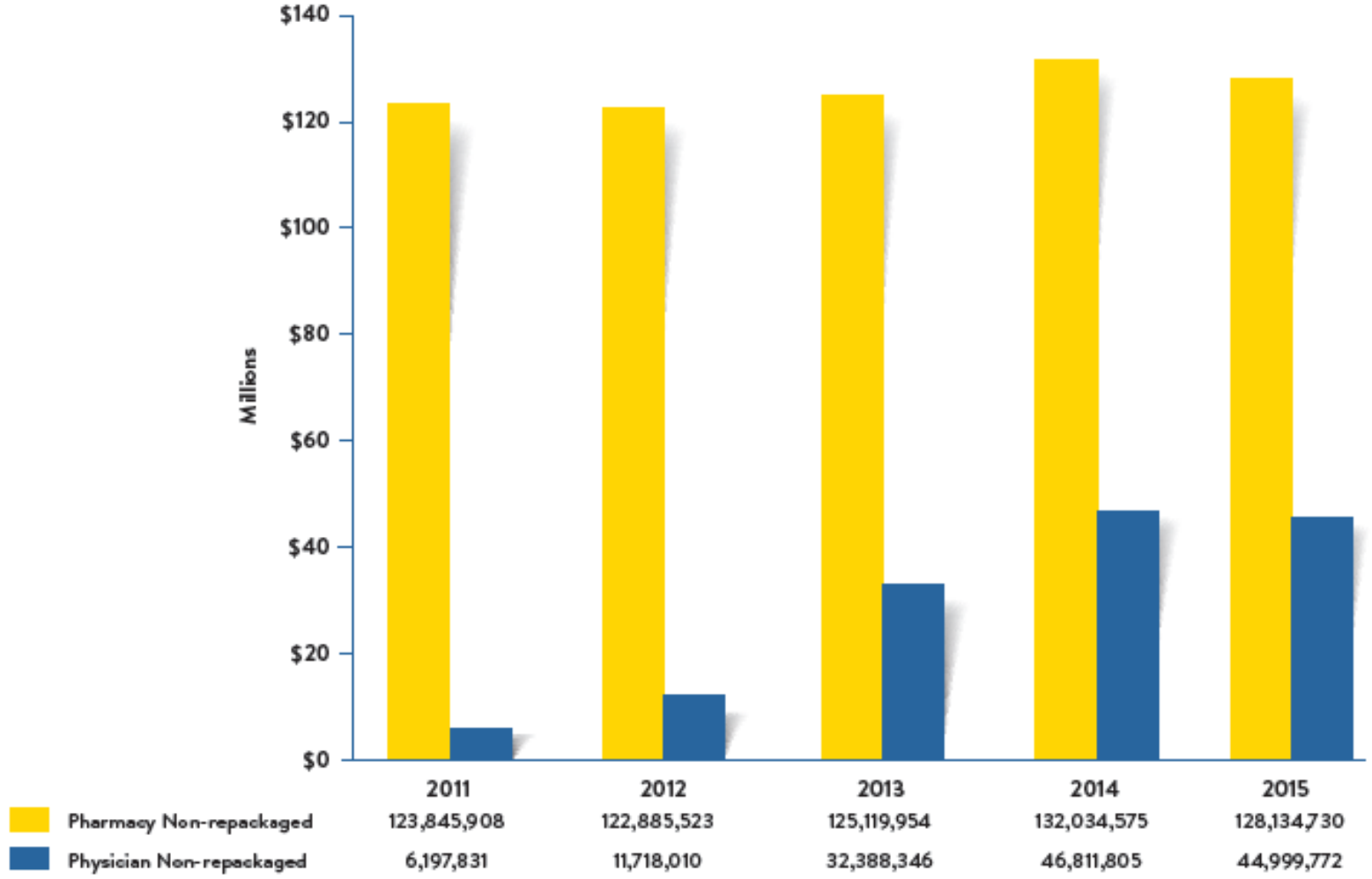
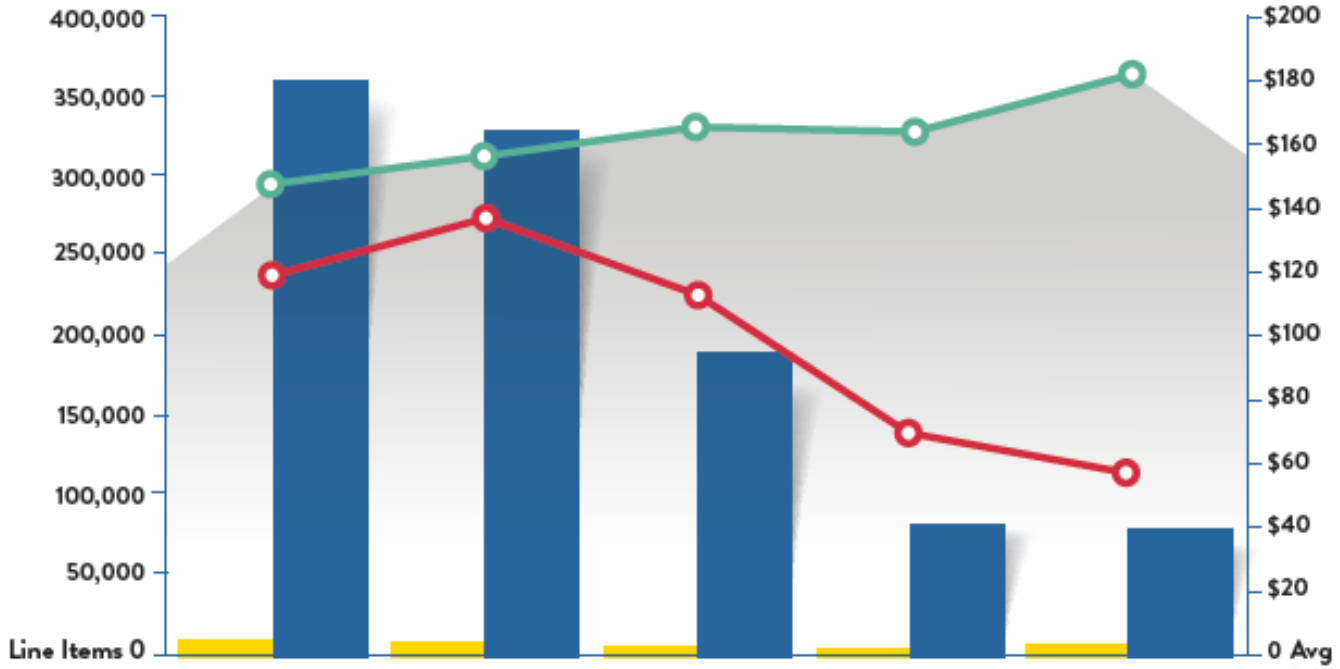


EXHIBIT 4 - PHARMACY VS. PHYSICIAN REPACKAGED DRUGS

DWC Annual Accomplishments Report 2016 Ed.



	2011	2012	2013	2014	2015
Pharmacy Repackaged Line Items	8,976	10,376	6,079	4,823	6,471
Physician Repackaged Line Items	357,573	320,560	188,374	83,351	78,910
Pharmacy Repackaged Avg $ Paid Per Line Item	119	137	113	70	57
Physician Repackaged Avg $ Paid Per Line Item	147	156	165	163	182

Graph compares drugs billed on DWC-10 forms (dispensed by pharmacies) to drugs billed on DWC-9 forms (dispensed by physicians). Reference to line items also means per prescription.

Note: Changes to the reimbursement methodology for repackaged drugs became effective July 1, 2013.

