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I. Workers' Compensation Reform Commission—POLICY AND CHARGE

A. Florida's Challenge

In Florida, the workers' compensation system has fallen far short of the purposes it was expected to achieve. According to the National Council on Compensation Insurance (NCCI) studies: costs for permanent total disability claims are almost three times the national average; medical costs for permanent partial claims are more than two times higher than the national average; medical costs for temporary total disability claims are 60% higher than the national average; and medical and indemnity benefits for cases with attorney involvement average more than 37% higher than the national average

Florida businesses pay among the highest premium rates in the country for workers' compensation insurance, while injured workers receive benefits that are among the lowest in the nation. Businesses, especially small ones, are having increasing difficulty in finding coverage. Medical practitioners at times refuse to treat workers' compensation patients, blaming the system's poor reimbursement rates and administrative burdens. The lack of a clearly defined and focused dispute resolution system has resulted in extensive litigation. Consequently, Judges of Compensation Claims are overwhelmed with large caseloads, case resolution is delayed, and costs are higher. Clearly, Florida's system is failing.

B. Florida's Opportunity

The wide range and complexity of problems facing Florida's workers' compensation system and the need for comprehensive reform led Governor Bush to create the Governor's Commission on Workers' Compensation Reform in May 2002. The Governor charged the Commission with evaluating Florida's workers' compensation system and making policy recommendations on the following:

1. The availability and affordability of workers' compensation insurance in Florida compared to other states with similar relevant characteristics,

2. Impediments to quick resolution of disputes and statutory changes necessary to facilitate timely resolution of workers' compensation cases,

3. Major cost factors in the workers' compensation system and statutory changes necessary to reduce the cost of workers' compensation insurance,

4. The adequacy of compensatory benefits for injured workers and statutory changes necessary to equitably compensate injured workers in the workers' compensation system.

Over the past several months, the Commission has met eight times throughout the state, taking extensive public testimony and evaluating workers' compensation reform proposals made by various groups. As a result of these deliberations, the Commission recommends a broad and comprehensive course of action that will provide timely, effective, and affordable medical

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treatment and economic support to injured workers while reducing the economic burden placed on Florida's employers from workers' compensation costs.

One of the goals of any workers' compensation system should be to provide timely and effective medical treatment and economic support to injured workers at affordable cost to employers. A properly functioning system will minimize the disruption to injured employees' lives by quickly restoring them to their pre-injury economic potential, or as close to that potential as possible. Employers will also benefit. The disruption to businesses as a result of the temporary loss of the skills and knowledge of the injured employees will be minimized. Beyond the benefits to individual employees and employers, the economy as a whole will be more productive and competitive.

Some of the primary objectives in this reform effort will strengthen Florida's economy:

1. **Better Benefits** for injured workers,
2. **Lower Insurance Rates** for employers,
3. **Healthier Employees** that can return to work sooner with better outcomes,
4. **Safer Workplaces** where injuries are prevented before they happen,
5. **Reduced Fraud** to improve fairness and reduce costs.

Ultimately, the findings and recommendations in this report should be used as the foundation for legislative proposals and statutory changes during the upcoming legislative session. The implementation of these recommendations will result in a better, more efficient and effective workers' compensation system for the state of Florida.

II. Market Conditions For Insurance Underwriting[1]

Public comments at the Commission meetings along with correspondence received by the Department of Insurance and legislators reveal that Florida employers are increasingly frustrated with high cost of workers' compensation insurance and the subsequent lack of availability. Common employer complaints include "The state is mandating workers' compensation coverage, but I can't find an insurer who will write me", "The cost is too high and will put me out of business." Or "Why isn't there a level playing field on coverage issues?"

At the January 9, 2003 Commission meeting, one general contractor informed the Commission that his workers' compensation rate is 42% of gross wages for framers, and in total, almost 20% of the bid price, which translates to $18,000 for a $100,000 construction job.

In Florida, insurers have tightened underwriting guidelines because of escalating claim costs, increased reinsurance costs, and a weak investment environment. Small employers, construction employers, the health care industry employers, and even employers with good loss histories are

[1] Sources Best's Aggregates and Averages, NCCI

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all having difficulty in obtaining workers' compensation coverage. Professional employer organizations (PEO) have been particularly hard hit ever since the primary insurer for PEOs decided not renew its PEO book of business. The Division of Workers' Compensation has reported that applications and inquiries for self-insurance have increased. Thirty-seven applications have been filed for the first six months of fiscal year 2002 – 2003, compared to a total of 21 applications filed for the entire fiscal year 2001 – 2002. This represents a 76% increase in self-insurance applications. Data from the Florida Workers' Compensation Joint Underwriting Association, which is Florida's insurer of last resort, show substantial increases in the number of applications received, policies issued, and premium written, when compared to 2001. All these factors lead to a strong probability that the availability of workers' compensation insurance will continue to be a major problem through 2003.

Workers' compensation underwriting in Florida is one of the poorest performing sectors of the insurance industry. Nationally, the workers' compensation combined ratio (claims paid / premiums received) was 118% in 2000 and 122% in 2001, while Florida's combined ratio was 127% in 2001. In other words, for every dollar in premium, insurers across the country paid out $1.22 in losses and expenses in 2001. In Florida, insurers paid out $1.27 in losses and expenses for every dollar in premium they collected. As a result, two of the three largest workers' compensation underwriters in Florida have discontinued writing new policies.

Moreover two of the three general workers' compensation cost drivers continue to create an upward pressure on rates. Preliminary NCCI data show that the countrywide average indemnity claim cost rose 9.2% in 2001, while medical claim costs increased 11.5%. These are the largest one-year increases in over a decade. However, frequency of lost-time claims decreased 5.8% continuing a ten-year trend toward lower frequency of claims.

In addition to losses as a result of claims, there has been much uncertainty in the market for commercial lines property and casualty insurance coverage, including workers' compensation coverage, in light of the substantial losses experienced by the industry on September 11, 2001.

Soon after the catastrophic events, many reinsurers announced their intention to eliminate coverage for acts of terrorism in future reinsurance contracts. This led to a concerted effort on behalf of all interested parties to seek a temporary federal backstop to calm market fears over future terrorist attacks and the ability of the insurance industry to allocate capital to provide coverage for these unpredictable and potentially catastrophic events. Congress recently enacted and the President has signed into law, the Terrorism Risk Insurance Act of 2002.

This federal law provides a federal backstop for defined acts of terrorism and imposes certain obligations on insurers. Private insurers and the federal government now share the risk of future losses from terrorism for a three-year period. The Act rescinds all state exclusions for terrorism. Insurers must notify existing commercial policyholders of the existence of the federal backstop, offer comparable terrorism coverage and specify the cost of that coverage. Policyholders have the option to accept or decline the coverage or negotiate other terms.

The hard insurance market of 2002 will most likely carry over into 2003. Global, national, and Florida-specific factors will all continue to affect the availability and affordability of workers'

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compensation insurance. Although the Commission cannot change global and national conditions, our recommendations to improve Florida's workers' compensation system can enhance the economic conditions of Florida's employers and the health and welfare of injured workers.

