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2008 Legislature

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 s. 440.13, F.S.; revising  
 8           terminology, to conform; providing an effective date.

9

10 Be It Enacted by the Legislature of the State of Florida:

11

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

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

24           440.13 Medical services and supplies; penalty for  
 25 violations; limitations.--

26           (1) DEFINITIONS.--As used in this section, the term:

27           (a) "Alternate medical care" means a change in treatment  
 28 or health care provider.

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29 (b) "Attendant care" means care rendered by trained  
30 professional attendants which is beyond the scope of household  
31 duties. Family members may provide nonprofessional attendant  
32 care, but may not be compensated under this chapter for care  
33 that falls within the scope of household duties and other  
34 services normally and gratuitously provided by family members.  
35 "Family member" means a spouse, father, mother, brother, sister,  
36 child, grandchild, father-in-law, mother-in-law, aunt, or uncle.

37 (c) "Carrier" means, for purposes of this section,  
38 insurance carrier, self-insurance fund or individually self-  
39 insured employer, or assessable mutual insurer.

40 (d) "Certified health care provider" means a health care  
41 provider who has been certified by the department ~~agency~~ or who  
42 has entered an agreement with a licensed managed care  
43 organization to provide treatment to injured workers under this  
44 section. Certification of such health care provider must include  
45 documentation that the health care provider has read and is  
46 familiar with the portions of the statute, impairment guides,  
47 practice parameters, protocols of treatment, and rules which  
48 govern the provision of remedial treatment, care, and  
49 attendance.

50 (e) "Compensable" means a determination by a carrier or  
51 judge of compensation claims that a condition suffered by an  
52 employee results from an injury arising out of and in the course  
53 of employment.

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

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56 (g) "Health care facility" means any hospital licensed  
 57 under chapter 395 and any health care institution licensed under  
 58 chapter 400 or chapter 429.

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

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

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

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

81 (l) "Medically necessary" or "medical necessity" means any  
 82 medical service or medical supply which is used to identify or  
 83 treat an illness or injury, is appropriate to the patient's

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84 diagnosis and status of recovery, and is consistent with the  
85 location of service, the level of care provided, and applicable  
86 practice parameters. The service should be widely accepted among  
87 practicing health care providers, based on scientific criteria,  
88 and determined to be reasonably safe. The service must not be of  
89 an experimental, investigative, or research nature.

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

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

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

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

109 (q) "Physician" or "doctor" means a physician licensed  
110 under chapter 458, an osteopathic physician licensed under  
111 chapter 459, a chiropractic physician licensed under chapter

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112 460, a podiatric physician licensed under chapter 461, an  
 113 optometrist licensed under chapter 463, or a dentist licensed  
 114 under chapter 466, each of whom must be certified by the  
 115 department ~~agency~~ as a health care provider.

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

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

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

133 (3) PROVIDER ELIGIBILITY; AUTHORIZATION.--

134 (a) As a condition to eligibility for payment under this  
 135 chapter, a health care provider who renders services must be a  
 136 certified health care provider and must receive authorization  
 137 from the carrier before providing treatment. This paragraph does  
 138 not apply to emergency care. The department ~~agency~~ shall adopt  
 139 rules to implement the certification of health care providers.

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

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

162 (d) A carrier must respond, by telephone or in writing, to  
163 a request for authorization from an authorized health care  
164 provider by the close of the third business day after receipt of  
165 the request. A carrier who fails to respond to a written request  
166 for authorization for referral for medical treatment by the  
167 close of the third business day after receipt of the request

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168 consents to the medical necessity for such treatment. All such  
169 requests must be made to the carrier. Notice to the carrier does  
170 not include notice to the employer.

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

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

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

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

190 (i) Notwithstanding paragraph (d), a claim for specialist  
191 consultations, surgical operations, physiotherapeutic or  
192 occupational therapy procedures, X-ray examinations, or special  
193 diagnostic laboratory tests that cost more than \$1,000 and other  
194 specialty services that the department ~~agency~~ identifies by rule  
195 is not valid and reimbursable unless the services have been

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196 expressly authorized by the carrier, or unless the carrier has  
 197 failed to respond within 10 days to a written request for  
 198 authorization, or unless emergency care is required. The insurer  
 199 shall authorize such consultation or procedure unless the health  
 200 care provider or facility is not authorized or certified, unless  
 201 such treatment is not in accordance with practice parameters and  
 202 protocols of treatment established in this chapter, or unless a  
 203 judge of compensation claims has determined that the  
 204 consultation or procedure is not medically necessary, not in  
 205 accordance with the practice parameters and protocols of  
 206 treatment established in this chapter, or otherwise not  
 207 compensable under this chapter. Authorization of a treatment  
 208 plan does not constitute express authorization for purposes of  
 209 this section, except to the extent the carrier provides  
 210 otherwise in its authorization procedures. This paragraph does  
 211 not limit the carrier's obligation to identify and disallow  
 212 overutilization or billing errors.

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



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223 or to otherwise interfere in the selection by the sick or  
 224 injured employee of a pharmacy or pharmacist.