EXHIBIT 5 - PHARMACY VS. PHYSICIAN COMPOUND DRUG PAYMENTS

DWC Annual Accomplishments Report 2016 Ed.

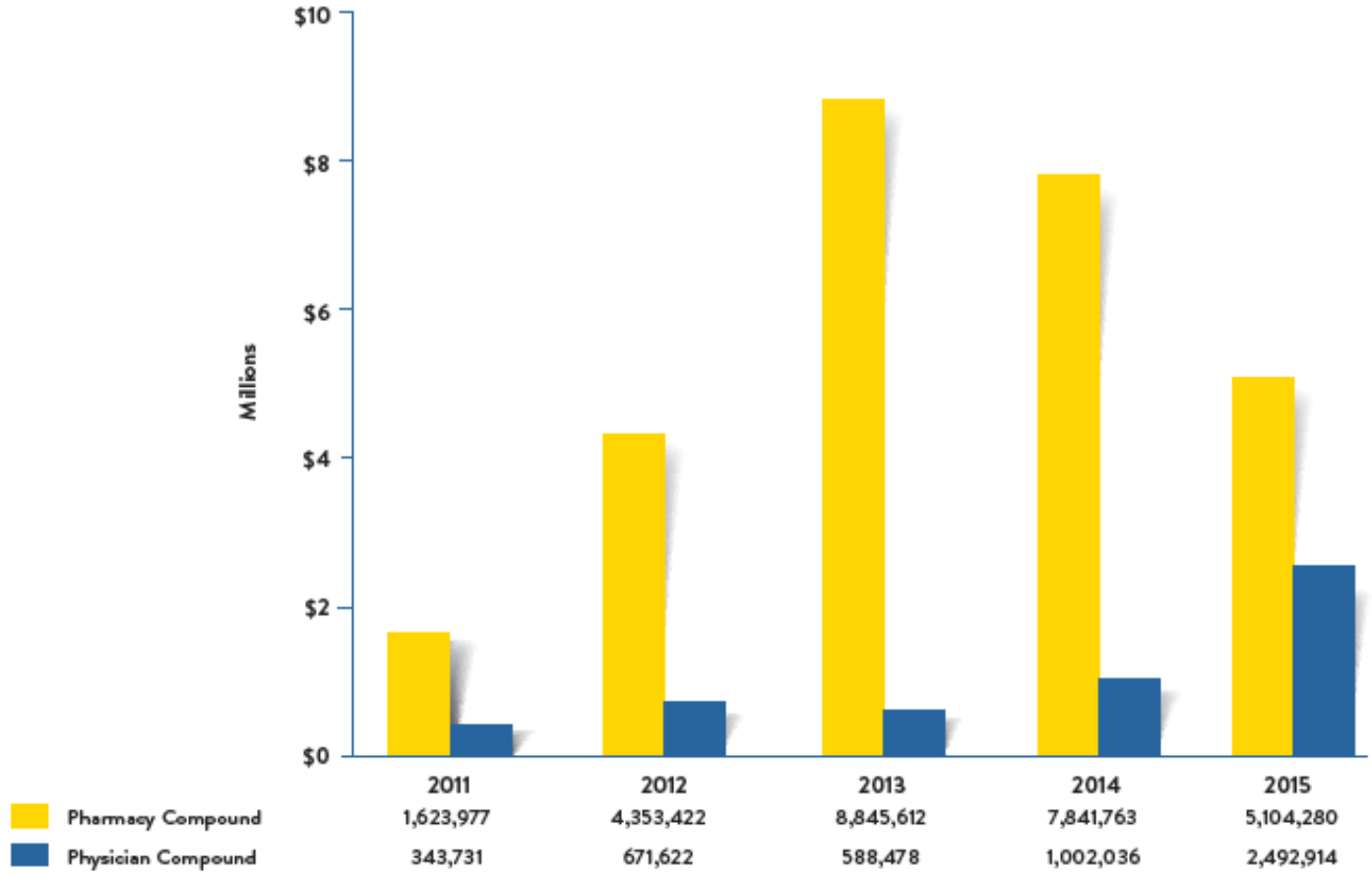


EXHIBIT 6 - "A DISCUSSION ON THE USE OF A FORUMLARY IN WORKERS' COMPENSATION"

IAIABC
Formulary_04-27-16_

A DISCUSSION ON THE USE OF A FORMULARY IN WORKERS' COMPENSATION

IAIABC Medical Issues Committee Approved by the IAIABC Board of Directors

2016A DISCUSSION ON THE USE OF A FORMULARY IN WORKERS' COMPENSATION

EXHIBIT 7 - HOSPITAL OUTPATIENT FEE REGULATIONS AS OF JANUARY 1, 2015

WCRI Workers' Compensation Medical Cost Containment: A National Inventory, 2015

Table 6 Hospital Outpatient Fee Regulations as of January 1, 2015

Jurisdictions often also regulate fees for services provided to injured workers in a hospital outpatient setting. This table indicates which jurisdictions have such fee schedules, the method used to determine allowable fees, and whether the schedule applies to all outpatient services. It also provides the appropriate statutory or rule reference if the reader wants additional information about any particular jurisdiction regulations.

Jurisdiction	Method Used For Hospital Outpatient Fee Regulations						All Outpatient Services Are Covered by the Regulations	Title and Rule Reference Number for Hospital Outpatient Fee Regulation
	Same as Hospital Inpatient Fees (Fee by Service Code)	Same as Hospital Inpatient Fees (Cost Based)	Same as Hospital Inpatient Fees (Discounted Charges)	Same as Non-Facility Provider Fees (Fee by Procedure Code)	Use a Varied Method (Explanation in Notes)	Other		
Alabama						(1)	Yes	Utilization Management and Bill Screening Code - 480-5-5
Alaska (2)				x			Yes	Fees for Medical Treatment & Services - AS 23.30.097 8 AAC 45.082
Arizona	No hospital outpatient fee regulations							
Arkansas				x			Yes	Medical Fee Schedule - http://www.awcc.state.ar.us/medfeetoc.html - Rule 30
California						The fee schedule is based primarily on the Medicare Hospital Outpatient Prospective Payment System	No	Title 8 California Code of Regulations Article 5.3 - Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers - sections 9789.30 - 9789.39 (3)
Colorado						(4)	Yes	Division of Workers' Compensation Rule 18 Medical Fee Schedule. Outpatient Surgery-18-6 (J) and Diagnostic Testing & Clinic-18-6 (K)
Connecticut						210% of Medicare	Yes	31-294d(d)
Delaware (5)						Effective, 01/31/2015, Hospital affiliated Ambulatory Surgery Centers will have a schedule of fees incorporated into the non-hospital affiliated ASC fee schedule		19 Del.C. §2322B (statute) and 19 DE Admin Code 1341 (fee schedule guidelines)
District of Columbia	No hospital outpatient fee regulations							
Florida					x (6)		(7)	The Florida Workers' Compensation Reimbursement Manual for Hospitals Rule, 69L-7.501, F.A.C., and the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, 69L-7.710, F.A.C.
Georgia						x (8)	Yes	O.C.G.A. 34-9-205 and Rule 205
Hawaii				x				Workers' Compensation Medical Fee Schedule
Idaho	x						Critical Access Hospitals (CAH) and Rehabilitation Hospitals allowed discounted charges	IDAPA 17.02.09.032
Illinois						Same as other fee schedules: 90% of the 80th percentile	Yes	50 IL Adm Code 7110.90(h)7
Indiana				x			No	IC 22-3-3-5.2, 22-3-6-1
Iowa	No hospital outpatient fee regulations							
Kansas			x				Yes	K.S.A.44-510 i (e) or Hospital/Ambulatory Surgical Center Ground Rules and Fees
Kentucky						Cost-to-charge ratio		
Louisiana						Reimbursement is 90% of billed charges	Yes	Hospital Reimbursement Schedule - Title 40, Chapter 25

