1 A bill to be entitled
2 An act relating to workers' compensation; amending s.
3 440.02, F.S.; redefining the term "specificity";
4 amending s. 440.105, F.S.; authorizing certain
5 attorneys to receive fees or other consideration for
6 services related to Workers' Compensation Law;
7 amending s. 440.13, F.S.; requiring carriers to take
8 specified actions by telephone or in writing relating
9 to a request for authorization; specifying that a
10 notice to the employer is not a notice to the carrier;
11 conforming a provision to changes made by the act;
12 requiring the Governor, or the Chief Financial Officer
13 in certain circumstances, to appoint a member to fill
14 a vacancy on a panel that establishes certain workers'
15 compensation schedules within a specified timeframe;
16 requiring such panel to annually adopt statewide
17 schedules of maximum reimbursement allowances by using
18 specified methodologies; authorizing such panel to
19 adopt a reimbursement methodology under certain
20 circumstances; revising and providing maximum
21 reimbursement methodologies to be incorporated in such
22 schedules; prohibiting dispensing practitioners from
23 possessing prescription medications in certain
24 circumstances; amending s. 440.15, F.S.; extending the
25 timeframe in which certain employees may receive

26 temporary total disability benefits; providing
27 conditions under which employees may receive permanent
28 impairment benefits; extending the timeframe in which
29 carriers must notify treating doctors of certain
30 requirements; deleting a provision relating to the
31 calculation of time periods for payment of benefits;
32 amending s. 440.192, F.S.; revising conditions under
33 which the Office of the Judges of Compensation Claims
34 must dismiss petitions for benefits; revising
35 requirements for such petitions; revising construction
36 relating to dismissals of petitions or portions
37 thereof; requiring judges of compensation claims to
38 enter orders on certain motions to dismiss within
39 specified timeframes; revising a restriction on
40 awarding attorney fees; amending s. 440.25, F.S.;
41 extending the timeframe in which attorney fees attach;
42 amending s. 440.34, F.S.; revising provisions relating
43 to awarding attorney fees; providing that retainer
44 agreements do not require approval by a judge of
45 compensation claims but are required to be filed with
46 the Office of the Judges of Compensation Claims;
47 conforming a cross-reference; extending the timeframe
48 in which attorney fees attach; authorizing a judge of
49 compensation claims to depart from the attorney fees
50 schedule under certain circumstances; requiring a

51 judge to consider certain factors when awarding
52 attorney fees that depart from such schedule; defining
53 terms; limiting the amount of such fee; providing for
54 the adjustment of such fee; requiring that the hourly
55 rate limit of such fee be determined and published
56 annually; amending s. 440.345, F.S.; providing
57 requirements for a carrier's report; amending s.
58 440.491, F.S.; specifying that training and education
59 benefits provided to a claimant are not in addition to
60 the maximum number of weeks in which a claimant may
61 receive temporary benefits; amending s. 627.211, F.S.;
62 authorizing a member of or subscriber to a rating
63 organization to depart from the rates set by such
64 organization under certain circumstances; providing
65 requirements for such departure; providing an
66 effective date.
67
68 Be It Enacted by the Legislature of the State of Florida:
69
70 Section 1. Subsection (40) of section 440.02, Florida
71 Statutes, is amended to read:
72 440.02 Definitions.—When used in this chapter, unless the
73 context clearly requires otherwise, the following terms shall
74 have the following meanings:
75 (40) "Specificity" means information on the petition for

76 benefits sufficient to put the employer or carrier on notice of
77 the exact statutory classification and outstanding time period
78 for each requested benefit, the specific amount of each
79 requested benefit, the calculation used for computing the
80 specific amount of each requested benefit, ~~of benefits being~~
81 ~~requested~~ and ~~includes~~ a detailed explanation of any benefits
82 received that should be increased, decreased, changed, or
83 otherwise modified. If the petition is for medical benefits, the
84 information must ~~shall~~ include specific details as to why such
85 benefits are being requested, why such benefits are medically
86 necessary, and why current treatment, if any, is not sufficient.
87 Any petition requesting alternate or other medical care,
88 including, but not limited to, petitions requesting psychiatric
89 or psychological treatment, must specifically identify the
90 physician, as defined in s. 440.13(1), who is recommending such
91 treatment. A copy of a report from such physician making the
92 recommendation for alternate or other medical care must ~~shall~~
93 also be attached to the petition. A judge of compensation claims
94 may ~~shall~~ not order such treatment if a physician is not
95 recommending such treatment.
96 Section 2. Paragraph (c) of subsection (3) of section
97 440.105, Florida Statutes, is amended to read:
98 440.105 Prohibited activities; reports; penalties;
99 limitations.—
100 (3) Whoever violates any provision of this subsection

101 commits a misdemeanor of the first degree, punishable as
102 provided in s. 775.082 or s. 775.083.
103 (c) Except for an attorney retained by or for an injured
104 worker receiving a fee or other consideration from or on behalf
105 of an injured worker, it is unlawful for any ~~attorney or other~~
106 person, in his or her individual capacity or in his or her
107 capacity as a public or private employee, or for any firm,
108 corporation, partnership, or association to receive any fee or
109 other consideration or any gratuity from a person on account of
110 services rendered for a person in connection with any
111 proceedings arising under this chapter, unless such fee,
112 consideration, or gratuity is approved by a judge of
113 compensation claims or by the Deputy Chief Judge of Compensation
114 Claims.
115 Section 3. Paragraphs (d) and (i) of subsection (3) and
116 subsection (12) of section 440.13, Florida Statutes, are amended
117 to read:
118 440.13 Medical services and supplies; penalty for
119 violations; limitations.—
120 (3) PROVIDER ELIGIBILITY; AUTHORIZATION.—
121 (d) By telephone or in writing, a carrier must authorize
122 or deny ~~respond, by telephone or in writing, to~~ a request for
123 authorization from an authorized health care provider, or inform
124 the provider of material deficiencies that prevent authorization
125 or denial, by the close of the third business day after receipt

