

1 A bill to be entitled
 2 An act relating to workers' compensation medical services
 3 and supplies; providing for a type two transfer of
 4 responsibilities with respect to the provision of workers'
 5 compensation medical services and supplies from the Agency
 6 for Health Care Administration to the Department of
 7 Financial Services; amending ss. 440.13 and 440.125, F.S.;
 8 revising terminology and removing language relating to the
 9 sharing and maintenance of confidential medical records,
 10 reports, and information, to conform; providing an
 11 effective date.

12
 13 Be It Enacted by the Legislature of the State of Florida:

14
 15 Section 1. All powers, duties, functions, rules, records,
 16 personnel, property, and unexpended balances of appropriations,
 17 allocations, and other funds of the Agency for Health Care
 18 Administration with respect to the agency's responsibilities for
 19 the provision of workers' compensation medical services and
 20 supplies are transferred intact by a type two transfer, as
 21 defined in s. 20.06(2), Florida Statutes, from the Agency for
 22 Health Care Administration to the Department of Financial
 23 Services.

24 Section 2. Subsections (1), (3), (6) through (9), and (11)
 25 through (13) of section 440.13, Florida Statutes, are amended to
 26 read:

27 440.13 Medical services and supplies; penalty for
 28 violations; limitations.--

29 (1) DEFINITIONS.--As used in this section, the term:
 30 (a) "Alternate medical care" means a change in treatment
 31 or health care provider.
 32 (b) "Attendant care" means care rendered by trained
 33 professional attendants which is beyond the scope of household
 34 duties. Family members may provide nonprofessional attendant
 35 care, but may not be compensated under this chapter for care
 36 that falls within the scope of household duties and other
 37 services normally and gratuitously provided by family members.
 38 "Family member" means a spouse, father, mother, brother, sister,
 39 child, grandchild, father-in-law, mother-in-law, aunt, or uncle.
 40 (c) "Carrier" means, for purposes of this section,
 41 insurance carrier, self-insurance fund or individually self-
 42 insured employer, or assessable mutual insurer.
 43 (d) "Certified health care provider" means a health care
 44 provider who has been certified by the department ~~agency~~ or who
 45 has entered an agreement with a licensed managed care
 46 organization to provide treatment to injured workers under this
 47 section. Certification of such health care provider must include
 48 documentation that the health care provider has read and is
 49 familiar with the portions of the statute, impairment guides,
 50 practice parameters, protocols of treatment, and rules which
 51 govern the provision of remedial treatment, care, and
 52 attendance.
 53 (e) "Compensable" means a determination by a carrier or
 54 judge of compensation claims that a condition suffered by an
 55 employee results from an injury arising out of and in the course
 56 of employment.

57 (f) "Emergency services and care" means emergency services
58 and care as defined in s. 395.002.

59 (g) "Health care facility" means any hospital licensed
60 under chapter 395 and any health care institution licensed under
61 chapter 400 or chapter 429.

62 (h) "Health care provider" means a physician or any
63 recognized practitioner who provides skilled services pursuant
64 to a prescription or under the supervision or direction of a
65 physician and who has been certified by the department ~~agency~~ as
66 a health care provider. The term "health care provider" includes
67 a health care facility.

68 (i) "Independent medical examiner" means a physician
69 selected by either an employee or a carrier to render one or
70 more independent medical examinations in connection with a
71 dispute arising under this chapter.

72 (j) "Independent medical examination" means an objective
73 evaluation of the injured employee's medical condition,
74 including, but not limited to, impairment or work status,
75 performed by a physician or an expert medical advisor at the
76 request of a party, a judge of compensation claims, or the
77 department ~~agency~~ to assist in the resolution of a dispute
78 arising under this chapter.

79 (k) "Instance of overutilization" means a specific
80 inappropriate service or level of service provided to an injured
81 employee that includes the provision of treatment in excess of
82 established practice parameters and protocols of treatment
83 established in accordance with this chapter.

84 (l) "Medically necessary" or "medical necessity" means any
85 medical service or medical supply which is used to identify or
86 treat an illness or injury, is appropriate to the patient's
87 diagnosis and status of recovery, and is consistent with the
88 location of service, the level of care provided, and applicable
89 practice parameters. The service should be widely accepted among
90 practicing health care providers, based on scientific criteria,
91 and determined to be reasonably safe. The service must not be of
92 an experimental, investigative, or research nature.