Table 6 Hospital Outpatient Fee Regulations as of January 1, 2015

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Maine	x						x	90 M.A.R. 351 Ch. 5 Medical Fees
Maryland	x					The Maryland Health Services Cost Review Commission has had authority to set hospital rates since 1971	x	
Massachusetts					x		Emergency services and major surgeries are covered by 114.1 CMR 41.00	Non-emergent services and minor surgeries are covered by 114.3 CMR 40.00
Michigan		x					Yes	R 418.101016 Reimbursement; payment ratio methodology R 418.10923 Hospital Billing for Practitioner Services
Minnesota			x	x		Except that this does not apply to services at a hospital with 100 or fewer licensed beds, which are paid at 100% of the hospital's usual and customary charge	(9)	Minn. Stat. 176.136, subd. 1a and 1b; Minn. Rules, Part 5221.4005 to 4070; 5221.0500
Mississippi					x (10)		Yes	Mississippi Workers' Compensation Commission Fee Schedule
Missouri	No specific hospital outpatient fee regulations (11)							
Montana						Payments for outpatient services in a hospital or ASC are based on the Montana APC system	Yes	39-71-704, MCA; ARM 24.29.1433
Nebraska			x			Professional fees are paid at nonfacility provider fee schedule rate	Yes	Rule 26 of the court's Rules of Procedure adopts the schedule by reference
Nevada				x		Facilities Same as Ambulatory Surgical Centers (Fee by 2007 Medicare Groups) (12)	Yes	As part of fee schedule, NRS 616C.260
New Hampshire	No hospital outpatient fee regulations							
New Jersey	No hospital outpatient fee regulations							
New Mexico		x					Yes	Title 11, chapter 4, part 7, paragraph 9
New York				x			Yes	12 NYCRR 329 - 13(a)WCL
North Carolina	(13)					We use a different method from our hospital or provider fee schedule rates. Reimbursed at 79% of charges. Please see note below	No (pediatrics and maternity)	NCGS 97-26 Fees Allowed for Medical Treatment
North Dakota				x		Since the payments on the Workforce Safety and Insurance (WSI) Outpatient Hospital Fee Schedule are based largely on Medicare's outpatient department prospective payment system methodology, WSI has adopted many of the OPPS payment parameters. However, some differences between the Medicare OPPS and the WSI Outpatient Hospital Fee Schedule parameters exist	Yes	92-01-02-27; 92-01-02-29.2; 92-01-02-33; 92-01-02-34

Table 6 Hospital Outpatient Fee Regulations as of January 1, 2015

Jurisdictions often also regulate fees for services provided to injured workers in a hospital outpatient setting. This table indicates which jurisdictions have such fee schedules, the method used to determine allowable fees, and whether the schedule applies to all outpatient services. It also provides the appropriate statutory or rule reference if the reader wants additional information about any particular jurisdiction regulations.

Jurisdiction	Method Used For Hospital Outpatient Fee Regulations						All Outpatient Services Are Covered by the Regulations	Title and Rule Reference Number for Hospital Outpatient Fee Regulation
	Same as Hospital Inpatient Fees (Fee by Service Code)	Same as Hospital Inpatient Fees (Cost Based)	Same as Hospital Inpatient Fees (Discounted Charges)	Same as Non-Facility Provider Fees (Fee by Procedure Code)	Use a Varied Method (Explanation in Notes)	Other		
Ohio						(14)	Yes	Ohio Administrative Code rules 4123-6-37 and 4123-6-37.2
Oklahoma						Allowance is lesser of usual and customary charge, discount of charges, or inpatient reimbursement calculation	Yes	2012 Schedule of Medical and Hospital Fees
Oregon					x (15)		Yes	Oregon Administrative Rules Chapter 436, Section 009: 0020, 0040, 0050, 0060, 0070, 0080, 0090
Pennsylvania				x	Use service code and cost	Charge master	Yes	34 PA Code, Chapter 127
Rhode Island				x			Yes	RIGL 28-33-8
South Carolina						Paid specific predetermined payment rates for services that are calculated based on grouping outpatient services into ambulatory payment classifications (APCs). See CMS website for more details	Yes	Regulation 67-1304 and Hospital and Ambulatory Surgery Center Payment Manual
South Dakota					x	Facility charges are subject to discount, provider fees are scheduled by procedure code	Yes	ARSD 47:03:05:05; 47:03:05:12
Tennessee						150% of Medicare's national OPPS; unlisted procedures are at 80% of the billed amount; multiple procedure rules apply	Yes	0800-02-18-.07, The Medical Fee Schedule
Texas						(16)	Yes	Hospital Facility Fee Guideline - Outpatient, Division Rule 134.403
US Federal Programs - FECA					x	Some services are cross-walked to specific Current Procedure Terminology and/or HCPCs (Healthcare Common Procedure Coding System) and paid at fee schedule maximum amount allowable based on the geographic area of billing provider, and other services are paid at the billed amount for that particular Revenue Cost Center (RCC)	Yes	Claims for Compensation Under the Federal Employees' Compensation Act; 20 C.F.R. Subpart I
US Federal Programs - Longshore	No hospital outpatient fee regulations							
Utah	No hospital outpatient fee regulations							
Vermont					83% of billed charges		Yes	Workers' Compensation Medical Fee Schedule - Rule 40
Virginia								VA Code Sections. 65.2-601.1, -603, -605; Commission Rules 5 and 14; Peer review – Chapter 13 of Title 65.2 and 16 VAC 30-60-10 and VAC 30-70-10 et seq.

Table 6 Hospital Outpatient Fee Regulations as of January 1, 2015

Jurisdictions often also regulate fees for services provided to injured workers in a hospital outpatient setting. This table indicates which jurisdictions have such fee schedules, the method used to determine allowable fees, and whether the schedule applies to all outpatient services. It also provides the appropriate statutory or rule reference if the reader wants additional information about any particular jurisdiction regulations.

Jurisdiction	Method Used For Hospital Outpatient Fee Regulations						All Outpatient Services Are Covered by the Regulations	Title and Rule Reference Number for Hospital Outpatient Fee Regulation
	Same as Hospital Inpatient Fees (Fee by Service Code)	Same as Hospital Inpatient Fees (Cost Based)	Same as Hospital Inpatient Fees (Discounted Charges)	Same as Non-Facility Provider Fees (Fee by Procedure Code)	Use a Varied Method (Explanation in Notes)	Other		
Washington						Use Medicare's Outpatient Prospective Payment System pricing methodology with a hospital-specific blended APC rate	Yes	Medical Aid Rules and Fee Schedule
West Virginia						Maximum fee equals Medicare reimbursement + 35%		Statute 23.4.3 and Legislative Rule Title 85 CSR, Series 20; Statute 102.16 and Admin. Rules 80.72 and 80.74
Wisconsin	No hospital outpatient fee regulations							
Wyoming (17)							Yes	Wyoming Workers' Compensation Rules, Regulations and Fee Schedule - Chapter 9 - Fee Schedules

