SENATE AMENDMENT

Bill No. CS for CS for SB 1206, 1st Eng.

Amendment No. ___

CHAMBER ACTION

Senate	House
. . . . . .	

Senator Kirkpatrick moved the following amendment:

Senate Amendment (with title amendment)

On page 63, line 30, through page 64, line 8, delete those lines

and insert:

Section 41. Present subsection (3) of section 440.02, Florida Statutes, is redesignated as subsection (4), a new subsection (3) is added to that section and subsequent subsections are redesignated, and subsections (11) and (13) are amended to read:

440.02 Definitions.--When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(3) "Agency" means the Agency for Health Care Administration.

(11) "Department" means the Department of Insurance ~~Labor and Employment Security~~.

(13) "Division" means the Division of Workers' Compensation of the Department of Insurance ~~Labor and~~

~~Employment Security~~.

Section 42. Subsections (3), (4), (5), (6), (7), (8), (9), (11), (12), and (13) of section 440.13, Florida Statutes, are amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.--

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.--

(a) As a condition to eligibility for payment under this chapter, a health care provider who renders services must be a certified health care provider and must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care. The agency ~~division~~ shall adopt rules to implement the certification of health care providers. As a one-time prerequisite to obtaining certification, the agency ~~division~~ shall require each physician to demonstrate proof of completion of a minimum 5-hour course that covers the subject areas of cost containment, utilization control, ergonomics, and the practice parameters adopted by the agency ~~division~~ governing the physician's field of practice. The agency ~~division~~ shall coordinate with ~~the Agency for Health Care Administration,~~the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Chiropractic Association, the Florida Podiatric Medical Association, the Florida Optometric Association, the Florida Dental Association, and other health professional organizations and their respective boards as deemed necessary by the agency ~~Agency for Health Care Administration~~ in complying with this subsection. No later than October 1, 1994, the agency ~~division~~ shall adopt rules regarding the criteria and procedures for approval of courses and the filing of proof of completion by the physicians.

(b) A health care provider who renders emergency care must notify the carrier by the close of the third business day after it has rendered such care. If the emergency care results in admission of the employee to a health care facility, the health care provider must notify the carrier by telephone within 24 hours after initial treatment. Emergency care is not compensable under this chapter unless the injury requiring emergency care arose as a result of a work-related accident. Pursuant to chapter 395, all licensed physicians and health care providers in this state shall be required to make their services available for emergency treatment of any employee eligible for workers' compensation benefits. To refuse to make such treatment available is cause for revocation of a license.

(c) A health care provider may not refer the employee to another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the carrier, except when emergency care is rendered. Any referral must be to a health care provider that has been certified by the agency ~~division~~, unless the referral is for emergency treatment.

(d) A carrier must respond, by telephone or in writing, to a request for authorization by the close of the third business day after receipt of the request. A carrier who fails to respond to a written request for authorization for referral for medical treatment by the close of the third business day after receipt of the request consents to the medical necessity for such treatment. All such requests must be made to the carrier. Notice to the carrier does not include notice to the employer.

(e) Carriers shall adopt procedures for receiving, reviewing, documenting, and responding to requests for

authorization. Such procedures shall be for a health care provider certified under this section.

(f) By accepting payment under this chapter for treatment rendered to an injured employee, a health care provider consents to the jurisdiction of the agency ~~division~~ as set forth in subsection (11) and to the submission of all records and other information concerning such treatment to the agency ~~division~~ in connection with a reimbursement dispute, audit, or review as provided by this section. The health care provider must further agree to comply with any decision of the agency ~~division~~ rendered under this section.

(g) The employee is not liable for payment for medical treatment or services provided pursuant to this section except as otherwise provided in this section.

(h) The provisions of s. 455.654 are applicable to referrals among health care providers, as defined in subsection (1), treating injured workers.

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other specialty services that the agency ~~division~~ identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, or unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall not refuse to authorize such consultation or procedure unless the health care provider or facility is not authorized or certified or unless an expert medical advisor has determined that the consultation or procedure is not medically necessary or

otherwise compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to identify and disallow overutilization or billing errors.

(j) Notwithstanding anything in this chapter to the contrary, a sick or injured employee shall be entitled, at all times, to free, full, and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines required under this chapter. It is expressly forbidden for the agency ~~division~~, an employer, or a carrier, or any agent or representative of the agency ~~division~~, an employer, or a carrier to select the pharmacy or pharmacist which the sick or injured employee must use; condition coverage or payment on the basis of the pharmacy or pharmacist utilized; or to otherwise interfere in the selection by the sick or injured employee of a pharmacy or pharmacist.