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

hb7085-00

126 of the request. A carrier who fails to respond to a written
127 request for authorization for referral for medical treatment by
128 the close of the third business day after receipt of the request
129 consents to the medical necessity for such treatment. All such
130 requests must be made to the carrier. Notice to the employer
131 ~~carrier~~ does not include notice to the carrier ~~employer~~.
132 (i) Notwithstanding paragraph (d), a claim for specialist
133 consultations, surgical operations, physiotherapeutic or
134 occupational therapy procedures, X-ray examinations, or special
135 diagnostic laboratory tests that cost more than $1,000 and other
136 specialty services that the department identifies by rule is not
137 valid and reimbursable unless the services have been expressly
138 authorized by the carrier, unless the carrier has failed to
139 authorize or deny, or inform the provider of material
140 deficiencies that prevent authorization or denial, ~~respond~~
141 within 10 days after ~~to~~ a written request for authorization, or
142 unless emergency care is required. The insurer shall authorize
143 such consultation or procedure unless the health care provider
144 or facility is not authorized, unless such treatment is not in
145 accordance with practice parameters and protocols of treatment
146 established in this chapter, or unless a judge of compensation
147 claims has determined that the consultation or procedure is not
148 medically necessary, not in accordance with the practice
149 parameters and protocols of treatment established in this
150 chapter, or otherwise not compensable under this chapter.

151 Authorization of a treatment plan does not constitute express
152 authorization for purposes of this section, except to the extent
153 the carrier provides otherwise in its authorization procedures.
154 This paragraph does not limit the carrier's obligation to
155 identify and disallow overutilization or billing errors.
156 (12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM
157 REIMBURSEMENT ALLOWANCES.—
158 (a)1. A three-member panel is created, consisting of the
159 Chief Financial Officer, or the Chief Financial Officer's
160 designee, and two members to be appointed by the Governor,
161 subject to confirmation by the Senate, one member who, on
162 account of present or previous vocation, employment, or
163 affiliation, shall be classified as a representative of
164 employers, the other member who, on account of previous
165 vocation, employment, or affiliation, shall be classified as a
166 representative of employees. The Governor shall appoint a new
167 member to the panel within 45 days after a vacancy occurs. If
168 the Governor fails to fill such vacancy, the Chief Financial
169 Officer shall appoint a new member to the panel within 45 days
170 after the expiration of the Governor's opportunity to fill the
171 vacancy, subject to confirmation by the Senate.
172 2. Annually, the panel shall adopt ~~determine~~ statewide
173 schedules of maximum reimbursement allowances for medically
174 necessary treatment, care, and attendance provided by
175 physicians, hospitals, ambulatory surgical centers, work-

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

176 hardening programs, pain programs, and durable medical
177 equipment. ~~The maximum reimbursement allowances for inpatient~~
178 ~~hospital care shall be based on a schedule of per diem rates, to~~
179 ~~be approved by the three-member panel no later than March 1,~~
180 ~~1994, to be used in conjunction with a precertification manual~~
181 ~~as determined by the department, including maximum hours in~~
182 ~~which an outpatient may remain in observation status, which~~
183 ~~shall not exceed 23 hours. All compensable charges for hospital~~
184 ~~outpatient care shall be reimbursed at 75 percent of usual and~~
185 ~~customary charges, except as otherwise provided by this~~
186 ~~subsection. Annually, the three-member panel shall adopt~~
187 ~~schedules of maximum reimbursement allowances for physicians,~~
188 ~~hospital inpatient care, hospital outpatient care, ambulatory~~
189 ~~surgical centers, work-hardening programs, and pain programs. An~~
190 ~~individual physician, hospital, ambulatory surgical center, pain~~
191 ~~program, or work-hardening program shall be reimbursed either~~
192 ~~the agreed-upon contract price or the maximum reimbursement~~
193 ~~allowance in the appropriate schedule.~~
194 (b) Except as provided in this subsection, the schedules
195 of maximum reimbursement allowances adopted by the panel must be
196 based upon the reimbursement methodologies provided in this
197 subsection. However, the panel may adopt a reimbursement
198 methodology for compensable medical care for which a
199 reimbursement methodology is not provided in this subsection.
200 Reimbursements shall be made based upon adopted schedules of

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

201 maximum reimbursement allowances. ~~It is the intent of the~~
202 ~~Legislature to increase the schedule of maximum reimbursement~~
203 ~~allowances for selected physicians effective January 1, 2004,~~
204 ~~and to pay for the increases through reductions in payments to~~
205 ~~hospitals. Revisions developed pursuant to this subsection are~~
206 ~~limited to the following:~~
207 1. Payments for outpatient physical, occupational, and
208 speech therapy provided by hospitals shall be reimbursed at
209 ~~reduced to~~ the schedule of maximum reimbursement allowances for
210 these services which apply ~~applies~~ to nonhospital providers.
211 2. Payments for scheduled outpatient nonemergency
212 radiological and clinical laboratory services that are not
213 provided in conjunction with a surgical procedure shall be
214 reimbursed at ~~reduced to~~ the schedule of maximum reimbursement
215 allowances for these services which applies to nonhospital
216 providers.
217 3.a. Reimbursement for scheduled outpatient surgery in a
218 hospital or ambulatory surgical center shall be 160 percent of
219 the fee or rate established by the Medicare outpatient
220 prospective payment system, except as otherwise provided by this
221 subsection.
222 b. Reimbursement for scheduled outpatient surgery in a
223 hospital or ambulatory surgical center that does not have a fee
224 or rate under the Medicare outpatient prospective payment system
225 shall be 60 percent of the statewide average charge for that

