2019 Biennial Report

October 30, 2019

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INTRODUCTION

Section 440.015, F.S. proscribes the legislative intent of Florida's Workers' Compensation Law. Numerous directives are contained in this section including:

- The law is to be interpreted so as to assure the quick and efficient delivery of disability and medical benefits to an injured worker and to facilitate the worker's return to gainful employment at a reasonable cost to the employer.
- An efficient and self-executing system must be created which is not an economic nor an administrative burden.
- The department shall administer the Workers' Compensation Law in a manner which facilitates the self-execution of the system and the process of ensuring a prompt and cost-effective delivery of benefits.

Since the last major workers' compensation reform, which occurred in 2003, Florida has experienced a period of market stability and decreasing rates. In fact, of the 21 workers' compensation rate filings submitted by the National Council on Compensation Insurance (NCCI) and approved by the Office of Insurance Regulation (OIR), 15 have been rate decreases. Workers' compensation rates decreased again in 2019 by 13.8%. Cumulatively, workers' compensation rates have decreased 65% since 2003. As noted in NCCI's Overview of the Proposed Florida Workers Compensation Rate Filing Effective January 1, 2019: *Consistent improvement in loss experience is the primary driver underlying the filing. More specifically, the long-term decline in claim frequency has continued to more than offset moderate increases in claim severity. This has resulted in continued downward pressure on the overall average rate level need and is consistent with trends across most NCCI states.* The reduction in claims entering the workers' compensation system masks cost drivers within states' workers' compensation systems, including Florida's. Ignoring these cost drivers in Florida will eventually cause workers' compensation rates to increase should the reduction in claim frequency level off or increase in the future.

The Three-Member Panel is a statutorily created board that includes the Chief Financial Officer, or his or her designee. Presently, the Insurance Commissioner serves as the Chief Financial Officer's designee. The Governor appoints the other two members who by vocation, employment, or affiliation represent employer interests and employee interests, respectively. Paragraph 440.13(12)(a), F.S., requires the panel to annually determine and adopt statewide schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, and ambulatory surgical centers. Paragraph 440.13(12)(d), F.S. further

states: *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, F.S., 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.

The Legislature has clearly established certain medical reimbursement criteria for the Three-Member Panel to follow in establishing maximum reimbursement allowances. These criteria can be categorized as promoting cost containment for employers, ensuring medical treatment access for injured workers, and providing equitable and reasonable reimbursements to health care providers. However, specific statutory reimbursement methodologies are now in conflict with medical reimbursement criteria found in paragraph 440.13(12)(d), F.S. These specific reimbursement methodologies have created an imbalance in the workers' compensation health care delivery system to the detriment of employers, physicians, and injured workers. The share and amount of payments to hospitals, ambulatory surgical centers are higher than the national average, while payments to physicians for providing treatment to injured workers are lower than the national average. Medical reimbursement among health care providers needs re-balancing before serious, damaging effects are manifested in Florida's workers' compensation system.

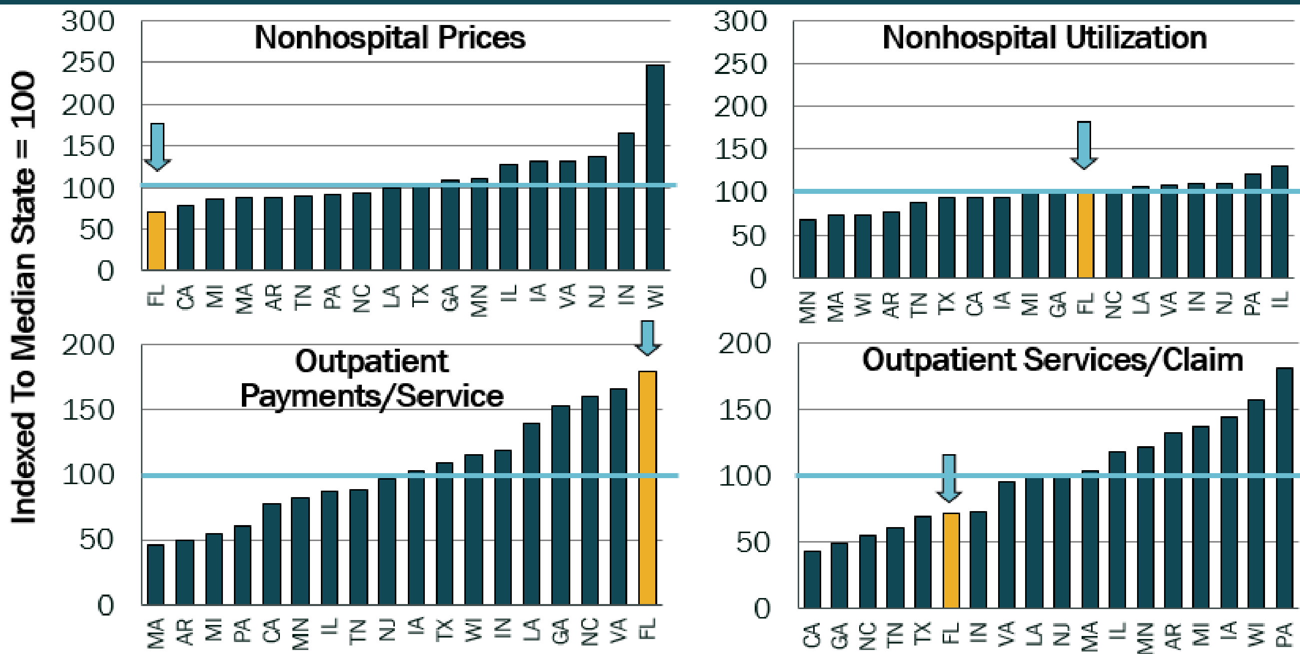
Beginning in 2003 and biennially thereafter, the Three-Member Panel has presented, to the Speaker of the House of Representatives and to the President of the Senate, a report on ways to improve the Florida workers' compensation health care delivery system. Over the years, the reports have offered recommendations in areas where regulatory efficiencies might be realized and where impediments to cost containment and access to care could be abated or eliminated. Each of those reports can be accessed via the Division of Workers' Compensation website at

www.myfloridacfo.com/Division/wc. The 2019 Biennial Report explains the need to re-balance medical payments and provide recommendations for the Legislature to:

- Increase reimbursements to physicians for medical treatment;
- Reduce costs to employers;
- Realign reimbursements for hospitals and ambulatory surgical centers; and
- Better meet the legislative intent of the Workers' Compensation Law.

Implementing these policy recommendations may also provide an opportunity for the legislature to reduce costs to employers and increase benefits to injured workers.

FL Had Lowest Price For Professional Services And Highest Price For Hospital Outpatient



2016/17 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix. Prices are for calendar year 2016 and for all paid claims.

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WCRI

OUTPATIENT REIMBURSEMENT

Current Situation

Subsection 440.13(12), F.S., requires charges for hospital outpatient care be reimbursed at 75% of usual and customary charges and at 60% of charges for scheduled surgeries, or an agreed-upon contract price. The statute does not define "usual and customary charges", nor provides a methodology to calculate "usual and customary charges". After a seven-year period of litigation and rule challenges, the Three-Member Panel successfully adopted a methodology to calculate a "usual and customary charge", which was incorporated in the 2014 Edition of the Hospital Reimbursement Manual, and became effective on January 1, 2015. The hospital "usual and customary charge" methodology is summarized below.

- 18 months of hospital outpatient charge data is used.
- A minimum of 40 procedures are used to calculate a statewide median charge per qualifying procedure.
- 75% or 60% of the statewide median charge per qualifying procedure, depending on whether the procedure was associated with a scheduled surgery, is calculated to establish a base rate.
- A base rate per qualifying procedure is then modified by a Medicare geographic wage adjustment factor based upon the location of the service to attain the maximum reimbursement allowance (MRA) per qualifying procedure. The MRAs remain in effect until newer editions of the manual are adopted and ratified.
- Procedures not subject to an MRA are reimbursed 60% or 75% of the individual hospital's charges. The reimbursements for these procedures fluctuate since each hospital has different charges for each procedure and can modify the charges as frequently as desired.

This methodology has been used to update maximum reimbursement allowances (MRAs) for outpatient procedures in newer editions of the Hospital Reimbursement Manuals, however, the Legislature has not ratified them.

In 2010, the Legislature enacted changes to Chapter 120, the Administrative Procedure Act. These changes require each state agency to submit for legislative ratification any rule that meets one or more of the following criteria:

1. The rule is likely to have an adverse impact on economic growth, private sector job creation or employment, or private sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule;

2. The rule is likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule; or

3. The rule is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

Florida has a $4.3 billion workers' compensation marketplace, impacting hundreds of thousands of employers, thousands of health care providers, and hundreds of insurance companies licensed to write workers' compensation insurance. Consequently, annually updating the maximum reimbursement allowances to be consistent with the law is likely to meet the third criteria because of the scope and reach the Health Care Provider, Hospital, and Ambulatory Surgical Center reimbursement manuals have on the parties within the system.

In an effort to balance the competing aspects of the Administrative Procedure Act and subsection 440.13(12), F.S., the Division of Workers' Compensation has taken the position that the rules incorporating the reimbursement manuals are subject to legislative ratification despite the statutory authority given to the Three-Member Panel to determine maximum reimbursement allowances and despite the explicit provisions that dictate the amount of reimbursement payable to various health care providers contained in subsection 440.13(12), F.S.

The 2014 Edition of the Hospital Manual resulted in a slight decrease of 1.0% in total workers' compensation costs. The downward result was a predicted, one-time occurrence and reflected a new baseline for the reimbursement for hospital outpatient procedures because of the implementation of the "usual and customary" methodology. This edition of the manual did not require legislative ratification because of the reduction in costs. This result is similar to what occurred after the passage of SB 50A in 2003. Prior to 2003, all hospital outpatient care was reimbursed at 75% of usual and customary charges. SB 50A retained the 75% of usual and customary charges methodology for most hospital outpatient care, but reduced the reimbursement for outpatient scheduled surgeries to 60% of usual and customary charges. Hospitals adjusted to the 75% to 60% decrease by subsequently increasing their charges. These outcomes are evidenced in the slide titled *Fl Hosp. Outp. Payments/Claim Grew 6% In 2016, After Being Stable in 2015 Following FS Change* produced by the Workers' Compensation

Research Institute (WCRI) in its Compscope Medical Benchmarks for Florida, 19th Edition. Hospitals control what they charge for their services, and generally, charges for those services increase year-over-year. The 2016 and 2017 editions of the Hospital Reimbursement Manuals proposed to increase hospital outpatient payments by 17.5%, which equates to increasing overall workers' compensation costs by 2.2% or $80 million. The Legislature did not ratify either of these editions. Given the current charge-based system, future editions of the Hospital Reimbursement Manual are also expected to exceed the ratification threshold.

Data from the WCRI, NCCI, and the Division of Workers' Compensation all reflect continued increase in hospital outpatient charges and reimbursements, which will increase costs and workers' compensation rates for Florida's employers. The data also show that Florida's charge-based hospital outpatient reimbursement methodology puts Florida at or near the top of the list of states with the highest outpatient reimbursements, especially when comparing hospital outpatient payments as a percentage of Medicare.

Hospital Outpatient Payments as a Percentage of Medicare

Medical Cost Category	Florida	Region	Countrywide
Hospital Outpatient	441%	223%	256%

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Ambulatory Surgical Centers (ASCs) also provide scheduled outpatient surgical care to workers' compensation patients and are reimbursed similarly to hospitals; 60% of "usual and customary charges". The 2015 edition of the Ambulatory Surgical Center Reimbursement Manual, which became effective on January 1, 2016, and remains in effect. The ASC "usual and customary charge" methodology is summarized below.

- 24 months of ASC charge data is used.
- A minimum of 50 procedures on bills representing at least 10 different ASCs are used to calculate a statewide median charge per qualifying procedure.
- MRAs equal 60% of the statewide median charge for a qualifying procedure. The MRAs remain in effect until newer editions of the manual are adopted and ratified.
- Procedures not qualifying for an MRA are reimbursed at 60% of the individual ASC's charges. The reimbursements for these procedures fluctuate since each ASC has

different charges for each procedure and can modify the charges as frequently as desired.

This methodology has been used to update maximum reimbursement allowances (MRAs) for outpatient procedures in 2016 and 2017 editions of the Ambulatory Surgical Center Reimbursement Manuals, however, the Legislature did not ratify them. The 2016 and 2017 editions of the Ambulatory Surgical Center Reimbursement Manuals were estimated to increase overall workers' compensation costs by 0.6% or $22 million and 1.1% or $40 million, respectively. Given the current charge-based system, future editions of the Ambulatory Surgical Center Reimbursement Manual are also expected to exceed the ratification threshold.