(4) NOTICE OF TREATMENT TO CARRIER; FILING WITH AGENCY ~~DIVISION~~.--

(a) Any health care provider providing necessary remedial treatment, care, or attendance to any injured worker shall submit treatment reports to the carrier in a format prescribed by the agency ~~division~~. A claim for medical or surgical treatment is not valid or enforceable against such employer or employee, unless, by the close of the third business day following the first treatment, the physician providing the treatment furnishes to the employer or carrier a preliminary notice of the injury and treatment on forms prescribed by the agency ~~division~~ and, within 15 days

thereafter, furnishes to the employer or carrier a complete report, and subsequent thereto furnishes progress reports, if requested by the employer or insurance carrier, at intervals of not less than 3 weeks apart or at less frequent intervals if requested on forms prescribed by the agency ~~division~~.

(b) Each medical report or bill obtained or received by the employer, the carrier, or the injured employee, or the attorney for the employer, carrier, or injured employee, with respect to the remedial treatment or care of the injured employee, including any report of an examination, diagnosis, or disability evaluation, must be filed with the Agency for Health Care Administration ~~Division of Workers' Compensation~~ pursuant to rules adopted by the agency ~~division~~. The health care provider shall also furnish to the injured employee or to his or her attorney, on demand, a copy of his or her office chart, records, and reports, and may charge the injured employee an amount authorized by the agency ~~division~~ for the copies. Each such health care provider shall provide to the agency ~~division~~ any additional information about the remedial treatment, care, and attendance that the agency ~~division~~ reasonably requests.

(c) It is the policy for the administration of the workers' compensation system that there be reasonable access to medical information by all parties to facilitate the self-executing features of the law. Notwithstanding the limitations in s. 455.667 and subject to the limitations in s. 381.004, upon the request of the employer, the carrier, or the attorney for either of them, the medical records of an injured employee must be furnished to those persons and the medical condition of the injured employee must be discussed with those persons, if the records and the discussions are restricted to

conditions relating to the workplace injury. Any such discussions may be held before or after the filing of a claim without the knowledge, consent, or presence of any other party or his or her agent or representative. A health care provider who willfully refuses to provide medical records or to discuss the medical condition of the injured employee, after a reasonable request is made for such information pursuant to this subsection, shall be subject by the agency ~~division~~ to one or more of the penalties set forth in paragraph (8)(b).

(5) INDEPENDENT MEDICAL EXAMINATIONS.--

(a) In any dispute concerning overutilization, medical benefits, compensability, or disability under this chapter, the carrier or the employee may select an independent medical examiner. The examiner may be a health care provider treating or providing other care to the employee. An independent medical examiner may not render an opinion outside his or her area of expertise, as demonstrated by licensure and applicable practice parameters.

(b) Each party is bound by his or her selection of an independent medical examiner and is entitled to an alternate examiner only if:

1. The examiner is not qualified to render an opinion upon an aspect of the employee's illness or injury which is material to the claim or petition for benefits;

2. The examiner ceases to practice in the specialty relevant to the employee's condition;

3. The examiner is unavailable due to injury, death, or relocation outside a reasonably accessible geographic area; or

4. The parties agree to an alternate examiner.

Any party may request, or a judge of compensation claims may require, designation of an agency ~~a division~~ medical advisor as an independent medical examiner. The opinion of the advisors acting as examiners shall not be afforded the presumption set forth in paragraph (9)(c).

(c) The carrier may, at its election, contact the claimant directly to schedule a reasonable time for an independent medical examination. The carrier must confirm the scheduling agreement in writing within 5 days and notify claimant's counsel, if any, at least 7 days before the date upon which the independent medical examination is scheduled to occur. An attorney representing a claimant is not authorized to schedule independent medical evaluations under this subsection.

(d) If the employee fails to appear for the independent medical examination without good cause and fails to advise the physician at least 24 hours before the scheduled date for the examination that he or she cannot appear, the employee is barred from recovering compensation for any period during which he or she has refused to submit to such examination. Further, the employee shall reimburse the carrier 50 percent of the physician's cancellation or no-show fee unless the carrier that schedules the examination fails to timely provide to the employee a written confirmation of the date of the examination pursuant to paragraph (c) which includes an explanation of why he or she failed to appear. The employee may appeal to a judge of compensation claims for reimbursement when the carrier withholds payment in excess of the authority granted by this section.