III. Analytical Perspective

According to both historical origins and current statutory framework, workers' compensation is supposed to be an exclusive remedy alternative to the tort system and is supposed to be self-executing in nature. In essence, it is a "contractual" agreement between management and labor, sometimes referred to as the "great trade-off." In exchange for an exclusive remedy system that eliminates both the requirement to prove negligence and the ability to sue the employer, as well as other usual trappings of a civil litigation system, the employer agrees to provide prompt medical and indemnity (wage replacement) benefits regardless of fault in causing the accident.

The failings of the workers' compensation system are the result of a complex and inter-related set of problems, and require a comprehensive, integrated resolution. However, over the years the situation has only been exacerbated by repeated attempts to remediate the system through various "band-aid" legislative efforts that were essentially procedural in nature and failed to address the fundamental root of the problems. Therefore, any truly successful reform effort must define the core issues that are problematic, distill the underlying breach in principle or application and assure that the solution is both inherently logical and practical. This principle-based approach is the only way an integrated system that all parties can comply with can be designed and implemented. Looking past the "symptoms" of the day-to-day dysfunction of the current system, past the statistics and anecdotal evidence, beyond the technical or procedural considerations, it becomes apparent that there are but a few core issues that are both the basis for the problems and the source of the solutions:

1. Lack of consensus regarding **medical care authorization and decisions**, that all serve as a source of poor outcomes, frequent dispute and litigation, and excessive costs.
2. A dysfunctional **medical reimbursement** system that, in general, is too low for the providers, too high for the hospitals, is inconsistently applied and unnecessarily bureaucratic and cumbersome to administer, fostering difficulties with access to quality care, inappropriate utilization of services, excessive disputes and litigation and ultimately, poor case outcomes.
3. A **dispute resolution system** that creates incentives for further conflict, treats all issues the same regardless of nature or significance in the claim and is unnecessarily cumbersome, resulting in long delays, excessive costs, and poor case outcomes, as well as serving as the primary driver of negative "front-end" behavior for all system participants.
4. The **residual indemnity benefits**, system is naturally flawed because they are based not on a loss of function and the resultant economic impact regarding ability to work, but on an unrelated **impairment system** that serves as an inappropriate driver of medical benefits and services and does not correlate with appropriate financial support for the injured workers most affected by their work related injury.

5. A lack of meaningful, quality **system data** to guide management and maintenance of the system as a whole.
6. Wide variations and excessive requirements for **medical documentation**, operational policies and procedures, authorization and reimbursement, all creating unnecessary infrastructure and related costs, as well as creating a greater source of work and potential conflict by the consumers in interpreting and utilizing that critical information.
7. Lack of a central and coordinated **government regulatory and administrative agency**, properly staffed and funded to provide oversight, support, and as necessary, dispute resolution.

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IV. Medical

A. Definitions

A workers' compensation case begins when employees have a work-related incident causing injury or illness. As a result, the injured worker is eligible, as needed, for medical and indemnity benefits. Inherent in that equation is the identification of four separate and distinct elements that should serve as the basis for all major case decisions and determinations. It is essential to define those elements so that they are considered and treated in a consistent manner in every case:

1) Accident/incident (work related)
2) Injury/illness
3) Functional limitations/restrictions
4) Economic impact (loss of wages or earning capacity)

By identifying and operationally defining these elements, as well as establishing clear criteria for their relationships and the benefits that are tied to them, an effective system for providing services and benefits can be created and implemented. Both public testimony and system statistics clearly demonstrate that the fundamental and most frequent cause of complaint, dispute, litigation, and poor outcome is the debate over medical issues and related consequences. Ultimately, almost every request for or debate over services or benefits stems from one of the following:

1. Whether or not an employee has an injury or illness, whether or not it is work related, and if the employee had any pre-existing conditions.
2. Whether or not the illness or injury requires medical treatment and if so, what type of treatment and for how long?
3. Whether the employee experienced any functional loss or disturbance, and if so, whether the employee has any work related limitations/restrictions.
4. What is the employee's prognosis, what are the estimated timeframes, costs, and expected clinical and functional outcomes?
5. What is the employee's progress and discharge status, what specific medical services or treatment are required, what will produce resolution of the clinical problem, and what is the overall status of the employee's case?

Although they may seem to be basic questions, they are difficult to answer or obtain consensus on in the current environment. The most fundamental and critical question is the first one, relating to the definition and criteria for defining the presence, nature, and extent of the injury or illness. All the other issues derive from that one.

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Therefore, the first series of recommendations involves defining and differentiating the above variables to establish a framework for delivering services and benefits to the injured worker. The key change is a shift from the current focus on subjective symptoms (i.e. pain), or potentially misleading anatomical abnormalities (i.e. herniated lumbar disc on a MRI), which are not accurately representative of the presence, nature, or extent of an injury or illness, to one based on objective and relevant clinical findings demonstrating abnormal physiology (function of a body system). This is not a new concept; in fact, it is the routine standard of medicine practiced outside of workers' compensation every day.

One example of this standard of medicine might occur when an individual complains of sudden chest pain, arm pain, shortness of breath, and excessive sweating. A heart attack or other related cardiac event is likely the first consideration. However, the patient would not receive treatment until he was examined and tested to assess and confirm his malady. He might receive additional evaluative tests, to rule out other problems, but in the absence of any "confirmed abnormal relevant physiology" he would not receive any treatment. In other words, a patient is normal until confirmed to have a clinical problem (physiologic abnormality).

In another example, even if a patient's exam revealed a mitral valve prolapse, which is a well-defined anatomical abnormality of the valve between the left atrium and ventricle of the heart, it is not enough to confirm the relevance of the finding or the presence of an illness unless it correlates to his clinical condition or is shown to negatively affect the cardiac function (physiology).

In workers' compensation today, when a back patient complains of pain or anatomical abnormality, he receives potentially every treatment available including pain medication, chiropractic manipulation, physical therapy, spinal injections, and even surgery. Treatment is provided without the same standard of clinical confirmation that is routine in non-workers' compensation medicine. Using enhanced operational definitions and criteria and providing support for their use empowers physicians to focus on quality medicine and clinically based decision-making, rather administrative, legal, or financial behavior.

Just as illness must be defined and confirmed clinically (to demonstrate abnormal physiology), so must any functional loss or disturbance. The Americans with Disabilities Act (ADA), provides that function cannot be "presumed" from an illness and research demonstrates that there is little direct correlation between one's illness and the resultant impact on overall function. Therefore, function will be a separate analysis made by the appropriate relevant provider (physician, physical therapist, neuro-psychologist, etc) and correlated clinically to assure that the functional restrictions documented are in fact a result of the work-related clinical condition.

This functional framework is one of the fundamental "pillars" of the this proposed system and will serve as the basis for subsequent recommendations included in this report regarding determinations for work status and residual indemnity benefits.

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Today each insurer has its own set of "practice parameters," which each considers proprietary information, requiring the practitioner to guess what is and isn't acceptable practice for the practitioner, with significant variances throughout. Conversely, the insurer routinely struggles to determine what is or is not a reasonable request for referral or service regarding the patient's ability to work, etc.