Notes:	
1	**Alabama** - Discount off allowable charges. Professional services provided in an outpatient setting are paid under that profession's fee schedule.
2	**Alaska** - House Bill 316, passed by the legislature and signed into law effective 9/19/2014, mandates the adoption of a new fee schedule on 7/1/2015. The new fee schedule will be based on Medicare OPPS relative weight, with regulations to be adopted by the Alaska Workers' Compensation Board.
3	**California** - Emergency room services, surgeries, and Facility Only Services are determined using the Medicare HOPPS method. All other services are determined using elements of a different fee schedule. Services that are on the Medicare inpatient only list are not payable except when the service is pre-authorized at a pre-negotiated fee arrangement.
4	**Colorado** - The Division utilizes Medicare's Ambulatory Payment Classification (APC) groupers for outpatient surgery and some other procedures that require the use of a separate facility. The APC grouper dollars are multiplied by a Division designated percentage or assigned a zero dollar. The professional fee schedule is utilized for diagnostic testing and some procedures. Observation room rates are established by the Division. Unless the clinic is a Medicare certified Rural Health Facility, no separate facility fee is payable for clinic visits. All Rural Health Facilities are paid at 80% of billed charges.
5	**Delaware** - Effective 5/23/2008, Delaware adopted a health care payment system (HCPS), which can be accessed at http://www.delawareworks.com. The hospital outpatient fee schedule methodology will change, effective 01/31/2015.
6	**Florida** - Reimburses compensable outpatient charges at 75% of usual and customary charges. Scheduled outpatient surgeries are reimbursed at 60% of charges. Outpatient physical, occupational, and speech therapy as well as non-emergency radiological and clinical laboratory services provided not in conjunction with a surgical procedure are paid the same as nonhospital providers.
7	**Florida** - Outpatient physical, occupational, and speech therapy as well as non-emergency radiological and clinical laboratory services provided not in conjunction with a surgical procedure are paid the same as non hospital providers.
8	**Georgia** - Rates based on a percentage above Medicare OPPS, with some state-specific guidelines.
9	**Minnesota** - Services not covered by the fee schedule are paid at the lower of 85% of the hospital's usual and customary charge or 85% of the prevailing charge (or 100% for hospitals with 100 or fewer licensed beds).
10	**Mississippi** - Use Ambulatory Payment Classification (APC) system as developed by CMS along with some state-specific exceptions.
11	**Missouri** - However, Section 287.140.3, RSMo, provides, in pertinent part: "3. All fees and charges under this chapter shall be fair and reasonable * * * A health care provider shall not charge a fee for treatment and care which is governed by the provisions of this chapter greater than the usual and customary fee the provider receives for the same treatment or service when the payor for such treatment or service is a private individual or a private health insurance carrier."
12	**Nevada** - Physicians/facilities are reimbursed separately.
13	**North Carolina** - As of April 1, 2013, inpatient charges are reimbursed at 67.50% of adjusted charges.

Table 6 Hospital Outpatient Fee Regulations as of January 1, 2015

Jurisdictions often also regulate fees for services provided to injured workers in a hospital outpatient setting. This table indicates which jurisdictions have such fee schedules, the method used to determine allowable fees, and whether the schedule applies to all outpatient services. It also provides the appropriate statutory or rule reference if the reader wants additional information about any particular jurisdiction regulations.

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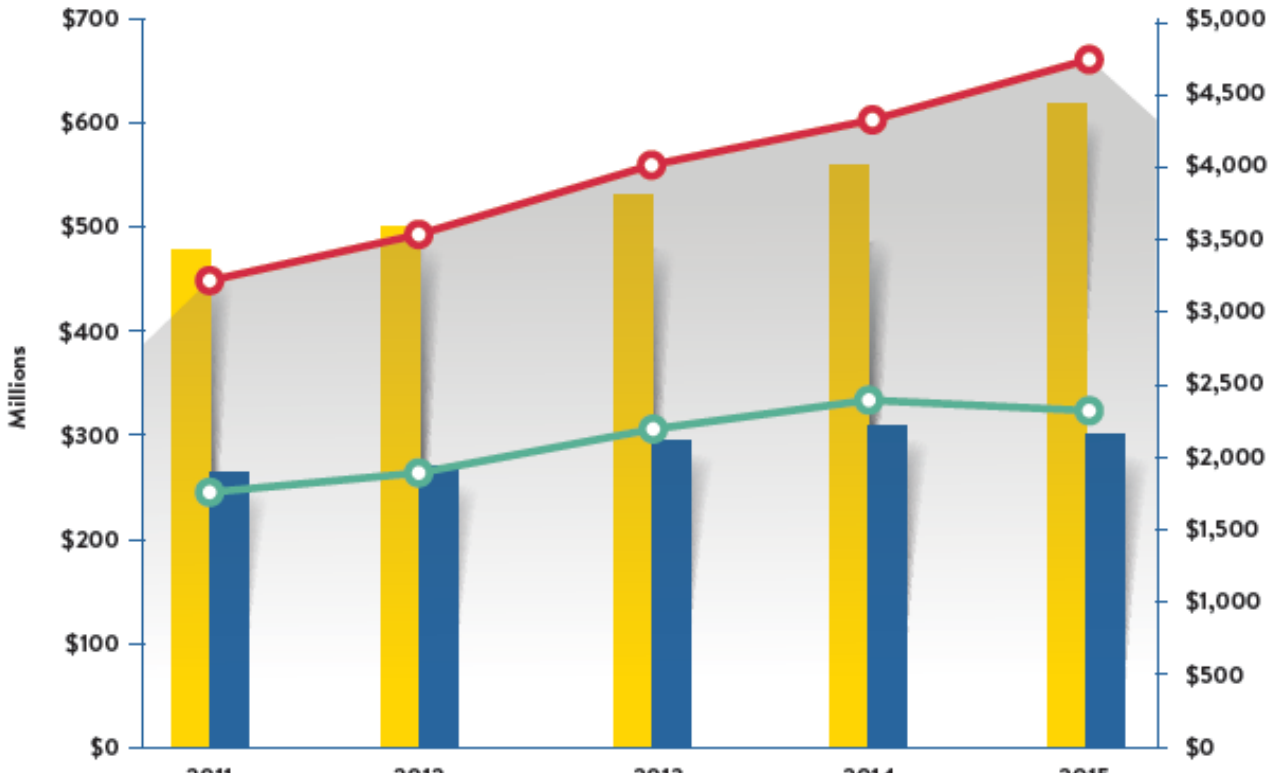
	Same as Hospital Inpatient Fees (Fee by Service Code)	Same as Hospital Inpatient Fees (Cost Based)	Same as Hospital Inpatient Fees (Discounted Charges)	Same as Non-Facility Provider Fees (Fee by Procedure Code)	Use a Varied Method (Explanation in Notes)	Other		
14	**Ohio** - Administrative Code rule 4123-6-37.2, Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement for hospital outpatient services with a date of service of May 1, 2014 or after shall be the applicable rate set forth in paragraphs (A)(1) to (A)(6) of this rule as follows, multiplied by a payment adjustment factor of 1.0212: (1) Except as otherwise provided in this rule, reimbursement for hospital outpatient services shall be equal to the applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system as implemented by the materials specified in paragraph (A)(7) of this rule, multiplied by a bureau-specific payment adjustment factor, which shall be 2.53 for children's hospitals and 1.62 for all hospitals other than children's hospitals, with the following additional adjustments for specific services: (a) For services reimbursed under the medicare clinical lab fee schedule, the applicable medicare rate specified in this paragraph shall be further multiplied by a 2014 bureau adjustment factor of 1.0175; (b) For services reimbursed under the medicare physician fee schedule, the applicable medicare rate specified in this paragraph shall be further multiplied by a 2014 bureau adjustment factor of 1.201. All exceptions and additional details are noted in the rule. Also, alternatives for self insuring employers to reimburse hospital outpatient services are notes in the rule.							
15	**Oregon** - Services billed under Revenue Codes 0320 - 0359, 0400 - 0409, 0420 - 0449, 0610 - 0619, or 0960 - 0989 are paid according to the physician fee schedule (fee paid by procedure code). All other services are paid the same as hospital inpatient fees (cost based).							
16	**Texas** - Medicare's Outpatient Department Prospective Payment System x multiplier.							
17	**Wyoming** - Regulations are varied as you now use several methods to reimburse.							