(e) No medical opinion other than the opinion of a medical advisor appointed by the judge of compensation claims

or agency ~~division~~, an independent medical examiner, or an authorized treating provider is admissible in proceedings before the judges of compensation claims.

(f) Attorney's fees incurred by an injured employee in connection with delay of or opposition to an independent medical examination, including, but not limited to, motions for protective orders, are not recoverable under this chapter.

(6) UTILIZATION REVIEW.--Carriers shall review all bills, invoices, and other claims for payment submitted by health care providers in order to identify overutilization and billing errors, and may hire peer review consultants or conduct independent medical evaluations. Such consultants, including peer review organizations, are immune from liability in the execution of their functions under this subsection to the extent provided in s. 766.101. If a carrier finds that overutilization of medical services or a billing error has occurred, it must disallow or adjust payment for such services or error without order of a judge of compensation claims or the agency ~~division~~, if the carrier, in making its determination, has complied with this section and rules adopted by the agency ~~division~~.

(7) UTILIZATION AND REIMBURSEMENT DISPUTES.--

(a) Any health care provider, carrier, or employer who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 30 days after receipt of notice of disallowance or adjustment of payment, petition the agency ~~division~~ to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a

petitioner to submit such documentation to the agency ~~division~~ results in dismissal of the petition.

(b) The carrier must submit to the agency ~~division~~ within 10 days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to submit the requested documentation to the agency ~~division~~ within 10 days constitutes a waiver of all objections to the petition.

(c) Within 60 days after receipt of all documentation, the agency ~~division~~ must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The agency ~~division~~ must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, in rendering its determination.

(d) If the agency ~~division~~ finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider, facility, insurer, or employer within 30 days, subject to the penalties provided in this subsection.

(e) The agency ~~division~~ shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a petitioner and expanding the timetable for rendering a determination upon a consolidated petition.

(f) Any carrier that engages in a pattern or practice of arbitrarily or unreasonably disallowing or reducing payments to health care providers may be subject to one or more of the following penalties imposed by the agency ~~division~~:

1. Repayment of the appropriate amount to the health

care provider.

2. An administrative fine assessed by the agency ~~division~~ in an amount not to exceed $5,000 per instance of improperly disallowing or reducing payments.

3. Award of the health care provider's costs, including a reasonable attorney's fee, for prosecuting the petition.

(8) PATTERN OR PRACTICE OF OVERUTILIZATION.--

(a) Carriers must report to the agency ~~division~~ all instances of overutilization including, but not limited to, all instances in which the carrier disallows or adjusts payment. The agency ~~division~~ shall determine whether a pattern or practice of overutilization exists.

(b) If the agency ~~division~~ determines that a health care provider has engaged in a pattern or practice of overutilization or a violation of this chapter or rules adopted by the agency ~~division~~, it may impose one or more of the following penalties:

1. An order of the agency ~~division~~ barring the provider from payment under this chapter;

2. Deauthorization of care under review;

3. Denial of payment for care rendered in the future;

4. Decertification of a health care provider certified as an expert medical advisor under subsection (9) or of a rehabilitation provider certified under s. 440.49;

5. An administrative fine assessed by the agency ~~division~~ in an amount not to exceed $5,000 per instance of overutilization or violation; and

6. Notification of and review by the appropriate licensing authority pursuant to s. 440.106(3).

(9) EXPERT MEDICAL ADVISORS.--

(a) The agency ~~division~~ shall certify expert medical advisors in each specialty to assist the agency ~~division~~ and the judges of compensation claims within the advisor's area of expertise as provided in this section. The agency ~~division~~ shall, in a manner prescribed by rule, in certifying, recertifying, or decertifying an expert medical advisor, consider the qualifications, training, impartiality, and commitment of the health care provider to the provision of quality medical care at a reasonable cost. As a prerequisite for certification or recertification, the agency ~~division~~ shall require, at a minimum, that an expert medical advisor have specialized workers' compensation training or experience under the workers' compensation system of this state and board certification or board eligibility.

(b) The agency ~~division~~ shall contract with or employ expert medical advisors to provide peer review or medical consultation to the agency ~~division~~ or to a judge of compensation claims in connection with resolving disputes relating to reimbursement, differing opinions of health care providers, and health care and physician services rendered under this chapter. Expert medical advisors contracting with the agency ~~division~~ shall, as a term of such contract, agree to provide consultation or services in accordance with the timetables set forth in this chapter and to abide by rules adopted by the agency ~~division~~, including, but not limited to, rules pertaining to procedures for review of the services rendered by health care providers and preparation of reports and recommendations for submission to the agency ~~division~~.