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

243 (7) UTILIZATION AND REIMBURSEMENT DISPUTES.--

244 (a) Any health care provider, carrier, or employer who  
 245 elects to contest the disallowance or adjustment of payment by a  
 246 carrier under subsection (6) must, within 30 days after receipt  
 247 of notice of disallowance or adjustment of payment, petition the  
 248 department ~~agency~~ to resolve the dispute. The petitioner must  
 249 serve a copy of the petition on the carrier and on all affected  
 250 parties by certified mail. The petition must be accompanied by

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251 all documents and records that support the allegations contained  
 252 in the petition. Failure of a petitioner to submit such  
 253 documentation to the department ~~agency~~ results in dismissal of  
 254 the petition.

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

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

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

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

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

283 1. Repayment of the appropriate amount to the health care  
 284 provider.

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

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

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

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

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

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

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

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

354 |       (c) If there is disagreement in the opinions of the health  
355 | care providers, if two health care providers disagree on medical  
356 | evidence supporting the employee's complaints or the need for  
357 | additional medical treatment, or if two health care providers  
358 | disagree that the employee is able to return to work, the  
359 | department ~~agency~~ may, and the judge of compensation claims  
360 | shall, upon his or her own motion or within 15 days after  
361 | receipt of a written request by either the injured employee, the  
362 | employer, or the carrier, order the injured employee to be

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363 evaluated by an expert medical advisor. The opinion of the  
364 expert medical advisor is presumed to be correct unless there is  
365 clear and convincing evidence to the contrary as determined by  
366 the judge of compensation claims. The expert medical advisor  
367 appointed to conduct the evaluation shall have free and complete  
368 access to the medical records of the employee. An employee who  
369 fails to report to and cooperate with such evaluation forfeits  
370 entitlement to compensation during the period of failure to  
371 report or cooperate.

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

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

384 (f) If the department ~~agency~~ or a judge of compensation  
385 claims orders the services of a certified expert medical advisor  
386 to resolve a dispute under this section, the party requesting  
387 such examination must compensate the advisor for his or her time  
388 in accordance with a schedule adopted by the department ~~agency~~.  
389 If the employee prevails in a dispute as determined in an order  
390 by a judge of compensation claims based upon the expert medical

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

400 |           (11) AUDITS.--

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

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419 outside practice parameters or protocols established in  
 420 accordance with this chapter, it must return those payments to  
 421 the carrier. The department ~~agency~~ may assess a penalty not to  
 422 exceed \$500 for each overpayment that is not refunded within 30  
 423 days after notification of overpayment by the department ~~agency~~  
 424 or carrier.

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



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447 insurer or group self-insurance fund is subject to disciplinary  
 448 action by the Office of Insurance Regulation.

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

454 (d) The following department ~~agency~~ actions do not  
 455 constitute agency action subject to review under ss. 120.569 and  
 456 120.57 and do not constitute actions subject to s. 120.56:  
 457 referral by the entity responsible for utilization review; a  
 458 decision by the department ~~agency~~ to refer a matter to a peer  
 459 review committee; establishment by a health care provider or  
 460 entity of procedures by which a peer review committee reviews  
 461 the rendering of health care services; and the review  
 462 proceedings, report, and recommendation of the peer review  
 463 committee.

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

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

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

496 |       (b) It is the intent of the Legislature to increase the  
497 | schedule of maximum reimbursement allowances for selected  
498 | physicians effective January 1, 2004, and to pay for the  
499 | increases through reductions in payments to hospitals. Revisions  
500 | developed pursuant to this subsection are limited to the  
501 | following:

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

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

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

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

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

522           (c) As to reimbursement for a prescription medication, the  
523 reimbursement amount for a prescription shall be the average  
524 wholesale price plus \$4.18 for the dispensing fee, except where  
525 the carrier has contracted for a lower amount. Fees for  
526 pharmaceuticals and pharmaceutical services shall be  
527 reimbursable at the applicable fee schedule amount. Where the  
528 employer or carrier has contracted for such services and the  
529 employee elects to obtain them through a provider not a party to

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530 the contract, the carrier shall reimburse at the schedule,  
531 negotiated, or contract price, whichever is lower. No such  
532 contract shall rely on a provider that is not reasonably  
533 accessible to the employee.

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

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

555 2. The impact upon cost to employers for providing a level  
556 of reimbursement for treatment, care, and attendance which will

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557 ensure the availability of treatment, care, and attendance  
558 required by injured workers;

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

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

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

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

580 2. Survey certified health care providers and health care  
581 facilities to determine the availability and accessibility of  
582 workers' compensation health care delivery systems for injured  
583 workers.

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

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

592  
 593 The ~~agency and the~~ department, as requested, shall provide data  
 594 to the panel, including, but not limited to, utilization trends  
 595 in the workers' compensation health care delivery system. The  
 596 department ~~agency~~ shall provide the panel with an annual report  
 597 regarding the resolution of medical reimbursement disputes and  
 598 any actions pursuant to s. 440.13(8). The department shall  
 599 provide administrative support and service to the panel to the  
 600 extent requested by the panel.

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

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

610           (b) Exceeded the limits of his or her or its professional  
 611 competence in rendering medical care under this chapter, or to

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612 have made materially false statements regarding his or her or  
613 its qualifications in his or her application;

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

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

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

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

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

633 Section 3. This act shall take effect July 1, 2008.