93 (m) "Medicine" means a drug prescribed by an authorized
94 health care provider and includes only generic drugs or single-
95 source patented drugs for which there is no generic equivalent,
96 unless the authorized health care provider writes or states that
97 the brand-name drug as defined in s. 465.025 is medically
98 necessary, or is a drug appearing on the schedule of drugs
99 created pursuant to s. 465.025(6), or is available at a cost
100 lower than its generic equivalent.

101 (n) "Palliative care" means noncurative medical services
102 that mitigate the conditions, effects, or pain of an injury.

103 (o) "Pattern or practice of overutilization" means
104 repetition of instances of overutilization within a specific
105 medical case or multiple cases by a single health care provider.

106 (p) "Peer review" means an evaluation by two or more
107 physicians licensed under the same authority and with the same
108 or similar specialty as the physician under review, of the
109 appropriateness, quality, and cost of health care and health
110 services provided to a patient, based on medically accepted
111 standards.

112 (q) "Physician" or "doctor" means a physician licensed
 113 under chapter 458, an osteopathic physician licensed under
 114 chapter 459, a chiropractic physician licensed under chapter
 115 460, a podiatric physician licensed under chapter 461, an
 116 optometrist licensed under chapter 463, or a dentist licensed
 117 under chapter 466, each of whom must be certified by the
 118 department ~~agency~~ as a health care provider.

119 (r) "Reimbursement dispute" means any disagreement between
 120 a health care provider or health care facility and carrier
 121 concerning payment for medical treatment.

122 (s) "Utilization control" means a systematic process of
 123 implementing measures that assure overall management and cost
 124 containment of services delivered, including compliance with
 125 practice parameters and protocols of treatment as provided for
 126 in this chapter.

127 (t) "Utilization review" means the evaluation of the
 128 appropriateness of both the level and the quality of health care
 129 and health services provided to a patient, including, but not
 130 limited to, evaluation of the appropriateness of treatment,
 131 hospitalization, or office visits based on medically accepted
 132 standards. Such evaluation must be accomplished by means of a
 133 system that identifies the utilization of medical services based
 134 on practice parameters and protocols of treatment as provided
 135 for in this chapter.

136 (3) PROVIDER ELIGIBILITY; AUTHORIZATION.--

137 (a) As a condition to eligibility for payment under this
 138 chapter, a health care provider who renders services must be a
 139 certified health care provider and must receive authorization

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140 from the carrier before providing treatment. This paragraph does
141 not apply to emergency care. The department ~~agency~~ shall adopt
142 rules to implement the certification of health care providers.

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

156 (c) A health care provider may not refer the employee to
157 another health care provider, diagnostic facility, therapy
158 center, or other facility without prior authorization from the
159 carrier, except when emergency care is rendered. Any referral
160 must be to a health care provider that has been certified by the
161 department ~~agency~~, unless the referral is for emergency
162 treatment, and the referral must be made in accordance with
163 practice parameters and protocols of treatment as provided for
164 in this chapter.

165 (d) A carrier must respond, by telephone or in writing, to
166 a request for authorization from an authorized health care
167 provider by the close of the third business day after receipt of

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168 the request. A carrier who fails to respond to a written request
169 for authorization for referral for medical treatment by the
170 close of the third business day after receipt of the request
171 consents to the medical necessity for such treatment. All such
172 requests must be made to the carrier. Notice to the carrier does
173 not include notice to the employer.

174 (e) Carriers shall adopt procedures for receiving,
175 reviewing, documenting, and responding to requests for
176 authorization. Such procedures shall be for a health care
177 provider certified under this section.

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

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

190 (h) The provisions of s. 456.053 are applicable to
191 referrals among health care providers, as defined in subsection
192 (1), treating injured workers.