Data from the WCRI, NCCI, and the Division of Workers' Compensation all reflect continued increase in ambulatory surgical center charges and reimbursements, which will increase costs and workers' compensation rates for Florida's employers. The data also show that Florida's charge-based ASC outpatient reimbursement methodology puts Florida near the top of the list of states with the highest ASC outpatient reimbursements, especially when comparing ASC outpatient payments as a percentage of Medicare. In addition, the ASC median payments are higher than the median payments for hospitals for some of the most common surgical procedures.

ASC Payments as a Percentage of Medicare

Medical Cost Category	Florida	Region	Countrywide
Ambulatory Surgical Center	312%	286%	285%

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

For a statutorily, charge-based outpatient reimbursement system to achieve some level of cost-containment, hospitals and ASCs must exhibit self-constraint in what they charge for their services. Unfortunately, this self-constraint is not occurring, as evidenced by the data. The statutorily, charge-based outpatient reimbursement system is now in direct conflict with the broader statutory criteria the Three-Member Panel must evaluate to annually update the schedules of maximum reimbursement allowances. This conflict places the Three-Member Panel and the Division of Workers' Compensation at a critical juncture when they deliberate and determine what outpatient reimbursement policy actions should occur in the 2019 editions of the Hospital and Ambulatory Surgical Center Reimbursements Manuals; should the charge-based outpatient reimbursement system still be in law.

Policy Recommendation

As recommended in previous Biennial Reports, the Legislature should reduce reimbursements for outpatient services to rebalance system costs. The Legislature should replace the charge-based reimbursement system for outpatient services in hospitals and ambulatory surgical centers with a percentage of Medicare or other alternative framework that adequately reimburses facilities and provides cost containment and reimbursement predictability.

According to the Workers' Compensation Research Institute's *Hospital Outpatient Payment Index: Interstate Variations and Policy Analysis; 7th Edition,* 13 states reimburse workers' compensation outpatient services based upon Medicare. The states are: California, Colorado, Connecticut, Georgia, Idaho, Indiana, Massachusetts, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and West Virginia.

Data Supporting the Policy Recommendation

WCRI Compscope Medical Benchmarks for Florida, 19th Edition

FL Medical Growth in 2016 From Both Nonhospital And Hospital Providers; Longer-Term Hospital More of a Driver – Exhibit 1

FL Had Lowest Price for Professional Services And Highest Price For Hospital Outpatient – Exhibit 2

FL Hosp. Outp. Payments/Claim Grew 6% in 2016, After Being Stable in 2015 Following FS Change – Exhibit 3

Growth in Hospital Outpatient Payments Per Claim In FL Faster Than In Most Study States – Exhibit 4

Rapid Increase In Hosp. Outpatient Payments Per Service In 2016 Drove Growth In Payments/Claim – Exhibit 5

In 2016, FL Hosp. Outp. Payments Per Service For Treat/Oper./Recovery Rooms Grew With Charges – Exhibit 6

FL Had Higher Hosp. Outp. Payments/Claim, But Lower % of Claims With These Services Among 18 States – Exhibit 7

Payments Per Service For Many Types Of Hospital Outpatient Services In FL Higher Than Typical – Exhibit 8

FL ASC Facility Payments Per Claim Increased 6% in 2016/17 Following Fee Schedule Update – Exhibit 9

FL ASC Facility Payments/Claim Slightly Higher Than Median State At 12 Mos.; Typical At 36 Mos. – Exhibit 10

NCCI: Medical Data Report for the State of Florida, October 2018

Medical Share of Total Benefit Costs by Accident Year – Exhibit 11

Overall Medical Average Cost per Lost Time Claim (in 000s) – Exhibit 12

Distribution of Medical Payments for Florida – Exhibit 13

Hospital Outpatient Payments as a Percentage of Medicare – Exhibit 14

Average Amount Paid per Surgical Visit for Hospital Outpatient Services – Exhibit 15

Average Amount Paid per Nonsurgical Visit for Hospital Outpatient Services – Exhibit 16

Average Amount Paid per Emergency Room Visit – Exhibit 17

Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services – Exhibit 18

ASC Payments as a Percentage of Medicare – Exhibit 19

Average Amount Paid per Visit for ASC Services – Exhibit 20

Top 10 Diagnosis Groups by Amount Paid for ASC Services – Exhibit 21

Division of Workers' Compensation

Total Charges and Total Paid for Hospital Outpatient Services – Exhibit 22

Total Charges and Total Paid for Ambulatory Surgical Center Services – Exhibit 23

Median Paid Amounts for Common Scheduled Surgical Procedures by Hospital and ASC – Exhibit 24

Comparison of Florida Workers' Compensation Reimbursement and Medicare Payment Rates – Exhibit 25

Hospital Outpatient by Amount Charged (Excludes the cost of implants) – Exhibit 26

Number of Hospital Outpatient Bills by Amount Charged (Excludes the cost of implants) – Exhibit 27

Hospital Outpatient by Amount Paid (Excludes the cost of implants) – Exhibit 28

Number of Hospital Outpatient Bills by Amount Paid (Excludes the cost of implants) – Exhibit 29

ASC by Amount Charged (Excludes the cost of implants) – Exhibit 30

Number of ASC Bills by Amount Charged (Excludes the cost of implants) – Exhibit 31

ASC by Amount Paid (Excludes the cost of implants) – Exhibit 32

Number of ASC Bills by Amount Paid (Excludes the cost of implants) – Exhibit 33

INPATIENT REIMBURSEMENT

Current Situation

Paragraph 440.13(12)(a), F.S., requires inpatient services to be reimbursed based upon a schedule of per-diem rates. The schedule of per-diem rates, as adopted in the 2014 edition of the Hospital Reimbursement Manual, and which are still in effect, are as follows:

- $3,850.33 per day for a surgical stay in a trauma center
- $2,313.69 per day for a non-surgical stay in a trauma center
- $3,849.16 per day for a surgical stay in an acute care hospital
- $2,283.40 per day for a non-surgical stay in an acute care hospital

The schedule of per-diem rates includes a stop-loss amount that should only financially address infrequent, catastrophic injuries for which a hospital would be inadequately reimbursed if only the per-diem amounts were used for reimbursement purposes. The stop-loss amount is $59,891.34, as adopted in the 2014 edition of the Hospital Reimbursement Manual, and is still in effect. If a hospital's total charges for an inpatient stay exceeds $59,961.34, excluding the cost of implants, the hospital is reimbursed 75% of its charges rather than at the per-diem rates or an agreed upon contract price.

Data from the WCRI, NCCI, and the Division of Workers' Compensation all reflect a continued increase in inpatient charges and reimbursements, which will increase costs and workers' compensation rates for Florida's employers. This increase is not due to a rise in catastrophic workers' compensation injuries, but rather due to the rapid acceleration of hospital charges, as noted in the previous section; as more inpatient bills exceed the stop-loss amount, and consequently, are reimbursed 75% of the hospital's charges. The data also show that Florida is near the top or at the top of the list of states with the highest inpatient reimbursements, especially when comparing inpatient payments as a percentage of Medicare.

Hospital Inpatient Payments as a Percentage of Medicare

Medical Cost Category	Florida	Region	Countrywide
Hospital Inpatient	346%	176%	191%

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Policy Recommendation

The Legislature should establish specific per diem amounts and a stop-loss threshold to appropriately reimburse hospitals for catastrophic and complex injuries. The new amounts and threshold should create long-term cost-containment and reimbursement predictability.

Data Supporting the Policy Recommendation

WCRI Compscope Medical Benchmarks for Florida, 19th Edition

Hospital Inpatient Payments Per Episode in FL Grew Rapidly Since 2010, Incl. Two Years After FS Update – Exhibit 34

Average Hospital Inpatient Payment For Both Surgical And Nonsurgical Episodes Increased in 2015 & 2016 – Exhibit 35

Hospital Payments/Inpatient Episode in FL Grew Faster Than in Many States From 2011 to 2016 – Exhibit 36

FL Had Higher Hospital Inpatient Payments Per Episode And Fairly Typical Use of Inpatient Care – Exhibit 37

NCCI: Medical Data Report for the State of Florida, October 2018

Hospital Inpatient Payments as a Percentage of Medicare – Exhibit 38

Average Inpatient Paid per Stay for Hospital Inpatient Services – Exhibit 39

Average Inpatient Amount Paid per Day for Hospital Inpatient Services – Exhibit 40

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services – Exhibit 41

Division of Workers' Compensation

Hospital Inpatient Bill Type Comparison: Number of Bills, Total Paid, Length of Stay – Exhibit 42

Hospital Inpatient Comparison: Avg. Paid Per Diem vs. Avg. Paid per Stop-Loss – Exhibit 43

Total Charges and Total Paid for Hospital Inpatient Services – Exhibit 44

Hospital Inpatient by Amount Charged (Excludes the cost of implants) – Exhibit 45

Number of Hospital Inpatient Bills by Amount Charged (Excludes the cost of implants) – Exhibit 46

Hospital Inpatient by Amount Paid (Excludes the cost of implants) – Exhibit 47

Number of Hospital Inpatient Bills by Amount Paid (Excludes the cost of implants) – Exhibit 48

PHYSICIAN REIMBURSEMENT

Current Situation

Pursuant to paragraph 440.13(12)(b), F.S., physicians are reimbursed 110% of Medicare rates for various professional services and non-surgical procedures and 140% of Medicare rates for surgical procedures or an agreed upon contract price. The 2016 edition of the Health Care Provider Reimbursement Manual has been in effect since July 1, 2017 and incorporates the 2016 Medicare values. The 2017 edition of the Health Care Provider Reimbursement Manual was adopted, but not ratified during the 2018 Legislative Session. The 2017 edition of the Health Care Provider Reimbursement Manual was estimated to increase overall workers' compensation costs by 0.1% or $4 million. Future editions of the Health Care Provider Reimbursement Manual are also expected to exceed the ratification threshold although not as drastically as the Hospital and Ambulatory Surgical Center Reimbursement Manuals.

Reimbursements to physicians are much lower compared to reimbursements to facilities for outpatient and inpatient services. Whereas the escalation of facility charges results in higher reimbursements to hospitals and ambulatory surgical centers, thus undermining the statutory medical cost-containment criteria; the statutory reimbursement amounts paid to physicians and other practitioners are jeopardizing the criteria of providing equitable and reasonable reimbursements to health care providers and possibly access to care for injured workers.

Many states have established physician fee schedules using a percentage of Medicare rates, and they have proven to be effective in controlling costs while providing financially appropriate payments to physicians for treating working compensation patients. However, data from the WCRI, NCCI, and the Division of Workers' Compensation reflect Florida's percentage of Medicare rates are at or near financial inadequacy for the purposes of reimbursing physicians for directly treating injured workers. See NCCI data below.

Physician Payments as a Percentage of Medicare

Physician Service Category	Florida	Region	Countrywide
Surgery	155%	234%	275%
Radiology	154%	216%	236%
General and Physical Medicine	87%	124%	131%
Evaluation and Management	102%	135%	141%
All Physician Services	**110%**	**154%**	**167%**

Policy Recommendation

The Legislature should increase the percentage of Medicare rates paid to physicians. The increase in physician reimbursements can be off-set by the justifiable decrease in reimbursements to hospitals and ambulatory surgical centers, as discussed in the previous sections.

Data Supporting the Policy Recommendation

WCRI Compscope Medical Benchmarks for Florida, 19th Edition

Overall Prices Paid for Professional Services in FL Grew 7% From 2015 To 2017 Following FS Update – Exhibit 49

FL Profession FS Rates Likely Remain Lower Than Most States After Update in July 2016 – Exhibit 50

FL Overall Prices Paid For Professional Services Remained The Lowest of Study States In 2017 – Exhibit 51

Prices Paid For All Types of Professional Services In FL Remained Lower Than Typical After FS Update – Exhibit 52

NCCI: Medical Data Report for the State of Florida, October 2018

Medical Cost Distributions by Payment Share – Exhibit 53

Physician Payments as a Percentage of Medicare – Exhibit 54

Distribution of Medical Payments for Physicians – Exhibit 55

Top 10 Evaluation and Management Procedure Codes by Amount Paid – Exhibit 56

Top 10 Surgery Procedure Codes by Amount Paid – Exhibit 57

Division of Workers' Compensation

Total Charges and Total Paid for Health Care Provider Treatment – Exhibit 58

LEGISLATIVE RATIFICATION OF THE REIMBURSEMENT MANUALS

Current Situation

The Division of Workers' Compensation presents recommendations to the Three-Member Panel on reimbursement changes to the Health Care Provider Reimbursement Manual, Hospital Reimbursement Manual, and the Ambulatory Surgical Center Reimbursement Manual. The Three-Member Panel receives public comments on the proposed changes and either adopts the recommendations, amends the recommendations, or does not accept them. The Three-Member Panel's recommendations are implemented within each reimbursement manual. The Division undertakes administrative rulemaking to formally adopt each manual. The opportunity for public comment is extensive, beginning with Three-Member Panel meetings and continuing through the Division's rulemaking process.