226 service derived from the division's database of billed hospital
227 or ambulatory surgical center charges, as applicable, over a
228 consecutive 18-month period within the 36 months before the
229 adoption of the schedule, as designated by the panel if at least
230 50 bills for the billed service are contained in the database
231 during the 18-month period. Services related to scheduled
232 outpatient surgery in a hospital or ambulatory surgical center
233 which do not have a fee or rate under the Medicare outpatient
234 prospective payment system and do not have a statewide average
235 charge shall be reimbursed at 60 percent of the facility's
236 actual billed charge ~~Outpatient reimbursement for scheduled~~
237 ~~surgeries shall be reduced from 75 percent of charges to 60~~
238 ~~percent of charges~~.
239 4.a. Reimbursement for nonscheduled hospital outpatient
240 care shall be 200 percent of the fee or rate established by the
241 Medicare outpatient prospective payment system, except as
242 otherwise provided by this subsection.
243 b. Reimbursement for nonscheduled hospital outpatient
244 surgical services that do not have a fee or rate under the
245 Medicare outpatient prospective payment system shall be 75
246 percent of the statewide average charge for that service derived
247 from the division's database of billed hospital charges over a
248 consecutive 18-month period within the 36 months before the
249 adoption of the schedule, as designated by the panel, if at
250 least 50 bills for the billed service are contained in the

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

251 database during the 18-month period. Nonscheduled hospital
252 outpatient surgical services that do not have a fee or rate
253 under the Medicare outpatient prospective payment system and do
254 not have a statewide average charge shall be reimbursed at 75
255 percent of the hospital's actual billed charge.
256 5. Maximum reimbursement for a physician licensed under
257 chapter 458 or chapter 459 shall be at ~~increased to~~ 110 percent
258 of the reimbursement allowed by Medicare, using appropriate
259 codes and modifiers or the medical reimbursement level adopted
260 by the ~~three-member~~ panel as of January 1, 2003, whichever is
261 greater.
262 6.~~5.~~ Maximum reimbursement for surgical procedures shall
263 be at ~~increased to~~ 140 percent of the reimbursement allowed by
264 Medicare or the medical reimbursement level adopted by the
265 ~~three-member~~ panel as of January 1, 2003, whichever is greater.
266 7. Maximum reimbursement for inpatient hospital care shall
267 be based on a schedule of per diem rates, subject to a stop-loss
268 amount, approved by the panel to be used in conjunction with a
269 precertification manual as determined by the department,
270 including maximum hours in which an outpatient may remain in
271 observation status, which reimbursement may not exceed 23 hours
272 of observation, regardless of whether more than 23 hours of
273 observation occurred.
274 8. Maximum reimbursement for a physician, hospital,
275 ambulatory surgical center, work-hardening program, pain-

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

276 management program, or durable medical equipment provider shall
277 be the agreed-upon contract price or the maximum reimbursement
278 allowance in the appropriate schedule adopted by the panel.
279 (c)1. ~~As to reimbursement for a prescription medication,~~
280 The reimbursement amount for a prescription medication shall be
281 the average wholesale price plus $4.18 for the dispensing fee.
282 For repackaged or relabeled prescription medications dispensed
283 by a dispensing practitioner as provided in s. 465.0276, the fee
284 schedule for reimbursement shall be 112.5 percent of the average
285 wholesale price, plus $8.00 for the dispensing fee. For purposes
286 of this subsection, the average wholesale price shall be
287 calculated by multiplying the number of units dispensed times
288 the per-unit average wholesale price set by the original
289 manufacturer of the underlying drug dispensed by the
290 practitioner, based upon the published manufacturer's average
291 wholesale price published in the Medi-Span Master Drug Database
292 as of the date of dispensing. All pharmaceutical claims
293 submitted for repackaged or relabeled prescription medications
294 must include the National Drug Code of the original
295 manufacturer. Fees for pharmaceuticals and pharmaceutical
296 services shall be reimbursable at the applicable fee schedule
297 amount except where the employer or carrier, or a service
298 company, third party administrator, or any entity acting on
299 behalf of the employer or carrier directly contracts with the
300 provider seeking reimbursement for a lower amount.

301 <u>2. For prescription medication purchased under the</u>
302 <u>requirements of this paragraph, a dispensing practitioner may</u>
303 <u>not possess a prescription medication unless payment has been</u>
304 <u>made by the practitioner, the practitioner's professional</u>
305 <u>practice, or the practitioner's practice management company or</u>
306 <u>employer to the supplying manufacturer, wholesaler, distributor,</u>
307 <u>or drug repackager within 60 days after such practitioner takes</u>
308 <u>possession of such medication.</u>
309 (d) Reimbursement for all fees and other charges for such
310 treatment, care, and attendance, including treatment, care, and
311 attendance provided by any hospital or other health care
312 provider, ambulatory surgical center, work-hardening program, or
313 pain program, must not exceed the amounts provided by the
314 ~~uniform~~ schedule of maximum reimbursement allowances as
315 determined by the panel or as otherwise provided in this
316 section. This subsection also applies to independent medical
317 examinations performed by health care providers under this
318 chapter. In determining the ~~uniform~~ schedule, the panel shall
319 first approve the data which it finds representative of
320 prevailing charges in the state for similar treatment, care, and
321 attendance of injured persons. Each health care provider, health
322 care facility, ambulatory surgical center, work-hardening
323 program, or pain program receiving workers' compensation
324 payments shall maintain records verifying their usual charges.
325 In establishing the ~~uniform~~ schedule of maximum reimbursement