193 (i) Notwithstanding paragraph (d), a claim for specialist
194 consultations, surgical operations, physiotherapeutic or
195 occupational therapy procedures, X-ray examinations, or special

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196 diagnostic laboratory tests that cost more than \$1,000 and other
197 specialty services that the department ~~agency~~ identifies by rule
198 is not valid and reimbursable unless the services have been
199 expressly authorized by the carrier, or unless the carrier has
200 failed to respond within 10 days to a written request for
201 authorization, or unless emergency care is required. The insurer
202 shall authorize such consultation or procedure unless the health
203 care provider or facility is not authorized or certified, unless
204 such treatment is not in accordance with practice parameters and
205 protocols of treatment established in this chapter, or unless a
206 judge of compensation claims has determined that the
207 consultation or procedure is not medically necessary, not in
208 accordance with the practice parameters and protocols of
209 treatment established in this chapter, or otherwise not
210 compensable under this chapter. Authorization of a treatment
211 plan does not constitute express authorization for purposes of
212 this section, except to the extent the carrier provides
213 otherwise in its authorization procedures. This paragraph does
214 not limit the carrier's obligation to identify and disallow
215 overutilization or billing errors.

216 (j) Notwithstanding anything in this chapter to the
217 contrary, a sick or injured employee shall be entitled, at all
218 times, to free, full, and absolute choice in the selection of
219 the pharmacy or pharmacist dispensing and filling prescriptions
220 for medicines required under this chapter. It is expressly
221 forbidden for the department ~~agency~~, an employer, or a carrier,
222 or any agent or representative of the department ~~agency~~, an
223 employer, or a carrier, to select the pharmacy or pharmacist

224 | which the sick or injured employee must use; condition coverage
 225 | or payment on the basis of the pharmacy or pharmacist utilized;
 226 | or to otherwise interfere in the selection by the sick or
 227 | injured employee of a pharmacy or pharmacist.

228 | (6) UTILIZATION REVIEW.--Carriers shall review all bills,
 229 | invoices, and other claims for payment submitted by health care
 230 | providers in order to identify overutilization and billing
 231 | errors, including compliance with practice parameters and
 232 | protocols of treatment established in accordance with this
 233 | chapter, and may hire peer review consultants or conduct
 234 | independent medical evaluations. Such consultants, including
 235 | peer review organizations, are immune from liability in the
 236 | execution of their functions under this subsection to the extent
 237 | provided in s. 766.101. If a carrier finds that overutilization
 238 | of medical services or a billing error has occurred, or there is
 239 | a violation of the practice parameters and protocols of
 240 | treatment established in accordance with this chapter, it must
 241 | disallow or adjust payment for such services or error without
 242 | order of a judge of compensation claims or the department
 243 | ~~agency~~, if the carrier, in making its determination, has
 244 | complied with this section and rules adopted by the department
 245 | ~~agency~~.

246 | (7) UTILIZATION AND REIMBURSEMENT DISPUTES.--

247 | (a) Any health care provider, carrier, or employer who
 248 | elects to contest the disallowance or adjustment of payment by a
 249 | carrier under subsection (6) must, within 30 days after receipt
 250 | of notice of disallowance or adjustment of payment, petition the
 251 | department ~~agency~~ to resolve the dispute. The petitioner must

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252 | serve a copy of the petition on the carrier and on all affected
253 | parties by certified mail. The petition must be accompanied by
254 | all documents and records that support the allegations contained
255 | in the petition. Failure of a petitioner to submit such
256 | documentation to the department ~~agency~~ results in dismissal of
257 | the petition.

258 | (b) The carrier must submit to the department ~~agency~~
259 | within 10 days after receipt of the petition all documentation
260 | substantiating the carrier's disallowance or adjustment. Failure
261 | of the carrier to timely submit the requested documentation to
262 | the department ~~agency~~ within 10 days constitutes a waiver of all
263 | objections to the petition.

264 | (c) Within 60 days after receipt of all documentation, the
265 | department ~~agency~~ must provide to the petitioner, the carrier,
266 | and the affected parties a written determination of whether the
267 | carrier properly adjusted or disallowed payment. The department
268 | ~~agency~~ must be guided by standards and policies set forth in
269 | this chapter, including all applicable reimbursement schedules,
270 | practice parameters, and protocols of treatment, in rendering
271 | its determination.

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

277 | (e) The department ~~agency~~ shall adopt rules to carry out
278 | this subsection. The rules may include provisions for
279 | consolidating petitions filed by a petitioner and expanding the

280 timetable for rendering a determination upon a consolidated
 281 petition.

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

286 1. Repayment of the appropriate amount to the health care
 287 provider.

