Bill No. CS for CS for CS for SB 2548, 1st Eng.

Amendment No. ___

CHAMBER ACTION

Senate		House
	.	

Senator Kirkpatrick moved the following amendment:

Senate Amendment (with title amendment)

On page 236, lines 12-21, delete those lines

and insert:

Section 120. 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 121. 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

1 provider certified under this section.
2 (f) By accepting payment under this chapter for
3 treatment rendered to an injured employee, a health care
4 provider consents to the jurisdiction of the agency ~~division~~
5 as set forth in subsection (11) and to the submission of all
6 records and other information concerning such treatment to the
7 agency ~~division~~ in connection with a reimbursement dispute,
8 audit, or review as provided by this section. The health care
9 provider must further agree to comply with any decision of the
10 agency ~~division~~ rendered under this section.
11 (g) The employee is not liable for payment for medical
12 treatment or services provided pursuant to this section except
13 as otherwise provided in this section.
14 (h) The provisions of s. 455.654 are applicable to
15 referrals among health care providers, as defined in
16 subsection (1), treating injured workers.
17 (i) Notwithstanding paragraph (d), a claim for
18 specialist consultations, surgical operations,
19 physiotherapeutic or occupational therapy procedures, X-ray
20 examinations, or special diagnostic laboratory tests that cost
21 more than $1,000 and other specialty services that the agency
22 ~~division~~ identifies by rule is not valid and reimbursable
23 unless the services have been expressly authorized by the
24 carrier, or unless the carrier has failed to respond within 10
25 days to a written request for authorization, or unless
26 emergency care is required. The insurer shall not refuse to
27 authorize such consultation or procedure unless the health
28 care provider or facility is not authorized or certified or
29 unless an expert medical advisor has determined that the
30 consultation or procedure is not medically necessary or
31 otherwise compensable under this chapter. Authorization of a

1 treatment plan does not constitute express authorization for
2 purposes of this section, except to the extent the carrier
3 provides otherwise in its authorization procedures. This
4 paragraph does not limit the carrier's obligation to identify
5 and disallow overutilization or billing errors.
6 (j) Notwithstanding anything in this chapter to the
7 contrary, a sick or injured employee shall be entitled, at all
8 times, to free, full, and absolute choice in the selection of
9 the pharmacy or pharmacist dispensing and filling
10 prescriptions for medicines required under this chapter. It is
11 expressly forbidden for the agency ~~division~~, an employer, or a
12 carrier, or any agent or representative of the agency
13 ~~division~~, an employer, or a carrier to select the pharmacy or
14 pharmacist which the sick or injured employee must use;
15 condition coverage or payment on the basis of the pharmacy or
16 pharmacist utilized; or to otherwise interfere in the
17 selection by the sick or injured employee of a pharmacy or
18 pharmacist.
19 (4) NOTICE OF TREATMENT TO CARRIER; FILING WITH AGENCY
20 ~~DIVISION~~.--
21 (a) Any health care provider providing necessary
22 remedial treatment, care, or attendance to any injured worker
23 shall submit treatment reports to the carrier in a format
24 prescribed by the agency ~~division~~. A claim for medical or
25 surgical treatment is not valid or enforceable against such
26 employer or employee, unless, by the close of the third
27 business day following the first treatment, the physician
28 providing the treatment furnishes to the employer or carrier a
29 preliminary notice of the injury and treatment on forms
30 prescribed by the agency ~~division~~ and, within 15 days
31 thereafter, furnishes to the employer or carrier a complete

1 report, and subsequent thereto furnishes progress reports, if
2 requested by the employer or insurance carrier, at intervals
3 of not less than 3 weeks apart or at less frequent intervals
4 if requested on forms prescribed by the agency ~~division~~.
5 (b) Each medical report or bill obtained or received
6 by the employer, the carrier, or the injured employee, or the
7 attorney for the employer, carrier, or injured employee, with
8 respect to the remedial treatment or care of the injured
9 employee, including any report of an examination, diagnosis,
10 or disability evaluation, must be filed with the Agency for
11 Health Care Administration ~~Division of Workers' Compensation~~
12 pursuant to rules adopted by the agency ~~division~~. The health
13 care provider shall also furnish to the injured employee or to
14 his or her attorney, on demand, a copy of his or her office
15 chart, records, and reports, and may charge the injured
16 employee an amount authorized by the agency ~~division~~ for the
17 copies. Each such health care provider shall provide to the
18 agency ~~division~~ any additional information about the remedial
19 treatment, care, and attendance that the agency ~~division~~
20 reasonably requests.
21 (c) It is the policy for the administration of the
22 workers' compensation system that there be reasonable access
23 to medical information by all parties to facilitate the
24 self-executing features of the law. Notwithstanding the
25 limitations in s. 455.667 and subject to the limitations in s.
26 381.004, upon the request of the employer, the carrier, or the
27 attorney for either of them, the medical records of an injured
28 employee must be furnished to those persons and the medical
29 condition of the injured employee must be discussed with those
30 persons, if the records and the discussions are restricted to
31 conditions relating to the workplace injury. Any such

