A bill to be entitled

An act relating to workers' compensation; amending s. 440.02, F.S.; redefining the term "specificity"; amending s. 440.13, F.S.; revising the scope of the health care provider's authorization under certain circumstances; requiring carriers to take specified actions by telephone or in writing relating to a request for authorization from certain health care providers; specifying that a notice to the employer is not a notice to the carrier; deleting a provision that specifies that a notice to the carrier is not a notice to the employer; conforming a provision to changes made by the act; requiring a panel to annually adopt statewide workers' compensation schedules of maximum reimbursement allowances by using specified methodologies; authorizing such panel to adopt a reimbursement methodology under certain circumstances; revising and providing maximum reimbursement methodologies to be incorporated in such schedules; amending s. 440.15, F.S.; extending the timeframe in which certain employees may receive temporary total disability benefits; providing conditions under which employees may receive permanent impairment benefits; extending the timeframe in which carriers must notify treating doctors of certain requirements; deleting a

provision relating to the calculation of time periods for payment of benefits; conforming provisions; creating s. 440.1915, F.S.; requiring claimants to sign an attestation before engaging the services of an attorney related to a workers' compensation claim; providing requirements; amending s. 440.192, F.S.; revising conditions under which the Office of the Judges of Compensation Claims must dismiss petitions for benefits; revising requirements for such petitions; prohibiting the office from dismissing a petition and from deeming any information on average wage accurate under certain circumstances; requiring a good faith effort to resolve a dispute; requiring dismissal of a petition for failure to make such good faith effort; revising construction relating to dismissals of petitions or portions thereof; requiring judges of compensation claims to enter orders on certain motions to dismiss within specified timeframes; amending s. 440.345, F.S.; providing requirements for a carrier's report of attorney fees; amending s. 440.491, F.S.; specifying that training and education benefits provided to a claimant are not in addition to the maximum number of weeks in which a claimant may receive temporary benefits; amending s. 627.211, F.S.; authorizing a member of or subscriber

to a rating organization to depart from the rates set by such organization under certain circumstances; providing requirements for such departure; providing an effective date.

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

Section 1. Subsection (40) of section 440.02, Florida Statutes, is 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:

(40) "Specificity" means information on the petition for benefits sufficient to put the employer or carrier on notice of the exact statutory classification and outstanding time period for each requested benefit, the specific amount of each requested benefit, the calculation used for computing the specific amount of each requested benefit, ~~of benefits being requested~~ and ~~includes~~ a detailed explanation of any benefits received that should be increased, decreased, changed, or otherwise modified. If the petition is for medical benefits, the information must ~~shall~~ include specific details as to why such benefits are being requested, why such benefits are medically necessary, and why current treatment, if any, is not sufficient. Any petition requesting alternate or other medical care,

including, but not limited to, petitions requesting psychiatric or psychological treatment, must specifically identify the physician, as defined in s. 440.13(1), who is recommending such treatment. A copy of a report from such physician making the recommendation for alternate or other medical care must ~~shall~~ also be attached to the petition. A judge of compensation claims may ~~shall~~ not order such treatment if a physician is not recommending such treatment.

Section 2. Paragraphs (a), (c), (d), and (i) of subsection (3) and subsection (12) 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)1. As a condition to eligibility for payment under this chapter, a health care provider who renders services must receive authorization from the carrier before providing treatment. However, a carrier's authorization of a physician that includes the provision of palliative care also authorizes the provision of such care by health care providers affiliated with the authorized physician.

2. The requirements in this paragraph for a health care provider to receive authorization before providing treatment do ~~does~~ not apply to emergency care.

(c)1. Except as provided in subparagraph 2., 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, unless the referral is for emergency treatment, and must be made in accordance with practice parameters and protocols of treatment as provided for in this chapter.

2. Testing or treatment under an authorized physician's referral for diagnostic testing or palliative care, including the provision of prescribed medical supplies or durable medical equipment with a reimbursable value of less than $500 for such supplies or equipment, to be provided by a health care provider affiliated with the authorized physician is deemed authorized. However, such referral and treatment or testing must be reported to the carrier pursuant to subsection (4).

(d) By telephone or in writing, a carrier must authorize or deny ~~respond, by telephone or in writing, to~~ a request for authorization from an authorized health care provider, or inform the health care provider of material deficiencies that prevent authorization or denial, 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 employer ~~carrier~~ does not include notice to the carrier ~~employer~~.