EXHIBIT 8 - TOTAL CHARGES AND TOTAL PAID FOR HOSPITAL OUTPATIENT SERVICES

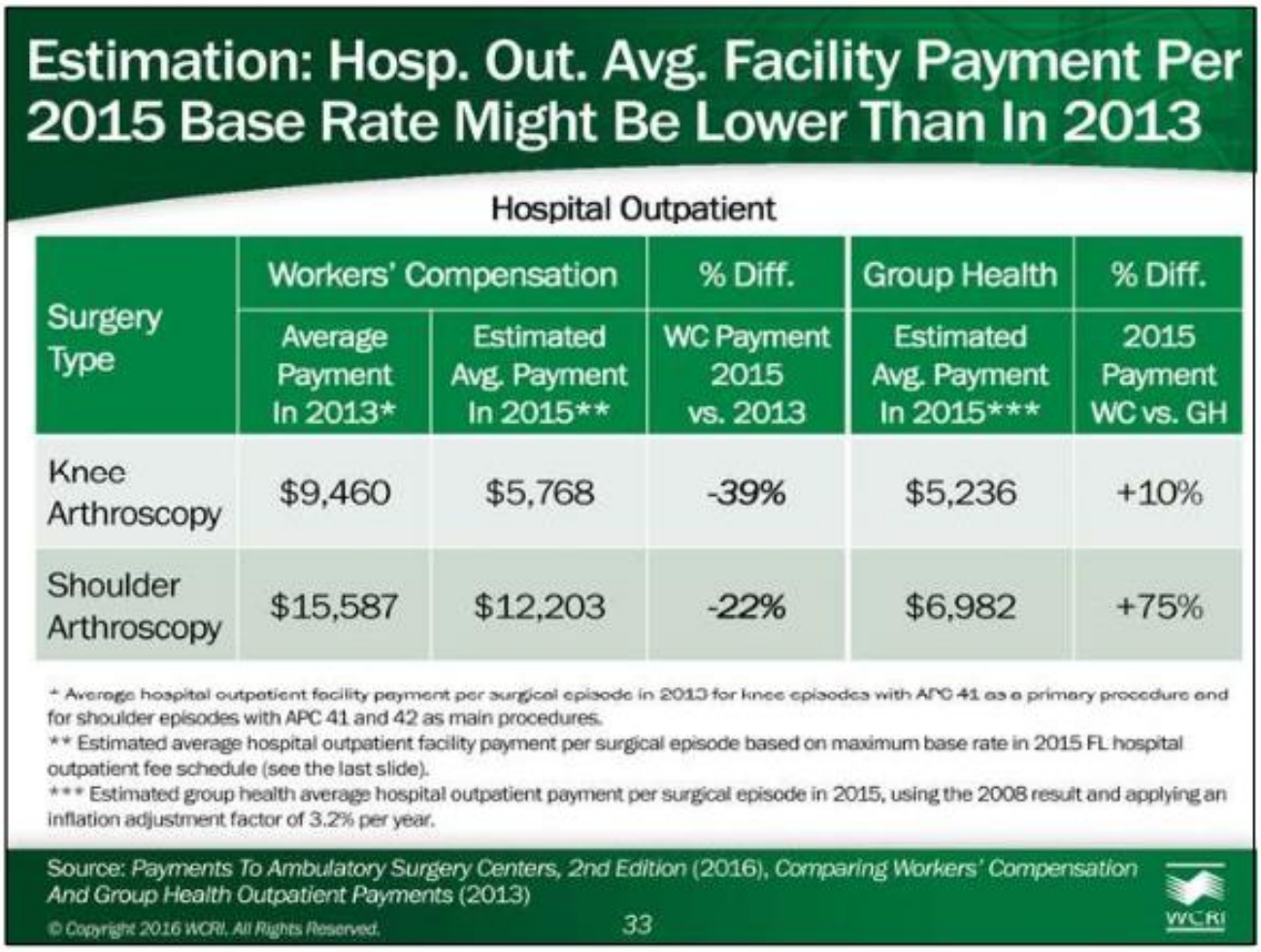
Hospital Outpatient billed charges include; outpatient surgeries, emergency room services, outpatient cardiology, pain injections, outpatient radiology and laboratory, physical, occupational, and speech therapies, and other non-surgical outpatient medical services such as observation, pulmonary testing, GI studies, etc. Outpatient radiology and laboratory, physical, occupational, and speech therapies are reimbursed at 110% of Medicare rates.

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



	2011	2012	2013	2014	2015
Charges	479,780,182	504,336,710	534,598,136	559,400,486	617,107,008
Paid	265,411,897	276,260,109	295,551,288	308,346,876	301,316,847
Avg Chg Per Bill	3,212	3,519	3,976	4,313	4,734
Avg Paid Per Bill	1,777	1,928	2,198	2,378	2,312
Number of Bills	149,385	143,305	134,468	129,692	130,346

EXHIBIT 9 - HOSPITAL OUTPATIENT AVG. FACILTY PAYMENT PER 2015 BASE RATE MIGHT BE LOWER THAN 2013



Estimation: Hosp. Out. Avg. Facility Payment Per 2015 Base Rate Might Be Lower Than In 2013

Hospital Outpatient

Surgery Type	Workers' Compensation		% Diff.	Group Health	% Diff.
	Average Payment In 2013*	Estimated Avg. Payment In 2015**	WC Payment 2015 vs. 2013	Estimated Avg. Payment In 2015***	2015 Payment WC vs. GH
Knee Arthroscopy	$9,460	$5,768	-39%	$5,236	+10%
Shoulder Arthroscopy	$15,587	$12,203	-22%	$6,982	+75%

* Average hospital outpatient facility payment per surgical episode in 2013 for knee episodes with APC 41 as a primary procedure and for shoulder episodes with APC 41 and 42 as main procedures.
** Estimated average hospital outpatient facility payment per surgical episode based on maximum base rate in 2015 FL hospital outpatient fee schedule (see the last slide).
*** Estimated group health average hospital outpatient payment per surgical episode in 2015, using the 2008 result and applying an inflation adjustment factor of 3.2% per year.

Source: *Payments To Ambulatory Surgery Centers, 2nd Edition* (2016), *Comparing Workers' Compensation And Group Health Outpatient Payments* (2013)

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Key: **Hosp. Out.:** Hospital outpatient. **Diff.:** Difference. **WC:** Workers' compensation. **GH:** Group health. **APC:** Ambulatory payment classification. **BLS:** Bureau of Labor Statistics.

Sources:
Savych. 2016. *Payments to Ambulatory Surgery Centers, 2nd Edition.*
Fomenko. 2013. *Comparing Workers' Compensation and Group Health Outpatient Payments.*

EXHIBIT 10 - ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA REIMBURSEMENT MANUAL FOR HOSPITALS PROPOSED TO BE EFFECTIVE JULY 1, 2017

Content begins on the next page.

ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA REIMBURSEMENT MANUAL FOR HOSPITALS PROPOSED TO BE EFFECTIVE JULY 1, 2017

NCCI estimates that the proposed changes to the Florida Workers' Compensation Reimbursement Manual for Hospitals (RMH), proposed to be effective July 1, 2017, would result in an impact of +2.2% (+$80M[1]) on overall workers compensation system costs in Florida.