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

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

293 (8) PATTERN OR PRACTICE OF OVERUTILIZATION.--

294 (a) Carriers must report to the department ~~agency~~ all
 295 instances of overutilization including, but not limited to, all
 296 instances in which the carrier disallows or adjusts payment or a
 297 determination has been made that the provided or recommended
 298 treatment is in excess of the practice parameters and protocols
 299 of treatment established in this chapter. The department ~~agency~~
 300 shall determine whether a pattern or practice of overutilization
 301 exists.

302 (b) If the department ~~agency~~ determines that a health care
 303 provider has engaged in a pattern or practice of overutilization
 304 or a violation of this chapter or rules adopted by the
 305 department ~~agency~~, including a pattern or practice of providing
 306 treatment in excess of the practice parameters or protocols of
 307 treatment, it may impose one or more of the following penalties:

- 308 1. An order of the department ~~agency~~ barring the provider
 309 from payment under this chapter;
- 310 2. Deauthorization of care under review;
- 311 3. Denial of payment for care rendered in the future;
- 312 4. Decertification of a health care provider certified as
 313 an expert medical advisor under subsection (9) or of a
 314 rehabilitation provider certified under s. 440.49;
- 315 5. An administrative fine assessed by the department
 316 ~~agency~~ in an amount not to exceed \$5,000 per instance of
 317 overutilization or violation; and
- 318 6. Notification of and review by the appropriate licensing
 319 authority pursuant to s. 440.106(3).
- 320 (9) EXPERT MEDICAL ADVISORS.--
- 321 (a) The department ~~agency~~ shall certify expert medical
 322 advisors in each specialty to assist the department ~~agency~~ and
 323 the judges of compensation claims within the advisor's area of
 324 expertise as provided in this section. The department ~~agency~~
 325 shall, in a manner prescribed by rule, in certifying,
 326 recertifying, or decertifying an expert medical advisor,
 327 consider the qualifications, training, impartiality, and
 328 commitment of the health care provider to the provision of
 329 quality medical care at a reasonable cost. As a prerequisite for
 330 certification or recertification, the department ~~agency~~ shall
 331 require, at a minimum, that an expert medical advisor have
 332 specialized workers' compensation training or experience under
 333 the workers' compensation system of this state and board
 334 certification or board eligibility.

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335 (b) The department ~~agency~~ shall contract with one or more
336 entities that employ, contract with, or otherwise secure expert
337 medical advisors to provide peer review or expert medical
338 consultation, opinions, and testimony to the department ~~agency~~
339 or to a judge of compensation claims in connection with
340 resolving disputes relating to reimbursement, differing opinions
341 of health care providers, and health care and physician services
342 rendered under this chapter, including utilization issues. The
343 department ~~agency~~ shall by rule establish the qualifications of
344 expert medical advisors, including training and experience in
345 the workers' compensation system in the state and the expert
346 medical advisor's knowledge of and commitment to the standards
347 of care, practice parameters, and protocols established pursuant
348 to this chapter. Expert medical advisors contracting with the
349 department ~~agency~~ shall, as a term of such contract, agree to
350 provide consultation or services in accordance with the
351 timetables set forth in this chapter and to abide by rules
352 adopted by the department ~~agency~~, including, but not limited to,
353 rules pertaining to procedures for review of the services
354 rendered by health care providers and preparation of reports and
355 testimony or recommendations for submission to the department
356 ~~agency~~ or the judge of compensation claims.

357 (c) If there is disagreement in the opinions of the health
358 care providers, if two health care providers disagree on medical
359 evidence supporting the employee's complaints or the need for
360 additional medical treatment, or if two health care providers
361 disagree that the employee is able to return to work, the
362 department ~~agency~~ may, and the judge of compensation claims

363 shall, upon his or her own motion or within 15 days after
364 receipt of a written request by either the injured employee, the
365 employer, or the carrier, order the injured employee to be
366 evaluated by an expert medical advisor. The opinion of the
367 expert medical advisor is presumed to be correct unless there is
368 clear and convincing evidence to the contrary as determined by
369 the judge of compensation claims. The expert medical advisor
370 appointed to conduct the evaluation shall have free and complete
371 access to the medical records of the employee. An employee who
372 fails to report to and cooperate with such evaluation forfeits
373 entitlement to compensation during the period of failure to
374 report or cooperate.