As discussed in previous sections of the report, the Three-Member Panel is statutorily required to annually update the schedules of maximum reimbursement allowances, while adhering to the specific reimbursement amounts and criteria stated within subsection 440.13(12), F.S. Medical costs represent nearly 70% of total workers' compensation costs in Florida, and consequently, any update to the reimbursement manuals will trigger legislative ratification; unless, the updates to the maximum reimbursement allowances result in cost savings, which has only occurred once for only one reimbursement manual. The chart on the next page shows the recent history of legislative ratification for each of the reimbursement manuals. All the reimbursement manuals that proposed to increase costs have not been ratified, except for the 2015 edition of the Health Care Provider Reimbursement Manual. The primary reason this edition was ratified was because maximum reimbursement allowances for physicians did not increase for seven years.

*Edition currently in effect

Health Care Provider Reimbursement Manual, 69L-7.020, F.A.C.

Ratification Year	Edition	Effective Date	Notes	Overall Cost Impact
2011	2010	Not ratified	2009 edition remains in effect	minor
2013	2012	Not ratified	2009 edition remains in effect	minor
2014	2013	Not ratified	2009 edition remains in effect	minor
2015	2014	Not ratified	2009 edition remains in effect	minor
2016	2015	7/1/2016	Ratified	+1.8%, $64 M
2017	2016 *	7/1/2017	Ratification not required	-0.1%, -$4 M
2018	2017	Not ratified	2016 edition remains in effect	+0.1%, $4 M

Ambulatory Surgical Centers Reimbursement Manual, 69L-7.100, F.A.C.

Ratification Year	Edition	Effective Date	Notes	Overall Cost Impact
2016	2015*	1/1/2016	Ratification not required	-0.1%, -$3 M
2017	2016	Not ratified	2015 edition remains in effect	+0.6%, $22 M
2018	2017	Not ratified	2015 edition remains in effect	+1.1%, $40 M

Hospital Reimbursement Manual, 69L-7.501, F.A.C.

Ratification Year	Edition	Effective Date	Notes	Overall Cost Impact
2015	2014*	1/1/2015	Ratification not required	-1.0%, -$29 M
2017	2016	Not ratified	2014 edition remains in effect	+2.2%, $80 M
2018	2017	Not ratified	2014 edition remains in effect	+2.2%, $80 M

Unless statutory changes are made regarding the Hospital and Ambulatory Surgical Center Reimbursement Manuals, workers' compensation costs relating to updating the maximum reimbursement allowances will increase as facility charges continue to escalate. Going forward the cycle of updating the maximum reimbursement allowances; having the Three-Member Panel adopt the new maximum reimbursement allowances; having the Division promulgate rules adopting the reimbursements manuals; submitting the rules and manuals for legislative ratification; and not receiving legislative ratification will continue to repeat itself.

For the Health Care Provider Reimbursement Manual, updating the maximum reimbursement allowances based upon new Medicare values has had minimal effect on overall workers' compensation costs, unless a significant time elapses when the reimbursement manuals are not ratified.

The use of outdated or inappropriate medical procedure codes is another unintended consequence of not having the most recent editions of the reimbursement manuals ratified. Keeping medical procedure codes aligned with national standards helps reduce medical billing inconsistencies and reimbursement adjudication problems between health care providers and insurance carriers. Frictional costs associated with processing a medical bill increase when medical procedure codes are not continuously updated.

Policy Recommendation

To promote the self-execution of the workers' compensation system, the Legislature should either exempt the reimbursement manuals from legislative ratification or establish a maximum cost impact percentage threshold for each reimbursement manual for which ratification is not required.

MEDICAL AUTHORIZATION

Current Situation

Medical authorization continues to be an integral component of an efficient and self-executing workers' compensation system. The request for authorization and the timely decision to authorize or not authorize has a direct impact on the injured worker's medical care and treatment, the length of time the injured worker is out of work, whether the injured worker hires an attorney, health care provider participation in the workers' compensation system, and the cost of the claim. Streamlining the medical authorization process is likely to lead to better patient outcomes, less litigation, increased health care provider participation, and less administrative costs for the health care provider and carrier.

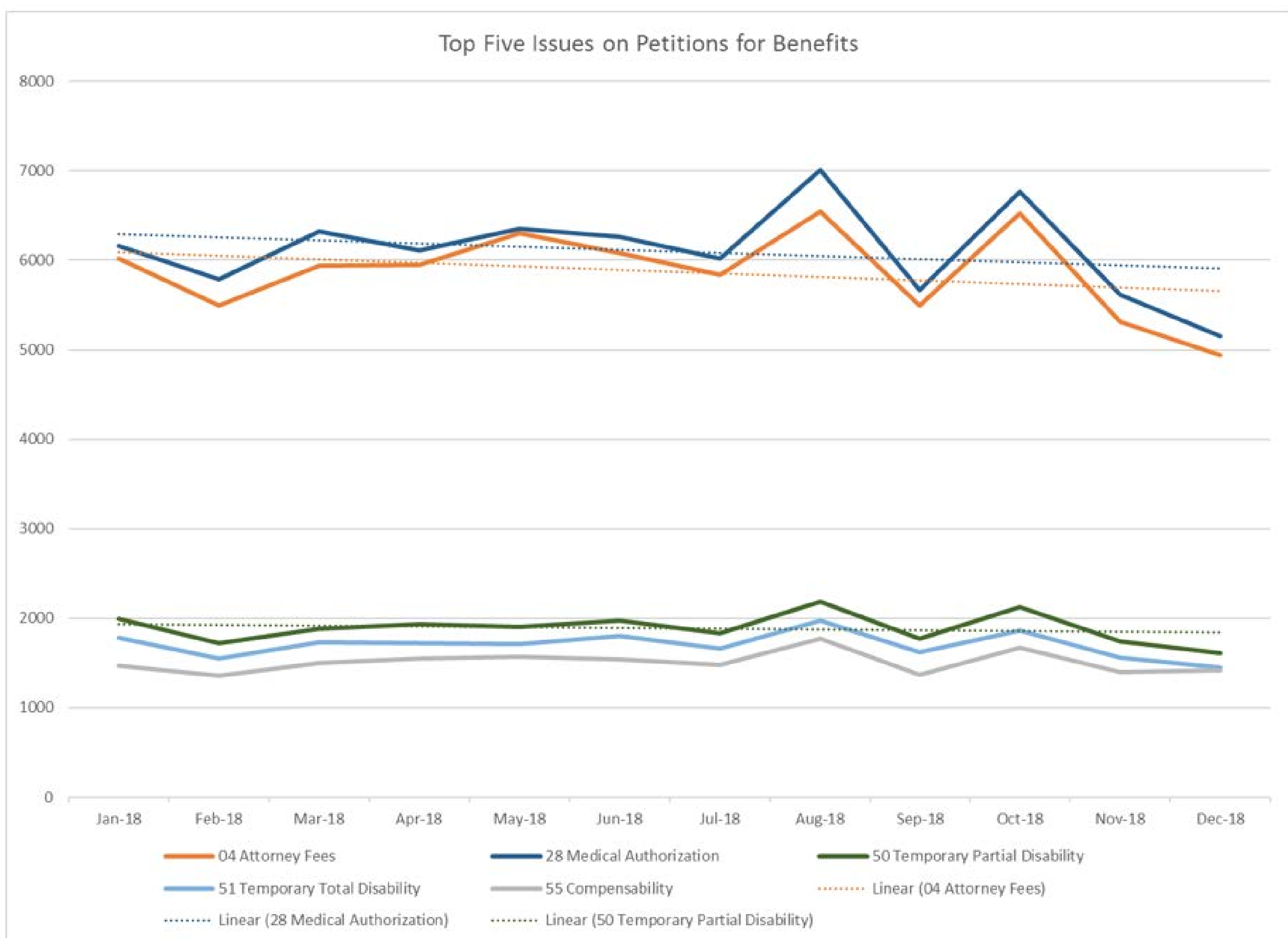
S. 440.13(3), F.S., describes the current authorization procedures under Florida's workers' compensation system. Highlights include:

- A health care provider must receive authorization from a carrier before providing treatment.
- For emergency care, a health care provider must notify the carrier by the close of the third business day after care has been provided. If the injured worker is admitted to a medical facility, the provider must notify the carrier within 24 hours of initial treatment.
- When an authorized health care provider requests a referral, the carrier must respond, by telephone or in writing, to the referral request by the close of the third business day after receipt of the request. Failure to respond within this timeframe results in the carrier consenting to the medical necessity of the treatment.
- Prior authorization is required 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 identified by department rule. For these services, carriers must respond within 10 days to a written request for authorization.
- Carriers are required to adopt procedures for receiving, reviewing, documenting, and responding to requests for authorization.

The authorization statutes do not provide a definitive answer as to whether the service will be authorized and when. The statutes consistently require the carrier to "respond" to a request for

authorization. The term "respond" is not defined in statute, and thus is subject to various degrees of interpretation, which can lead to confusion and inconsistency.

The Three-Member Panel supports a medical authorization structure, which ensures workers' compensation patients are appropriately treated in a timely manner. Despite having an entire section of the workers' compensation law devoted to medical authorization, the Petition for Benefits data from the Office of the Judges of Compensation Claims show that medical authorization is consistently the number 1 or 2 issue listed on a Petition for Benefits. Opportunities may exist for insurance carriers to increase an injured worker's understanding and their expectations of the medical authorization process through better and more frequent communication with an injured worker and the health care provider, and coupled with statutory changes, could lead to a more streamlined, patient-centered, and less litigious medical authorization process.



Policy Recommendation

The Legislature should amend paragraph 440.13(3)(d), F.S., to clarify the term "respond" as that term does not definitively obligate carriers to render a decision on a request for authorization in a consistent manner. The Legislature should also consider modifying a carrier's 3-day and 10-day "response" deadline to expedite requested medical treatment based on a physician's use of evidence-based treatment guidelines.

Data Supporting the Policy Recommendation

Division of Workers Compensation

Top Five Issues on a Petition for Benefits – Exhibit 59

TREATMENT GUIDELINES

Current Situation

The Legislature recognized the importance of establishing practice parameters and protocols for treating workers' compensation patients when it established subsection 440.13(14), F.S. in 2003. Subsection 440.13(14), F.S. states "*The practice parameters and protocols mandated under this chapter shall be the practice parameters and protocols adopted by the United States Agency for Healthcare Research and Quality (AHRQ) in effect on January 1, 2003.*" The purpose for establishing practice guidelines is to ensure quality medical care is provided to injured workers based upon evidence-based clinical outcomes, promote better medical utilization, reduce medical treatment disputes, and expedite authorization between health care providers and insurance companies.

The AHRQ maintained a public database called the National Guideline Clearinghouse (NGC), which contained a listing and access to practice guidelines. An inherent deficiency in the 2003 law limited its effectiveness in meeting its purpose. AHRQ adopted very few, if any, relevant practice guidelines, as of January 1, 2003. Even more problematic, the NGC is no longer available, as of August 2018. According to the AHRQ website, "*The contract that supported the NGC ended in August, and funds to continue support for the NGC were unavailable.*"

Consequently, subsection 440.13(14), F.S. and all the references to practice parameters and protocols contained in section 440.13, F.S., are no longer relevant nor meaningful. Two of the most recognized evidence-based treatment guidelines used in workers' compensation systems are the Official Disabilities Guidelines and the American College of Occupational and the Environmental Medicine. Each of these publications offer comprehensive evidence-based treatment guidelines, which can be accessed and used by system stakeholders. Some states have developed their own treatment guidelines applicable in their jurisdictions.

Policy Recommendation

At a minimum, the Legislature should repeal subsection 440.13(14), F.S. and all the references to practice parameters and protocols contained in section 440.13, F.S. If the Legislature still supports in the merits of evidence-based treatment guidelines, subsection 440.13(15), F.S., Standards of Care should be amended to include the use evidence-based treatment guidelines in providing medical care to injured workers, and all references to practice parameters and protocols should be eliminated.

