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What's New In Our Industry
Florida

Each branch of the government in Florida played some new role in the development of our state's workers' compensation system. The following are summaries of these actions.

Executive Branch

Proposed Inpatient Hospital Fee Schedule – So What Happened? You Decide

The development of a viable fee schedule for hospital inpatient medical care provides a central focus on industry's attempt at trying to control medical costs in the Florida workers' compensation system and at the same time equitably reimbursing hospitals for services provided. Approximately 70% of the total benefits paid in Florida's workers' compensation benefit structure relates to medical costs, an amount that is almost unconscionable when considering similar rates of costs in other states and considering benefits paid to injured workers. The largest component of these medical costs relates to hospital expenses. Florida has one of the most expensive inpatient, and for that matter outpatient, costs in the country.

The efforts made to control inpatient hospital costs really began to evolve following a case decided by an Administrative Law Judge (ALJ) in 2019 in the matter of *Zenith Insurance Company v. Department of Financial Services, Division of Workers' Compensation, Medical Services* DOAH Case No.: 18-3844 (Fla. DOAH) dated May 8, 2019. (The actual petition requesting a ruling on the propriety of the inpatient fee schedule adopted by rule had been filed in 2018.)

At the time of the ruling in the *Zenith* case, Section 440.13(12), Florida Statutes, established the fee schedule for inpatient medical care by stating that the inpatient schedule would be "per diem" rates. (This remains the statutory law at this time.) In part, the Division created rates on a per diem basis consistent with the statute. However, the rate schedule created by the Division included a stop-loss provision that said that if the per diem payouts exceeded a certain amount, the hospital would be paid 75% of its charges. The *Zenith* case found that the 75% of charges standard adopted by rule did not constitute a "per diem" payment schedule and was inconsistent with the statutory mandate for creating inpatient hospital reimbursements.

As a result of the *Zenith* case, Florida stakeholders began to develop new rules for the payment of inpatient reimbursements without considering a percentage of submitted hospital bills. The employer/carrier industry was primarily concerned that by paying a percentage of

billings, hospitals could simply increase their billings resulting in higher payouts. Ultimately, a new fee schedule was adopted by the department which did not include the percentage of billing procedures. Accordingly, this percentage of bill payouts was not a proper basis upon which hospital bills should be paid consistent with the *Zenith* case.

But what about the thousands of pending claims representing millions of dollars that have yet to be finally resolved and how will those bills be adjudicated consistent with the *Zenith* case without using the 75% reimbursement of hospital billings? Notwithstanding assurances to the contrary, the Division entered an Amended Order dated May 23, 2023 that "per diem" rate payments included percentage of bill payments. This administrative stretch in defining "per diem" is currently on appeal. In addition, the new per diem standard adopted by the Division without a 25% of bill payment has been appealed. The Department has indicated that it intends to put the rule in place establishing the new inpatient reimbursement rates without the percentage of bill reimbursement provisions on May 25, 2023. A Motion to Stay was filed to preserve the status quo pending appeal thereby allowing the parties to seek appellate review without undoing the Order under review. That Motion was denied by the ALJ and this denial is also being appealed.

Where this case goes from here is unclear. Your "guess" is as good as ours.

Department of Financial Services (DFS) Proposed Rules relating to Practitioner Prescribing and Dispensing Medications Final Order and Appeal

Background

On December 29, 2022, the Department of Financial Services (DFS), Division of Workers' Compensation (Division) published Notice of Proposed Rules 69L-7. 730 & 7.740, FAC, which requires in very general terms mandatory authorization of medical practitioners prescribing and dispensing medications in the workers' compensation system (includes oral surgeons, physician assistants, ARNPs and other recognized practitioners pursuant to Section 465.0276, Florida Statutes). DFS simultaneously published a Statement of Estimated Regulatory Costs (SERC) indicating that this would increase prescription costs by $42.8 million over 5 years, or $8.6 million per year. These cost increases were for fully insured employers, and presumably did not include estimated costs for self-insured governmental entities, such as most State, County and Municipal government and school district employees.