326 allowances, the panel must consider:
327 1. The levels of reimbursement for similar treatment,
328 care, and attendance made by other health care programs or
329 third~~-~~party providers;
330 2. The impact upon cost to employers for providing a level
331 of reimbursement for treatment, care, and attendance which will
332 ensure the availability of treatment, care, and attendance
333 required by injured workers;
334 3. The financial impact of the reimbursement allowances
335 upon health care providers and health care facilities, including
336 trauma centers as defined in s. 395.4001, and its effect upon
337 their ability to make available to injured workers such
338 medically necessary remedial treatment, care, and attendance.
339 The ~~uniform~~ schedule of maximum reimbursement allowances must be
340 reasonable, must promote health care cost containment and
341 efficiency with respect to the workers' compensation health care
342 delivery system, and must be sufficient to ensure availability
343 of such medically necessary remedial treatment, care, and
344 attendance to injured workers; and
345 4. The most recent average maximum allowable rate of
346 increase for hospitals determined by the Health Care Board under
347 chapter 408.
348 (e) In addition to establishing the ~~uniform~~ schedule of
349 maximum reimbursement allowances, the panel shall:
350 1. Take testimony, receive records, and collect data to

351 evaluate the adequacy of the workers' compensation fee schedule,
352 nationally recognized fee schedules and alternative methods of
353 reimbursement to health care providers and health care
354 facilities for inpatient and outpatient treatment and care.
355 2. Survey health care providers and health care facilities
356 to determine the availability and accessibility of workers'
357 compensation health care delivery systems for injured workers.
358 3. Survey carriers to determine the estimated impact on
359 carrier costs and workers' compensation premium rates by
360 implementing changes to the carrier reimbursement schedule or
361 implementing alternative reimbursement methods.
362 4. Submit recommendations on or before January 15, 2017,
363 and biennially thereafter, to the President of the Senate and
364 the Speaker of the House of Representatives on methods to
365 improve the workers' compensation health care delivery system.
366 <u>(f)</u> The department, as requested, shall provide data to
367 the panel, including, but not limited to, utilization trends in
368 the workers' compensation health care delivery system. The
369 department shall provide the panel with an annual report
370 regarding the resolution of medical reimbursement disputes and
371 ~~any~~ actions pursuant to subsection (8). The department shall
372 provide administrative support and service to the panel to the
373 extent requested by the panel. ~~For prescription medication~~
374 ~~purchased under the requirements of this subsection, a~~
375 ~~dispensing practitioner shall not possess such medication unless~~

376 ~~payment has been made by the practitioner, the practitioner's~~
377 ~~professional practice, or the practitioner's practice management~~
378 ~~company or employer to the supplying manufacturer, wholesaler,~~
379 ~~distributor, or drug repackager within 60 days of the dispensing~~
380 ~~practitioner taking possession of that medication.~~
381 Section 4. Paragraph (a) of subsection (2), paragraph (d)
382 of subsection (3), paragraph (e) of subsection (4), and
383 subsection (6) of section 440.15, Florida Statutes, are amended
384 to read:
385 440.15 Compensation for disability.—Compensation for
386 disability shall be paid to the employee, subject to the limits
387 provided in s. 440.12(2), as follows:
388 (2) TEMPORARY TOTAL DISABILITY.—
389 (a) Subject to subsection (7), in case of disability total
390 in character but temporary in quality, 66 2/3 or 66.67 percent
391 of the average weekly wages shall be paid to the employee during
392 the continuance thereof, ~~not to exceed 104 weeks~~ except as
393 provided in this subsection, subparagraph (3)(d)3., and s.
394 440.12(1), not to exceed 260 weeks ~~and s. 440.14(3)~~. Once the
395 employee reaches the maximum number of weeks allowed, or the
396 employee reaches overall ~~the date of~~ maximum medical
397 improvement, whichever occurs earlier, temporary disability
398 benefits shall cease and the injured worker's permanent
399 impairment shall be determined. If the employee reaches the
400 maximum number of weeks allowed, but has not reached overall

401 maximum medical improvement, benefits shall be provided pursuant
402 to subparagraph (3)(d)3.
403 (3) PERMANENT IMPAIRMENT BENEFITS.—
404 (d) After the employee has been certified by a doctor as
405 having reached maximum medical improvement or 6 weeks before the
406 expiration of temporary benefits, whichever occurs earlier, the
407 certifying doctor shall evaluate the condition of the employee
408 and assign an impairment rating, using the impairment schedule
409 referred to in paragraph (b). If the certification and
410 evaluation are performed by a doctor other than the employee's
411 treating doctor, the certification and evaluation must be
412 submitted to the treating doctor, the employee, and the carrier
413 within 10 days after the evaluation. The treating doctor must
414 indicate to the carrier agreement or disagreement with the other
415 doctor's certification and evaluation.
416 1. The certifying doctor shall issue a written report to
417 the employee and the carrier certifying that maximum medical
418 improvement has been reached, stating the impairment rating to
419 the body as a whole, and providing any other information
420 required by the department by rule. The carrier shall establish
421 an overall maximum medical improvement date and permanent
422 impairment rating, based upon all such reports.
423 2. Within 14 days after the carrier's knowledge of each
424 maximum medical improvement date and impairment rating to the
425 body as a whole upon which the carrier is paying benefits, the