375 (d) The expert medical advisor must complete his or her
376 evaluation and issue his or her report to the department ~~agency~~
377 or to the judge of compensation claims within 15 days after
378 receipt of all medical records. The expert medical advisor must
379 furnish a copy of the report to the carrier and to the employee.

380 (e) An expert medical advisor is not liable under any
381 theory of recovery for evaluations performed under this section
382 without a showing of fraud or malice. The protections of s.
383 766.101 apply to any officer, employee, or agent of the
384 department ~~agency~~ and to any officer, employee, or agent of any
385 entity with which the department ~~agency~~ has contracted under
386 this subsection.

387 (f) If the department ~~agency~~ or a judge of compensation
388 claims orders the services of a certified expert medical advisor
389 to resolve a dispute under this section, the party requesting
390 such examination must compensate the advisor for his or her time

391 in accordance with a schedule adopted by the department ~~agency~~.
 392 If the employee prevails in a dispute as determined in an order
 393 by a judge of compensation claims based upon the expert medical
 394 advisor's findings, the employer or carrier shall pay for the
 395 costs of such expert medical advisor. If a judge of compensation
 396 claims, upon his or her motion, finds that an expert medical
 397 advisor is needed to resolve the dispute, the carrier must
 398 compensate the advisor for his or her time in accordance with a
 399 schedule adopted by the department ~~agency~~. The department ~~agency~~
 400 may assess a penalty not to exceed \$500 against any carrier that
 401 fails to timely compensate an advisor in accordance with this
 402 section.

403 (11) AUDITS.--

404 (a) The department ~~Agency for Health Care Administration~~
 405 may investigate health care providers to determine whether
 406 providers are complying with this chapter and with rules adopted
 407 by the department ~~agency~~, whether the providers are engaging in
 408 overutilization, whether providers are engaging in improper
 409 billing practices, and whether providers are adhering to
 410 practice parameters and protocols established in accordance with
 411 this chapter. If the department ~~agency~~ finds that a health care
 412 provider has improperly billed, overutilized, or failed to
 413 comply with department ~~agency~~ rules or the requirements of this
 414 chapter, including, but not limited to, practice parameters and
 415 protocols established in accordance with this chapter, it must
 416 notify the provider of its findings and may determine that the
 417 health care provider may not receive payment from the carrier or
 418 may impose penalties as set forth in subsection (8) or other

419 sections of this chapter. If the health care provider has
420 received payment from a carrier for services that were
421 improperly billed, that constitute overutilization, or that were
422 outside practice parameters or protocols established in
423 accordance with this chapter, it must return those payments to
424 the carrier. The department ~~agency~~ may assess a penalty not to
425 exceed \$500 for each overpayment that is not refunded within 30
426 days after notification of overpayment by the department ~~agency~~
427 or carrier.

428 (b) The department shall monitor carriers as provided in
429 this chapter and the Office of Insurance Regulation shall audit
430 insurers and group self-insurance funds as provided in s.
431 624.3161, to determine if medical bills are paid in accordance
432 with this section and rules of the department and Financial
433 Services Commission, respectively. Any employer, if self-
434 insured, or carrier found by the department or Office of
435 Insurance Regulation not to be within 90 percent compliance as
436 to the payment of medical bills after July 1, 1994, must be
437 assessed a fine not to exceed 1 percent of the prior year's
438 assessment levied against such entity under s. 440.51 for every
439 quarter in which the entity fails to attain 90-percent
440 compliance. The department shall fine or otherwise discipline an
441 employer or carrier, pursuant to this chapter or rules adopted
442 by the department, and the Office of Insurance Regulation shall
443 fine or otherwise discipline an insurer or group self-insurance
444 fund pursuant to the insurance code or rules adopted by the
445 Financial Services Commission, for each late payment of
446 compensation that is below the minimum 95-percent performance

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447 standard. Any carrier that is found to be not in compliance in
448 subsequent consecutive quarters must implement a medical-bill
449 review program approved by the department or office, and an
450 insurer or group self-insurance fund is subject to disciplinary
451 action by the Office of Insurance Regulation.