A group of carriers and self-insured employers challenged the mandatory authorization provision, with concerns over decreased patient safety and increased costs with physician dispensing. Organizations such as the Workers' Compensation Research Institute (WCRI) have suggested through various data studies over several years that practitioner prescribing and dispensing can be associated with changes in prescribing behavior, including use of different medications, more medications, and more-expensive medications. Anecdotal evidence from Florida carriers supports the notion that many practitioners dispense questionable topical medications, and often charge anywhere from hundreds up to $2,000 for creams and gels that are available either over the counter, or at a pharmacy for a small fraction of the cost being charged when medical providers prescribe and dispense.

Legal Findings

On **March 27, 2023,** an Administrative Law Judge (ALJ) issued a Final Order in DOAH Case No.: 23-0276RP finding that DFS/Division has rule-making authority to interpret the Law to mean that injured workers have a free, full and absolute choice as to where they wish to obtain their workers' compensation medications. This choice is conditioned upon the definition of a "pharmacy" over which the injured worker has the right to choose as provided for in Section 440.13(3)(j), Florida Statutes and since the medical provider can dispense medications, this makes him/her a pharmacy. This finding by the ALJ was totally a reversal of a prior ALJ's decision adopted by the Department/Division that had ruled the medical practitioner is not a pharmacy or pharmacist.

This case and its determinations defining a "pharmacy" have been appealed.

Basis of Appeal

In general, the basis of the appeal is that:

- The plain language of the Law gives the employee the choice of pharmacy or pharmacist, nothing more.
- Pharmacists, doctors and nurses are each educated and licensed differently, and are not legally the same under the Law.
- The Law gives the carrier the right to authorize all other providers, and to limit what each, non-pharmacy provider is authorized to do. The Proposed Rules intrude upon this carrier right, and the DFS/DWC has no authority to determine by rule that a carrier must authorize practitioner dispensing.

Legislative Action Taken in Regards to Proposed Rules

It should be noted that the Legislature pursuant to §120.541(3), F.S., has ratified the proposed rules related to providers prescribing and dispensing medication. (See Summary of HB 487.) This was done since these rules, if adopted, would create costs in excess of one million dollars over a period of 5 years. However, such ratification would not affect the legality of the proposed rules.

Legislative Branch

The vast majority of bills filed during the 2023 Legislative Session as related to workers' compensation did not pass. The following summarized legislation related to workers' compensation did pass. See previous Newsletter for summary of bills related to workers' compensation that were introduced but did not pass.

CS for CS for SB 1550 – The bill creates an amendment to the Florida Drug and Cosmetic Act described as the "Prescription Drug Reform Act." The bill in part relates to the announcement of drug price increases by manufacturers including non-resident prescription drug manufacturers and what caused the increase creating a justification for such increases. The notice is provided to the Agency for Healthcare Administration. The bill also concerns pharmacy benefit managers' transparency and accountability concerning contracts between a pharmacy benefit manager and participating pharmacies and Health Maintenance Organizations, prohibited practices for pharmacy benefit managers, investigations and examinations of pharmacy benefit managers and

the filing of annual financial statements. The bill passed defines "pharmacy benefit plans or programs" and specifically states that "the term excludes such a plan or program under Chapter 440." The term "pharmacy" however is defined vastly liberalized potentially having an effect on the definition of a "pharmacy" as defined in Chapter 440 relating to a claimant's ability to select a dispensing physician as a "pharmacy" allowing for the injured worker to choose the pharmacy for drug dispensing.