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other specialty services that the department identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, unless the carrier has failed to authorize or deny, or inform the provider of material deficiencies that prevent authorization or denial, ~~respond~~ within 10 days after ~~to~~ a written request for authorization, or unless emergency care is required. The carrier ~~insurer~~ shall authorize such consultation or procedure unless the health care provider or facility is not authorized, unless such treatment is not in accordance with practice parameters and protocols of treatment established in this chapter, or unless a judge of compensation claims has determined that the consultation or procedure is not medically necessary, not in accordance with the practice parameters and protocols of treatment established in this chapter, or otherwise not compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to

identify and disallow overutilization or billing errors.

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

(a)1. A three-member panel is created, consisting of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one of whom ~~member who~~, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other ~~member who~~, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees.

2. Annually, the panel shall adopt ~~determine~~ statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. ~~The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in observation status, which shall not exceed 23 hours. All compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and~~

~~customary charges, except as otherwise provided by this subsection. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.~~

(b) Except as otherwise provided in this subsection, the schedules of maximum reimbursement allowances adopted by the panel must be based upon the reimbursement methodologies provided in this subsection. However, the panel may adopt a reimbursement methodology for compensable medical care for which a reimbursement methodology is not provided in this subsection. Reimbursements shall be made based upon adopted schedules of maximum reimbursement allowances. ~~It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions developed pursuant to this subsection are limited to the following:~~

1. Payments for outpatient physical, occupational, and speech therapy provided by hospitals shall be reimbursed at ~~reduced to~~ the schedule of maximum reimbursement allowances for

these services that ~~which~~ applies to nonhospital providers.

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

3.a. Reimbursement for scheduled outpatient surgery in a hospital or ambulatory surgical center shall be 160 percent of the fee or rate established by the Medicare outpatient prospective payment system, except as otherwise provided in this subsection.

b. Reimbursement for scheduled outpatient surgery in a hospital or ambulatory surgical center that does not have a fee or rate under the Medicare outpatient prospective payment system shall be 60 percent of the statewide average charge for that service derived from the division's database of billed hospital or ambulatory surgical center charges, as applicable, over any consecutive 18-month period chosen by the panel that is within the 36 months before the adoption of the schedule, if at least 50 bills for the billed service are contained in the database during this 18-month period. Reimbursement for services related to scheduled outpatient surgery in a hospital or ambulatory surgical center that do not have a fee or rate under the Medicare outpatient prospective payment system and do not have a

statewide average charge shall be 60 percent of the facility's actual billed charge ~~Outpatient reimbursement for scheduled surgeries shall be reduced from 75 percent of charges to 60 percent of charges~~.

4.a. Reimbursement for nonscheduled hospital outpatient care shall be 200 percent of the fee or rate established by the Medicare outpatient prospective payment system, except as otherwise provided in this subsection.

b. Reimbursement for nonscheduled hospital outpatient care that does not have a fee or rate under the Medicare outpatient prospective payment system shall be 75 percent of the statewide average charge for those services derived from the division's database of billed hospital charges over any consecutive 18-month period chosen by the panel that is within the 36 months before the adoption of the schedule, if at least 50 bills for the billed service are contained in the database during this 18-month period. Reimbursement for nonscheduled hospital outpatient care that does not have a fee or rate under the Medicare outpatient prospective payment system and does not have a statewide average charge shall be 75 percent of the hospital's actual billed charge.

5. Except as provided in subparagraph 6., maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be at ~~increased to~~ 110 percent of the reimbursement allowed by Medicare, using appropriate codes and

modifiers or the medical reimbursement level adopted by the ~~three-member~~ panel as of January 1, 2003, whichever is greater.

6.~~5.~~ Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 for surgical procedures shall be at ~~increased to~~ 140 percent of the reimbursement allowed by Medicare or the medical reimbursement level adopted by the ~~three-member~~ panel as of January 1, 2003, whichever is greater.

7. Maximum reimbursement for inpatient hospital care shall be based on a schedule of per diem rates, subject to a stop-loss amount, approved by the panel to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which a patient may remain in observation status, which reimbursement may not exceed 23 hours of observation, regardless of whether more than 23 hours of observation occurred.