To assure the practical application and resulting consensus on the use of operationally defined and criteria-based clinical practice, the concept of "evidence-based medicine" must be introduced into the workers' compensation system and codified. The medical community's movement to an evidenced-based medicine approach over the last few decades has been largely responsible for enhanced clinical progress and consistency and has been the foundation of the quality assurance industry. By requiring clinicians to base their decisions and recommendations on actually observed evidence, the bar of clinical practice has actually been raised far beyond the walls of academia. However, knowledge and documentation in the scientific health care literature, especially about the conditions that are common to workers' compensation (i.e. low back pain, soft tissue injuries), is still quite limited. Therefore, a practical model for establishing what constitutes evidenced-based practice has evolved:

1) Research support (published scientific studies)
   a) Actual efficacy studies and related research (i.e. random controlled trials)
2) Professional consensus
   a) Guidelines or related positions from relevant, recognized professional societies or institutions (i.e. American Academy of Orthopedic Surgery, Agency for Health Care Policy and Research)
3) Principle-based decision-making (anatomy, physiology, pathology, clinical principles)
   a) Inherent logic model utilizing a problem-based approach to management

A clinician may use any or all of the above standards to substantiate his work, depending on the state of the art for a given procedure or content area. The standards are listed in order of deference and should be used accordingly. The last standard allows for the clinician to use the inherent logic of the exam and resultant clinical problem list to proceed in an orderly, accountable manner, even when there is a paucity of available information. The clinician is then measured against the ability to address the very findings believed germane to the clinical condition.

The above model accommodates individual differences in schools of clinical thought and discipline, but holds all equally accountable for responsible practice. It allows thoughtful consumerism by the payors and patients, but minimizes arbitrary resistance to the forward progression of a case.

Specific principles should be defined to obtain both optimal clinical efficacy and resultant superior outcomes, as well as obtain consensus between providers, payors, and regulators. This

consensus will expedite access to care with less resistance and aid in minimizing inappropriate variations in management, especially those secondary to defensive medical practices. This framework should be grounded in fundamental principles that are unlikely to substantively change regardless of advancements in clinical practice. The Commission recommends adopting a number of principles as a foundation for establishing evidence-based medicine in the workers' compensation system.

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Recommendations:

1. A patient is considered normal until there is confirmed abnormal relevant physiology as determined by objective, relevant physical exam findings and/or diagnostic testing.
2. Relevant is defined as correlating with subjective complaints and reported functional disturbances presented by the patient.
3. Pain alone, in the absence of confirmed abnormal relevant physiology, is not an indicator of injury, illness, or functional disturbance.
4. Abnormal anatomical findings alone (e.g., herniated disc on MRI, mitral valve prolapse), in the absence of confirmed abnormal relevant physiology are not an indicator of injury, illness, or functional disturbance.
5. The presence of confirmed abnormal relevant physiology does not necessarily result in an automatic limitation or restriction in function. Function must be measured directly, and correlated clinically. The functional loss must be connected to the relevant physiologic findings.
6. Clinical management should:
   a. be progressive in practice and acknowledge the research that clearly demonstrates that case outcomes worsen as case duration increases.
      i. In general, clinical management should be based on a "sports medicine" approach, utilizing high intensity; short duration treatment approaches that focus on early activation and a restoration of function.
      ii. Treatment plans, regimes, therapies, prescriptions, and functional limitations/restrictions must all be reassessed regularly by the prescribing provider, and never longer than 30 days without review of the progress, order, plan, or status.
   b. be problem-based (i.e. tissue inflammation, abnormal spinal biomechanics, neurological deficit), rather than providing for treatment based on treating diagnostic labels (i.e. herniated lumbar disc, degenerative joint disease`) which do not reflect an individual's specific clinical dysfunction or status.
      i. A problem-based orientation results in clinical accuracy and relevancy, as opposed to generic diagnostic labels that routinely allow for wide ranges of clinical presentation.
      ii. Clinical management must be inherently logical and the evaluation or treatment procedure must match the documented physiologic and clinical problem.
      iii. All treatment rendered should match the type, intensity, and duration of service required by the problem identified.
   c. be consistent with the macro framework of patient classification:

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i. Level I: Patient has a well-defined, work-related clinical condition associated with specific physiologic dysfunction(s); there are no significant psychological or vocational factors; there is no discordance between physical findings and the reported complaints. Typically, this status is identified in the time period that is days to weeks following the reported work-related injury/exposure.
ii. Level II: Patient is defined by the presence of systemic abnormalities such as deficits in strength, flexibility, endurance, motor control (coordination); the patient may or may not have a well-defined, specific physiologic dysfunction(s); there are no significant psychological or vocational factors. Typically, this status is identified 30-90 days (or more) following the report of work-related injury/exposure.
iii. Level III: Patient is defined by the presence of significant, associated psychological or vocational issues; typically, the patient does have systemic abnormalities (see above); the patient may or may not have specific physiologic dysfunctions. Typically, this status is identified 3 – 6 months (or more) following the reported work-related injury/exposure.

d. Contain content specific guidelines and indications that are clear and widely enough acknowledged in the medical communities to enhance quality and optimal utilization management.
   i. Examples of services requiring guidelines and indication include procedures such as x-rays and other imaging technologies, surgery, therapy, medication, injections, etc.
   ii. Examples of clinical conditions requiring specific guidelines include low back or neck dysfunction and other musculoskeletal injuries.
   iii. These criteria should be developed in conjunction with the Medical Oversight Board.
   iv. These guidelines should be promulgated as rules as they are developed.

7. Return to work, duty status, and work modifications are the sole domain of the employer and employee. Medical providers (and other relevant clinicians and health care practitioners) role is limited to providing information regarding clinically relevant, functional restrictions or limitations, including time frames and prognostic expectations.
   a. Limitations are functional deficits that are actually measured (e.g. lifting capacity, sitting tolerance, hearing).
   b. Restrictions are functional parameters that are prescribed, based on clinical protocol (e.g. non-weight bearing post fracture, exposure of a wound to environmental factors).
8. Causation:
   a. Reporting a work-related incident/accident and illness/injury:
      i. All work-related accidents and incidents shall be reported to the employer within 3-7 days from the occurrence.
      ii. It will be up to the employee whether to seek medical care; however, the employee must report the incident/accident to the employer and a Notice of Injury must be completed by the employer. The employer, at his discretion, may do whatever investigation (accident, drug testing, etc) is appropriate and

consistent with the policies of that employer (and consistent with statutory rights and responsibilities).

iii. In cases where the work related injury or illness is alleged to be the result of an accident or incident (vs. prolonged exposure), and it is has not been reported in the 3-7 day required time frame, the burden of proof, by clear and convincing evidence, regarding causal relationship shifts to the employee.

b. An employee has no more than 30 days from the date of a physical accident/incident (trauma, exertion, positional, or movement related), to file a workers compensation claim. Other than insidious exposure cases, claims may not be filed beyond that time frame.

c. Causation should be presumed unless the preponderance of the evidence establishes otherwise.

d. To refute the presumption of causation;
   i. There should be case specific clinical indication that the injury/illness is not work-related, or,
   ii. The clinical condition is one of the scheduled lists of conditions requiring specific confirmation of causality (which will be detailed via rule). Examples include carpal tunnel, Reflex Sympathetic Dystrohy (RSD), myofascial pain syndromes, spondylolisthesis, sexual dysfunction, emotional/psychological dysfunction, headache, fibromyalgia.

e. Issues involving environmental exposure, inhalation, or ingestion of a substance should not be entitled to a presumption of causation, the burden of proof should be on the claimant.

f. The employer/carrier should not be restricted from investigating and obtaining discovery regarding the accident, coverage, previous history, or other defenses.