Please note that the estimated cost impact is based on the provisions summarized below, which may differ from the final implemented version. If the final version is different from the provisions included here, NCCI would perform an analysis based on the ratified rule and the impacts stated in this analysis may change accordingly. Additionally, the changes to the RMH are being evaluated in isolation. Any other changes not in the RMH that could interact with this analysis could result in a different estimated cost impact.

Summary of Proposed Changes

Currently, hospital inpatient services are reimbursed based on per-diem rates defined in the 2014 edition of the RMH. The 2016 proposed rules contain the following changes:

- Increases the Stop-Loss Reimbursement threshold from $59,891.34 to $65,587.00
- Increases the per-diem rates at trauma centers from $3,850.33 to $4,216.00 for surgical stays, and from $2,313.69 to $2,534.00 for non-surgical stays
- Increases the per-diem rates at acute care hospitals from $3,849.16 to $4,215.00 for surgical stays, and from $2,283.40 to $2,501.00 for non-surgical stays

The current reimbursement for a workers' compensation hospital outpatient service in Florida depends on the category of service as described below:

- Category 1: Reimbursement for a scheduled, non-emergency outpatient radiology or clinical laboratory service that is not performed in conjunction[2] with a scheduled surgery is subject to the schedule of maximum reimbursement allowances (MRAs) listed in *Florida Workers' Compensation Health Care Provider Reimbursement Manual (HCPRM), 2015 Edition*. In addition, the reimbursement for an outpatient physical therapy, occupational therapy, or speech therapy service is subject to the MRA listed in the HCPRM.

- Category 2: The maximum reimbursement for a scheduled surgical service is calculated as the base rate from *Florida Workers' Compensation Reimbursement Manual for Hospitals, 2014 Edition*, Appendix C, multiplied by the geographic modifier listed for the

[1] Overall system costs are based on 2015 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. The estimated dollar impact is the percent impact(s) displayed multiplied by $3,645M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.
[2] "In Conjunction" is defined as on the day of or up to three days before

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county of the location of service from Appendix A. The maximum reimbursement for a procedure with no specified MRA is 60% of usual and customary charges (UCC). In addition, the maximum reimbursement for any scheduled radiology service or clinical laboratory service performed in conjunction with a scheduled surgery is also 60% of UCC.

- Category 3: Similarly, the maximum reimbursement for a non-scheduled surgical service is calculated as the base rate from Appendix B, multiplied by the geographic modifier from Appendix A. The maximum reimbursement for a procedure with no specified MRA is 75% of UCC.

The proposed changes to the hospital reimbursement manual would update the base rates and geographic modifiers for Category 2 and Category 3 services.

Actuarial Analysis

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
   a. Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code
   b. Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights

2. Estimate the price level change as a result of the proposed fee schedule
   a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
      i. In response to a fee schedule decrease, NCCI's research indicates that payments decline by approximately 50% of the fee schedule change.
      ii. In response to a fee schedule increase, NCCI's research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
      The formula used to determine the percent realized for fee schedule increases is 80% x (1.10 + 1.20 x (price departure)).

3. Determine the share of costs that are subject to the fee schedule
   a. The share is based on a combination of fields, such as bill type and procedure code, as reported in the FL Division of Workers' Compensation (DWC) detailed medical data, to categorize payments that are subject to the fee schedule.

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ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA REIMBURSEMENT MANUAL FOR HOSPITALS PROPOSED TO BE EFFECTIVE JULY 1, 2017

The detailed medical transactions are obtained from the FL DWC medical data management system reported on form DWC-90 for services performed between January 1, 2015 and December 31, 2015. This data is collected by the FL DWC from workers compensation insurance carriers and self-insured employers. The analysis of hospital outpatient services includes data reported with bill types 13x, 14x, and 85x. The analysis for hospital inpatient services includes data reported with bill types 11x, 12x, 18x, 21x, 22x, 23x, 81x, and 82x.

The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from Policy Years 2012 and 2013 projected to July 1, 2017.

In some components of the analysis NCCI may rely on other data sources, which are referenced where applicable.

Hospital Inpatient Fee Schedule

In Florida, payments for hospital inpatient services represent 19.0% of total medical payments. To calculate the percentage change in maximums for hospital inpatient services, we compare the maximum reimbursements for each hospital inpatient bill under the current and proposed fee schedule.

The current MRA for each hospital inpatient bill is calculated as follows:

- If total trended charges (excluding charges for implants) are $59,891.34 or less,

  Current MRA = current per-diem allowance x length of stay (LOS)

- If total trended charges (excluding charges for implants) are greater than $59,891.34,

  Current MRA = total trended charges (excluding charges for implants) x 75%

The proposed MRA for each hospital inpatient bill is calculated as follows:

- If total trended charges (excluding charges for implants) are $65,587.00 or less,

  Proposed MRA = proposed per-diem allowance x LOS

- If total trended charges (excluding charges for implants) are greater than $65,587.00,

  Proposed MRA = total trended charges (excluding charges for implants) x 75%

Note that implants are excluded from the above reimbursement since they are reimbursed separately as a function of invoice cost.

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The charge for each hospital inpatient bill was adjusted to reflect changes from past price levels ("coverage from" date, indicating the beginning of an inpatient episode) to the price levels projected to be in effect on the proposed effective date of the hospital inpatient fee schedule (July 1, 2017). The trend factor is based on the U.S. hospital inpatient component of the medical consumer price index (MCPI).

Service Year	Hospital Inpatient MCPI Change from July of Previous Year
2013	4.4%
2014	5.7%
2015	3.8%
2016	*4.6% (Estimated)*

The MCPI change from 7/1/2015 to 7/1/2016 is estimated using a three-year average of the observed MCPI for 2013-2015 which is equal to 1.046 (= [1.044+1.057+1.038] / 3). The trend factor applied to each inpatient bill is calculated as follows:

$$\text{Trend Factor} = 1.046^{(7/1/2017\ -\ \text{coverage from date})}$$

The overall change in maximum reimbursements for hospital inpatient services is a weighted average of the percentage change in MRA (proposed MRA / current MRA) by bill, using current costs by bill as the weights. The overall weighted-average percentage change in MRA is estimated to be -0.2%.

The table below summarizes the estimated impacts by category:

Category of Inpatient Bill	Distribution of Costs	Percentage Change in MRA
Bills With Trended Charges Less Than $59,891.34	15.4%	+9.5%
Bills With Trended Charges Between $59,891.34 and $65,587.00	2.4%	-71.4%
Bills With Trended Charges Greater Than $65,587.00	82.2%	0.0%
Total	**100.0%**	**-0.2%**

Since the overall average maximum reimbursement for hospital inpatient services decreased, NCCI expects that 50% of the decrease in maximum reimbursements would be realized on hospital inpatient price levels. The estimated impact on hospital inpatient after applying the price realization factor of 0.50 is -0.1% (= -0.2% x 0.50). The estimated impact for hospital inpatient services is then multiplied by the Florida percentage of medical costs attributed to hospital inpatient payments (19.0%) to arrive at the estimated negligible decrease on medical and overall workers compensation costs.

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Hospital Outpatient Fee Schedule

In Florida, payments for hospital outpatient services, excluding surgical implants, represent 17.6% of total medical payments. To calculate the percentage change in maximum reimbursements for hospital outpatient services, we calculate the percentage change in MRA for each procedure. The overall change in maximum reimbursements for hospital outpatient is a weighted average of the percentage change in MRA (proposed MRA / current MRA) for each procedure code using the observed payments for each procedure code as the weights. The current and proposed MRAs are calculated as follows:

Category 1 Procedures:

Reimbursement for hospital outpatient category 1 procedures will remain under the schedule of MRAs listed in the HCPRM, 2014 edition.