8. Maximum reimbursement for a physician, hospital, ambulatory surgical center, work-hardening program, pain-management program, or durable medical equipment provider shall be the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule adopted by the panel.

(c)1. ~~As to reimbursement for a prescription medication,~~ The reimbursement amount for a prescription medication shall be the average wholesale price plus $4.18 for the dispensing fee. For repackaged or relabeled prescription medications dispensed by a dispensing practitioner as provided in s. 465.0276, the fee

schedule for reimbursement shall be 112.5 percent of the average wholesale price, plus $8.00 for the dispensing fee. For purposes of this subsection, the average wholesale price shall be calculated by multiplying the number of units dispensed times the per-unit average wholesale price set by the original manufacturer of the underlying drug dispensed by the practitioner, based upon the published manufacturer's average wholesale price published in the Medi-Span Master Drug Database as of the date of dispensing. All pharmaceutical claims submitted for repackaged or relabeled prescription medications must include the National Drug Code of the original manufacturer. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount except where the employer or carrier, or a service company, third party administrator, or any entity acting on behalf of the employer or carrier directly contracts with the provider seeking reimbursement for a lower amount.

2. For prescription medication purchased under the requirements of this paragraph, a dispensing practitioner may not possess a prescription medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days after the practitioner takes possession of such medication.

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

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

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

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

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

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

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

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

3. Survey carriers to determine the estimated impact on

carrier costs and workers' compensation premium rates by implementing changes to the carrier reimbursement schedule or implementing alternative reimbursement methods.

4. Submit recommendations on or before January 15, 2017, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

(f) The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and ~~any~~ actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel. ~~For prescription medication purchased under the requirements of this subsection, a dispensing practitioner shall not possess such medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days of the dispensing practitioner taking possession of that medication.~~

Section 3. Paragraph (a) of subsection (2), paragraph (d) of subsection (3), paragraphs (a) and (e) of subsection (4), and subsection (6) of section 440.15, Florida Statutes, are amended,

and subsection (13) is added to that section, to read:

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

(2) TEMPORARY TOTAL DISABILITY.—

(a) Subject to subparagraph (3)(d)3. and subsections ~~subsection~~ (7) and (13), in case of disability total in character but temporary in quality, 66 2/3 or 66.67 percent of the average weekly wages shall be paid to the employee during the continuance thereof, ~~not to exceed 104 weeks~~ except as provided in this subsection and~~,~~ s. 440.12(1)~~, and s. 440.14(3)~~. Once the employee reaches the maximum number of weeks allowed, or the employee reaches overall ~~the date of~~ maximum medical improvement, whichever occurs earlier, temporary disability benefits must ~~shall~~ cease and the injured worker's permanent impairment shall be determined. If the employee reaches the maximum number of weeks allowed but has not reached overall maximum medical improvement, benefits shall be provided pursuant to subparagraph (3)(d)3.

(3) PERMANENT IMPAIRMENT BENEFITS.—

(d) After the employee has been certified by a doctor as having reached maximum medical improvement or 6 weeks before the expiration of temporary benefits, whichever occurs earlier, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating, using the impairment schedule

referred to in paragraph (b). If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation must be submitted to the treating doctor, the employee, and the carrier within 10 days after the evaluation. The treating doctor must indicate to the carrier agreement or disagreement with the other doctor's certification and evaluation.

1. The certifying doctor shall issue a written report to the employee and the carrier certifying that maximum medical improvement has been reached, stating the impairment rating to the body as a whole, and providing any other information required by the department by rule. The carrier shall establish an overall maximum medical improvement date and permanent impairment rating, based upon all such reports.

2. Within 14 days after the carrier's knowledge of each maximum medical improvement date and impairment rating to the body as a whole upon which the carrier is paying benefits, the carrier shall report such maximum medical improvement date and, when determined, the overall maximum medical improvement date and associated impairment rating to the department in a format as set forth in department rule. If the employee has not been certified as having reached overall maximum medical improvement before the expiration of 254 ~~98~~ weeks after the date temporary disability benefits begin to accrue, the carrier shall notify the treating doctor of the requirements of this section.