9. If it is determined that pre-existing clinical conditions are a substantive part of the current work related condition, all reasonable effort should be made at determining the clinical significance of the pre-existing factors. Goals for treatment should aim at restoring pre-injury levels of health and function, and *not* necessarily complete resolution of the illness (e.g., if it is determined that a lifting injury irritated an existing low back condition, treatment responsibility, from a workers compensation perspective, would be limited to managing the irritation). This distinction would factor in as well at MMI regarding any residual determinations.

B. Providers and Consultations

A number of health care provider issues generate significant debate and frequent dispute and litigation:

- Who is and isn't a "good" provider?
- When is a consultation or referral to a specialist indicated?
- Who is ultimately responsible for the overall management of an injured workers' care when there are multiple providers on a case?
- When should a medical opinion or recommendation be accepted or questioned?
- What should reasonably be expected of providers and where do their responsibilities end?

As a result, the debate over requests for referrals to other providers and/or services driven by attorneys, judges, carriers, and injured workers has become the most disputed and litigated issue

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in workers' compensation. This has led to a distrust of medical opinions, "doctor shopping" until the desired medical opinion is found and providers practicing defensive medicine.

To optimize the appropriateness of referrals for services and consultation and minimize provider and clinical service based disputes, the Commission recommends implementing the following system.

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Recommendations:

1) As a prerequisite to rendering workers' compensation services, all health care providers must become Workers' compensation Certified. To become certified, the provider must agree in writing to adhere to the clinical, administrative, and procedural rules, terms and conditions of providing medical services in a manner and format required by the Division of Workers' Compensation.
2) Employers shall be responsible for providing injured workers with prompt, reasonable access to quality medical care and related health care services.
3) A principle treating provider model (**PTP**) shall be utilized. The PTP will be responsible for referrals, consultations, coordinating care and status determinations, medications, and other clinically or functionally related matters as outlined by the Division by rule.
   a) The PTP model differs from the typical "gatekeeper" model in that:
      i) It is exclusively a clinical distinction, with no financial, administrative, or overall case management responsibilities.
      ii) The PTP may change several times during the duration of a case, depending on which provider (by specialty or area of practice) is most appropriate to the main clinical issues at that point in the continuum of the case.
4) Referrals, consultations & transfers of care:
   a) The PTP determines the need for clinical or other healthcare services and providers, and will document the relevant clinical indications. Of course, all referrals for evaluation or service will still require authorization from the employer/carrier.
   b) In cases where additional care or referrals to evaluation that is not recommended by the PTP is requested by either the injured worker or the employer/carrier, the following rules will apply:
      i) There are no independent medical examinations (IME) allowed by either side.
      ii) Confirmatory consultations (issue-focused second opinions) may be used to clarify clinical and related issues:
         (1) One (1) discretionary confirmatory consultation is available per case to both the injured worker and the employer/carrier.
         (2) By either side following an affirmative surgical recommendation.
         (3) By either side if there is a dispute regarding functional determination at MMI.
         (4) By mutual agreement of the injured worker and employer/carrier.
      iii) A confirmatory consultation may only be used by the disputing party. Once there are two defined sides to a clinical or functional dispute, the providers and/or parties may confer to resolve the issue. If still at impasse, the issue may be referred to the COU for Dispute Resolution (see Dispute Resolution section). Neither side may obtain additional consultations.

iv) The injured worker has the option for one (1) discretionary change of provider per case.

v) A PTP may transfer the care of an injured worker to a more appropriate specialist or provider at the PTP's professional discretion at any time during the case as clinically appropriate (through the appropriate employer/carrier authorization process).

   (1) If a treating provider who is not the PTP on a given case requests to transfer their own care to a different provider (same or different discipline), it would need to be coordinated through the PTP and the employer/carrier.

vi) If an injured worker requests either a transfer of care or a confirmatory consultation, the employer/carrier must provide the injured worker with a sufficient number of choices within the appropriate specialty and appropriate geographical consideration as promulgated by the Division by rule.

vii) The change of provider or the confirmatory consultation option may not be used to circumvent the result of a completed dispute resolution process. For example, an injured worker may not request us of his discretionary provider option to attempt to get a particular treatment, or referral to a different specialist if the issue has already been addressed through the dispute resolution process.

5) Regarding intention and competency, there should be deference on behalf of the treating practitioners. Therefore, recommendations and requests for evaluation, diagnostic testing, and/or treatment should be routinely approved by the employer/carrier unless there are specific, relevant, merit-based reasons to question or deny authorization (i.e. requested service is clearly not necessary or appropriate, additional information or clarification is required). This same deference should be applied in dispute resolution (see page 19) in that, given essentially equal levels of documentation and support for either side of a dispute between the treating clinician and a consulting clinician, the treating clinician would receive a deference of correctness.

C. Behavioral Dysfunction/Psychological and Psychiatric Issues

Behavioral dysfunction and the related psychological and psychiatric services are a highly controversial aspect of workers' compensation cases that are disputed in many cases. Employers and carriers are concerned with the disproportional frequency in which these services are requested (and utilized) when compared to the non-workers' compensation population with the same injuries and illnesses. In addition, there is concern on how these less tangible issues are used to obtain higher financial settlements. Conversely, some injured workers, nurse case managers, and physicians complain that they have a difficult time getting these services approved even when they are clearly medically indicated. In addition, many psychologists and psychiatrists acknowledge that there is too liberal use of behavioral terminology, diagnoses, and medications by non-specialized physicians.

Any practical solution has to focus on limitations of behavioral aspects of a workers' compensation case and require a demonstration of the specific merits of the services and criteria for their indications.

Psychosocial factors are acknowledged to be an important component in the clinical management of a work related injury/illness and some injured workers may benefit from psychological

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support services or management that is clinically indicated. Support services should be utilized in conjunction with (not substituted for) the primary management for the principle injury, focused on and limited in duration in duration to the specific psychological aspects of the work related injury. Instances of such support and indications for treatment are not necessarily relevant to eligibility for indemnity benefits. The relevance of psychological or psychiatric treatment to eligibility for indemnity benefits should be based upon the presence of substantive medical or organic psychological or psychiatric disorders.

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Recommendations:

1. Psychological or psychiatric treatment will be relevant to an impairment rating as a basis for obtaining indemnity benefits only when there is a presence of substantive medical or organic psychological or psychiatric disorder caused by the work related injury.

V. Medical Reimbursement

Medical and indemnity issues in the workers' compensation system are inextricably linked. Unfortunately, the current system offers opportunities for financial incentives that can encourage 'undesirable behavior' which in turn result in worsened case outcomes and higher overall claim costs. These behaviors may include over-utilization by providers; 'illness behavior' or malingering by injured workers to prolong indemnity benefits; employer obstruction of return-to-work processes; carrier delays in authorizing care or payment for benefits or vendors; and protracted litigation which may permit claimants to manipulate the benefits system more to their advantage than an expeditious resolution. Further, the low level of reimbursement reportedly limits access to quality care, access to a certain types of providers, and timely access to a sufficient number of providers. In addition, the current practice of fee negotiation for providers and outpatient services has created an inappropriate economic focus on provider selection, rather than on the more appropriate clinical indicators of quality and service.