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

426 carrier shall report such maximum medical improvement date and,
427 when determined, the overall maximum medical improvement date
428 and associated impairment rating to the department in a format
429 as set forth in department rule. If the employee has not been
430 certified as having reached overall maximum medical improvement
431 before the expiration of 254 ~~98~~ weeks after the date temporary
432 disability benefits begin to accrue, the carrier shall notify
433 the treating doctor of the requirements of this section.
434 3. If an employee receiving benefits under subsection (2)
435 has not reached overall maximum medical improvement before
436 receiving the maximum number of weeks of temporary disability
437 benefits, the maximum number of weeks are extended for up to an
438 additional 26 weeks. If the employee has not reached overall
439 maximum medical improvement after receiving the additional weeks
440 allowed under this subparagraph, a judge of compensation claims,
441 upon petition, must determine the employee's current eligibility
442 for benefits under subsection (1).
443 4. If an employee receiving benefits under subsection (4)
444 has not reached overall maximum medical improvement before
445 receiving the maximum number of weeks of temporary disability
446 benefits, the employee shall receive benefits under this
447 subsection in accordance with the greatest single impairment
448 rating assigned to the employee. Impairment benefits received
449 under this subparagraph shall be credited against indemnity
450 benefits subsequently due to the employee.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

451 (4) TEMPORARY PARTIAL DISABILITY.—
452 (e) Such benefits shall be paid during the continuance of
453 such disability, ~~not to exceed a period of 104 weeks,~~ as
454 provided by this subsection and subsection (2), not to exceed
455 260 weeks, except as provided in subparagraph (3)(d)4. ~~Once the~~
456 ~~injured employee reaches the maximum number of weeks, temporary~~
457 ~~disability benefits cease and the injured worker's permanent~~
458 ~~impairment must be determined.~~ If the employee is terminated
459 from postinjury employment based on the employee's misconduct,
460 temporary partial disability benefits are not payable as
461 provided for in this section. The department shall by rule
462 specify forms and procedures governing the method and time for
463 payment of temporary disability benefits for dates of accidents
464 before January 1, 1994, and for dates of accidents on or after
465 January 1, 1994.
466 (6) EMPLOYEE REFUSES EMPLOYMENT.—If an injured employee
467 refuses employment suitable to the capacity thereof, offered to
468 or procured therefor, such employee shall not be entitled to any
469 compensation at any time during the continuance of such refusal
470 unless at any time in the opinion of the judge of compensation
471 claims such refusal is justifiable. ~~Time periods for the payment~~
472 ~~of benefits in accordance with this section shall be counted in~~
473 ~~determining the limitation of benefits as provided for in~~
474 ~~paragraphs (2)(a), (3)(e), and (4)(b).~~
475 Section 5. Subsections (2), (5), and (7) of section

476 440.192, Florida Statutes, are amended to read:
477 440.192 Procedure for resolving benefit disputes.—
478 (2) Upon receipt, the Office of the Judges of Compensation
479 Claims shall review each petition and shall dismiss each
480 petition or any portion of such a petition that does not on its
481 face <u>meet the requirements of this section and the definition of</u>
482 <u>specificity under s. 440.02, and</u> specifically identify or
483 itemize the following:
484 (a) <u>The</u> name, address, <u>and</u> telephone number~~, and social~~
485 ~~security number~~ of the employee.
486 (b) <u>The</u> name, address, and telephone number of the
487 employer.
488 (c) A detailed description of the injury and cause of the
489 injury, including the <u>Florida county or, if outside of Florida,</u>
490 <u>the state</u> ~~location~~ of the occurrence and the date or dates of
491 the accident.
492 (d) A detailed description of the employee's job, work
493 responsibilities, and work the employee was performing when the
494 injury occurred.
495 (e) The <u>specific</u> time period for which compensation and
496 the specific classification of compensation were not timely
497 provided.
498 (f) <u>The specific</u> date of maximum medical improvement,
499 character of disability, and specific statement of all benefits
500 or compensation that the employee is seeking. <u>A claim for</u>

501 permanent benefits must include the specific date of maximum
502 medical improvement and the specific date that such permanent
503 benefits are claimed to begin.
504 (g) All specific travel costs to which the employee
505 believes she or he is entitled, including dates of travel and
506 purpose of travel, means of transportation, and mileage and
507 including the date the request for mileage was filed with the
508 carrier and a copy of the request filed with the carrier.
509 (h) A specific listing of all medical charges alleged
510 unpaid, including the name and address of the medical provider,
511 the amounts due, and the specific dates of treatment.
512 (i) The type or nature of treatment care or attendance
513 sought and the justification for such treatment. If the employee
514 is under the care of a physician for an injury identified under
515 paragraph (c), a copy of the physician's request, authorization,
516 or recommendation for treatment, care, or attendance must
517 accompany the petition.
518 (j) The specific amount of compensation claimed and the
519 methodology used to calculate the average weekly wage, if the
520 average weekly wage calculated by the employer or carrier is
521 disputed; otherwise, the average weekly wage and corresponding
522 compensation calculated by the employer or carrier are presumed
523 to be accurate.
524 (k) ~~(j)~~ A specific explanation of any other disputed issue
525 that a judge of compensation claims will be called to rule upon.