3. If an employee receiving benefits under subsection (2) has not reached overall maximum medical improvement before receiving the maximum number of weeks of temporary disability benefits, the maximum number of weeks are extended for up to an additional 26 weeks. If the employee has not reached overall maximum medical improvement after receiving the additional weeks allowed under this subparagraph, a judge of compensation claims, upon petition, must determine the employee's current eligibility for benefits under this subsection and subsection (1).

4. If an employee receiving benefits under subsection (4) has not reached overall maximum medical improvement before receiving the maximum number of weeks of temporary disability benefits, the employee shall receive benefits under this subsection in accordance with the greatest single impairment rating assigned to the employee. Impairment benefits received under this subparagraph shall be credited against indemnity benefits subsequently due to the employee.

(4) TEMPORARY PARTIAL DISABILITY.—

(a) Subject to subparagraph (3)(d)3. and subsections ~~subsection~~ (7) and (13), in case of temporary partial disability, compensation shall be equal to 80 percent of the difference between 80 percent of the employee's average weekly wage and the salary, wages, and other remuneration the employee is able to earn postinjury, as compared weekly; however, weekly temporary partial disability benefits may not exceed an amount

equal to 66 2/3 or 66.67 percent of the employee's average weekly wage at the time of accident. In order to simplify the comparison of the preinjury average weekly wage with the salary, wages, and other remuneration the employee is able to earn postinjury, the department may by rule provide for payment of the initial installment of temporary partial disability benefits to be paid as a partial week so that payment for remaining weeks of temporary partial disability can coincide as closely as possible with the postinjury employer's work week. The amount determined to be the salary, wages, and other remuneration the employee is able to earn shall in no case be less than the sum actually being earned by the employee, including earnings from sheltered employment. Benefits shall be payable under this subsection only if overall maximum medical improvement has not been reached and the medical conditions resulting from the accident create restrictions on the injured employee's ability to return to work.

(e) Subject to subparagraph (3)(d)3. and subsections (7) and (13), such benefits shall be paid during the continuance of such disability, ~~not to exceed a period of 104 weeks,~~ as provided by this subsection and subsection (2). ~~Once the injured employee reaches the maximum number of weeks, temporary disability benefits cease and the injured worker's permanent impairment must be determined.~~ If the employee is terminated from postinjury employment based on the employee's misconduct,

temporary partial disability benefits are not payable as provided for in this section. The department shall by rule specify forms and procedures governing the method and time for payment of temporary disability benefits for dates of accidents before January 1, 1994, and for dates of accidents on or after January 1, 1994.

(6) EMPLOYEE REFUSES EMPLOYMENT.—If an injured employee refuses employment suitable to the capacity thereof, offered to or procured therefor, such employee is ~~shall~~ not ~~be~~ entitled to any compensation at any time during the continuance of such refusal, unless at any time, in the opinion of the judge of compensation claims, such refusal is justifiable. ~~Time periods for the payment of benefits in accordance with this section shall be counted in determining the limitation of benefits as provided for in paragraphs (2)(a), (3)(c), and (4)(b).~~

(13) MAXIMUM BENEFITS ALLOWED.—The total number of weeks of benefits received by an employee for temporary total disability payable pursuant to subsection (2), temporary partial disability payable pursuant to subsection (4), and temporary total disability payable pursuant to s. 440.491 may not exceed 260 weeks, except as provided in subparagraph (3)(d)3.

Section 4. Section 440.1915, Florida Statutes, is created to read:

440.1915 Notice regarding payment of attorney fees.—An injured employee or any other party making a claim for benefits

under this chapter through an attorney must provide his or her personal signature attesting that he or she has reviewed, understands, and acknowledges the following statement, which must be in at least 14-point bold type, before engaging an attorney for services related to a petition for benefits under s. 440.192 or s. 440.25: "THE WORKERS' COMPENSATION LAW REQUIRES YOU TO PAY YOUR OWN ATTORNEY FEES. YOUR EMPLOYER AND ITS INSURANCE CARRIER ARE NOT REQUIRED TO PAY YOUR ATTORNEY FEES, EXCEPT IN CERTAIN CIRCUMSTANCES. EVEN THEN, YOU MAY BE RESPONSIBLE FOR PAYING ATTORNEY FEES IN ADDITION TO ANY AMOUNT YOUR EMPLOYER OR ITS INSURANCE CARRIER MAY BE REQUIRED TO PAY, DEPENDING ON THE DETAILS OF YOUR AGREEMENT WITH YOUR ATTORNEY OR REPRESENTATIVE. CAREFULLY READ AND MAKE SURE YOU UNDERSTAND ANY AGREEMENT OR RETAINER FOR REPRESENTATION BEFORE YOU SIGN IT." If the injured employee or other party does not sign or refuses to sign the document attesting that he or she has reviewed, understands, and acknowledges the statement, the injured employee or other party making a claim for benefits under this chapter is prohibited from proceeding with a petition for benefits under s. 440.192 or s. 440.25, except pro se, until a signature is obtained.