Specifically the level of reimbursement for outpatient, non-hospital treatment is inadequate; 17% lower than Medicare, the lowest in the country. Yet Florida has some of the highest medical costs per case in the nation. Further, in many specialties, medical malpractice insurance premiums have more than doubled over the last 3 years, further aggravating the issue of low reimbursement. Disputes over authorization/reimbursement levels may also result in providers not being paid as promptly as they should.

Of the forty (40) states that have medical fee schedules, Florida has the lowest reimbursement levels, which on average are 17% below Medicare reimbursement levels, according to the Workers' Compensation Research Institute (WCRI). Fourteen (14) states set provider fees that on average are 50% above Medicare reimbursement levels. An additional twelve (12) states set provider fees that on average, are between 30% and 49% above Medicare reimbursement levels.

In addition, huge disparities exist in the level of reimbursement for the same outpatient service depending on whether the service is rendered in a physician's office or a hospital (which includes a free-standing facility that is owned by a hospital). Hospitals are paid 75% of their

usual and customary fee for outpatient services. According to WCRI, it is not unusual for Florida hospitals to be paid three to five times the payment for the same service than when it is provided by a non-hospital provider.

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In patient hospital treatment costs are much higher in Florida than many states. Huge disparities exist between the reimbursement for inpatient hospital treatment under workers' compensation compared with group health insurance and other third party payors, according to anecdotal information received from other third party payor systems. This contributes to higher system costs and raises equity issues by other providers. The Florida Hospital Association defended the rates it charges in the workers' compensation system as necessary to offset costs incurred and not recovered in other aspects of its operations. It also claimed that workers' compensation cases are more complicated and require more resources. To address these exigencies, the Commission recommends a number of changes.

Recommendations:

1. Increase reimbursement to providers from current levels to 150% of Medicare. Also pay for all non-inpatient hospital treatment based on the new increased reimbursement, regardless of where the non-inpatient treatment is rendered or who owns the facility. The Three Member Panel should continue to establish maximum reimbursement allowances (MRAs) for workers' compensation specific codes.
2. Establish an absolute per-service fee schedule (*no* paying above *or* below fee-for-service) so that the rates encourage quality care, access to an increased number of providers, and system compliance.
3. Decrease reimbursement for inpatient hospitalization. Maintain per diem methodology, but reduce per diem amounts by 10-20%, change stop loss from $50,000 to $75,000, and change reimbursement for charges over the stop loss amount to 65% of the usual and customary charges. Permit negotiation of inpatient hospitalization per diem rates that are outside the fee schedule by carriers and managed care arrangements.
4. Permit the use of case rates, alternative in-patient per diem rates, and other global-type pricing if agreed to by parties, according to parameters established by Three Member Panel.
5. Require that authorization for service obligates carrier to services, unless the authorized service is not rendered.
6. The Three Member Panel should conduct a study to determine the feasibility of converting to a Diagnostic-Related Group (DRG) reimbursement methodology for inpatient hospitalization and Medicare Ambulatory Payment Classification (APC) System reimbursement methodology or some other national model/methodology for outpatient surgical procedures.

VI. Indemnity Benefits

Florida's indemnity system does not comply with the legislative intent of the workers' compensation law, "to facilitate the worker's return to gainful employment at a reasonable cost to the employer." The system lacks incentives to encourage employers to take employees back as soon as medically feasible. Indemnity benefits are, generally speaking, those benefits paid to

the injured worker in lieu of lost wages. The indemnity benefit system currently provides benefits based on various criteria, especially residual impairment ratings. However, Florida's present system is not based on residual functional loss or how that loss of function affects the injured workers' future earning capacity or access to the labor market. The current system cannot make indemnity decisions based upon function loss. Indeed, the AMA Guides to Evaluation of Permanent Impairment admits that the impairment ratings it provides cannot serve to measure work-related disability. [2]

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Even in today's temporary indemnity benefits system, there is a nexus between loss of function and economic impact. Indemnity is tied to lost wages as a result of not being able to work secondary to the work related illness. However, when the injured worker reaches maximum medical improvement (MMI), there is a shift to a reward or payment for illness, rather than remaining consistent with the core premise, providing financial support secondary to a loss of ability to generate income.

A. Residual Indemnity Benefits Model

A fundamental flaw in the determination of residual indemnity benefits is that the determination has no relation to loss of function or the resultant effect upon ability to work. Instead, it relies upon an unrelated impairment system that serves as an inappropriate driver of medical benefits and services. The current system has no process to determine appropriate financial support for the injured workers most affected by their work related injury. This often results in inappropriate and unfair financial payments (excessive or insufficient) to injured workers who still have residual problems when benefits cease. In addition, it serves as incentive to "build up the medicals," an industry term for documenting a lot of medical "complaints" and requests for subsequent activity and care solely to position the case for a larger settlement. In other words, there is an inappropriate relationship between "staying sick" and financial "reward".

Recommendations:

1. Impairment ratings should no longer be utilized in the Florida Workers' Compensation system.
2. Residual benefits (post MMI) should be awarded in two situations;
    a. There is a residual loss of function, as a consequence of the work injury, which limits a return to work at previous economic levels (disability)
    b. The work-related injury/illness is one of the specific clinical conditions set for scheduled benefits (i.e. traumatic amputations, spinal cord injury, severe burns, etc).
3. The process for determining non-scheduled residual indemnity benefits should be comprised of three parameters: function, vocational information and labor market information. This determination includes the following steps:
    a. Define any clinically substantiated, substantive, residual functional loss at the time of MMI.

[2] AMA Guides to Evaluation of Permanent Impairment, Fifth Edition, 2000, chapter 1.2b, 1.7, 2.5d

b. Develop vocational information into a grid/formula for determining residual loss of job market eligibility based upon functional loss that will be used to calculate indemnity benefit duration.
c. Develop vocational information into a grid/formula for determining changes to the injured worker's earning capacity that will be used to determine a representative wage to use in the calculation of the indemnity benefit rate.
d. Vocational evaluations should process under the following parameters:
    i. Evaluations will be provided by a "blind rotation" of workers' compensation certified evaluators.
    ii. Certification would be limited to Certified Vocational Evaluators (CVE) and Certified Rehabilitation Counselors with significant workers' compensation experience.
    iii. A standardized, rule-defined evaluation protocol (including testing), criteria for interpretation, and report format and requirements should be utilized by all evaluators.
    iv. The cost of the evaluation will be established by fee schedule.

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B. Permanent Total Disability

Florida has four times as many permanent total disability (PTD) claims as the national average, according to the WCRI. As a result of this higher frequency, Florida's total cost for PTD claims is almost 3 times greater than countrywide (NCCI). Since 1994, claimants have been eligible for PTD benefits if the injury would have qualified the claimant for disability or supplemental income benefits under the July 1, 1992, Social Security Act.