HB 487 – This bill authorizes, rather than requires, a Judge of Compensation Claims to order an injured worker's evaluation by an Expert Medical Advisor when medical opinions differ. The bill also limits the three-member panel from determining statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by hospitals and ambulatory surgical centers. These entities shall be reimbursed on either the agreed upon contract price or the maximum reimbursement allowance in the appropriate schedules. The bill deletes the three-member panel's jurisdiction to recommend maximum reimbursement allowances for physicians, work hardening programs, pain programs and durable medical equipment (non-hospital medical services). Annually, the Department will notify the carrier and self-insurers of medical providers and non-hospital services of maximum reimbursement allowances. This Notice does not include reimbursement for prescription medication. Maximum reimbursement allowances begin on January 1 following the July 1, 2024 notice of the medical provider and non-hospital services. Physician maximum reimbursement for services rendered shall be 110% of the reimbursement allowed by Medicare and 140% of reimbursement allowed by Medicare for surgical procedures or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater, or the medical reimbursement level adopted by the three-member panel as of January 1, 2023, whichever is less. Maximum reimbursement for surgical procedures is 140% of the reimbursement allowed by Medicare or the reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater. Outpatient reimbursement for scheduled surgeries is 60% of charges. Section 626.9892, Florida Statutes, was amended to allow the Department to pay up to a $25,000 reward to persons providing information leading to the arrest of persons committing crimes investigated by the Department arising from violations of Section 440.105, Florida Statutes. Previous statutory provision allowed for the payment of a reward only if the informant provided information that lead to an arrest and conviction of persons committing crimes as provided for in Section 440.105, Florida Statutes, who had been investigated by the Department. Since the requested fee schedules above summarized increased payments of one million dollars ($1,000,000) over a five-year, legislative ratification was required to legally validate the rules. Section 120.541(3), Florida Statutes, required ratification of a proposed rule. The proposed rules above referenced were ratified by the Legislature as provided for in this bill. The bill specifically states that "This section does not cure any rulemaking defect or preempt any challenge based on a lack of authority or a violation of the legal requirements governing the adoption of any rule cited." The rules above referenced were ratified by the Legislature but an appeal has been taken on the legality of the rules. These rule changes related to increases in fees by health care providers titled "Florida Workers' Compensation Health Care Provider Reimbursement Manual" (Rule 69L-7.020 FAC); "Health Care Provider Medical Billing" (Rule 69L-7.730, FAC); and "Insurer Authorization and Medical Bill Review Responsibilities" (Rule 7.740, FAC). Rule 69L-7.020 FAC relates to the adoption of an updated Fee Schedule for health care providers (which has subsequently been filed by the Department) and proposed Rules 7.730 and 7.740, FAC relate to health care providers prescribing and dispensing medications. (Currently on appeal to the Florida District Court of Appeals.)

CS for SB1552 – The bill relates to pharmacy benefit managers which, according to the above summary, does not include such programs as provided for in Chapter 440. However, if applicable, this bill states that there is a public records exemption for the books and records of administrators held by the Office of Insurance Regulation for purposes of examination, audit, and inspection to incorporate the inclusion of pharmacy benefit managers as administrators under the Florida Insurance Code.

CS/CS/HB 535 – Cited as the "Respecting their Sacrifice Act", this bill allows for the head of a law enforcement agency to authorize travel expenses for an employee of the agency whose duties are those of a law enforcement officer to attend a funeral service within the state of Florida of a law enforcement officer who was killed in the line of duty. If a full-time law enforcement correctional or a correctional probation officer is killed in the line of duty while the officer is engaged in the performance of law enforcement duties or as a result of an assault against the officer under riot conditions, the sum of $10,000 is payable toward the funeral and burial expenses of such officer. Previously, the funeral and burial expenses totaled $1,000. For law enforcement officers attending a funeral for another law enforcement officer, administrative leave not to exceed 8 hours may be granted. Such administrative leave may be denied in order to maintain adequate staffing requirements. If a motor vehicle of the state is used, the term "official state business" shall be construed to permit the use of such a vehicle to attend the funeral service.

CS for SB 914 – This bill concerns first responder benefits based on PTSD. The diagnosed PTSD can be diagnosed in person or through telehealth by an authorized treating physician as provided for in Chapter 440, Florida Statutes. Renames Commission on Mental Health and Substance to Commission on Mental Health and Substance Use Disorder which is charged with the assessment of the adequacy of Florida's infrastructure including the state's 988 suicide and crisis life line system and other components of the state's crisis response services.