1 discussions may be held before or after the filing of a claim
2 without the knowledge, consent, or presence of any other party
3 or his or her agent or representative. A health care provider
4 who willfully refuses to provide medical records or to discuss
5 the medical condition of the injured employee, after a
6 reasonable request is made for such information pursuant to
7 this subsection, shall be subject by the agency ~~division~~ to
8 one or more of the penalties set forth in paragraph (8)(b).
9 (5) INDEPENDENT MEDICAL EXAMINATIONS.--
10 (a) In any dispute concerning overutilization, medical
11 benefits, compensability, or disability under this chapter,
12 the carrier or the employee may select an independent medical
13 examiner. The examiner may be a health care provider treating
14 or providing other care to the employee. An independent
15 medical examiner may not render an opinion outside his or her
16 area of expertise, as demonstrated by licensure and applicable
17 practice parameters.
18 (b) Each party is bound by his or her selection of an
19 independent medical examiner and is entitled to an alternate
20 examiner only if:
21 1. The examiner is not qualified to render an opinion
22 upon an aspect of the employee's illness or injury which is
23 material to the claim or petition for benefits;
24 2. The examiner ceases to practice in the specialty
25 relevant to the employee's condition;
26 3. The examiner is unavailable due to injury, death,
27 or relocation outside a reasonably accessible geographic area;
28 or
29 4. The parties agree to an alternate examiner.
30
31 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

1 authorized treating provider is admissible in proceedings
2 before the judges of compensation claims.
3 (f) Attorney's fees incurred by an injured employee in
4 connection with delay of or opposition to an independent
5 medical examination, including, but not limited to, motions
6 for protective orders, are not recoverable under this chapter.
7 (6) UTILIZATION REVIEW.--Carriers shall review all
8 bills, invoices, and other claims for payment submitted by
9 health care providers in order to identify overutilization and
10 billing errors, and may hire peer review consultants or
11 conduct independent medical evaluations. Such consultants,
12 including peer review organizations, are immune from liability
13 in the execution of their functions under this subsection to
14 the extent provided in s. 766.101. If a carrier finds that
15 overutilization of medical services or a billing error has
16 occurred, it must disallow or adjust payment for such services
17 or error without order of a judge of compensation claims or
18 the agency ~~division~~, if the carrier, in making its
19 determination, has complied with this section and rules
20 adopted by the agency ~~division~~.
21 (7) UTILIZATION AND REIMBURSEMENT DISPUTES.--
22 (a) Any health care provider, carrier, or employer who
23 elects to contest the disallowance or adjustment of payment by
24 a carrier under subsection (6) must, within 30 days after
25 receipt of notice of disallowance or adjustment of payment,
26 petition the agency ~~division~~ to resolve the dispute. The
27 petitioner must serve a copy of the petition on the carrier
28 and on all affected parties by certified mail. The petition
29 must be accompanied by all documents and records that support
30 the allegations contained in the petition. Failure of a
31 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.