In August, 2002, the Government Accounting Office (GAO) issued a report entitled "Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity." In this report, the GAO reported that to qualify for social security benefits, an applicant must only demonstrate that his "impairment" has lasted or is expected to last for at least 12 months. As a result, a 20-year old claimant in Florida could receive workers' compensation benefits for life merely by demonstrating that an injury will prevent him from working for 12 months.

This becomes especially egregious when considering that the disability criteria used by both the Social Security Administration and the Veteran's Administration for determining disability have not incorporated labor market changes. The GAO report observed that the programs continue to use outdated information about the types and demands of jobs in the economy. Moreover, the GAO reported that efforts to update the criteria have not incorporated innovations in assistive technologies, such as advanced prosthetics and wheelchairs.

Recommendations:

1. Repeal the provision in the definition of catastrophic injury, s. 440.02(37)(f), F.S., that defines a catastrophic injury as a permanent impairment constituted by any injury that meets the social security eligibility test.

C. Permanent Partial Impairment Benefits

Permanent partial impairment claims in Florida have resulted in medical costs that exceed almost twice the national average, according to NCCI. On the other hand, indemnity benefits are far less than other states provide. Presently, an injured worker is paid benefits at the rate of 3 weeks for each percentage point of impairment, whether or not the employee experiences any permanent functional loss or loss of earning capacity, but are paid at 50% of the temporary total disability benefit rate. Until the functional loss model is implemented, the legislature should increase the permanent partial impairment benefits schedule to increase awards to injured employees.

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Recommendations:

1. Implement an increase in permanent partial benefits until the impairment benefits schedule is replaced by a functional loss model.

D. Temporary Benefits

Medical costs in temporary total disability claims are more than 50% higher than the rest of the country. There is little, if any, incentive for employers to take injured workers back or for injured workers (whose earnings are on the lower end of the wage scale) to return to work. Workers whose earnings far exceed the statewide average weekly wage find far fewer financial rewards from prolonging their return-to-work. An injured worker whose wage loss is less than the maximum weekly compensation rate and does not earn any post injury wages will receive 64% of his/her lost wages under the present formula. Given these findings, the Commission has several recommendations.

Recommendations:

1. Increase the percentage of lost wages that are paid for temporary partial disability benefits if the employee returns to work within his/her restrictions prior to maximum medical improvement or the employer fails to offer bonafide light duty work within the employee's restrictions and limitations. (Recommendation: Pay 70-80% of lost wages, subject to current maximum weekly compensation rate mechanism.)

E. Funeral Expense and Death Benefits

Funeral Expense Benefits were increased from $2500 to $5000 several years ago, yet the average funeral costs about $6,000. Funeral benefits should be increased to $6,000. Death benefits have been capped at $100,000 for a very long time and have not been increased to provide a reasonable level or benefits for surviving dependents.

Recommendations:

1. Increase death benefits to $200,000 and funeral costs from $7500.

F. Return to Work

Return-to-work issues have become a frequently litigated issue and an area of dispute between injured workers, employers and medical providers. Assessments of injured worker's capabilities and the functional requirements and availability of a given job have become a battlefield for debate and litigation. In 1993, an obligation to rehire provision was added to the workers' compensation law, s. 440.15(6) F.S., that provides that if an employer failed to offer an employee work appropriate to the employee's physical limitations within 30 days of maximum medical improvement (MMI), the employer would have to pay into the WC Administrative Trust Fund a fine between $250 and $2,000 per violation, as the division required by rule. However, the law as currently written is unenforceable and the Division has been unable to promulgate rules to salvage the law.

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Every employer should have a goal to rehire or provide retraining to an employee who has an on the job injury. However, such retraining/rehiring programs should not place an undue financial burden on the employer and must ensure that the injured employee obtains the most effective return-to-work service. Currently, the obligation to rehire and retraining provisions in Chapter 440 lack effectiveness because of the subjective definitions of "good faith" and "suitable gainful employment."

Retraining an employee in the event he cannot return to work at the same position is the key to making the obligation to rehire work. The current retraining system as run by the Department of Education inadequately addresses the need for retraining and should be changed. Instead of operating retraining programs out of the Department of Education, the Commission recommends instituting a bid process in which retraining providers and community colleges can bid on providing retraining programs in a particular area on a capitated basis. These retraining programs can be paid for out of funding currently allocated to the Department of Education to administer and run the current retraining program.

Recommendations:

1. Amend 440.15 (6) F.S. and 440.491 F.S. to provide for more objective and appropriate measures and outcomes so employers and injured employees both benefit from effective return-to-work services.
2. Provide employer incentives to retrain or rehire injured employees.
3. Privatize the current state run retraining program by removing the program from the Department of Education and moving to a bid process, leveraging the abilities of private industry and move oversight of the program to the Division of Workers' Compensation.

G. Average Weekly Wage Calculations

Under the current statute an employee's weekly wage is calculated based upon substantially the whole of thirteen weeks of earnings. Case law has interpreted that to mean at least the most recent 91 days of work. Almost all employers pay employees on a weekly basis. Given this, the 91-day method results in frequent erroneous calculations because employers are unable to

calculate wages based on weekly earnings as contained in corporate records, and must instead manually add the previous 91 days wages. To avoid administrative errors caused by this method for calculating AWW, the statute should be changed to calculate AWW based on the previous full 13 weeks worked.

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Finally employers have little, if any, incentive to take injured workers back or for injured workers (whose earnings are on the lower end of the wage scale) to return to work. Workers whose earnings far exceed the statewide average weekly wage find far fewer financial rewards from prolonging their return-to-work. An injured worker whose wage loss is less that the maximum weekly compensation rate and does not earn any post injury wages will receive 64% of his/her lost wages under the present formula. Given these findings, the Commission has several recommendations.

Recommendations:

1. Simplify AWW determination and calculation.

H. Fraud/Compliance Resources

According to a 2000 study by the Coalition Against Insurance Fraud, 32 states have fraud bureaus. (Separate statistics were not available for workers' compensation fraud alone.) Florida, had the third largest budget at $10.4 million, which was less than half that of New Jersey and California's at $25.8 million and $22.3 million, respectively. Florida led the nation with the number of cases (688) referred for prosecution as well as the number of convictions (386). However, with 171 full-time employees (FTEs), Florida also has a smaller staff than New Jersey (262) and California (220.5).

During fiscal year 2001/02, the Bureau of Workers' Compensation Fraud received 2298 referrals, and opened 499 new cases. One hundred fifty-four cases were presented for prosecution, which thus far have resulted in 117 arrests and 96 convictions. The Division of Fraud receives a significant number of complaints on large premium fraud that require a significant amount of resources to investigate. Increased funding for law enforcement would permit increased investigative resources.

The Bureau of Compliance is responsible for investigating civil compliance with coverage requirements in Chapter 440. Authorizing additional positions would enhance the ability of the Bureau of Compliance to rapidly bring into compliance those employers losing their workers' compensation coverage by policy cancellations or operating without coverage. When employers operate without workers' compensation insurance coverage, their employees are no longer covered under workers' compensation and should on-the-job injuries occur those employees could become dependent upon public assistance for medical and financial help. The Bureau of Compliance suggests 10 additional fraud investigators and 35 additional compliance officers

Recommendations:

1. Authorize additional fraud investigator positions throughout the state to respond to increasing incidents of fraud.
2. Authorize additional compliance positions throughout the state to investigate coverage/ exemption issues.