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

457 (d) The following department ~~agency~~ actions do not
458 constitute agency action subject to review under ss. 120.569 and
459 120.57 and do not constitute actions subject to s. 120.56:
460 referral by the entity responsible for utilization review; a
461 decision by the department ~~agency~~ to refer a matter to a peer
462 review committee; establishment by a health care provider or
463 entity of procedures by which a peer review committee reviews
464 the rendering of health care services; and the review
465 proceedings, report, and recommendation of the peer review
466 committee.

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

469 (a) A three-member panel is created, consisting of the
470 Chief Financial Officer, or the Chief Financial Officer's
471 designee, and two members to be appointed by the Governor,
472 subject to confirmation by the Senate, one member who, on
473 account of present or previous vocation, employment, or
474 affiliation, shall be classified as a representative of

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475 employers, the other member who, on account of previous
476 vocation, employment, or affiliation, shall be classified as a
477 representative of employees. The panel shall determine statewide
478 schedules of maximum reimbursement allowances for medically
479 necessary treatment, care, and attendance provided by
480 physicians, hospitals, ambulatory surgical centers, work-
481 hardening programs, pain programs, and durable medical
482 equipment. The maximum reimbursement allowances for inpatient
483 hospital care shall be based on a schedule of per diem rates, to
484 be approved by the three-member panel no later than March 1,
485 1994, to be used in conjunction with a precertification manual
486 as determined by the department, including maximum hours in
487 which an outpatient may remain in observation status, which
488 shall not exceed 23 hours. All compensable charges for hospital
489 outpatient care shall be reimbursed at 75 percent of usual and
490 customary charges, except as otherwise provided by this
491 subsection. Annually, the three-member panel shall adopt
492 schedules of maximum reimbursement allowances for physicians,
493 hospital inpatient care, hospital outpatient care, ambulatory
494 surgical centers, work-hardening programs, and pain programs. An
495 individual physician, hospital, ambulatory surgical center, pain
496 program, or work-hardening program shall be reimbursed either
497 the agreed-upon contract price or the maximum reimbursement
498 allowance in the appropriate schedule.

499 (b) It is the intent of the Legislature to increase the
500 schedule of maximum reimbursement allowances for selected
501 physicians effective January 1, 2004, and to pay for the
502 increases through reductions in payments to hospitals. Revisions

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503 developed pursuant to this subsection are limited to the
504 following:

505 1. Payments for outpatient physical, occupational, and
506 speech therapy provided by hospitals shall be reduced to the
507 schedule of maximum reimbursement allowances for these services
508 which applies to nonhospital providers.

509 2. Payments for scheduled outpatient nonemergency
510 radiological and clinical laboratory services that are not
511 provided in conjunction with a surgical procedure shall be
512 reduced to the schedule of maximum reimbursement allowances for
513 these services which applies to nonhospital providers.

514 3. Outpatient reimbursement for scheduled surgeries shall
515 be reduced from 75 percent of charges to 60 percent of charges.

516 4. Maximum reimbursement for a physician licensed under
517 chapter 458 or chapter 459 shall be increased to 110 percent of
518 the reimbursement allowed by Medicare, using appropriate codes
519 and modifiers or the medical reimbursement level adopted by the
520 three-member panel as of January 1, 2003, whichever is greater.

521 5. Maximum reimbursement for surgical procedures shall be
522 increased to 140 percent of the reimbursement allowed by
523 Medicare or the medical reimbursement level adopted by the
524 three-member panel as of January 1, 2003, whichever is greater.

525 (c) As to reimbursement for a prescription medication, the
526 reimbursement amount for a prescription shall be the average
527 wholesale price plus \$4.18 for the dispensing fee, except where
528 the carrier has contracted for a lower amount. Fees for
529 pharmaceuticals and pharmaceutical services shall be
530 reimbursable at the applicable fee schedule amount. Where the

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531 employer or carrier has contracted for such services and the
532 employee elects to obtain them through a provider not a party to
533 the contract, the carrier shall reimburse at the schedule,
534 negotiated, or contract price, whichever is lower. No such
535 contract shall rely on a provider that is not reasonably
536 accessible to the employee.