1 2. An administrative fine assessed by the agency
2 ~~division~~ in an amount not to exceed $5,000 per instance of
3 improperly disallowing or reducing payments.
4 3. Award of the health care provider's costs,
5 including a reasonable attorney's fee, for prosecuting the
6 petition.
7 (8) PATTERN OR PRACTICE OF OVERUTILIZATION.--
8 (a) Carriers must report to the agency ~~division~~ all
9 instances of overutilization including, but not limited to,
10 all instances in which the carrier disallows or adjusts
11 payment. The agency ~~division~~ shall determine whether a pattern
12 or practice of overutilization exists.
13 (b) If the agency ~~division~~ determines that a health
14 care provider has engaged in a pattern or practice of
15 overutilization or a violation of this chapter or rules
16 adopted by the agency ~~division~~, it may impose one or more of
17 the following penalties:
18 1. An order of the agency ~~division~~ barring the
19 provider from payment under this chapter;
20 2. Deauthorization of care under review;
21 3. Denial of payment for care rendered in the future;
22 4. Decertification of a health care provider certified
23 as an expert medical advisor under subsection (9) or of a
24 rehabilitation provider certified under s. 440.49;
25 5. An administrative fine assessed by the agency
26 ~~division~~ in an amount not to exceed $5,000 per instance of
27 overutilization or violation; and
28 6. Notification of and review by the appropriate
29 licensing authority pursuant to s. 440.106(3).
30 (9) EXPERT MEDICAL ADVISORS.--
31 (a) The agency ~~division~~ shall certify expert medical

1 advisors in each specialty to assist the agency ~~division~~ and
2 the judges of compensation claims within the advisor's area of
3 expertise as provided in this section. The agency ~~division~~
4 shall, in a manner prescribed by rule, in certifying,
5 recertifying, or decertifying an expert medical advisor,
6 consider the qualifications, training, impartiality, and
7 commitment of the health care provider to the provision of
8 quality medical care at a reasonable cost. As a prerequisite
9 for certification or recertification, the agency ~~division~~
10 shall require, at a minimum, that an expert medical advisor
11 have specialized workers' compensation training or experience
12 under the workers' compensation system of this state and board
13 certification or board eligibility.
14 (b) The agency ~~division~~ shall contract with or employ
15 expert medical advisors to provide peer review or medical
16 consultation to the agency ~~division~~ or to a judge of
17 compensation claims in connection with resolving disputes
18 relating to reimbursement, differing opinions of health care
19 providers, and health care and physician services rendered
20 under this chapter. Expert medical advisors contracting with
21 the agency ~~division~~ shall, as a term of such contract, agree
22 to provide consultation or services in accordance with the
23 timetables set forth in this chapter and to abide by rules
24 adopted by the agency ~~division~~, including, but not limited to,
25 rules pertaining to procedures for review of the services
26 rendered by health care providers and preparation of reports
27 and recommendations for submission to the agency ~~division~~.
28 (c) If there is disagreement in the opinions of the
29 health care providers, if two health care providers disagree
30 on medical evidence supporting the employee's complaints or
31 the need for additional medical treatment, or if two health

1 care providers disagree that the employee is able to return to
2 work, the agency ~~division~~ may, and the judge of compensation
3 claims shall, upon his or her own motion or within 15 days
4 after receipt of a written request by either the injured
5 employee, the employer, or the carrier, order the injured
6 employee to be evaluated by an expert medical advisor. The
7 opinion of the expert medical advisor is presumed to be
8 correct unless there is clear and convincing evidence to the
9 contrary as determined by the judge of compensation claims.
10 The expert medical advisor appointed to conduct the evaluation
11 shall have free and complete access to the medical records of
12 the employee. An employee who fails to report to and cooperate
13 with such evaluation forfeits entitlement to compensation
14 during the period of failure to report or cooperate.
15 (d) The expert medical advisor must complete his or
16 her evaluation and issue his or her report to the agency
17 ~~division~~ or to the judge of compensation claims within 45 days
18 after receipt of all medical records. The expert medical
19 advisor must furnish a copy of the report to the carrier and
20 to the employee.
21 (e) An expert medical advisor is not liable under any
22 theory of recovery for evaluations performed under this
23 section without a showing of fraud or malice. The protections
24 of s. 766.101 apply to any officer, employee, or agent of the
25 agency ~~division~~ and to any officer, employee, or agent of any
26 entity with which the agency ~~division~~ has contracted under
27 this subsection.
28 (f) If the agency ~~division~~ or a judge of compensation
29 claims determines that the services of a certified expert
30 medical advisor are required to resolve a dispute under this
31 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