SUMMARY

The enactment of SB-50A in 2003 along with the long-term decline in claim frequency has led to workers' compensation market stability and an era of lower workers' compensation rates for Florida's employers. Florida is not experiencing a workers' compensation crisis defined by unaffordable rates, escalating costs, and market constriction, as it was in the years prior to 2003. This situation presents the Legislature with a unique opportunity to advance Florida's workers' compensation system and continue to foster this era of lower workers' compensation rates.

The Three-Member Panel recognizes that some of these recommendations might generate concern from certain interested parties. However, the Three-Member Panel has made them based upon independent and objective data along with its statutory obligation to promote cost containment for employers, ensure injured workers access to quality medical treatment, provide equitable and reasonable reimbursements to health care providers, and to fulfill the legislative intent of Florida's Workers' Compensation Law.

ORGANIZATION DESCRIPTIONS

About the Division of Workers' Compensation

The Division of Workers' Compensation administers chapter 440, Florida's Workers' Compensation Law. Its mission is to actively ensure the self-execution of the workers' compensation system by educating system participants of their rights and responsibilities; by leveraging data to deliver exceptional value; and by holding participants accountable for fulfilling their obligations. The Division assists injured workers, employers, health care providers, and insurers in following the Florida workers' compensation rules and laws. While the Division is not responsible for adjusting any claims, it is a resource to help ensure that claims are being adjusted and reimbursed properly.

The Division provides administrative support and service to the Three-Member Panel. Medical bills from all types of health care providers for services and treatment given to workers' compensation patients are submitted to insurances carriers for review and payment. Subsequently, insurance carriers are required to electronically report all medical bill data to the Division. Nearly four million workers' compensation medical bills are annually reported to the Division and then analyzed and used to assist the Three-Member Panel in establishing schedules of maximum reimbursement. Data from these medical bills were also used to support the recommendations contained in the 2019 Three-Member Panel Biennial Report.

For more information about the Division of Workers' Compensation and its activities, please contact Tanner Holloman, Director, at tanner.holloman@myfloridacfo.com or Andrew Sabolic, Assistant Director, at andrew.sabolic@myfloridacfo.com.

About WCRI

Founded in 1983, WCRI is an independent, not-for-profit research organization which strives to help those interested in making improvements to the workers' compensation system by providing highly regarding, objective data and analysis.

WCRI does not take positions on the issues it researches; rather, it provides information obtained through studies and data collection efforts, which conform to recognized scientific methods. Objectivity is further ensured through rigorous, unbiased peer review procedures.

WCRI’s work includes the following:

- Original research studies of major issues confronting workers’ compensation systems
- Studies of individual state systems where policymakers have shown an interest in change and where there is an unmet need for objective information
- Studies of states that have undergone major legislative changes to measure the impact those reforms and draw possible lessons for other states
- Presentations on research findings to legislators, workers’ compensation administrators, industry groups, and other stakeholders

For more information about WCRI and its studies, please contact Laure Lamy at llamy@wcrinet.org.

About NCCI

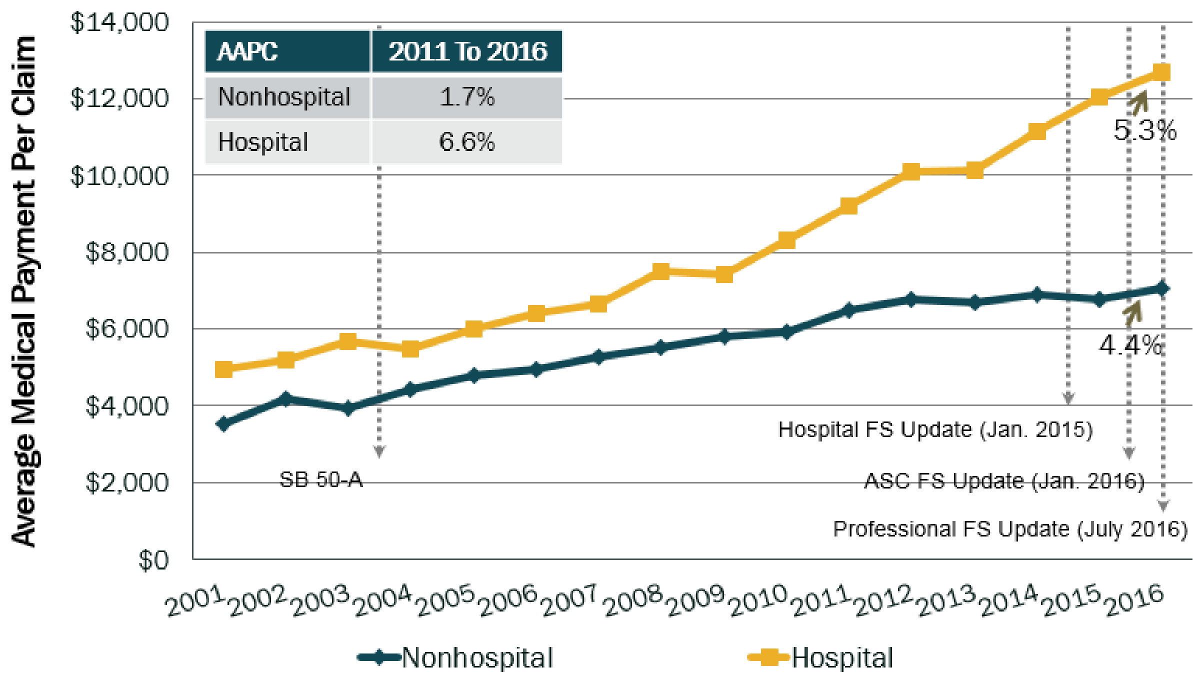
Founded in 1923, the mission of NCCI is to foster a healthy workers compensation system. In support of this mission, NCCI gathers data, analyzes industry trends, and provides objective insurance rate and loss cost recommendations.

The *Florida Medical Data Report 2018* is a data source for regulators and others who are interested in the driving forces behind increasing medical costs in workers’ compensation claims. The information in the report provides important benchmarks against which cost containment strategies may be measured and gives valuable insight into the medical cost drivers that threaten the financial soundness of the workers’ compensation system.

For more information about NCCI and its studies, please contact Dawn Ingham at Dawn_Ingham@ncci.com.

EXHIBITS

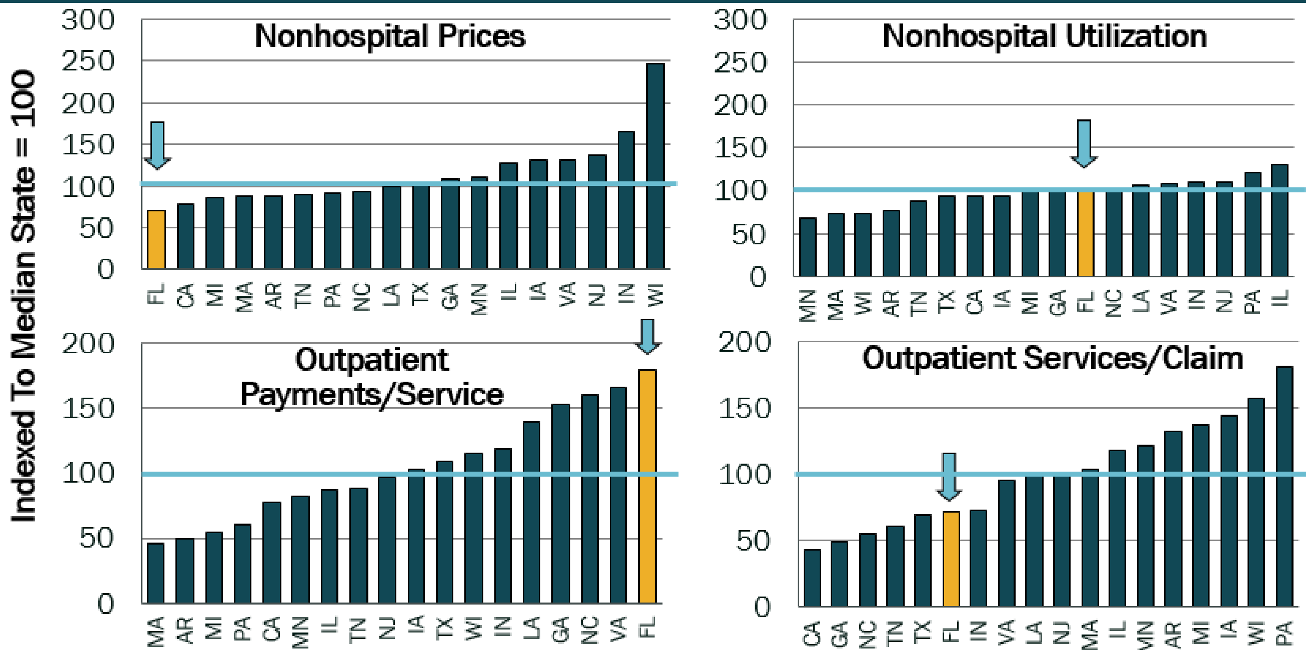
Exhibit 1



© WCRI 2018

Exhibit 2

FL Had Lowest Price For Professional Services And Highest Price For Hospital Outpatient

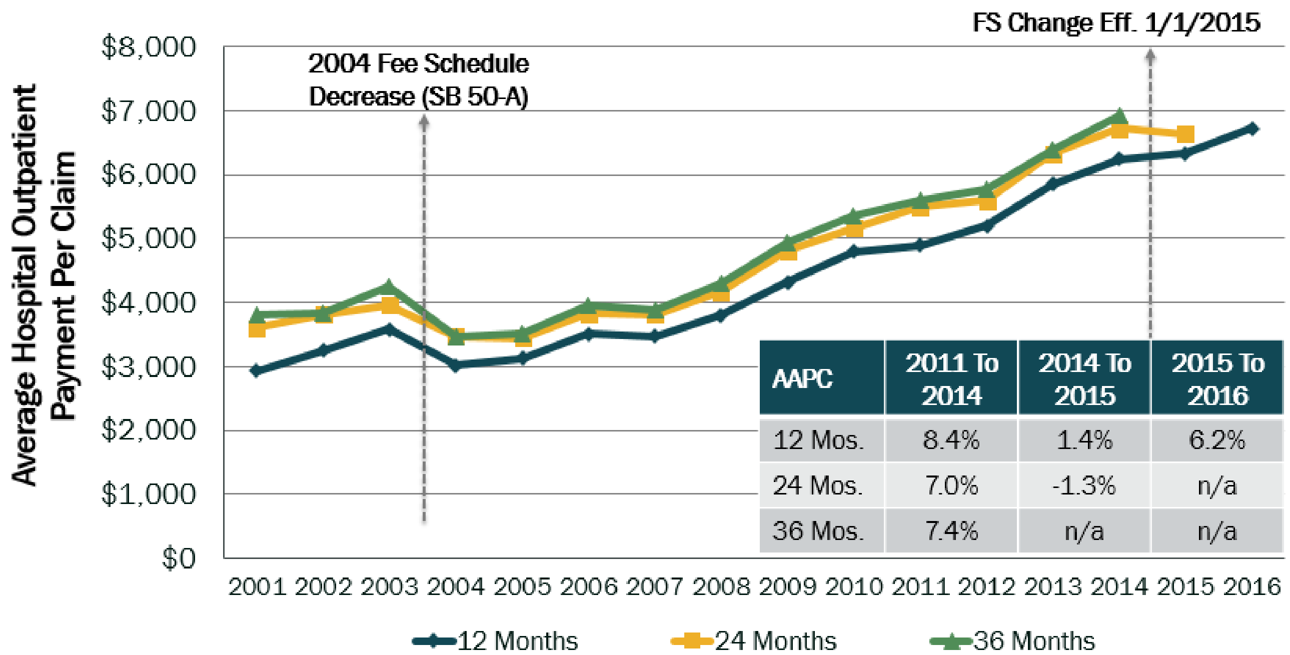


2016/17 Claims With > 7 Days Of Lost Time, Adjusted For Injury/Industry Mix. Prices are for calendar year 2016 and for all paid claims.