CS/CS/HB 1285 – Creates the Division of the State Guard within the Department of Military Affairs which shall be headed by a director who shall be appointed by and serve at the pleasure of the governor, subject to confirmation by the Senate. The Division is responsible for the organization, recruitment, training, equipping, management, and functions of the Florida State Guard. The Florida State Guard may be activated by order of the governor during a declared state of emergency for various reasons including to "protect and defend the people of Florida from threats to public safety," augment any existing state or local agency or to provide support to other states under the Emergency Management Assistance Compact as provided for in Chapter 252, Florida Statutes. While activated or in training, members of the Florida State Guard are considered volunteers for the state as defined in Section 440.02(15)(d)6, Florida Statutes.

CS/CS/HB 837 (Tort Reform) – Evidence offered in a civil case of action to prove past and future medical expenses can include medical paid for workers' compensation benefits. Such past medical payments shall be limited to the amount actually paid. If the injured party is required to pay unpaid medical charges, such evidence would be admissible. (If the workers' compensation case has not been settled or otherwise resolved, there should be no amount admissible as evidence of past medical except in regards to possibly providing credit for the employer/carrier's rights to collect on lien payments in accordance with Section 440.39, Florida Statutes.)

Judicial Branch

The following are summaries of cases decided by the First District Court of Appeals since January 1, 2023 that relate to Workers' Compensation issues:

Alvero v. Watermark Retirement Communities
48 FLW D15
12/21/2022

The JCC found that the claimant while exiting a break room on the employer's premises fell and injured herself. The claimant testified that she did not know why she fell. Court reaffirmed its decision in *Soya v. Healthfirst Inc.,* 337 So. 3d 388(Fla. 1st DCA 2022) and determined that an incident on the job caused by unknown reasons was compensable under the workers' compensation law.

Williams v. Brevard County Fire Rescue
48 FLW D32
12/28/2022

Case Affirmed on Appeal because the expert medical advisor's testimony adopted by the Judge of Compensation Claims supported the conclusion reached by the Judge.

First responder claimants can seek workers' compensation benefits for PTSD under either Section 112.1815(2)(a)3 or paragraph (5), Florida Statutes, or both. However, the fact that benefits could be obtained from either of these sources did not alter the outcome of this case. In Concurring Opinion, judge explained that recovery for this first responder allegedly diagnosed with a post-traumatic stress disorder could collect medical benefits even where no physical injury accompanies the injury if PTSD had not been found to exist. (See Section 112.1815(2)(a)3, Florida Statutes or subsection 112.1815(5), Florida Statutes, which allows for medical and indemnity benefits for PTSD employing first responders with 11 specific events.)

Andrews v. McKim & Creed
48 FLW D263
2/1/2023

Claimant requested a one-time change in physicians that was not timely responded to by the employer/carrier. Thereafter a Petition for Benefits was filed seeking the one-time change of physician. That petition was subsequently dismissed by the injured worker. A second petition was filed requesting a one-time change. That request was timely responded to (within 5 days of the second request for a change in physician). Court determined that the claimant's request for a second doctor was not waived by the claimant as a result of the dismissal of the petition.

When the employer/carrier fails to timely respond to a request for a one-time change in doctors made by the claimant, the claimant obtains a vested right to an alternate doctor chosen by the claimant. Dismissal of the first petition did not constitute a waiver of this vested right so long as the claimant did not attend an appointment with the employer/carrier's selected alternate physician. The claimant's voluntary dismissal of the first petition did not automatically extinguish his request for an alternate physician nor waive the request.

The one-time change provision of Section 440.13(2)(f), Florida Statutes, is triggered by a claimant's written request for this benefit. The filing of a Petition for Benefits is not required to initiate the window for response by the employer/carrier although it does satisfy the definition of a written request. The claimant in this instance initiated his request for the one-time change via correspondence, not by the filing of a Petition for Benefits. He later filed a Petition for Benefits for enforcement purposes. The Petition for Benefits is required to secure jurisdiction with the JCC if the employer/carrier does not timely respond to the request for alternate medical care. This right does not require a pre-requisite showing a medical necessity and/or causation.