1 exceed 1 percent of the prior year's assessment levied against
2 such entity under s. 440.51 for every quarter in which the
3 entity fails to attain 90-percent compliance. The agency
4 ~~division~~ shall fine an employer or carrier, pursuant to rules
5 adopted by the agency ~~division~~, for each late payment of
6 compensation that is below the minimum 90-percent performance
7 standard. Any carrier that is found to be not in compliance in
8 subsequent consecutive quarters must implement a medical-bill
9 review program approved by the agency ~~division~~, and the
10 carrier is subject to disciplinary action by the Department of
11 Insurance.
12 (c) The agency ~~division~~ has exclusive jurisdiction to
13 decide any matters concerning reimbursement, to resolve any
14 overutilization dispute under subsection (7), and to decide
15 any question concerning overutilization under subsection (8),
16 which question or dispute arises after January 1, 1994.
17 (d) The following ~~division~~ actions do not constitute
18 agency action subject to review under ss. 120.569 and 120.57
19 and do not constitute actions subject to s. 120.56: referral
20 by the entity responsible for utilization review; a decision
21 by the agency ~~division~~ to refer a matter to a peer review
22 committee; establishment by a health care provider or entity
23 of procedures by which a peer review committee reviews the
24 rendering of health care services; and the review proceedings,
25 report, and recommendation of the peer review committee.
26 (12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM
27 REIMBURSEMENT ALLOWANCES.--
28 (a) A three-member panel is created, consisting of the
29 Insurance Commissioner, or the Insurance Commissioner's
30 designee, and two members to be appointed by the Governor,
31 subject to confirmation by the Senate, one member who, on

1 account of present or previous vocation, employment, or
2 affiliation, shall be classified as a representative of
3 employers, the other member who, on account of previous
4 vocation, employment, or affiliation, shall be classified as a
5 representative of employees. The panel shall determine
6 statewide schedules of maximum reimbursement allowances for
7 medically necessary treatment, care, and attendance provided
8 by physicians, hospitals, ambulatory surgical centers,
9 work-hardening programs, pain programs, and durable medical
10 equipment. The maximum reimbursement allowances for inpatient
11 hospital care shall be based on a schedule of per diem rates,
12 to be approved by the three-member panel no later than March
13 1, 1994, to be used in conjunction with a precertification
14 manual as determined by the agency ~~division~~. All compensable
15 charges for hospital outpatient care shall be reimbursed at 75
16 percent of usual and customary charges. Until the three-member
17 panel approves a schedule of per diem rates for inpatient
18 hospital care and it becomes effective, all compensable
19 charges for hospital inpatient care must be reimbursed at 75
20 percent of their usual and customary charges. Annually, the
21 three-member panel shall adopt schedules of maximum
22 reimbursement allowances for physicians, hospital inpatient
23 care, hospital outpatient care, ambulatory surgical centers,
24 work-hardening programs, and pain programs. However, the
25 maximum percentage of increase in the individual reimbursement
26 allowance may not exceed the percentage of increase in the
27 Consumer Price Index for the previous year. An individual
28 physician, hospital, ambulatory surgical center, pain program,
29 or work-hardening program shall be reimbursed either the usual
30 and customary charge for treatment, care, and attendance, the
31 agreed-upon contract price, or the maximum reimbursement

1 allowance in the appropriate schedule, whichever is less.
2 (b) As to reimbursement for a prescription medication,
3 the reimbursement amount for a prescription shall be the
4 average wholesale price times 1.2 plus $4.18 for the
5 dispensing fee, except where the carrier has contracted for a
6 lower amount. Fees for pharmaceuticals and pharmaceutical
7 services shall be reimbursable at the applicable fee schedule
8 amount. Where the employer or carrier has contracted for such
9 services and the employee elects to obtain them through a
10 provider not a party to the contract, the carrier shall
11 reimburse at the schedule, negotiated, or contract price,
12 whichever is lower.
13 (c) Reimbursement for all fees and other charges for
14 such treatment, care, and attendance, including treatment,
15 care, and attendance provided by any hospital or other health
16 care provider, ambulatory surgical center, work-hardening
17 program, or pain program, must not exceed the amounts provided
18 by the uniform schedule of maximum reimbursement allowances as
19 determined by the panel or as otherwise provided in this
20 section. This subsection also applies to independent medical
21 examinations performed by health care providers under this
22 chapter. Until the three-member panel approves a uniform
23 schedule of maximum reimbursement allowances and it becomes
24 effective, all compensable charges for treatment, care, and
25 attendance provided by physicians, ambulatory surgical
26 centers, work-hardening programs, or pain programs shall be
27 reimbursed at the lowest maximum reimbursement allowance
28 across all 1992 schedules of maximum reimbursement allowances
29 for the services provided regardless of the place of service.
30 In determining the uniform schedule, the panel shall first
31 approve the data which it finds representative of prevailing