Section 5. Subsections (2), (4), and (5) of section 440.192, Florida Statutes, are amended to read:

440.192 Procedure for resolving benefit disputes.—

(2) Upon receipt, the Office of the Judges of Compensation

Claims shall review each petition and shall dismiss each petition or any portion of such a petition that does not on its face meet the requirements of this section, provide the specificity as defined in s. 440.02, and specifically identify or itemize the following:

(a) The name, address, and telephone number~~, and social security number~~ of the employee.

(b) The name, address, and telephone number of the employer.

(c) A detailed description of the injury and cause of the injury, including the Florida county or, if outside of Florida, the state ~~location~~ of the occurrence and the date or dates of the accident.

(d) A detailed description of the employee's job, work responsibilities, and work the employee was performing when the injury occurred.

(e) The specific time period for which compensation and the specific classification of compensation were not timely provided.

(f) The specific date of maximum medical improvement, character of disability, and specific statement of all benefits or compensation that the employee is seeking. A claim for permanent benefits must include the specific date of maximum medical improvement and the specific date that such permanent benefits are claimed to begin.

(g) All specific travel costs to which the employee believes she or he is entitled, including dates of travel and purpose of travel, means of transportation, and mileage and including the date the request for mileage was filed with the carrier and a copy of the request filed with the carrier.

(h) A specific listing of all medical charges alleged unpaid, including the name and address of the medical provider, the amounts due, and the specific dates of treatment.

(i) The type or nature of treatment care or attendance sought and the justification for such treatment. If the employee is under the care of a physician for an injury identified under paragraph (c), a copy of the physician's request, authorization, or recommendation for treatment, care, or attendance must accompany the petition.

(j) The specific amount of compensation claimed and the methodology used to calculate the average weekly wage if the average weekly wage calculated by the employer or carrier is disputed; otherwise, the average weekly wage and corresponding compensation calculated by the employer or carrier are presumed to be accurate. If the employer failed to report wage information as required by rule, the office may not dismiss a petition for lack of specificity related to wage information and may not deem any information on average weekly wage to be accurate.

(k) ~~(j)~~ A specific explanation of any other disputed issue

that a judge of compensation claims will be called to rule upon.

(l) The signed attestation required pursuant to s. 440.1915.

(m) Evidence of a good faith effort to resolve the dispute pursuant to subsection (4).

The dismissal of any petition or portion of such a petition under this subsection ~~section~~ is without prejudice and does not require a hearing.

(4) Before filing a petition, the claimant or, if the claimant is represented by counsel, the claimant's attorney must make a good faith effort to resolve the dispute. The petition must include evidence and a certification by the claimant or, if the claimant is represented by counsel, the claimant's attorney~~,~~ stating that the claimant~~,~~ or the claimant's attorney ~~if the claimant is represented by counsel,~~ has made a good faith effort to resolve the dispute and that the claimant or the claimant's attorney was unable to resolve the dispute with the carrier or employer, if self-insured. If the petition is not dismissed under subsection (2), the judge of compensation claims must review the evidence required under this subsection and determine, in her or his independent discretion, whether a good faith effort to resolve the dispute was made by the claimant or the claimant's attorney. Upon a determination that the claimant or the claimant's attorney has not made a good faith effort to

resolve the dispute, the judge of compensation claims must dismiss the petition.

(5)(a) All motions to dismiss must state with particularity the basis for the motion. The judge of compensation claims shall enter an order upon such motions without hearing, unless good cause for hearing is shown. Dismissal of any petition or portion of a petition under this subsection is without prejudice.