© WCRI 2018

Exhibit 3

FL Hosp. Outp. Payments/Claim Grew 6% In 2016, After Being Stable In 2015 Following FS Change



AAPC	2011 To 2014	2014 To 2015	2015 To 2016
12 Mos.	8.4%	1.4%	6.2%
24 Mos.	7.0%	-1.3%	n/a
36 Mos.	7.4%	n/a	n/a

Claims With > 7 Days Of Lost Time, Not Adjusted For Injury/Industry Mix

© WCRI 2018

Exhibit 4

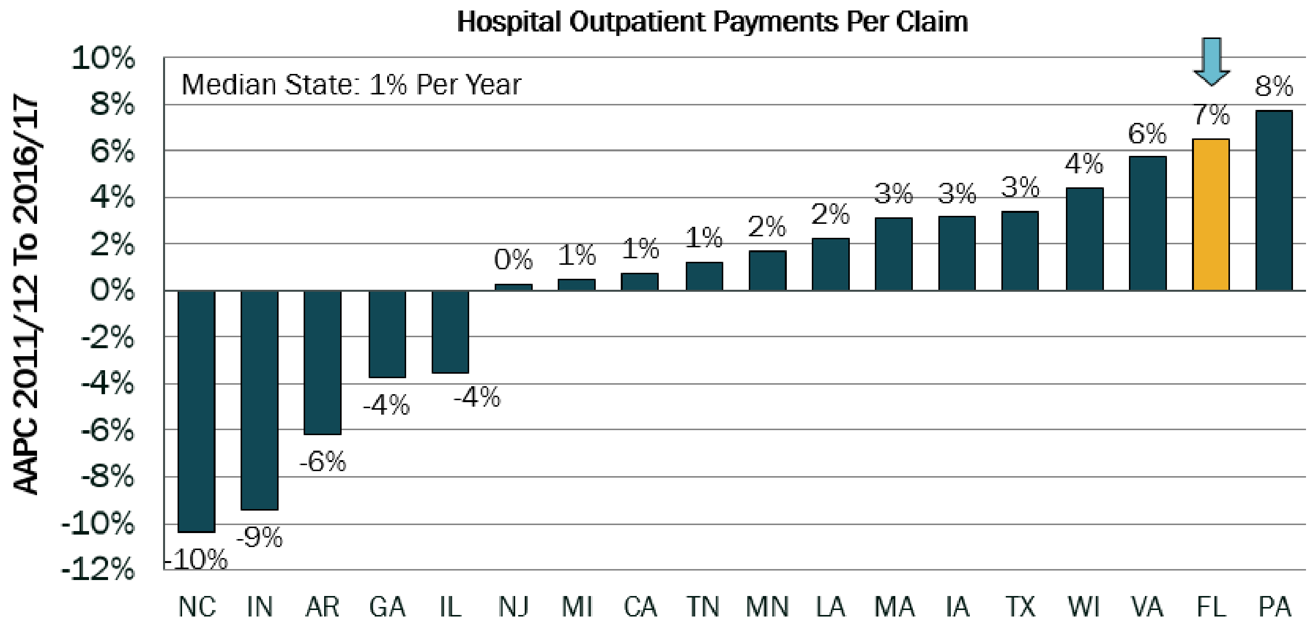


Exhibit 5

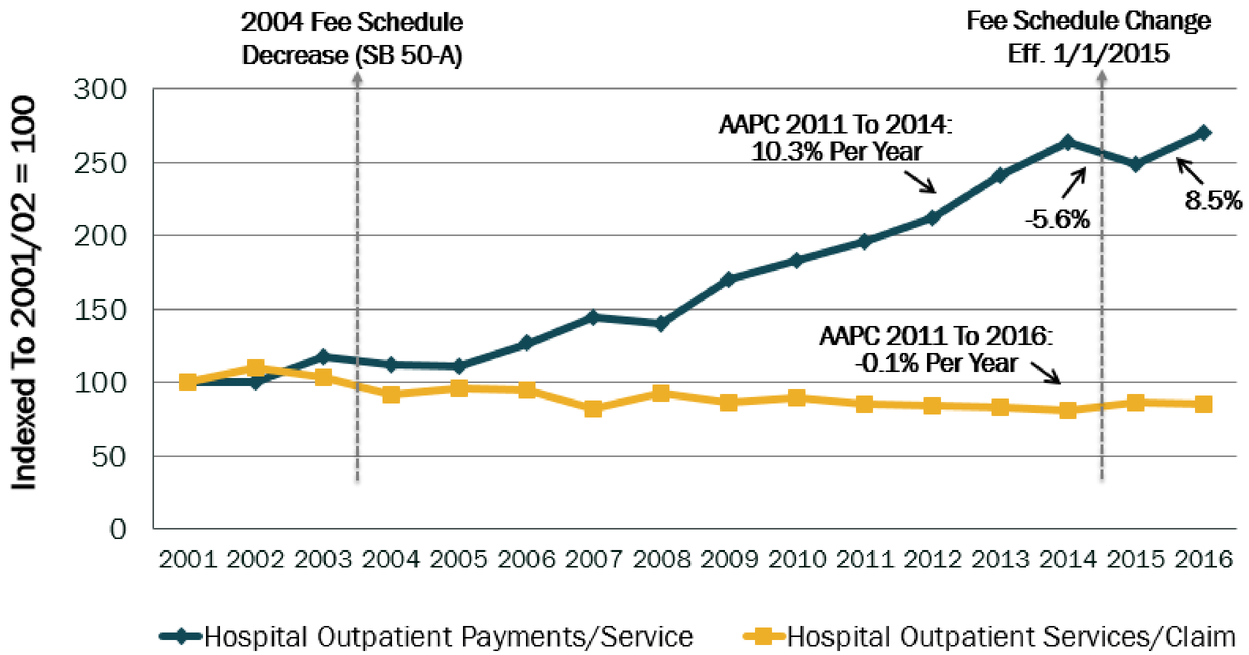
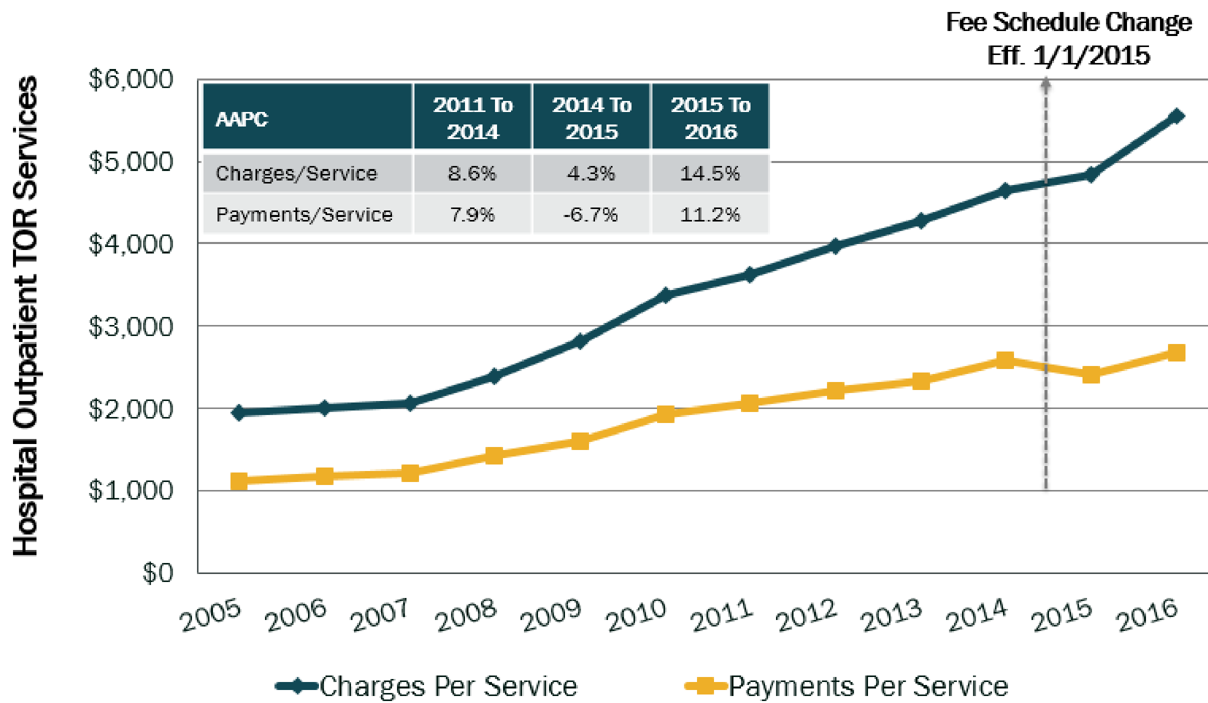


Exhibit 6

In 2016, FL Hosp. Outp. Payments Per Service For Treat./Oper./Recovery Rooms Grew With Charges



AAPC	2011 To 2014	2014 To 2015	2015 To 2016
Charges/Service	8.6%	4.3%	14.5%
Payments/Service	7.9%	-6.7%	11.2%

Claims With > 7 Days Of Lost Time At 12 Months Of Experience, Not Adjusted For Injury/Industry Mix