1 charges in the state for similar treatment, care, and
2 attendance of injured persons. Each health care provider,
3 health care facility, ambulatory surgical center,
4 work-hardening program, or pain program receiving workers'
5 compensation payments shall maintain records verifying their
6 usual charges. In establishing the uniform schedule of maximum
7 reimbursement allowances, the panel must consider:
8 1. The levels of reimbursement for similar treatment,
9 care, and attendance made by other health care programs or
10 third-party providers;
11 2. The impact upon cost to employers for providing a
12 level of reimbursement for treatment, care, and attendance
13 which will ensure the availability of treatment, care, and
14 attendance required by injured workers;
15 3. The financial impact of the reimbursement
16 allowances upon health care providers and health care
17 facilities, including trauma centers as defined in s. 395.401,
18 and its effect upon their ability to make available to injured
19 workers such medically necessary remedial treatment, care, and
20 attendance. The uniform schedule of maximum reimbursement
21 allowances must be reasonable, must promote health care cost
22 containment and efficiency with respect to the workers'
23 compensation health care delivery system, and must be
24 sufficient to ensure availability of such medically necessary
25 remedial treatment, care, and attendance to injured workers;
26 and
27 4. The most recent average maximum allowable rate of
28 increase for hospitals determined by the Health Care Board
29 under chapter 408.
30 (13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE
31 AUTHORIZED TO RENDER MEDICAL CARE.--The agency ~~division~~ shall

1 remove from the list of physicians or facilities authorized to
2 provide remedial treatment, care, and attendance under this
3 chapter the name of any physician or facility found after
4 reasonable investigation to have:
5 (a) Engaged in professional or other misconduct or
6 incompetency in connection with medical services rendered
7 under this chapter;
8 (b) Exceeded the limits of his or her or its
9 professional competence in rendering medical care under this
10 chapter, or to have made materially false statements regarding
11 his or her or its qualifications in his or her application;
12 (c) Failed to transmit copies of medical reports to
13 the employer or carrier, or failed to submit full and truthful
14 medical reports of all his or her or its findings to the
15 employer or carrier as required under this chapter;
16 (d) Solicited, or employed another to solicit for
17 himself or herself or itself or for another, professional
18 treatment, examination, or care of an injured employee in
19 connection with any claim under this chapter;
20 (e) Refused to appear before, or to answer upon
21 request of, the agency ~~division~~ or any duly authorized officer
22 of the state, any legal question, or to produce any relevant
23 book or paper concerning his or her conduct under any
24 authorization granted to him or her under this chapter;
25 (f) Self-referred in violation of this chapter or
26 other laws of this state; or
27 (g) Engaged in a pattern of practice of
28 overutilization or a violation of this chapter or rules
29 adopted by the agency ~~division~~.
30 Section 122. Paragraph (a) of subsection (3) of
31 section 440.15, Florida Statutes, is amended to read:

1 440.15 Compensation for disability.--Compensation for
2 disability shall be paid to the employee, subject to the
3 limits provided in s. 440.12(2), as follows:
4 (3) PERMANENT IMPAIRMENT AND WAGE-LOSS BENEFITS.--
5 (a) Impairment benefits.--
6 1. Once the employee has reached the date of maximum
7 medical improvement, impairment benefits are due and payable
8 within 20 days after the carrier has knowledge of the
9 impairment.
10 2. The three-member panel, in cooperation with the
11 agency ~~division~~, shall establish and use a uniform permanent
12 impairment rating schedule. This schedule must be based on
13 medically or scientifically demonstrable findings as well as
14 the systems and criteria set forth in the American Medical
15 Association's Guides to the Evaluation of Permanent
16 Impairment; the Snellen Charts, published by American Medical
17 Association Committee for Eye Injuries; and the Minnesota
18 Department of Labor and Industry Disability Schedules. The
19 schedule should be based upon objective findings. The schedule
20 shall be more comprehensive than the AMA Guides to the
21 Evaluation of Permanent Impairment and shall expand the areas
22 already addressed and address additional areas not currently
23 contained in the guides. On August 1, 1979, and pending the
24 adoption, by rule, of a permanent schedule, Guides to the
25 Evaluation of Permanent Impairment, copyright 1977, 1971,
26 1988, by the American Medical Association, shall be the
27 temporary schedule and shall be used for the purposes hereof.
28 For injuries after July 1, 1990, pending the adoption by
29 division rule of a uniform disability rating schedule, the
30 Minnesota Department of Labor and Industry Disability Schedule
31 shall be used unless that schedule does not address an injury.