(c) If there is disagreement in the opinions of the health care providers, if two health care providers disagree on medical evidence supporting the employee's complaints or

the need for additional medical treatment, or if two health care providers disagree that the employee is able to return to work, the agency ~~division~~ may, and the judge of compensation claims shall, upon his or her own motion or within 15 days after receipt of a written request by either the injured employee, the employer, or the carrier, order the injured employee to be evaluated by an expert medical advisor. The opinion of the expert medical advisor is presumed to be correct unless there is clear and convincing evidence to the contrary as determined by the judge of compensation claims. The expert medical advisor appointed to conduct the evaluation shall have free and complete access to the medical records of the employee. An employee who fails to report to and cooperate with such evaluation forfeits entitlement to compensation during the period of failure to report or cooperate.

(d) The expert medical advisor must complete his or her evaluation and issue his or her report to the agency ~~division~~ or to the judge of compensation claims within 45 days after receipt of all medical records. The expert medical advisor must furnish a copy of the report to the carrier and to the employee.

(e) An expert medical advisor is not liable under any theory of recovery for evaluations performed under this section without a showing of fraud or malice. The protections of s. 766.101 apply to any officer, employee, or agent of the agency ~~division~~ and to any officer, employee, or agent of any entity with which the agency ~~division~~ has contracted under this subsection.

(f) If the agency ~~division~~ or a judge of compensation claims determines that the services of a certified expert medical advisor are required to resolve a dispute under this

section, the carrier must compensate the advisor for his or her time in accordance with a schedule adopted by the agency ~~division~~. The agency ~~division~~ may assess a penalty not to exceed $500 against any carrier that fails to timely compensate an advisor in accordance with this section.

(11) AUDITS BY AGENCY ~~DIVISION~~; JURISDICTION.--

(a) The Agency for Health Care Administration ~~Division of Workers' Compensation of the Department of Labor and Employment Security~~ may investigate health care providers to determine whether providers are complying with this chapter and with rules adopted by the agency ~~division~~, whether the providers are engaging in overutilization, and whether providers are engaging in improper billing practices. If the agency ~~division~~ finds that a health care provider has improperly billed, overutilized, or failed to comply with agency ~~division~~ rules or the requirements of this chapter it must notify the provider of its findings and may determine that the health care provider may not receive payment from the carrier or may impose penalties as set forth in subsection (8) or other sections of this chapter. If the health care provider has received payment from a carrier for services that were improperly billed or for overutilization, it must return those payments to the carrier. The agency ~~division~~ may assess a penalty not to exceed $500 for each overpayment that is not refunded within 30 days after notification of overpayment by the agency ~~division~~ or carrier.

(b) The agency ~~division~~ shall monitor and audit carriers to determine if medical bills are paid in accordance with this section and agency ~~division~~ rules. Any employer, if self-insured, or carrier found by the agency ~~division~~ not to be within 90 percent compliance as to the payment of medical

bills after July 1, 1994, must be assessed a fine not to exceed 1 percent of the prior year's assessment levied against such entity under s. 440.51 for every quarter in which the entity fails to attain 90-percent compliance. The agency ~~division~~ shall fine an employer or carrier, pursuant to rules adopted by the agency ~~division~~, for each late payment of compensation that is below the minimum 90-percent performance standard. Any carrier that is found to be not in compliance in subsequent consecutive quarters must implement a medical-bill review program approved by the agency ~~division~~, and the carrier is subject to disciplinary action by the Department of Insurance.

(c) The agency ~~division~~ has exclusive jurisdiction to decide any matters concerning reimbursement, to resolve any overutilization dispute under subsection (7), and to decide any question concerning overutilization under subsection (8), which question or dispute arises after January 1, 1994.

(d) The following ~~division~~ actions do not constitute agency action subject to review under ss. 120.569 and 120.57 and do not constitute actions subject to s. 120.56: referral by the entity responsible for utilization review; a decision by the agency ~~division~~ to refer a matter to a peer review committee; establishment by a health care provider or entity of procedures by which a peer review committee reviews the rendering of health care services; and the review proceedings, report, and recommendation of the peer review committee.