The employer/carrier asserted that the claimant had waived his right of selection of an alternate physician by voluntarily dismissing the first petition. Waiver and estoppel are affirmative defenses which must be planned carefully or forever waived. Affirmative defenses must also be timely raised by the parties seeking to avoid responsibility or consequences. The party raising affirmative defenses has the burden of pleading and proving. Court determined that neither waiver nor estoppel existing in this instance.

Concurring opinion in result only.

Wolfe v. Ruby
48 FLW D718
4/5/2023

Judges of Workers' Compensation Claims are vested only with certain limited quasi judicial powers relating to the adjudication of claims for compensation benefits. Unlike general jurisdiction courts, a Judge of Compensation Claims does not have inherent judicial power but only the power expressly conferred by Chapter 440. Courts of Compensation Claims are not courts of general jurisdiction.

In accordance with 440.02(17)(c), Florida Statutes, domestic servants in private homes are excluded from the definition of "employment."

The claimant, who was a domestic servant, filed a Motion for Final Summary Order of Dismissal for lack of subject matter jurisdiction and attached to the motion an affidavit stating that she did not operate a business at a private residence. In opposition to this motion, the alleged employer objected to the affidavit on the basis that the affidavit was an unauthenticated hearsay statement, reliance upon which is not a sufficient basis to merit a Summary Final Order.

Court determined that a threshold question for subject matter jurisdiction is analogous to a Motion to Dismiss for lack of personal jurisdiction in a civil cause of action. The proper method for objecting to subject matter jurisdiction is through a Motion to Dismiss rather than by a Motion for Summary Final Order. In considering the Motion to Dismiss challenging subject matter jurisdiction, a trial court may properly go beyond the four corners of the complaint and consider affidavits. Such Motion to Dismiss challenging jurisdictional allegations of a complaint may be made by filing a Motion to Dismiss but most be supported by the affidavit. Once a Motion to Dismiss with an affidavit demonstrating that the OJCC did not have subject matter jurisdiction, the burden shifted to the appellee to provide a competing affidavit establishing subject matter jurisdiction.

In this case, appellee failed to carry her burden by providing a competing affidavit demonstrating that the OJCC has subject matter jurisdiction. In this case, there was no dispute that the appellee was providing housekeeping services in a private home. The Judge of Compensation Claims lacked subject matter jurisdiction.

Ortiz v. Winn Dixie
48 FLW D1107
5/31/2023

The question in this case was whether medical care was provided to the injured worker thereby tolling the running of the statute of limitations for one year in accordance with Section 440.19(2), Florida Statutes. The court determined that medical treatment provided to the claimant within the one-year tolling period for the provision of medical care was not linked to her underlying compensable injury. JCC determined that medical care was not provided to the claimant tolling the running of the statute of limitations since there was no showing that the claimant's medical care for the one-year limitation period was related to her compensable accident. Just simply seeing an authorized provider does not rise to a finding that the carrier had "furnished" care and treatment at those visits, as the terms is used in Section 440.19(2), Florida Statutes.

Court referenced the two-year statute of limitations as the "master limitation timer." In describing the procedures and proof necessary to assert a statute of limitations defense, court determined that the carrier bore the initial burden to produce evidence establishing a greater than a two-year gap between the date of injury and the date the Petition for Benefits was filed. (Because running of the statute of limitations is an affirmative defense, the employer has the burden of raising that defense and proving that the petitions for benefits were untimely.) Once the carrier did, the burden shifted to the claimant to avoid the statute of limitations with proof demonstrating that there in fact was still time remaining on the master two-year limitation timer. The claimant has the burden of establishing this exception to the master limitation time period, even if the tolling timer (medical care) had hit zero. To enable this alternate way of proving that the statute of limitations had not run, the claimant would have to present evidence of the time period between the date of accident and the date the initial claim was filed. During every period between the expiration of one tolling period and the start of another must then be determined. If the total sum of tolling events (receiving medical care) ended up being under two years, then the limitation period would not have run yet. The claimant in this instance did not pursue this form of avoidance for the running of the statute.