1 In such case, the Guides to the Evaluation of Permanent
2 Impairment by the American Medical Association shall be used.
3 Determination of permanent impairment under this schedule must
4 be made by a physician licensed under chapter 458, a doctor of
5 osteopathic medicine licensed under chapters 458 and 459, a
6 chiropractic physician licensed under chapter 460, a podiatric
7 physician licensed under chapter 461, an optometrist licensed
8 under chapter 463, or a dentist licensed under chapter 466, as
9 appropriate considering the nature of the injury. No other
10 persons are authorized to render opinions regarding the
11 existence of or the extent of permanent impairment.
12 3. All impairment income benefits shall be based on an
13 impairment rating using the impairment schedule referred to in
14 subparagraph 2. Impairment income benefits are paid weekly at
15 the rate of 50 percent of the employee's average weekly
16 temporary total disability benefit not to exceed the maximum
17 weekly benefit under s. 440.12. An employee's entitlement to
18 impairment income benefits begins the day after the employee
19 reaches maximum medical improvement or the expiration of
20 temporary benefits, whichever occurs earlier, and continues
21 until the earlier of:
22 a. The expiration of a period computed at the rate of
23 3 weeks for each percentage point of impairment; or
24 b. The death of the employee.
25 4. After the employee has been certified by a doctor
26 as having reached maximum medical improvement or 6 weeks
27 before the expiration of temporary benefits, whichever occurs
28 earlier, the certifying doctor shall evaluate the condition of
29 the employee and assign an impairment rating, using the
30 impairment schedule referred to in subparagraph 2.
31 Compensation is not payable for the mental, psychological, or

1 emotional injury arising out of depression from being out of
2 work. If the certification and evaluation are performed by a
3 doctor other than the employee's treating doctor, the
4 certification and evaluation must be submitted to the treating
5 doctor, and the treating doctor must indicate agreement or
6 disagreement with the certification and evaluation. The
7 certifying doctor shall issue a written report to the
8 division, the employee, and the carrier certifying that
9 maximum medical improvement has been reached, stating the
10 impairment rating, and providing any other information
11 required by the division. If the employee has not been
12 certified as having reached maximum medical improvement before
13 the expiration of 102 weeks after the date temporary total
14 disability benefits begin to accrue, the carrier shall notify
15 the treating doctor of the requirements of this section.
16 5. The carrier shall pay the employee impairment
17 income benefits for a period based on the impairment rating.
18 6. The division may by rule specify forms and
19 procedures governing the method of payment of wage loss and
20 impairment benefits for dates of accidents before January 1,
21 1994, and for dates of accidents on or after January 1, 1994.
22 Section 123. Subsection (7) of section 440.491,
23 Florida Statutes, is amended to read:
24 440.491 Reemployment of injured workers;
25 rehabilitation.--
26 (7) PROVIDER QUALIFICATIONS.--
27 (a) The Agency for Health Care Administration ~~division~~
28 shall investigate and maintain a directory of each qualified
29 public and private rehabilitation provider, facility, and
30 agency, and shall establish by rule the minimum
31 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

1 and standards.
2
3 (Redesignate subsequent sections.)
4
5
6 ================ T I T L E   A M E N D M E N T ===============
7 And the title is amended as follows:
8 On page 24, lines 2-6, delete those lines
9
10 and insert:
11 federal law; amending s. 440.02, F.S.;
12 providing a definition for the term "agency";
13 conforming definitions of "department" and
14 "division" to the transfer of the Division of
15 Workers' Compensation to the Department of
16 Insurance; amending s. 440.13, F.S., relating
17 to medical services and supplies under the
18 workers' compensation law; reassigning certain
19 functions from the Division of Workers'
20 Compensation to the Agency for Health Care
21 Administration; amending s. 440.15, F.S.;
22 providing for the agency to participate in the
23 establishment and use of a uniform permanent
24 impairment rating schedule; amending s.
25 440.491, F.S.; providing for agency oversight
26 of workers' compensation rehabilitation
27 providers; amending s. 440.207, F.S.;
28
29
30
31