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VII. Dispute Resolution

A. Introduction

There are several fundamental principles and criteria that the Dispute Resolution component of the workers' compensation system must embody in order for the system to work properly.

Much of the debate regarding judicial resolution has focused on timeliness; the ability to adjudicate disputes or facilitate resolution within reasonable timeframes. However, although this is clearly an admirable goal it is not the fundamental parameter that ultimately determines system success or failure. Even if the decisions were expedited, if they did not produce appropriate and consistent determinations, the system would continue to produce wide variations in behavior and case activity, poor results, and continued high dispute frequency.

The most important element of any dispute resolution system is its ability to fairly and consistently resolve disputes along predictable lines of reasoning and criteria. Court decisions provide guidance for the injured workers, employer/carriers, physicians, and most directly, attorneys in future cases. The most powerful example is that of the physicians and other providers in the health-care community. It is widely acknowledged that many highly qualified practitioners either don't participate in the WC system at all, or severely limit their access. In addition, the widespread use of defensive medical strategies produce poor results and excessive medical costs. The fact that non-medical individuals can "second-guess" and then override the medical decisions or actions of physicians, without any clinical criteria or accountability, leads to over-utilization of services and referrals. This override occurs in today's system to such an extent that it effectively changes provider behavior and sets aside compliance with the statutorily mandated practice parameters.

B. Claims Operational Unit

The formation of a single, dedicated, administrative/organizational unit (Claims Operational Unit, or COU) to coordinate, triage (screen and differentiate), manage, and track all disputes will bring organization and will focus resources to what today is scattered among several agencies an/or departments, and is failing by every measure. Timeframes, accuracy, consistency, even the ability to collect and utilize data are all unacceptable in today's system. By establishing a dedicated unit of qualified medical and claims personnel to provide all three elements of the dispute process (dispute coordination, data collection and utilization, and education and outreach), the entire system will operate as originally intended.

Another failing of today's system is the "one size fits all" nature of handling disputes. There are substantive differences in the nature, significance, and immediacy of various legal issues, and any responsible system for reviewing and resolving them should take that into account. An

abundance of essentially procedural issues currently clog up the system and delay case progression. These issues could be more adequately expedited through administrative determination. Medical issues and legal issues requiring professional review and consideration would be organized and funneled to the Peer Review Panel (PRP) and JCC's respectively. To create a disincentive for routinely appealing all PRP determinations, regardless of merit, the Commission recommends that no costs and fees be reimbursed to a claimant's attorney unless and until the claimant successfully appeals an adverse ruling by the PRP. The legal adjudication process for indemnity benefit disputes should allow for a two-tiered system; a streamlined, limited process for those disputes that are either simpler in nature, or require expedited consideration, and another, more fully developed process for more complex issues. By establishing pre-defined operational definitions and standards, standardizing the process and documentation, and categorizes the disputes at the COU as administrative, medical/functional, and legal issues, will all contribute to expedited reviews by the appropriately qualified personnel.

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Recommendations:

1. Establish a Claims Operational Unit to triage, coordinate, and manage all disputes and to make determinations on administrative issues.
2. No costs and fees should be reimbursed to a claimant's attorney unless and until the claimant successfully appeals an adverse ruling by the PRP and the COU.

C. Peer Review Panels for Medical Disputes

The legal adjudication process be divided according to indemnity and medical disputes. Disputes pertaining to medical necessity, functional capacity, or other relevant matters requiring clinical analysis should be reviewed and determined by qualified medical/clinical practitioners. Using a medical peer review panel process, utilizing a PRP via a fully accredited, national (out of state) Peer Review Organization (PRO) to resolve medically or functionally based disputes. It would not only provide an expedited vehicle for handling the single largest category of disputed issues, but more importantly, it would provide greater assurance to the medical provider community that it can practice responsible medicine. Decisions and actions will be reviewed by peers, based on the specific merits and not subject to a lack of critical understanding or tied to Solomonesque decrees to split the baby in an attempt to balance disputed issues, as is so often the case today. The current system creates a false sense of fairness that lacks a foundation in prudent, medically based decisions. The use of a national PRO would remove the medical dispute process from any perceived local clinical or political bias regarding physician selection or other operational issue. This is the standard medical model, and would alleviate many of the difficulties experienced with similar boards and panels in Florida in the past.

Recommendations:

1. Establish a peer review panel to address all medical disputes.

D. Operational Definitions

Another fundamental issue is the operational definition of what constitutes a dispute. Today, many employer/carriers acknowledge that often the first time they receive a request is via a Petition for Benefits (PFB). Defining a dispute as a request that has been specifically denied (or not responded to in a statutorily/administratively required time frame after being served), clarifies the issue in question for proper review and minimizes the shotgun approach of filing numerous claims on each Petition for Benefits in the hope that one or two will produce results so prolific in today's system. Focused, post-denial disputes, documented on a single Division of Workers' Compensation form outlining the issues and capturing the critical required information, would facilitate a merit-based and predictable determination and minimize the frequency of disputes filed in the first place.

Recommendations:

1. Establish definitions for key aspects of the system to reduce gamesmanship and confusion in the system.

E. Workers' Compensation Appellate Commission

Any appeal from a final JCC decision should go to dedicated Workers' Compensation Appellate Commission, staffed with experts in workers' compensation issues, who should strictly apply the intent of the workers' compensation statute. The ability for the appellate aspect of the system to reinforce the appropriate and desired "front-end" behavior of the system participants will be assured. The regional District Courts of Appeal and the Supreme Court would then have a certiorari jurisdiction over issues of constitutional integrity.

Recommendations:

1. Establish a Workers' Compensation Appellate Commission to decide all appeals from Judges of Compensation Claims decisions.

F. Arbitration

In some instances, the injured worker may place a priority on resolve his workers' compensation claim in an expedited fashion for which the injured worker believes arbitration is the best option. The Commission recommends that an option for arbitrating a claim be established.

Recommendations:

1. Final claim arbitration should be available solely at the discretion of the injured worker. The injured worker would select the arbitration option at the time a dispute arises in lieu of filing a Petition for Benefits. Election of arbitration would require full disclosure to the injured worker that he is waiving all other remedies except those provided in the Florida Arbitration Code. Arbitration would use the same process and observe the same limitations as the Peer Review Panel for determining medical necessity and related issues. The Claims Operational Unit could partner with a private entity such as the American

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Arbitration Association to manage the arbitration process. The insurer shall pay for the arbitration costs.

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VIII. System Administration

Throughout the Commission proceedings, a consensus arose that the workers' compensation laws must be effectively enforced. Without effective enforcement, the success of the workers' compensation and system reform could be seriously compromised. Enforcement has great practical value as a means of providing a "level playing field." Employers benefit from enforcement actions stopping unfair competition from businesses that have not properly secured compensation. Injured workers benefit from enforcement of laws, which ensure they have worker's compensation coverage, facilitate resolution of their claim and ensure they receive appropriate benefits. Insurers benefit from enforcement of compliance laws because premium is added into the system that previously had been evaded. While Florida's workers' compensation law is intended to be self-executing, a comprehensive enforcement process must have sufficient "teeth" to induce all participants in the system to meet their obligations.