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.--

(a) A three-member panel is created, consisting of the Insurance Commissioner, or the Insurance Commissioner's designee, and two members to be appointed by the Governor,

subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification manual as determined by the agency ~~division~~. All compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges. Until the three-member panel approves a schedule of per diem rates for inpatient hospital care and it becomes effective, all compensable charges for hospital inpatient care must be reimbursed at 75 percent of their usual and customary charges. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. However, the maximum percentage of increase in the individual reimbursement allowance may not exceed the percentage of increase in the Consumer Price Index for the previous year. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the usual and customary charge for treatment, care, and attendance, the

agreed-upon contract price, or the maximum reimbursement allowance in the appropriate schedule, whichever is less.

(b) As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price times 1.2 plus $4.18 for the dispensing fee, except where the carrier has contracted for a lower amount. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower.

(c) Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, ambulatory surgical center, work-hardening program, or pain program, must not exceed the amounts provided by the uniform schedule of maximum reimbursement allowances as determined by the panel or as otherwise provided in this section. This subsection also applies to independent medical examinations performed by health care providers under this chapter. Until the three-member panel approves a uniform schedule of maximum reimbursement allowances and it becomes effective, all compensable charges for treatment, care, and attendance provided by physicians, ambulatory surgical centers, work-hardening programs, or pain programs shall be reimbursed at the lowest maximum reimbursement allowance across all 1992 schedules of maximum reimbursement allowances for the services provided regardless of the place of service. In determining the uniform schedule, the panel shall first

approve the data which it finds representative of prevailing charges in the state for similar treatment, care, and attendance of injured persons. Each health care provider, health care facility, ambulatory surgical center, work-hardening program, or pain program receiving workers' compensation payments shall maintain records verifying their usual charges. In establishing the uniform schedule of maximum reimbursement allowances, the panel must consider:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers;

2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will ensure the availability of treatment, care, and attendance required by injured workers;

3. The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.401, and its effect upon their ability to make available to injured workers such medically necessary remedial treatment, care, and attendance. The uniform schedule of maximum reimbursement allowances must be reasonable, must promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers; and

4. The most recent average maximum allowable rate of increase for hospitals determined by the Health Care Board under chapter 408.

(13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE

AUTHORIZED TO RENDER MEDICAL CARE.--The agency ~~division~~ shall remove from the list of physicians or facilities authorized to provide remedial treatment, care, and attendance under this chapter the name of any physician or facility found after reasonable investigation to have:

(a) Engaged in professional or other misconduct or incompetency in connection with medical services rendered under this chapter;

(b) Exceeded the limits of his or her or its professional competence in rendering medical care under this chapter, or to have made materially false statements regarding his or her or its qualifications in his or her application;

(c) Failed to transmit copies of medical reports to the employer or carrier, or failed to submit full and truthful medical reports of all his or her or its findings to the employer or carrier as required under this chapter;

(d) Solicited, or employed another to solicit for himself or herself or itself or for another, professional treatment, examination, or care of an injured employee in connection with any claim under this chapter;

(e) Refused to appear before, or to answer upon request of, the agency ~~division~~ or any duly authorized officer of the state, any legal question, or to produce any relevant book or paper concerning his or her conduct under any authorization granted to him or her under this chapter;

(f) Self-referred in violation of this chapter or other laws of this state; or

(g) Engaged in a pattern of practice of overutilization or a violation of this chapter or rules adopted by the agency ~~division~~.

Section 43. Paragraph (a) of subsection (3) of section

440.15, Florida Statutes, is amended to read:

440.15 Compensation for disability.--Compensation for disability shall be paid to the employee, subject to the limits provided in s. 440.12(2), as follows:

(3) PERMANENT IMPAIRMENT AND WAGE-LOSS BENEFITS.--

(a) Impairment benefits.--

1. Once the employee has reached the date of maximum medical improvement, impairment benefits are due and payable within 20 days after the carrier has knowledge of the impairment.

2. The three-member panel, in cooperation with the agency ~~division~~, shall establish and use a uniform permanent impairment rating schedule. This schedule must be based on medically or scientifically demonstrable findings as well as the systems and criteria set forth in the American Medical Association's Guides to the Evaluation of Permanent Impairment; the Snellen Charts, published by American Medical Association Committee for Eye Injuries; and the Minnesota Department of Labor and Industry Disability Schedules. The schedule should be based upon objective findings. The schedule shall be more comprehensive than the AMA Guides to the Evaluation of Permanent Impairment and shall expand the areas already addressed and address additional areas not currently contained in the guides. On August 1, 1979, and pending the adoption, by rule, of a permanent schedule, Guides to the Evaluation of Permanent Impairment, copyright 1977, 1971, 1988, by the American Medical Association, shall be the temporary schedule and shall be used for the purposes hereof. For injuries after July 1, 1990, pending the adoption by division rule of a uniform disability rating schedule, the Minnesota Department of Labor and Industry Disability Schedule

shall be used unless that schedule does not address an injury. In such case, the Guides to the Evaluation of Permanent Impairment by the American Medical Association shall be used. Determination of permanent impairment under this schedule must be made by a physician licensed under chapter 458, a doctor of osteopathic medicine licensed under chapters 458 and 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, as appropriate considering the nature of the injury. No other persons are authorized to render opinions regarding the existence of or the extent of permanent impairment.