Category 2 and 3 Procedures:

For each relevant procedure code,

Current MRA = Base Rate x Geographic Modifier

Where:

- The base rate for a Category 2 or Category 3 service is provided in Appendices B and C of the Florida Workers Compensation Reimbursement Manual for Hospitals.
- The Geographic Modifier is provided in Appendix A.

For each relevant procedure code,

Proposed MRA = Base Rate x Geographic Modifier

Where:

- The base rate is provided in Appendices B and C of the proposed RMH
- The Geographic Modifier is provided in Appendix A.

The overall weighted percentage change in MRA for hospital outpatient services, including Category 2 and Category 3 but excluding surgical implants, is estimated to be +21.9%. Since the overall average maximum reimbursement for hospital outpatient services increased, the percent expected to be realized from the fee schedule increase is estimated according to the formula 80% x (1.10 + 1.20 (price departure)). Since a reliable price departure could not be calculated, the percent expected to be realized from the fee schedule increase is assumed to be 80%. The estimated impact on hospital outpatient payments after applying the price realization factor of 80% is +17.5% (=0.80 x +21.9%).

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The above impact of +17.5% is then multiplied by the Florida percentage of medical costs attributed to hospital outpatient payments excluding surgical implants (17.6%) to arrive at an estimated impact of +3.1% on medical costs. The resulting impact on medical costs is then multiplied by the percentage of Florida benefit costs attributed to medical costs (70.7%) to arrive at the estimated impact on Florida overall workers compensation costs of +2.2%.

Summary of Estimated Impacts

The estimated impacts due to the changes in the hospital inpatient and hospital outpatient fee schedules are summarized in the following table:

	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Estimated Impact on Overall Costs (C) × (2)
Hospital Inpatient	-0.1%	19.0%	negligible	negligible
Hospital Outpatient	+17.5	17.6%	+3.1%	+2.2%
(1) Total Estimated Impact on Florida Medical Costs			**+3.1%**	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in Florida				70.7%
(3) Total Impact on Overall Workers Compensation System Costs in Florida = (1) x (2)				**+2.2%**

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EXHIBIT 11 - ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA ASC MAXIMUM REIMBURSEMENTS PROPOSED TO BE EFFECTIVE JULY 1, 2017

Content begins on the next page.

ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA ASC MAXIMUM REIMBURSEMENTS PROPOSED TO BE EFFECTIVE JULY 1, 2017

NCCI estimates that the proposed changes to the Florida Ambulatory Surgical Center (ASC) Maximum Reimbursement Amounts (MRAs), proposed to be effective July 1, 2017, would result in an estimated overall Florida workers compensation system cost impact of +0.6% (+$22M[1]).

Please note that the estimated cost impact is based on the provisions summarized below, which may differ from the final implemented version. If the final version is different from the provisions included here, NCCI would perform an analysis based on the ratified rule and the impacts stated in this analysis may change accordingly.

Summary of Proposed Changes

The Florida Division of Workers' Compensation (FL DWC) proposes the following change to the ASC MRAs in the Reimbursement Manual for Ambulatory Surgical Centers (RMASC):

- Update the list of MRAs contained in Chapter 6 of the RMASC

For those procedure codes not listed on the proposed fee schedule, the maximum reimbursement would remain at 60% of billed charges.

Actuarial Analysis

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
   a. Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code
   b. Calculate the weighted average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights

2. Estimate the price level change as a result of the proposed fee schedule
   a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence From 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
   b. In response to a fee schedule decrease, NCCI research indicates that payments decline by approximately 50% of the fee schedule change.

[1] Overall system costs are based on 2015 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. The estimated dollar impact is the percent impact displayed multiplied by $3,645M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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c. In response to a fee schedule increase, NCCI research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
    i. The formula used to determine the percent realized for fee schedule increases is 80% x (1.10 + 1.20 x (price departure)).

3. Determine the share of costs that are subject to the fee schedule
    a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the FL DWC detailed medical data, to categorize payments that are subject to the fee schedule.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data provided by the FL DWC with dates of service between January 1, 2015 and December 31, 2015.

- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Florida from the latest two policy years projected to July 1, 2017.

In some components of the analysis NCCI may rely on other data sources, which are referenced where applicable.

ASC Services

In Florida, payments for ASC services represent 9.4% of total medical payments. To calculate the percentage change in maximums for ASC services, NCCI calculates the percentage change in maximums for each procedure code. The overall change in maximums for ASC services is a weighted-average of the percentage change in MRA (proposed MRA / current MRA) by procedure code weighted by the observed payments by procedure code as reported in detailed medical data provided by the FL DWC for Service Year 2015. The overall weighted-average percentage change in MRAs is estimated to be +12.6%.

Since the overall average maximum reimbursement for ASC services increased, the percent expected to be realized from the fee schedule increase is estimated according to the formula 80% x (1.10 + 1.20 (price departure)). Since a reliable price departure could not be calculated, the percent expected to be realized from the fee schedule increase is assumed to be 80%. The estimated impact on ASC payments after applying the price realization factor of 80% is +10.1% (=0.80 x +12.6%).

The above impact of +10.1% is then multiplied by the Florida percentage of medical costs attributed to ASC payments (9.4%) to arrive at the estimated impact on medical costs of +0.9%. The resulting impact on medical costs is then multiplied by the percentage of Florida benefit costs attributed to medical benefits (70.7%) to arrive at the estimated impact on Florida overall workers compensation costs of +0.6%.

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ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA ASC MAXIMUM REIMBURSEMENTS PROPOSED TO BE EFFECTIVE JULY 1, 2017

The estimated impact due to the changes to the ASC MRAs is summarized in the table below:

	(A) Estimated Impact on Type of Service	(B) Medical Cost Distribution	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Estimated Impact on Overall Costs (C) × (2)
ASC	+10.1%	9.4%	+0.9%	+0.6%
(1) Estimated Impact on Florida Medical Costs			**+0.9%**	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in Florida				70.7%
(3) Estimated Impact on Overall Workers Compensation System Costs in Florida = (1) x (2)				**+0.6%**

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EXHIBIT 12 - ISSUES ADDRESSED FY 2015-2016