(b) Upon motion that a petition or portion of a petition be dismissed for lack of specificity, a judge of compensation claims shall enter an order on the motion, unless stipulated in writing by the parties, within 10 days after the motion is filed or, if good cause for hearing is shown, within 20 days after hearing on the motion. When any petition or portion of a petition is dismissed for lack of specificity under this subsection, the claimant must be allowed 20 days after the date of the order of dismissal in which to file an amended petition. Any grounds for dismissal for lack of specificity under this section which are not asserted within 30 days after receipt of the petition for benefits are thereby waived.

Section 6. Section 440.345, Florida Statutes, is amended to read:

440.345 Reporting of attorney ~~attorney's~~ fees.—All fees paid to attorneys for services rendered under this chapter shall be reported to the Office of the Judges of Compensation Claims

as the Division of Administrative Hearings requires by rule. A carrier must specify in its report the total amount of attorney fees paid for and the total number of attorney hours spent on services related to the defense of petitions, and the total amount of attorney fees paid for services unrelated to the defense of petitions.

Section 7. Paragraph (b) of subsection (6) of section 440.491, Florida Statutes, is amended to read:

440.491 Reemployment of injured workers; rehabilitation.—

(6) TRAINING AND EDUCATION.—

(b) When an employee who has attained maximum medical improvement is unable to earn at least 80 percent of the compensation rate and requires training and education to obtain suitable gainful employment, the employer or carrier shall pay the employee additional training and education temporary total compensation benefits while the employee receives such training and education for a period not to exceed 26 weeks, which period may be extended for an additional 26 weeks or less, if such extended period is determined to be necessary and proper by a judge of compensation claims. The benefits provided under this paragraph are ~~shall~~ not ~~be~~ in addition to the maximum number of ~~104~~ weeks as specified in s. 440.15(2). However, a carrier or employer is not precluded from voluntarily paying additional temporary total disability compensation beyond that period. If an employee requires temporary residence at or near a facility

or an institution providing training and education which is located more than 50 miles away from the employee's customary residence, the reasonable cost of board, lodging, or travel must be borne by the department from the Workers' Compensation Administration Trust Fund established by s. 440.50. An employee who refuses to accept training and education that is recommended by the vocational evaluator and considered necessary by the department will forfeit any additional training and education benefits and any additional compensation ~~payment for lost wages~~ under this chapter. The carrier shall notify the injured employee of the availability of training and education benefits as specified in this chapter. The Department of Financial Services shall include information regarding the eligibility for training and education benefits in informational materials specified in ss. 440.207 and 440.40.

Section 8. Subsection (1) of section 627.211, Florida Statutes, is amended, and subsection (7) is added to that section, to read:

627.211 Deviations and departures; workers' compensation and employer's liability insurances.—

(1) Except as provided in subsection (7), every member of or subscriber to a rating organization shall, as to workers' compensation or employer's liability insurance, adhere to the filings made on its behalf by such organization; except that any such insurer may make written application to the office for

permission to file a uniform percentage decrease or increase to be applied to the premiums produced by the rating system so filed for a kind of insurance, for a class of insurance which is found by the office to be a proper rating unit for the application of such uniform percentage decrease or increase, or for a subdivision of workers' compensation or employer's liability insurance:

(a) Composed ~~Comprised~~ of a group of manual classifications which is treated as a separate unit for ratemaking purposes; or

(b) For which separate expense provisions are included in the filings of the rating organization.

Such application shall specify the basis for the modification and shall be accompanied by the data upon which the applicant relies. A copy of the application and data shall be sent simultaneously to the rating organization.

(7) Without approval of the office, a member of or subscriber to a rating organization may depart from the filings made on its behalf by a rating organization for a period of 12 months by a uniform decrease of up to 5 percent to be applied uniformly to the premiums resulting from the approved rates for the policy period. The member or subscriber must file an informational departure statement with the office within 30 days after the initial use of such departure specifying the

percentage of the departure from the approved rates and an explanation of how the departure will be applied. If the departure is to be applied over a subsequent 12-month period, the member or subscriber must file a supplemental informational departure statement at least 30 days before the end of the current period. If the office determines that a departure violates the applicable principles for ratemaking under ss. 627.062 and 627.072, would result in predatory pricing, or imperils the financial condition of the member or subscriber, the office must issue an order specifying its findings and stating the time period within which the departure expires, which must be within a reasonable time after the order is issued. The order does not affect an insurance contract or policy made or issued before the departure expiration period specified in the order.

Section 9. This act shall take effect July 1, 2019.