537 (d) Reimbursement for all fees and other charges for such
538 treatment, care, and attendance, including treatment, care, and
539 attendance provided by any hospital or other health care
540 provider, ambulatory surgical center, work-hardening program, or
541 pain program, must not exceed the amounts provided by the
542 uniform schedule of maximum reimbursement allowances as
543 determined by the panel or as otherwise provided in this
544 section. This subsection also applies to independent medical
545 examinations performed by health care providers under this
546 chapter. In determining the uniform schedule, the panel shall
547 first approve the data which it finds representative of
548 prevailing charges in the state for similar treatment, care, and
549 attendance of injured persons. Each health care provider, health
550 care facility, ambulatory surgical center, work-hardening
551 program, or pain program receiving workers' compensation
552 payments shall maintain records verifying their usual charges.
553 In establishing the uniform schedule of maximum reimbursement
554 allowances, the panel must consider:

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

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

562 3. The financial impact of the reimbursement allowances
563 upon health care providers and health care facilities, including
564 trauma centers as defined in s. 395.4001, and its effect upon
565 their ability to make available to injured workers such
566 medically necessary remedial treatment, care, and attendance.
567 The uniform schedule of maximum reimbursement allowances must be
568 reasonable, must promote health care cost containment and
569 efficiency with respect to the workers' compensation health care
570 delivery system, and must be sufficient to ensure availability
571 of such medically necessary remedial treatment, care, and
572 attendance to injured workers; and

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

576 (e) In addition to establishing the uniform schedule of
577 maximum reimbursement allowances, the panel shall:

578 1. Take testimony, receive records, and collect data to
579 evaluate the adequacy of the workers' compensation fee schedule,
580 nationally recognized fee schedules and alternative methods of
581 reimbursement to certified health care providers and health care
582 facilities for inpatient and outpatient treatment and care.

583 2. Survey certified health care providers and health care
584 facilities to determine the availability and accessibility of

585 workers' compensation health care delivery systems for injured
 586 workers.

587 3. Survey carriers to determine the estimated impact on
 588 carrier costs and workers' compensation premium rates by
 589 implementing changes to the carrier reimbursement schedule or
 590 implementing alternative reimbursement methods.

591 4. Submit recommendations on or before January 1, 2003,
 592 and biennially thereafter, to the President of the Senate and
 593 the Speaker of the House of Representatives on methods to
 594 improve the workers' compensation health care delivery system.

595
 596 The ~~agency and the~~ department, as requested, shall provide data
 597 to the panel, including, but not limited to, utilization trends
 598 in the workers' compensation health care delivery system. The
 599 department ~~agency~~ shall provide the panel with an annual report
 600 regarding the resolution of medical reimbursement disputes and
 601 any actions pursuant to subsection (8) ~~s. 440.13(8)~~. The
 602 department shall provide administrative support and service to
 603 the panel to the extent requested by the panel.

604 (13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE AUTHORIZED
 605 TO RENDER MEDICAL CARE.--The department ~~agency~~ shall remove from
 606 the list of physicians or facilities authorized to provide
 607 remedial treatment, care, and attendance under this chapter the
 608 name of any physician or facility found after reasonable
 609 investigation to have:

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

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

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

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

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

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

632 (g) Engaged in a pattern of practice of overutilization or
 633 a violation of this chapter or rules adopted by the department
 634 ~~agency~~, including failure to adhere to practice parameters and
 635 protocols established in accordance with this chapter.

636 Section 3. Section 440.125, Florida Statutes, is amended
 637 to read:

638 440.125 Medical records and reports; identifying
 639 information in employee medical bills; confidentiality.--Any
 640 medical records and medical reports of an injured employee and

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641 any information identifying an injured employee in medical bills
642 which are provided to the department, pursuant to s. 440.13, are
643 confidential and exempt from the provisions of s. 119.07(1) and
644 s. 24(a), Art. I of the State Constitution, except as otherwise
645 provided by this chapter. ~~The department may share any such~~
646 ~~confidential and exempt records, reports, or information~~
647 ~~received pursuant to s. 440.13 with the Agency for Health Care~~
648 ~~Administration and the Department of Education in furtherance of~~
649 ~~their official duties under ss. 440.13 and 440.134. The agency~~
650 ~~and the department shall maintain the confidential and exempt~~
651 ~~status of such records, reports, and information received.~~

652 Section 4. This act shall take effect July 1, 2008.