© WCRI 2018

Exhibit 7

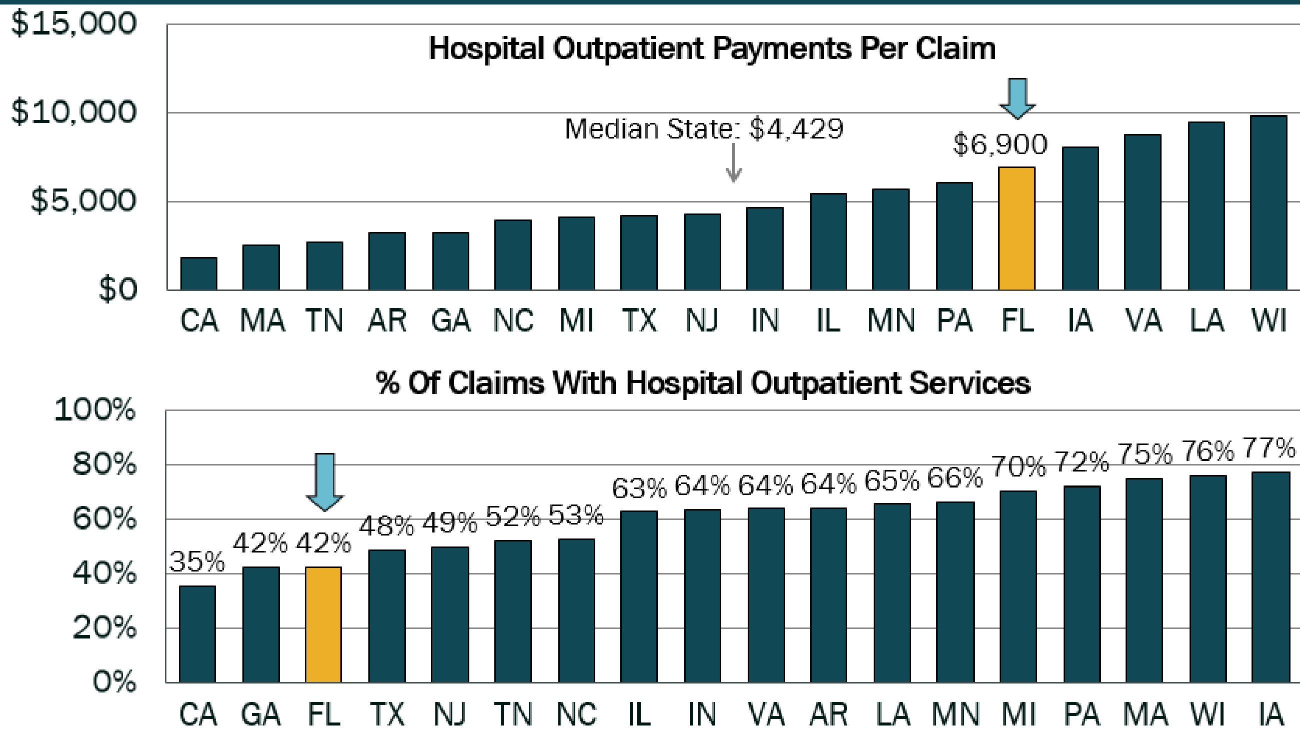


Exhibit 8

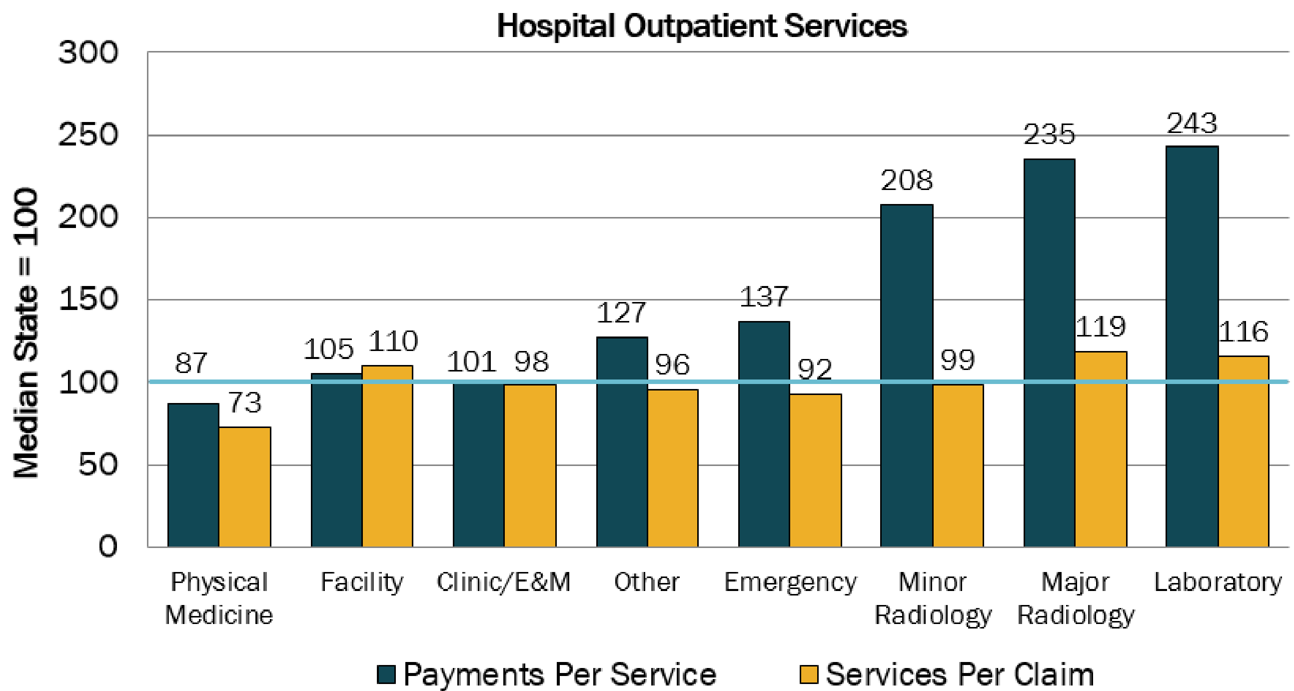
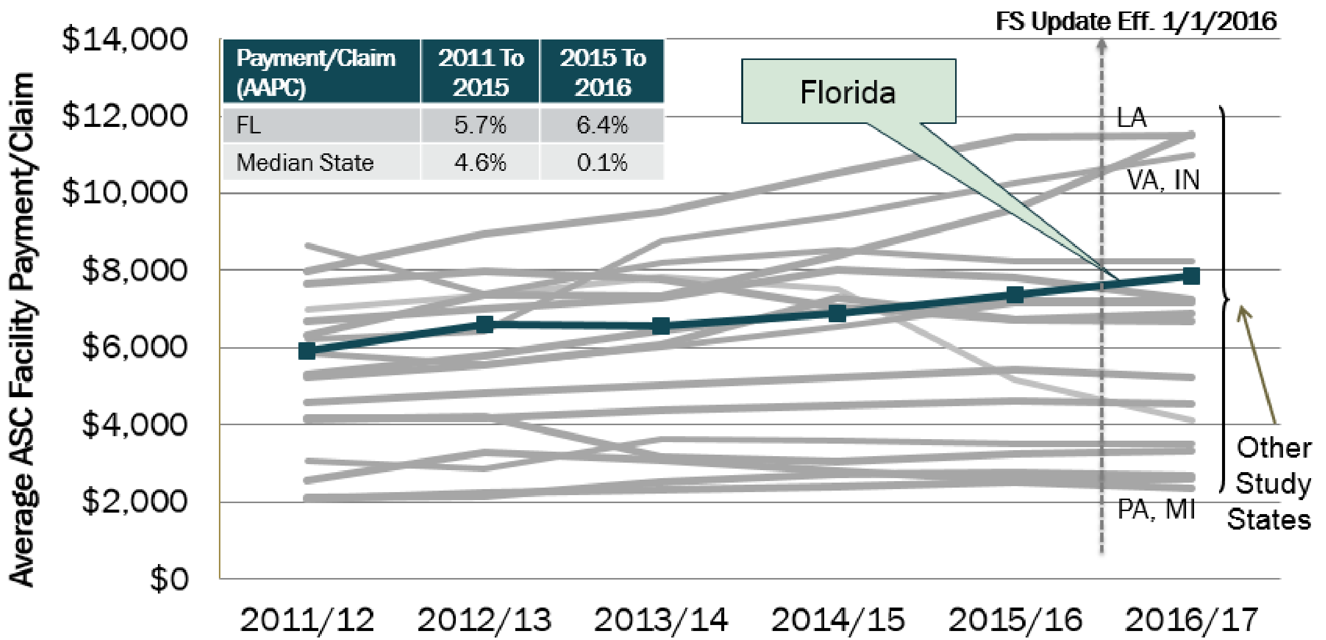


Exhibit 9

FL ASC Facility Payments Per Claim Increased 6% In 2016/17 Following Fee Schedule Update

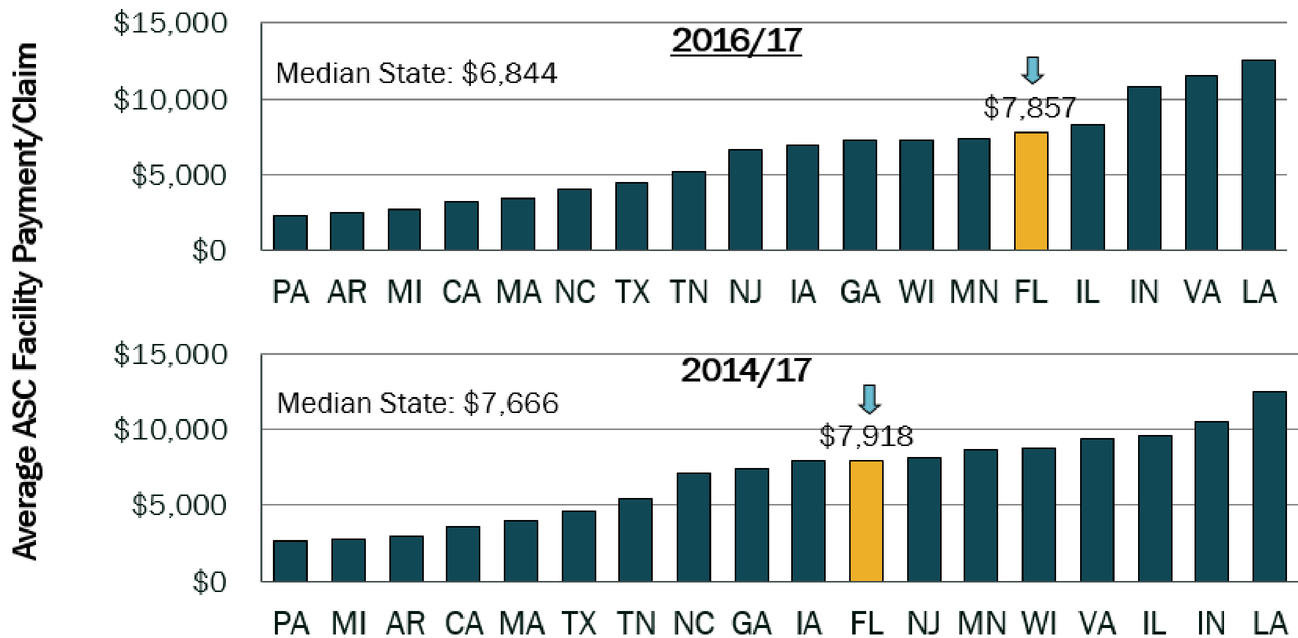


Claims With > 7 Days Of Lost Time At 12 Months Of Experience, Not Adjusted For Injury/Industry Mix

© WCRI 2018

Exhibit 10

FL ASC Facility Payments/Claim Slightly Higher Than Median State At 12 Mos.; Typical At 36 Mos.



Claims With > 7 Days Of Lost Time And ASC Facility Services, Adjusted For Injury/Industry Mix

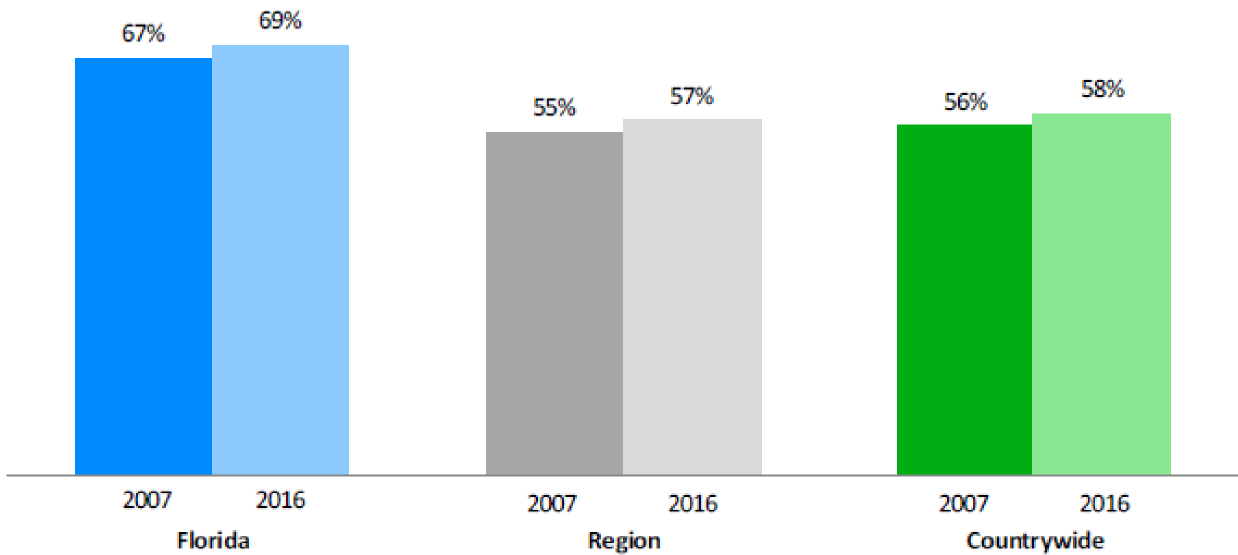
© WCRI 2018

Exhibit 11

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

The Florida Division of Workers' Compensation has submitted a request for medical report charts for Florida's 2019 Biennial Report. Each requested chart is listed individually per page below.

Medical Share of Total Benefit Costs by Accident Year

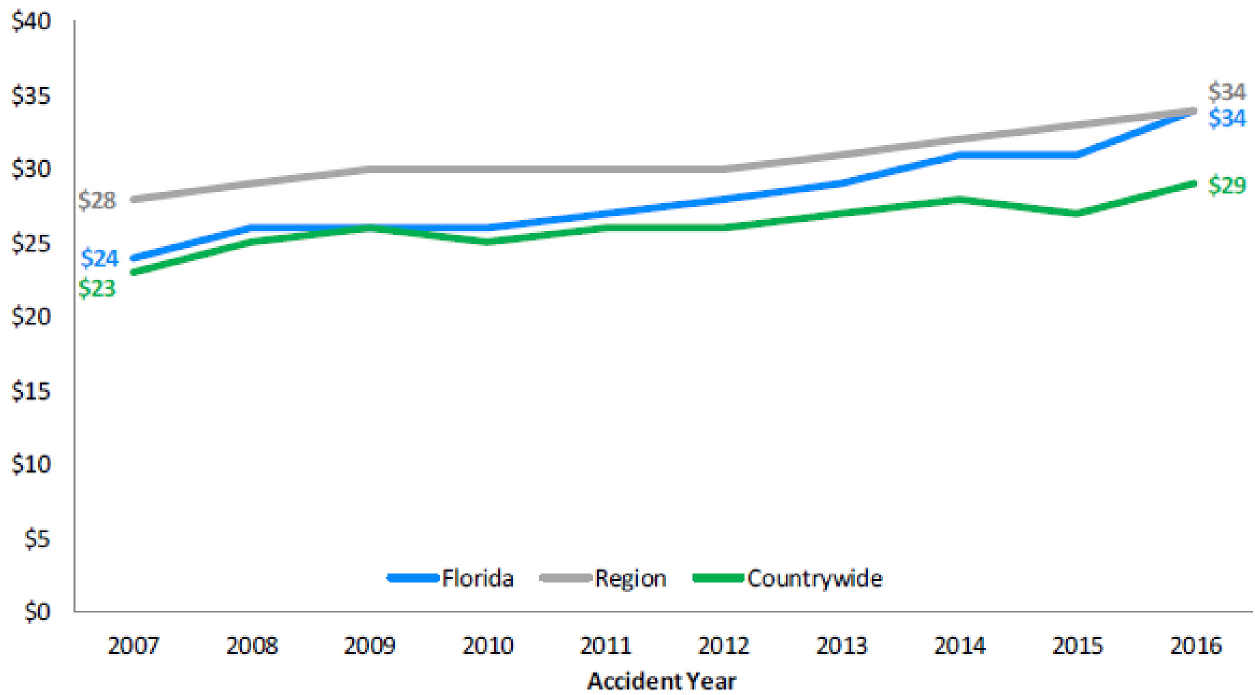


Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

Exhibit 12

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Overall Medical Average Cost per Lost Time Claim (in 000s)