526

527 The dismissal of any petition or portion of such a petition
528 under this subsection ~~section~~ is without prejudice and does not
529 require a hearing.
530 (5)(a) All motions to dismiss must state with
531 particularity the basis for the motion. The judge of
532 compensation claims shall enter an order upon such motions
533 without hearing, unless good cause for hearing is shown.
534 Dismissal of any petition or portion of a petition under this
535 subsection is without prejudice.
536 (b) Upon motion that a petition or portion of a petition
537 be dismissed for lack of specificity, a judge of compensation
538 claims shall enter an order on the motion, unless stipulated in
539 writing by the parties, within 10 days after the motion is filed
540 or, if good cause for hearing is shown, within 20 days after
541 hearing on the motion. When any petition or portion of a
542 petition is dismissed for lack of specificity under this
543 subsection, the claimant must be allowed 20 days after the date
544 of the order of dismissal in which to file an amended petition.
545 Any grounds for dismissal for lack of specificity under this
546 section which are not asserted within 30 days after receipt of
547 the petition for benefits are thereby waived.
548 (7) Notwithstanding ~~the provisions of~~ s. 440.34, a judge
549 of compensation claims may not award attorney ~~attorney's~~ fees
550 payable by the employer or carrier for services expended or

551 costs incurred before ~~prior to~~ the filing of a petition ~~that~~
552 ~~does not meet the requirements of this section~~.
553 Section 6. Paragraph (j) of subsection (4) of section
554 440.25, Florida Statutes, is amended to read:
555 440.25 Procedures for mediation and hearings.—
556 (4)
557 (j) A judge of compensation claims may not award interest
558 on unpaid medical bills and the amount of such bills may not be
559 used to calculate the amount of interest awarded. Regardless of
560 the date benefits were initially requested, attorney ~~attorney's~~
561 fees do not attach under this subsection until 45 ~~30~~ days after
562 the date the carrier ~~or self-insured employer~~ receives the
563 petition.
564 Section 7. Section 440.34, Florida Statutes, is amended to
565 read:
566 440.34 Attorney ~~Attorney's~~ fees; costs.—
567 (1) A judge of compensation claims may award attorney fees
568 payable to the claimant pursuant to this section to be paid by
569 the employer or carrier. An employer or carrier may not pay a
570 fee, gratuity, or other consideration ~~may not be paid~~ for a
571 claimant in connection with any proceedings arising under this
572 chapter, unless approved by the judge of compensation claims or
573 court having jurisdiction over such proceedings. Attorney fees
574 awarded ~~Any attorney's fee approved~~ by a judge of compensation
575 claims for benefits secured on behalf of a claimant must equal

576 ~~to~~ 20 percent of the first $5,000 of the amount of the benefits
577 secured, 15 percent of the next $5,000 of the amount of the
578 benefits secured, 10 percent of the remaining amount of the
579 benefits secured to be provided during the first 10 years after
580 the date the claim is filed, and 5 percent of the benefits
581 secured after 10 years. A ~~The judge of compensation claims shall~~
582 ~~not approve a compensation order, a joint stipulation for lump-~~
583 ~~sum settlement, a stipulation or agreement between a claimant~~
584 ~~and his or her attorney, or any other agreement related to~~
585 ~~benefits under this chapter which provides for an attorney's fee~~
586 ~~in excess of the amount permitted by this section. The judge of~~
587 ~~compensation claims is not required to approve any~~ retainer
588 agreement between the claimant and his or her attorney is not
589 subject to approval by a judge of compensation claims but must
590 be filed with the Office of the Judges of Compensation Claims.
591 Attorney fees are a lien upon compensation payable to the
592 claimant, notwithstanding s. 440.22. A retainer agreement may
593 not place any portion of the employee's compensation into an
594 escrow account until benefits are secured. ~~The retainer~~
595 ~~agreement as to fees and costs may not be for compensation in~~
596 ~~excess of the amount allowed under this subsection or subsection~~
597 ~~(7).~~
598 (2) In awarding a claimant's attorney fees ~~attorney's fee~~,
599 a ~~the~~ judge of compensation claims must ~~shall~~ consider only
600 those benefits secured by the attorney. ~~An~~ Attorney ~~is not~~

601 ~~entitled to attorney's~~ fees are not due for representation in
602 any issue that was ripe, due, and owing and that reasonably
603 could have been addressed, but was not addressed, during the
604 pendency of other issues for the same injury. The amount,
605 statutory basis, and type of benefits obtained through legal
606 representation shall be listed on all attorney ~~attorney's~~ fees
607 awarded by a ~~the~~ judge of compensation claims. For purposes of
608 this section, the term "benefits secured" does not include
609 future medical benefits to be provided ~~on any date~~ more than 5
610 years after the date the petition ~~claim~~ is filed. In the event
611 an offer to settle an issue pending before a judge of
612 compensation claims, including attorney ~~attorney's~~ fees ~~as~~
613 ~~provided for in this section~~, is communicated in writing to the
614 claimant or the claimant's attorney at least 30 days before
615 ~~prior to~~ the trial date on such issue, for purposes of
616 calculating the amount of attorney ~~attorney's~~ fees to be taxed
617 against the employer or carrier, the term "benefits secured"
618 includes ~~shall be deemed to include~~ only that amount awarded to
619 the claimant above the amount specified in the offer to settle.
620 If multiple issues are pending before a ~~the~~ judge of
621 compensation claims, said offer of settlement must ~~shall~~ address
622 each issue pending and ~~shall~~ state explicitly whether or not the
623 offer on each issue is severable. The written offer must ~~shall~~
624 also unequivocally state whether or not it includes medical
625 witness fees and expenses and all other costs associated with