Enforcement of the workers' compensation system laws begins with the employer's obligation to secure compensation for its employees. The Division of Workers' Compensation within the Department of Financial Services enforces the compliance provisions in Chapter 440. The Division of Workers' Compensation works closely with the Division of Insurance Fraud (within the Department of Financial Services) on criminal violations of compliance laws. For enforcement of employer compliance to be meaningful, the law should clearly provide that securing compensation requires not only purchasing a workers' compensation policy, but also correctly representing the payroll and classifications of the employees covered.

Under current law, the Division's authority for issuing a Stop Work Order specifically refers only to the failure to secure coverage (s.440.107(5), F.S.) Misrepresentation of payroll or classification of workers' is addressed in s.440.105(4)(b)6, F.S., as insurance fraud, punishable as a felony as set forth in s.440.205(4)(f), F.S. The irrational situation in which failure to purchase a workers' compensation policy is both an administrative and criminal violation (s.440.105(4)(a)3), F.S., while knowing misrepresentation of payroll or classification of workers' has only a specific and limited criminal sanction should be corrected. The Commission has several recommendations.

Recommendations:

1. Provide legislative authority to impose an administrative penalty on employers who materially misclassify employees and underreport payroll.
2. Provide legislative authority to impose an administrative penalty or to issue a Stop Work Order against employers that fail to maintain required business records relating to workers' compensation coverage, and/or fail to produce (to the Division) business records upon request.
3. Provide legislative authority to impose an administrative penalty against an employer that conducts any business operations following the service of a Stop Work Order.

4. Add statutory language for any Stop Work Order or unpaid penalties for a corporation, if the corporation is dissolved and another corporation is formed with the same principles and is engaged in the same or related enterprise, the stop work order or unpaid penalties apply to the new corporation.
5. Add statutory language that requires insurance carriers to immediately perform audits whenever the Division of Workers' Compensation documents underreporting of payroll, misrepresentation or misclassification of employees, or other improper workers' compensation activities by an employer or at an employer's place of business. Provide authority to impose an administrative penalty on the insurer for failure to perform required audits.
6. Define a "valid exemption" as an exemption approved and issued by the Division to an individual working within the scope of the trade identified on the application for exemption and listed on the exemption and grounds for withdrawal or suspension of an exemption if the exemption holder no longer meets the requirements for obtaining the exemption.
7. Eliminate construction exemptions except for corporate officers who own at least 10% of the corporation. A maximum of three exemptions per corporation should be allowed. Allow for a sufficient phase-in period.

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Administrative enforcement of the requirements of Chapter 440 is critical in assuring appropriate claims handling practices, avoiding claim disputes and litigation, and accurate and timely reporting of information to the Division of Workers' Compensation. However, many requirements for responding to claims set forth in Chapter 440 do not have a specific administrative penalty for violation. The Commission has several recommendations.

Recommendations:

1. Provide the Division with legislative authority to request and receive information from any party about instances of non-compliance, initiate an investigation, require cooperation, make administrative determinations on issues, and impose an administrative penalty for substantiated violations.
2. Eliminate the option of a five-dollar penalty in 440.20(6), F.S., for untimely subsequent indemnity benefit payments and retain the 20% penalty amount. The existing wording has resulted in penalties payable to the injured worker for untimely subsequent indemnity payments of $5, which is not a meaningful sanction.
3. Require any entity, such as third-party administrators and servicing agents, handling Florida workers' compensation claims to be subject to Division of Workers' Compensation administrative authority.
4. Add language to the seven-day waiting period that explains calendar days of disability do not have to be consecutive. The clarification will reduce litigation over this issue.
5. Clarify the information that employers and carriers must file with the Division of Workers' Compensation, how it is to be submitted to the Division, and the penalties for non-compliance. Adding specific language will strengthen the

integrity and accuracy of data and will give the division specific authority for application of penalties for non-compliance with filing requirements.

6. Strengthen the physicians' reporting responsibilities to the carrier and ensured workers and the carriers' reporting responsibilities to the Division.
7. Strengthen the privacy provisions regarding injured workers' personal information.

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In order to effectively monitor and evaluate the workers' compensation system and reforms to the system, accurate and meaningful data and the data must be collected efficiently. Under current law, responsibilities for data management and collection of relevant workers' compensation data are with the Division of Workers' Compensation, the Agency for Health Care Administration, and the Division of Administrative Hearings. The Commission has the following recommendation.

Recommendations:

1. Authorize the Claims Operation Unit within the Division of Workers' Compensation to consolidate, manage, and define all workers' compensation data and related responsibilities.

The Claims Operation Unit should also serve as the source for workers' compensation education and outreach. The Commission has the following recommendation.

Recommendations:

1. The Division of Workers' Compensation should implement consumer education and outreach services that are modeled upon and are coordinated with the Department of Financial Services education and outreach services for other lines of insurance.

IX. Safety

The Commission acknowledges that employers should develop and implement effective safety programs. The best type of workers' compensation injury is the one that never occurs. Implementing effective safety programs can result in fewer workplace injuries, thus lowering workers' compensation costs.

The Legislature has promoted safety programs by allowing employers to receive a premium credit for implementing an approved safety program. However, several issues have developed over the last few years related to the employer safety programs that need to be addressed. With the dissolution of the Division of Safety on July 1, 2000, no agency is responsible for approval and oversight of safety programs. In 2001, the Legislature amended s. 627.0915, F.S., to allow employers to receive a premium credit for implementing a safety program pursuant to a rating plan. Additionally, s. 440.1025, F.S., was amended the same year to allow the Division of Workers' Compensation to adopt rules to determine if a public employer is eligible for a safety

credit. A conflict exists between the two statutes; one allows for any employer to be potentially eligible for the safety credit, while the other appears to limit eligibility to public employers only.

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In addition, effective safety programs appear to be almost non-existent on an industry-wide basis in Florida. The University of South Florida has a grant program at the present time to provide safety consultation services to employers with less than 250 employees. They can also provide safety consultation services to some larger employers. Additionally, the Division of Safety had previously, in cooperation with industry, written 200 safety programs by industry, by SIC code. The consultation program is 90% federally funded and is of no cost to the requesting employer. Those safety programs are posted on the USF website. However, neither this program nor these resources appear to be very widely publicized. Moreover, the Joint Underwriting Association (JUA) should mandate that those seeking coverage from the JUA must participate in a specified safety program such as that provided by the University of South Florida. The Commission has several recommendations.

Recommendations:

1. Amend s. 440.1025, F.S., to allow for both public and private employers to be eligible for the safety credit.
2. Allow insurers to determine if their policyholders have met the eligibility criteria for a safety program, as established by the Division of Workers' Compensation, in order for the premium credit to be applied.
3. Implement a program through the University of South Florida and other community colleges to develop specific safety standards applicable to particular industries and occupations to assure compliance with the best possible safety standards for each industry and occupation, and mandate those seeking workers' compensation coverage from the Joint Underwriting Association to participate in a safety training or evaluation program.