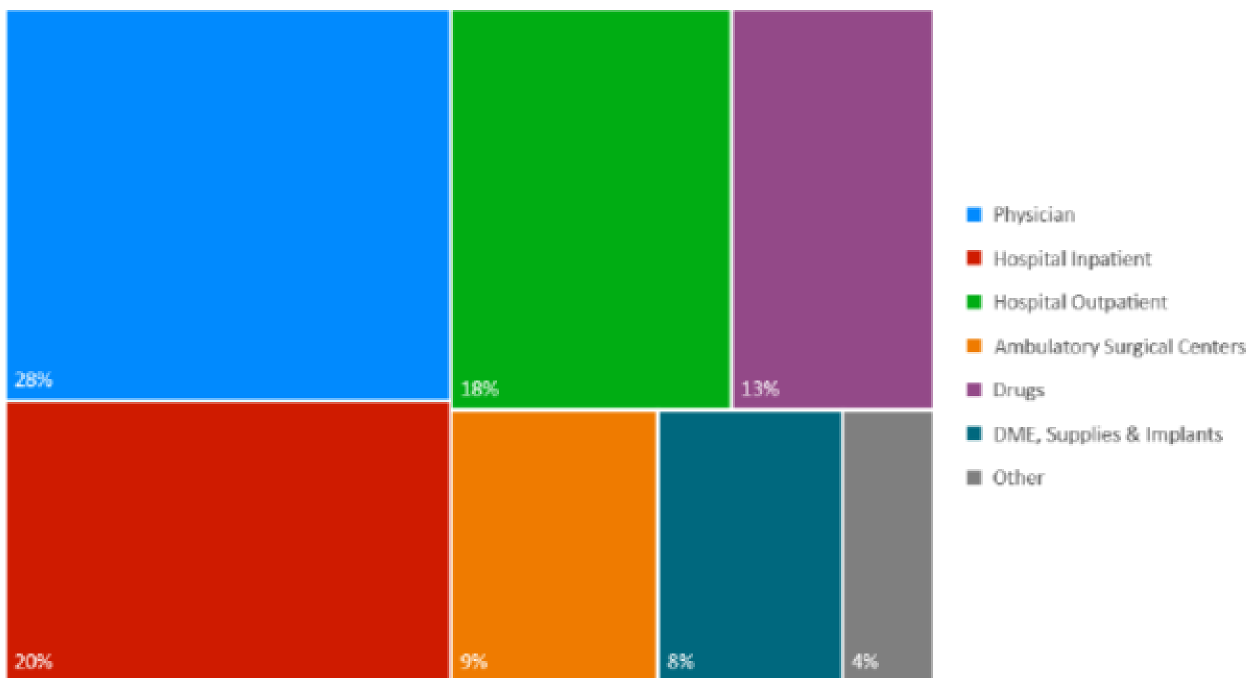


Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, and VA. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, and VT.

Exhibit 13

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Distribution of Medical Payments for Florida



Source: NCCI's Medical Data Call for Service Year 2017.

Exhibit 14

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Hospital Outpatient Payments as a Percentage of Medicare

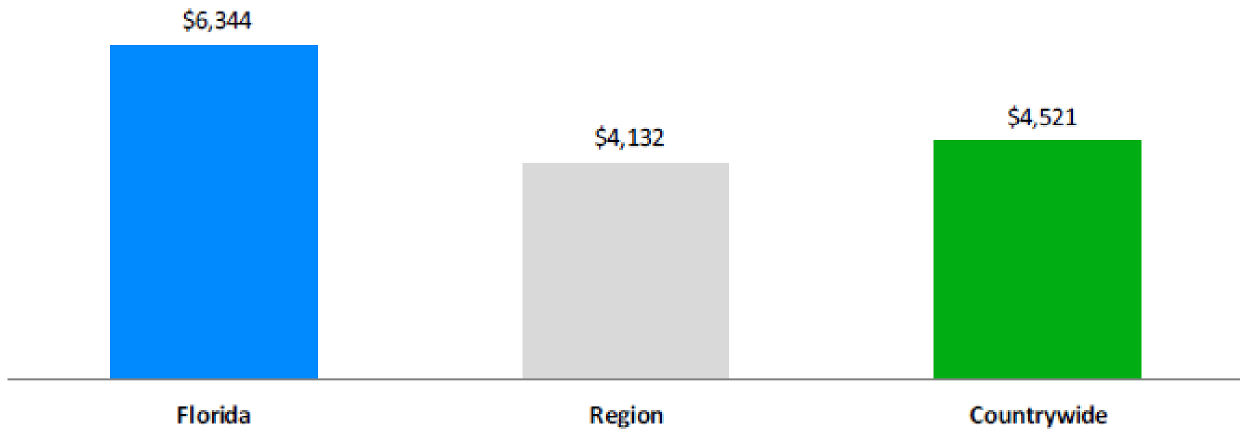
Medical Cost Category	Florida	Region	Countrywide
Hospital Outpatient	441%	223%	256%

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 15

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Average Amount Paid per Surgical Visit for Hospital Outpatient Services

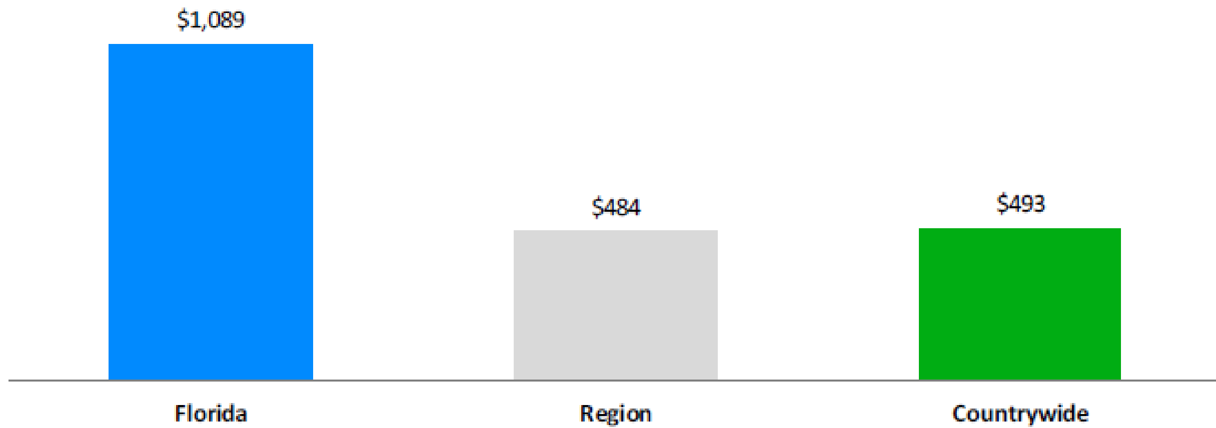


Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 16

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Average Amount Paid per Nonsurgical Visit for Hospital Outpatient Services

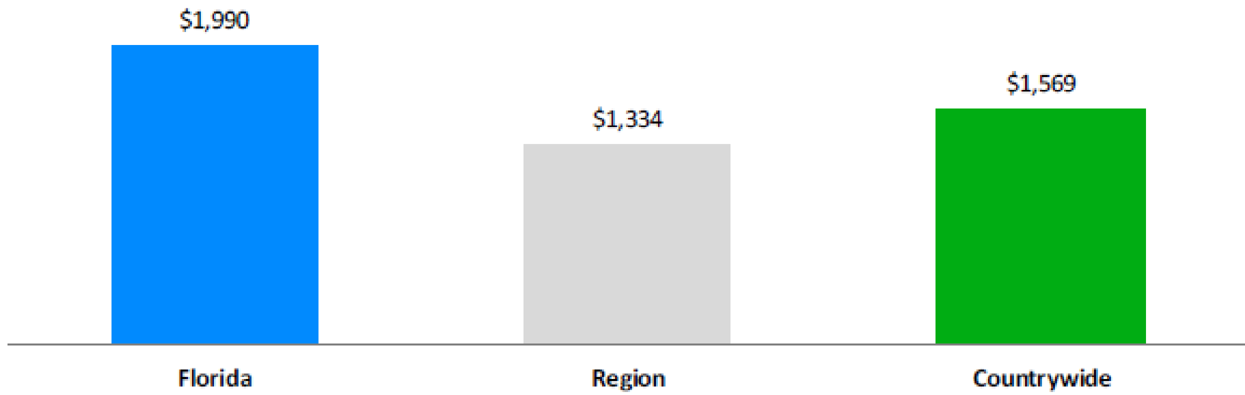


Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 17

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Average Amount Paid per Emergency Room Visit



Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 18

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services

		Median Amount Paid Per Visit		
Diagnosis Group	**Paid Share**	**Florida**	**Region**	**Countrywide**
Open wound of wrist, hand and fingers	4.6%	$815	$447	$507
Neck pain	3.7%	$898	$272	$239
Other and unspecified injuries of head	3.3%	$3,068	$735	$853
Low back pain	3.2%	$578	$194	$212
Inguinal hernia	2.9%	$7,287	$3,371	$3,755
Open wound of head	2.9%	$997	$643	$733
Fracture at wrist and hand level	2.7%	$1,040	$335	$292
Lumbosacral intervertebral disc disorders	2.4%	$465	$288	$304
Superficial injury of head	2.4%	$2,851	$681	$706
Fracture of lower leg, including ankle	2.2%	$143	$230	$224

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 19

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

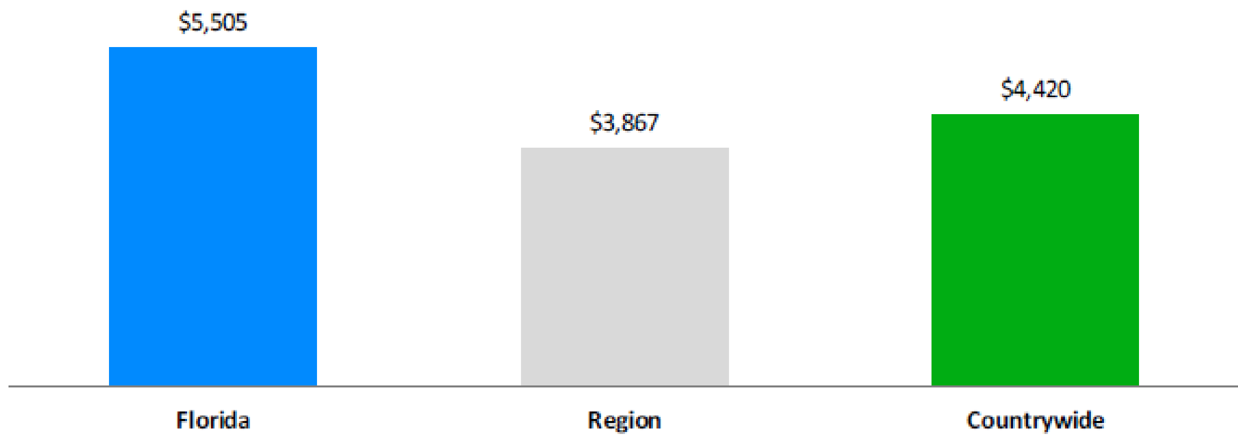
ASC Payments as a Percentage of Medicare

Medical Cost Category	Florida	Region	Countrywide
Ambulatory Surgical Center	312%	286%	285%

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 20

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT



Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 21

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Top 10 Diagnosis Groups by Amount Paid for ASC Services