626 the claim.
627 (3) If a ~~any~~ party prevails ~~should prevail~~ in ~~any~~
628 proceedings before a judge of compensation claims or court,
629 there shall be taxed against the nonprevailing party the
630 reasonable costs of such proceedings, not to include attorney
631 ~~attorney's~~ fees. A claimant is responsible for the payment of
632 her or his own attorney ~~attorney's~~ fees, except that a claimant
633 is entitled to recover attorney fees ~~an attorney's fee~~ in an
634 amount equal to the amount provided for in subsection (1) or
635 subsection (5), but not both, ~~(7)~~ from a carrier or employer:
636 (a) Against whom she or he successfully asserts a petition
637 for medical benefits only, if the claimant has not filed or is
638 not entitled to file at such time a claim for disability,
639 permanent impairment, ~~wage-loss,~~ or death benefits, arising out
640 of the same accident;
641 (b) In a ~~any~~ case in which the employer or carrier files a
642 response to petition denying benefits with the Office of the
643 Judges of Compensation Claims and the injured person has
644 employed an attorney in the successful prosecution of the
645 petition;
646 (c) In a proceeding in which a carrier or employer denies
647 that an accident occurred for which compensation benefits are
648 payable, and the claimant prevails on the issue of
649 compensability; or
650 (d) In cases in which ~~where~~ the claimant successfully

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

651 prevails in proceedings filed under s. 440.24 or s. 440.28.
652
653 Regardless of the date benefits were initially requested,
654 attorney ~~attorney's~~ fees do ~~shall~~ not attach under this
655 subsection until 45 ~~30~~ days after the date the carrier or
656 employer~~, if self-insured,~~ receives the petition.
657 ~~(4) In such cases in which the claimant is responsible for~~
658 ~~the payment of her or his own attorney's fees, such fees are a~~
659 ~~lien upon compensation payable to the claimant, notwithstanding~~
660 ~~s. 440.22.~~
661 (4)~~(5)~~ If ~~any~~ proceedings are had for review of a ~~any~~
662 claim, award, or compensation order before any court, the court
663 may, in its discretion, award the injured employee or dependent
664 attorney fees ~~an attorney's fee~~ to be paid by the employer or
665 carrier~~, in its discretion, which shall be paid~~ as the court may
666 direct.
667 (5)(a) As used in this subsection, the term:
668 1. "Attorney hours" means the number of hours necessary
669 for the attorney to obtain the benefits secured as determined by
670 a judge of compensation claims.
671 2. "Customary fee" means the average hourly rate that
672 attorneys customarily charge in the same locality for similar
673 legal services as determined by a judge of compensation claims,
674 which may include consideration of attorney fees awarded by
675 judges of compensation claims or services related to civil tort

676 claims.
677 3. "Departure fee" means the amount of attorney fees
678 calculated by a judge of compensation claims in place of the fee
679 allowed under subsection (1) when attorney fees are due under
680 this section.
681 (b) A judge of compensation claims may depart from the
682 attorney fees amount set forth in subsection (1) upon a finding
683 that the attorney fees provided for in that subsection are less
684 than 40 percent or greater than 125 percent of the customary fee
685 when the amount allowed under subsection (1) is converted to an
686 hourly rate by dividing that amount by the attorney hours. A
687 judge of compensation claims may determine the locality and is
688 not limited to an average hourly rate or number of attorney
689 hours pled by a party, but may not exceed the amount or hours
690 pled by the attorney for the claimant, and may rely on proffered
691 evidence or take notice of credible data, including claimant
692 attorney fee data on file with the office of the judges of
693 compensation claims or the Florida Bar. A judge of compensation
694 claims must make specific findings regarding the number of
695 attorney hours when resolving a motion for a departure fee under
696 this subsection. A departure fee under this subsection is in
697 place of, not in addition to, the amount allowed under
698 subsection (1).
699 (c) If a departure is permitted pursuant to paragraph (b),
700 a judge of compensation claims shall consider the following

701 factors when departing from the amount set forth in subsection
702 (1):
703 1. The time and labor required, the novelty and difficulty
704 of the questions involved, and the skill required to properly
705 perform the legal services.
706 2. The customary fee in the same locality for similar
707 legal services.
708 3. The amount involved in the controversy and the benefits
709 awarded to the claimant.
710 4. The time limits imposed by the circumstances.
711 5. The experience, reputation, and ability of the attorney
712 performing the legal services.
713 6. The contingency or certainty of a carrier-paid
714 claimant's attorney fee awarded under this section.
715 (d) Based on the considerations of the factors in
716 paragraph (c), a judge of compensation claims shall determine
717 the hourly rate used to compute the departure fee awarded under
718 this subsection, in $10 increments, which may not exceed the
719 hourly rate limit under paragraph (f). A judge of compensation
720 claims is not limited to an hourly rate pled by a party.
721 (e) Using the hourly rate determined under paragraph (d)
722 and number of attorney hours determined under paragraph (b), a
723 judge of compensation claims must determine the amount of the
724 departure fee under this subsection by multiplying the hourly
725 rate by the number of attorney hours. The claimant is

CODING: Words stricken are deletions; words underlined are additions.