In this case, the claimant did not take the position as above outlined but presented evidence that the tolling timer had re-set and was still running such that the limitation timer could not have reached zero. In this scenario, the claimant would have to show that the carrier furnished remedial treatment and care at one-half of her last doctor visits. In this case, there was no question that the employer/carrier was authorized to provide care for her compensable injury. However, authorization is not the same as furnishing treatment or care under Section 440.19(2), Florida Statutes. In order to trigger the tolling of the running of the statute of limitations pursuant to 440.19(2), Florida Statutes, either the carrier must have authorized the specific treatment or the authorized provider must have treated the employee pursuant to the previous approved treatment plan. The mere fact of visiting the authorized physician, regardless of the purpose or motive for the visit is sufficient to toll the running of the statute of limitations. Concurring opinion in result.

Churchill v. DBI Services LLC
48 FLW D1110
5/31/2023

Petition for Benefits filed by claimant's attorney for the payment of medical expenses which in part was paid by the employer/carrier. The acceptance of the partial payment of medical did not occur within 30 days of the date of the petition. Through the filing of the petition, court determined that this acceptance of medicals created entitlement to an attorney's fee. Case remanded to JCC to determine the amount of fees for securing the payment of certain medical bills.

Upon the filing of a Petition for Benefits, the employer/carrier has three choices - pay, pay and investigate, or deny. In this instance, the employer/carrier began to pay benefits without a "pay and investigate letter." The employer/carrier who has furnished benefits are deemed to have accepted the employee's injuries as compensable or to have waived the right to deny compensability unless it can be established that material facts relevant to the issue of compensability could not have been discovered through a reasonable investigation within the 120 day period. See Sections 440.192(8), 440.20(4), Florida Statutes. The employer/carrier's election to delay their decision about compensability by "paying and investigating" requires written notice to the injured worker pursuant to Section 440.20(4), Florida Statutes. The letter does not start the 120 day period. Rather, the initial provision of compensation or benefits does. Only the letter invokes the right to rely on the pay and investigate statutory mechanism. The employer/carrier has the burden to prove that they gave the injured worker written notice to pay and investigate. In this case, the claimant was not given written notice "upon commencement of payment." Court determined that 59 days between commencement of payment of benefits and the written notice invoking "pay and investigate" is too long a period between denial of benefits without notice to claimant.

In distinguishing between the facts in this instance and the case of *Checkers Restaurant v. Wiethoff*, 925 So. 2d 348, there was a recognition by the Court that there is a distinction between the concept of filing a Notice of Denial based on compensability and a worker's entitlement to benefits as those terms are contemplated in Section 440.24, Florida Statutes. The issue in this case is compensability while in *Checkers*, the issue was entitlement to benefits if an accident was compensable. In the *Checkers* case, the issue was entitlement to benefits and the employer/carrier's failure to provide Notice of Denial does not negate application of Section 440.20(4), Florida Statutes, waiver when the employer/carrier does not deny compensability within 120 days of the initial provision of benefits. In this case, the issue was compensability and the failure to file a pay and investigate notice must be given when benefits were initially paid.

Section 440.30, Florida Statutes, provides that depositions in connection with workers' compensation proceedings may be taken in the same manner and subject to the same rules as in civil actions in circuit court. See also Rule 60Q-6.114(2). The JCC's determination that the Florida Rules of Civil Procedure had no application to depositions in workers' compensation cases was incorrect. In this case, the claimant had filed a Motion for the Appointment of a Corporate Representative in accordance with the Rules of Civil Procedure. If the designated corporate representative cannot answer questions about the designated subject matters, the corporation has violated its Rule 1.310(b)(6) obligation and may be subject to sanctions by the court.