3. All impairment income benefits shall be based on an impairment rating using the impairment schedule referred to in subparagraph 2. Impairment income benefits are paid weekly at the rate of 50 percent of the employee's average weekly temporary total disability benefit not to exceed the maximum weekly benefit under s. 440.12. An employee's entitlement to impairment income benefits begins the day after the employee reaches maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier, and continues until the earlier of:

a. The expiration of a period computed at the rate of 3 weeks for each percentage point of impairment; or

b. The death of the employee.

4. After the employee has been certified by a doctor as having reached maximum medical improvement or 6 weeks before the expiration of temporary benefits, whichever occurs earlier, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating, using the impairment schedule referred to in subparagraph 2.

Compensation is not payable for the mental, psychological, or emotional injury arising out of depression from being out of work. If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation must be submitted to the treating doctor, and the treating doctor must indicate agreement or disagreement with the certification and evaluation. The certifying doctor shall issue a written report to the division, the employee, and the carrier certifying that maximum medical improvement has been reached, stating the impairment rating, and providing any other information required by the division. If the employee has not been certified as having reached maximum medical improvement before the expiration of 102 weeks after the date temporary total disability benefits begin to accrue, the carrier shall notify the treating doctor of the requirements of this section.

5. The carrier shall pay the employee impairment income benefits for a period based on the impairment rating.

6. The division may by rule specify forms and procedures governing the method of payment of wage loss and impairment benefits for dates of accidents before January 1, 1994, and for dates of accidents on or after January 1, 1994.

Section 44. Subsection (7) of section 440.491, Florida Statutes, is amended to read:

440.491 Reemployment of injured workers; rehabilitation.--

(7) PROVIDER QUALIFICATIONS.--

(a) The Agency for Health Care Administration ~~division~~ shall investigate and maintain a directory of each qualified public and private rehabilitation provider, facility, and agency, and shall establish by rule the minimum

qualifications, credentials, and requirements that each rehabilitation service provider, facility, and agency must satisfy to be eligible for listing in the directory. These minimum qualifications and credentials must be based on those generally accepted within the service specialty for which the provider, facility, or agency is approved.

(b) The agency ~~division~~ shall impose a biennial application fee of $25 for each listing in the directory, and all such fees must be deposited in the Workers' Compensation Administration Trust Fund.

(c) The agency ~~division~~ shall monitor and evaluate each rehabilitation service provider, facility, and agency qualified under this subsection to ensure its compliance with the minimum qualifications and credentials established by the division. The failure of a qualified rehabilitation service provider, facility, or agency to provide the agency ~~division~~ with information requested or access necessary for the agency ~~division~~ to satisfy its responsibilities under this subsection is grounds for disqualifying the provider, facility, or agency from further referrals.

(d) A qualified rehabilitation service provider, facility, or agency may not be authorized by an employer, a carrier, or the agency ~~division~~ to provide any services, including expert testimony, under this section in this state unless the provider, facility, or agency is listed or has been approved for listing in the directory. This restriction does not apply to services provided outside this state under this section.

(e) The agency ~~division~~, after consultation with representatives of employees, employers, carriers, rehabilitation providers, and qualified training and education

providers, shall adopt rules governing professional practices and standards.

(Redesignate subsequent sections.)

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

On page 8, lines 27-31, delete those lines

and insert:

federal law; amending s. 440.02, F.S.; providing a definition for the term "agency"; conforming definitions of "department" and "division" to the transfer of the Division of Workers' Compensation to the Department of Insurance; amending s. 440.13, F.S., relating to medical services and supplies under the workers' compensation law; reassigning certain functions from the Division of Workers' Compensation to the Agency for Health Care Administration; amending s. 440.15, F.S.; providing for the agency to participate in the establishment and use of a uniform permanent impairment rating schedule; amending s. 440.491, F.S.; providing for agency oversight of workers' compensation rehabilitation providers; amending s. 440.207, F.S.;