726 responsible for attorney fees pursuant to his or her retainer
727 agreement that exceed the departure fee.
728 (f) From July 1, 2017, through December 31, 2017, the
729 hourly rate limit applicable to departure fees under this
730 subsection is $250. On January 1, 2018, and annually each
731 January 1 thereafter, this amount shall be adjusted in
732 proportion to the percentage change between the statewide
733 average weekly wage in effect on the immediately previous
734 January 1 and the statewide average weekly wage in effect for
735 the applicable year rounded to the nearest dollar. For purposes
736 of this paragraph, the term "statewide average weekly wage" has
737 the same meaning as in s. 440.12(2).
738 (g) By January 1, 2018, and annually by each January 1
739 thereafter, the Deputy Chief Judge of Compensation Claims must
740 determine and publish the hourly rate limit provided under
741 paragraph (f).
742 ~~(6) A judge of compensation claims may not enter an order~~
743 ~~approving the contents of a retainer agreement that permits~~
744 ~~placing any portion of the employee's compensation into an~~
745 ~~escrow account until benefits have been secured.~~
746 ~~(7) If an attorney's fee is owed under paragraph (3)(a),~~
747 ~~the judge of compensation claims may approve an alternative~~
748 ~~attorney's fee not to exceed $1,500 only once per accident,~~
749 ~~based on a maximum hourly rate of $150 per hour, if the judge of~~
750 ~~compensation claims expressly finds that the attorney's fee~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

751 ~~amount provided for in subsection (1), based on benefits~~
752 ~~secured, fails to fairly compensate the attorney for disputed~~
753 ~~medical-only claims as provided in paragraph (3)(a) and the~~
754 ~~circumstances of the particular case warrant such action.~~
755 Section 8. Section 440.345, Florida Statutes, is amended
756 to read:
757 440.345 Reporting of attorney ~~attorney's~~ fees.—All fees
758 paid to attorneys for services rendered under this chapter shall
759 be reported to the Office of the Judges of Compensation Claims
760 as the Division of Administrative Hearings requires by rule. A
761 carrier must specify in its report the total amount of attorney
762 fees paid for and the total number of attorney hours spent on
763 services related to the defense of petitions, and the total
764 amount of attorney fees paid for services unrelated to the
765 defense of petitions.
766 Section 9. Paragraph (b) of subsection (6) of section
767 440.491, Florida Statutes, is amended to read:
768 440.491 Reemployment of injured workers; rehabilitation.—
769 (6) TRAINING AND EDUCATION.—
770 (b) When an employee who has attained maximum medical
771 improvement is unable to earn at least 80 percent of the
772 compensation rate and requires training and education to obtain
773 suitable gainful employment, the employer or carrier shall pay
774 the employee additional training and education temporary total
775 compensation benefits while the employee receives such training

776 and education for a period not to exceed 26 weeks, which period
777 may be extended for an additional 26 weeks or less, if such
778 extended period is determined to be necessary and proper by a
779 judge of compensation claims. The benefits provided under this
780 paragraph are ~~shall~~ not ~~be~~ in addition to the maximum number of
781 ~~104~~ weeks as specified in s. 440.15(2). However, a carrier or
782 employer is not precluded from voluntarily paying additional
783 temporary total disability compensation beyond that period. If
784 an employee requires temporary residence at or near a facility
785 or an institution providing training and education which is
786 located more than 50 miles away from the employee's customary
787 residence, the reasonable cost of board, lodging, or travel must
788 be borne by the department from the Workers' Compensation
789 Administration Trust Fund established by s. 440.50. An employee
790 who refuses to accept training and education that is recommended
791 by the vocational evaluator and considered necessary by the
792 department will forfeit any additional training and education
793 benefits and any additional compensation ~~payment for lost wages~~
794 under this chapter. The carrier shall notify the injured
795 employee of the availability of training and education benefits
796 as specified in this chapter. The Department of Financial
797 Services shall include information regarding the eligibility for
798 training and education benefits in informational materials
799 specified in ss. 440.207 and 440.40.
800 Section 10. Subsection (1) of section 627.211, Florida

801 Statutes, is amended, and subsection (7) is added to that
802 section, to read:
803 627.211 Deviations and departures; workers' compensation
804 and employer's liability insurances.—
805 (1) Except as provided in subsection (7), every member or
806 subscriber to a rating organization shall, as to workers'
807 compensation or employer's liability insurance, adhere to the
808 filings made on its behalf by such organization; except that any
809 such insurer may make written application to the office for
810 permission to file a uniform percentage decrease or increase to
811 be applied to the premiums produced by the rating system so
812 filed for a kind of insurance, for a class of insurance which is
813 found by the office to be a proper rating unit for the
814 application of such uniform percentage decrease or increase, or
815 for a subdivision of workers' compensation or employer's
816 liability insurance:
817 (a) Comprised of a group of manual classifications which
818 is treated as a separate unit for ratemaking purposes; or
819 (b) For which separate expense provisions are included in
820 the filings of the rating organization.
821
822 Such application shall specify the basis for the modification
823 and shall be accompanied by the data upon which the applicant
824 relies. A copy of the application and data shall be sent
825 simultaneously to the rating organization.

826 (7) Without approval of the office, a member or subscriber
827 to a rating organization may depart from the filings made on its
828 behalf by a rating organization for a period of 12 months by a
829 uniform decrease of up to 5 percent to be applied uniformly to
830 the premiums resulting from the approved rates for the policy
831 period. The member or subscriber must file an informational
832 departure statement with the office within 30 days after initial
833 use of such departure specifying the percentage of the departure
834 from the approved rates and an explanation of how the departure
835 will be applied. If the departure is to be applied over a
836 subsequent 12-month period, the member or subscriber must file a
837 supplemental informational departure statement pursuant to this
838 subsection at least 30 days before the end of the current
839 period. If the office determines that a departure violates the
840 applicable principles for ratemaking under ss. 627.062 and
841 627.072, would result in predatory pricing, or imperils the
842 financial condition of the member or subscriber, the office must
843 issue an order specifying its findings and stating the time
844 period within which the departure expires, which must be within
845 a reasonable time period after the order is issued. The order
846 does not affect an insurance contract or policy made or issued
847 before the departure expiration period set forth in the order.
848 Section 11. This act shall take effect July 1, 2017.