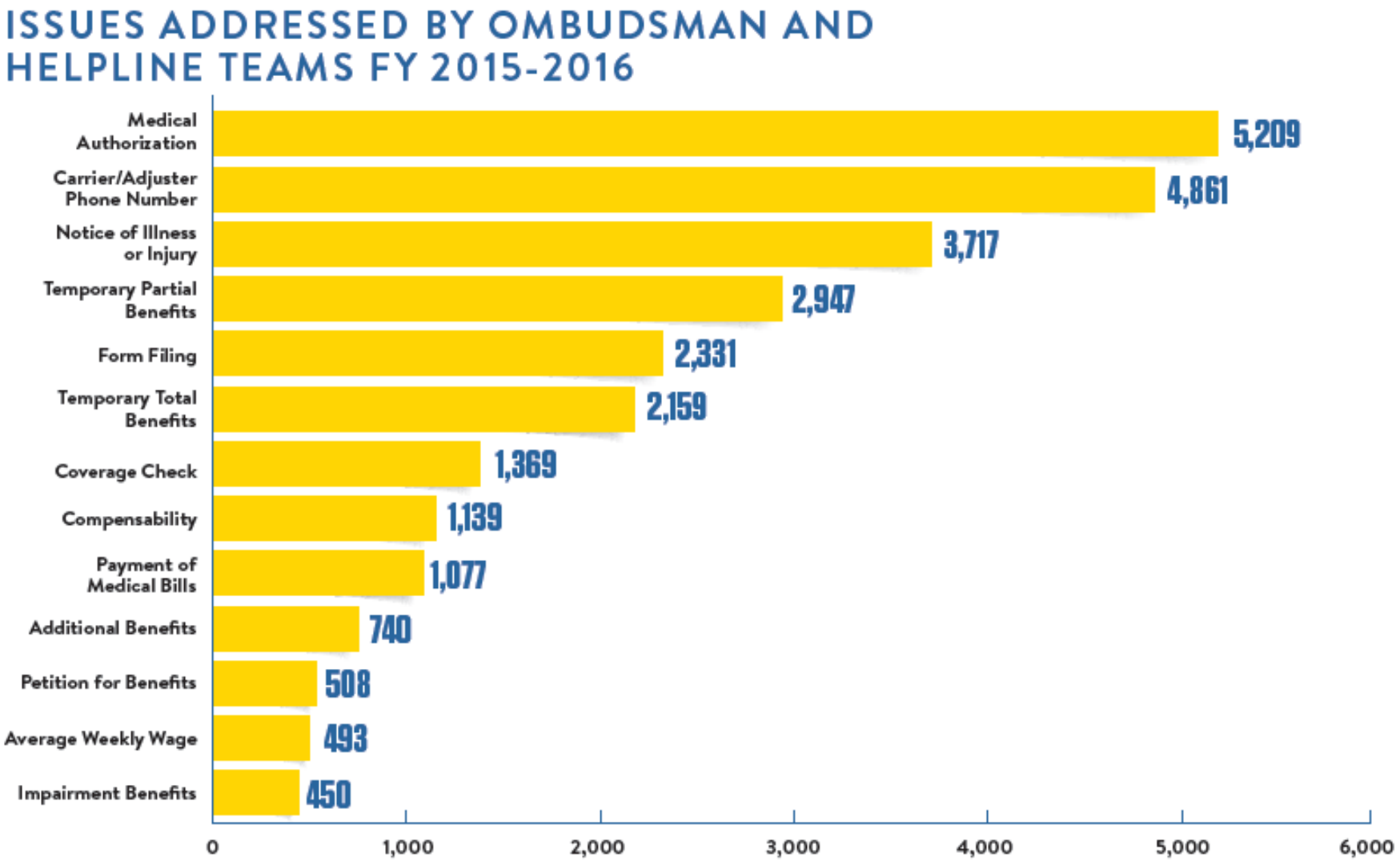

EXHIBIT 13 - INFORMAL DISPUTE ISSUES FY 2015-2016

TOP 10 ISSUES FY 2015-2016

Issue	Resolved	Unresolved	Resolved
Average Weekly Wage	13	2	87%
Medical Authorization	242	14	95%
First Report of Injury	3	0	100%
Indemnity - TPD	45	4	92%
Indemnity - TTD	38	2	95%
Compensability	1	4	20%
Penalties & Interest	26	0	100%
Medical Mileage	56	3	95%
Medical Bills	39	2	95%
Impairment Income Benefits	3	0	100%

EXHIBIT 14 - TOP 5 MOST FREQUENT ISSUES LISTED ON A PFB

Chart based on data from the Office of Judges of Compensation Claims between May of 2015 and November of 2016.

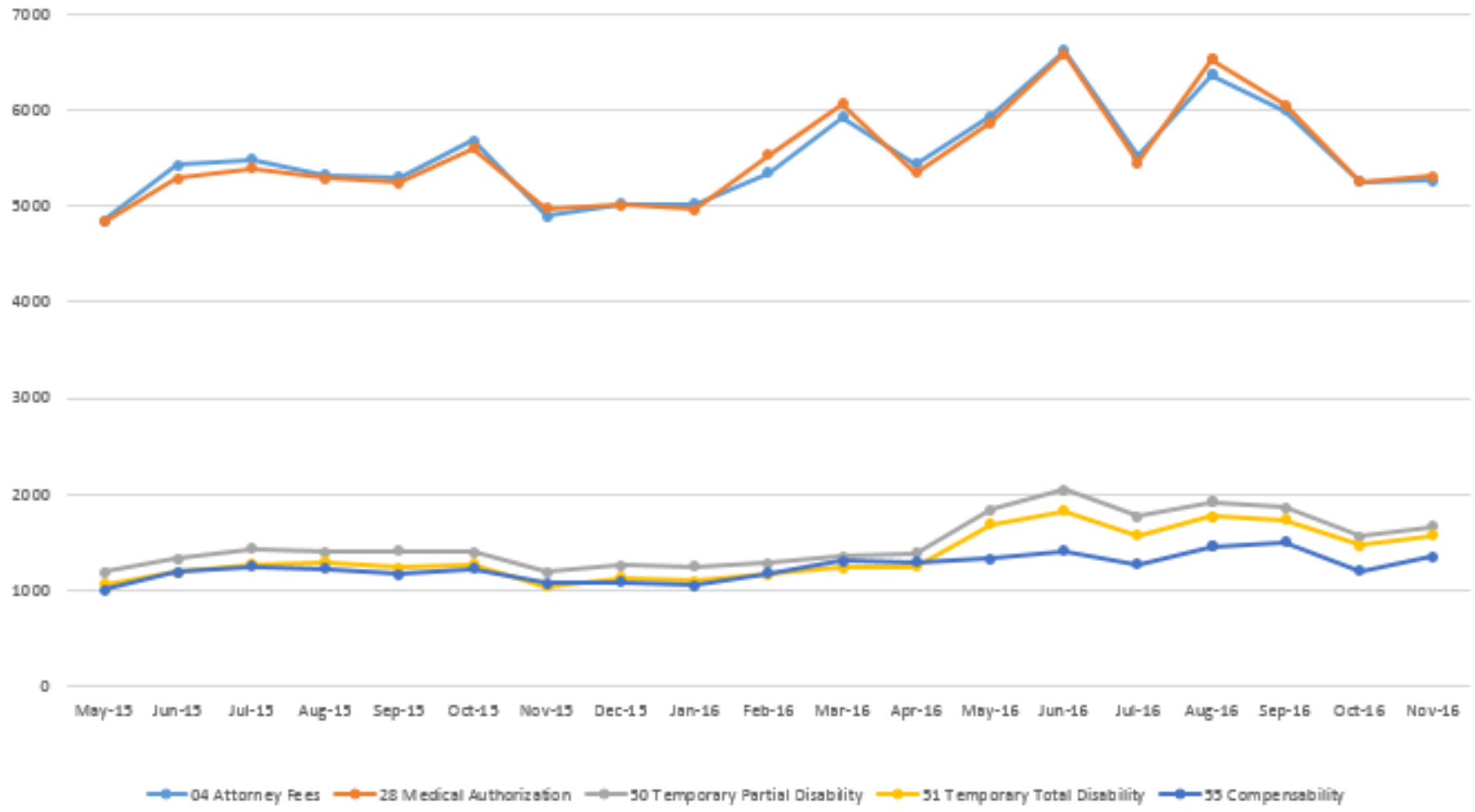

EXHIBIT 15 - NUMBER OF PFBS FOR MEDICAL AUTHORIZATION FILED WITHIN 28 WEEKS OF THE DATE OF ACCIDENT

Chart based on data from the Office of Judges of Compensation Claims between May of 2015 and November of 2016.