Diagnosis Group	Paid Share	Median Amount Paid per Visit		
		Florida	Region	Countrywide
Rotator cuff tear	10.6%	$13,569	$7,767	$8,684
Knee internal derangement - meniscus injury	6.1%	$3,568	$3,595	$3,692
Other specific joint derangements	4.4%	$9,039	$5,071	$5,847
Lumbar spine degeneration	4.4%	$2,528	$1,438	$1,710
Lumbosacral intervertebral disc disorders	3.4%	$1,809	$1,171	$1,264
Other and unspecified osteoarthritis	3.3%	$13,532	$6,093	$8,025
Shoulder impingement syndrome	3.3%	$10,005	$7,001	$7,374
Superior labral tear from anterior to posterior (SLAP) lesion	2.6%	$13,751	$7,519	$7,676
Minor shoulder injury	2.6%	$6,730	$5,555	$5,676
Low back pain	2.5%	$2,679	$746	$895

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 22

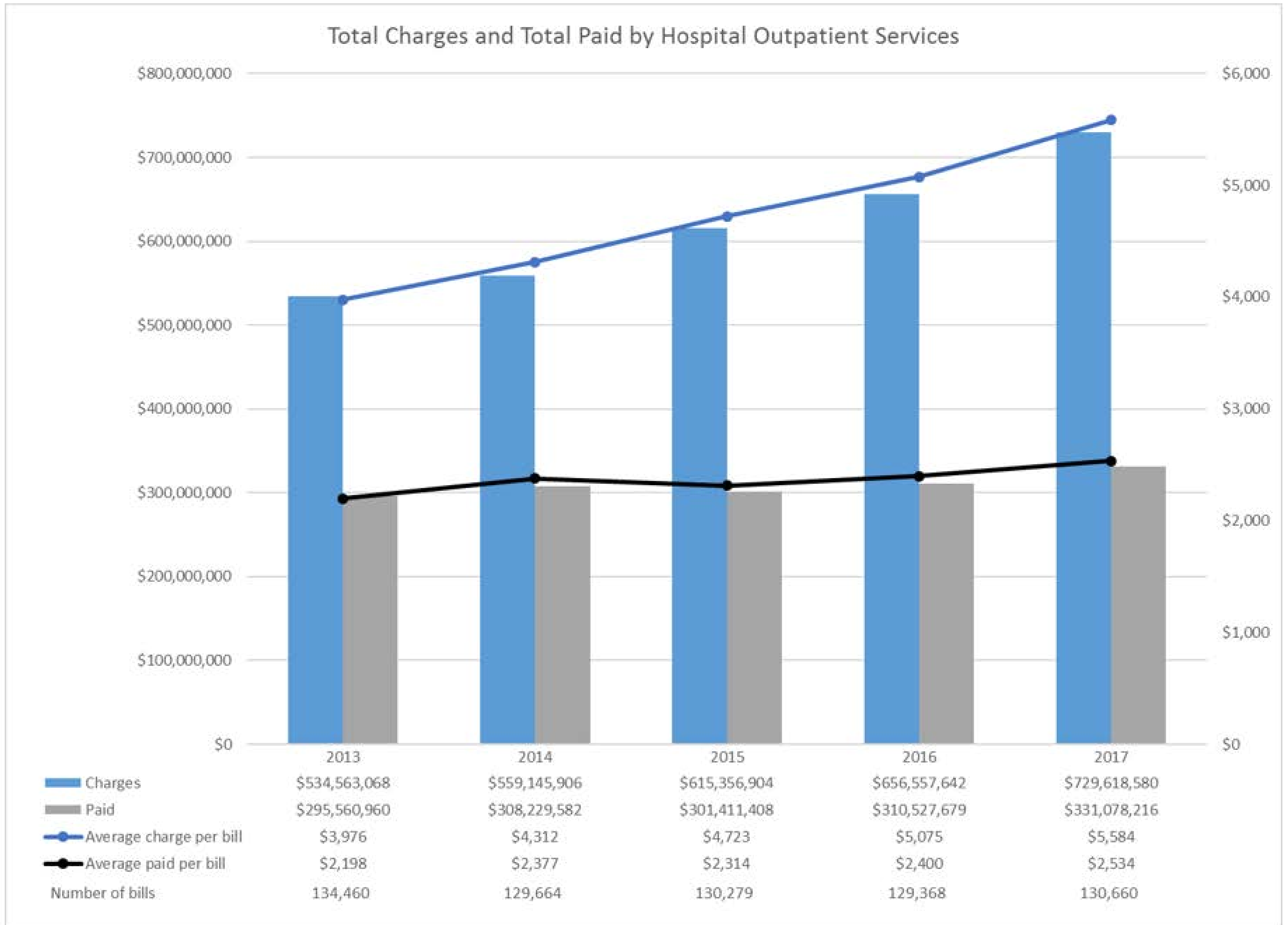
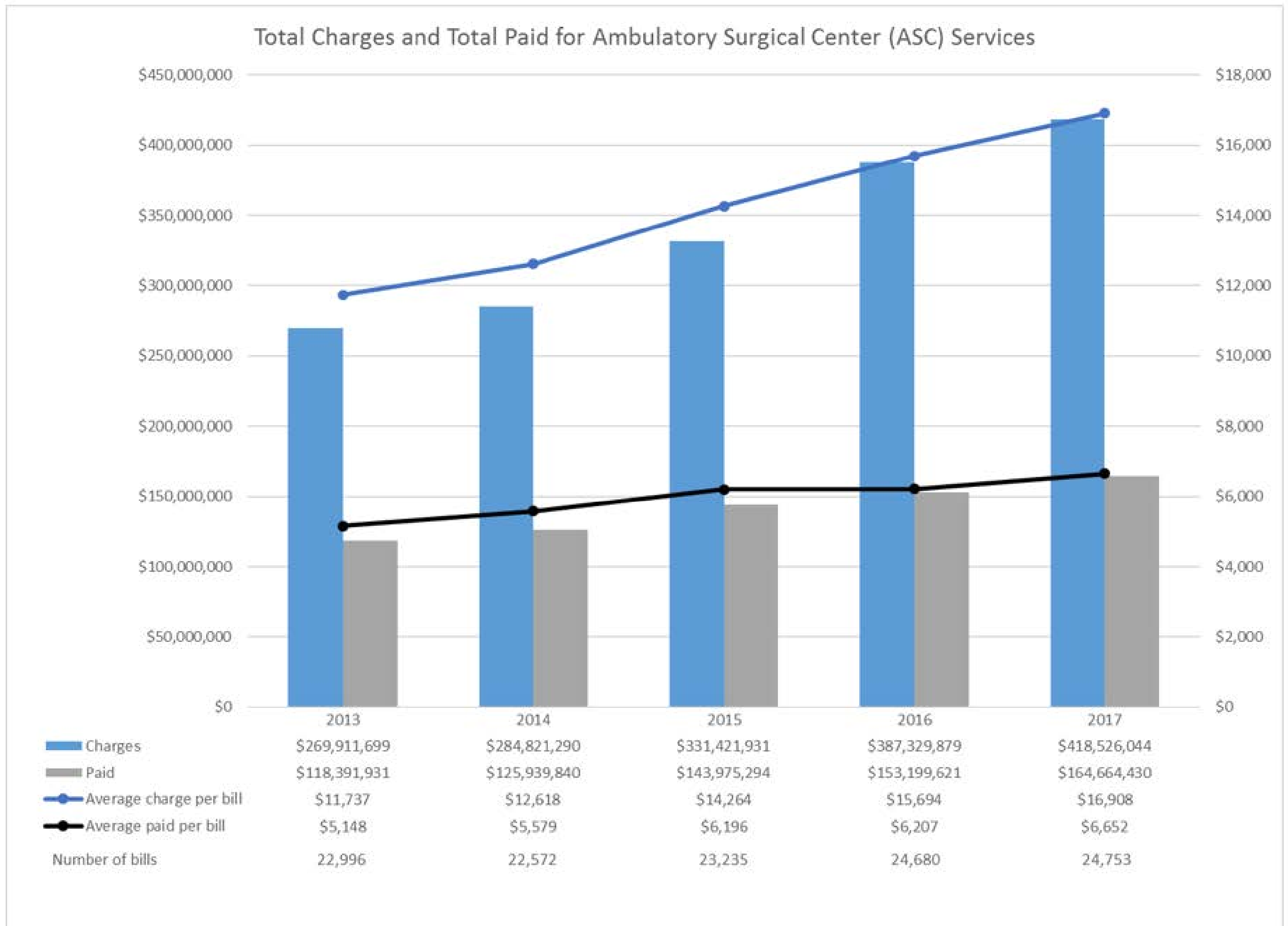


Exhibit 23



	2013	2014	2015	2016	2017
Charges	$269,911,699	$284,821,290	$331,421,931	$387,329,879	$418,526,044
Paid	$118,391,931	$125,939,840	$143,975,294	$153,199,621	$164,664,430
Average charge per bill	$11,737	$12,618	$14,264	$15,694	$16,908
Average paid per bill	$5,148	$5,579	$6,196	$6,207	$6,652
Number of bills	22,996	22,572	23,235	24,680	24,753

Exhibit 24

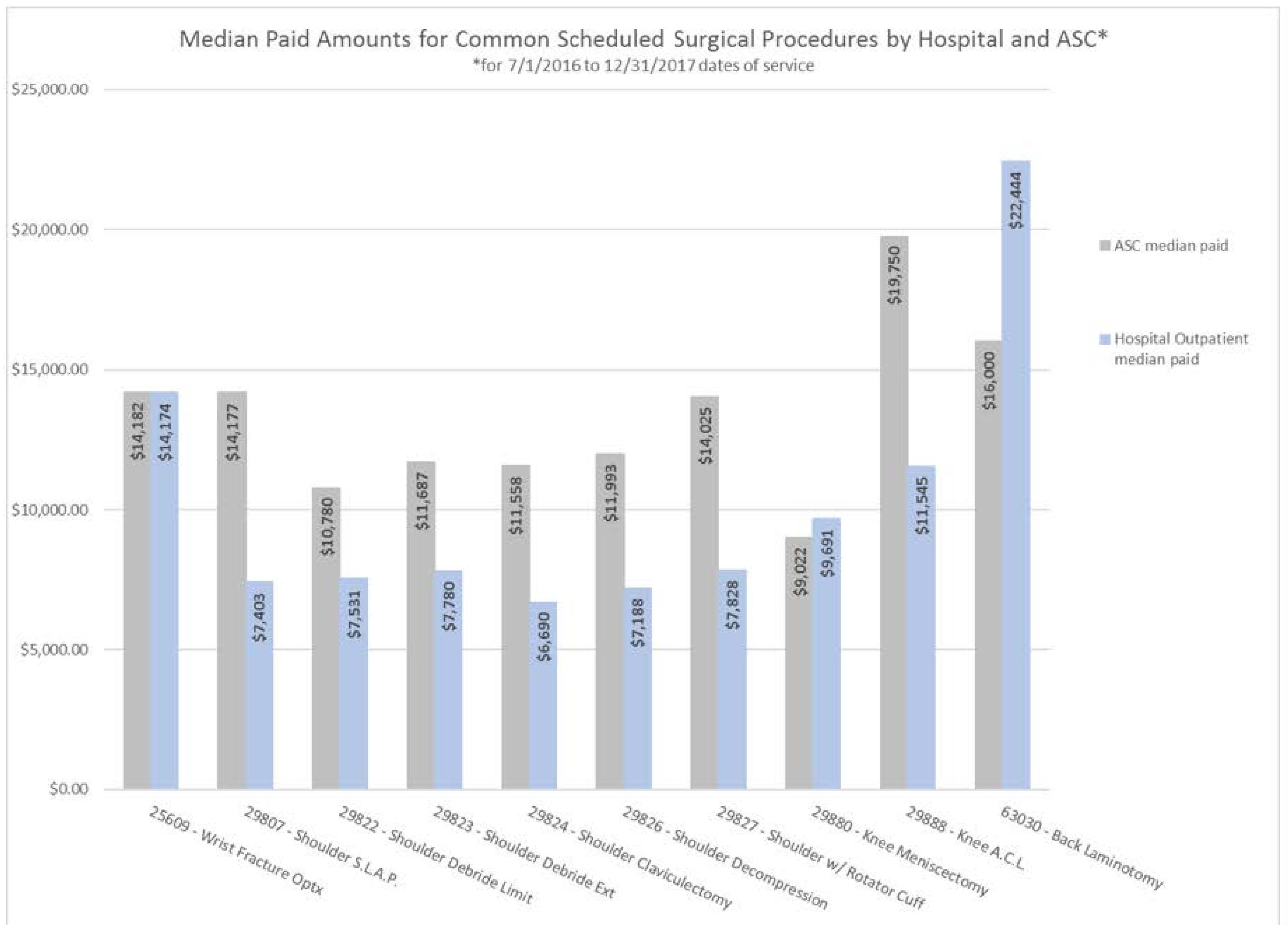


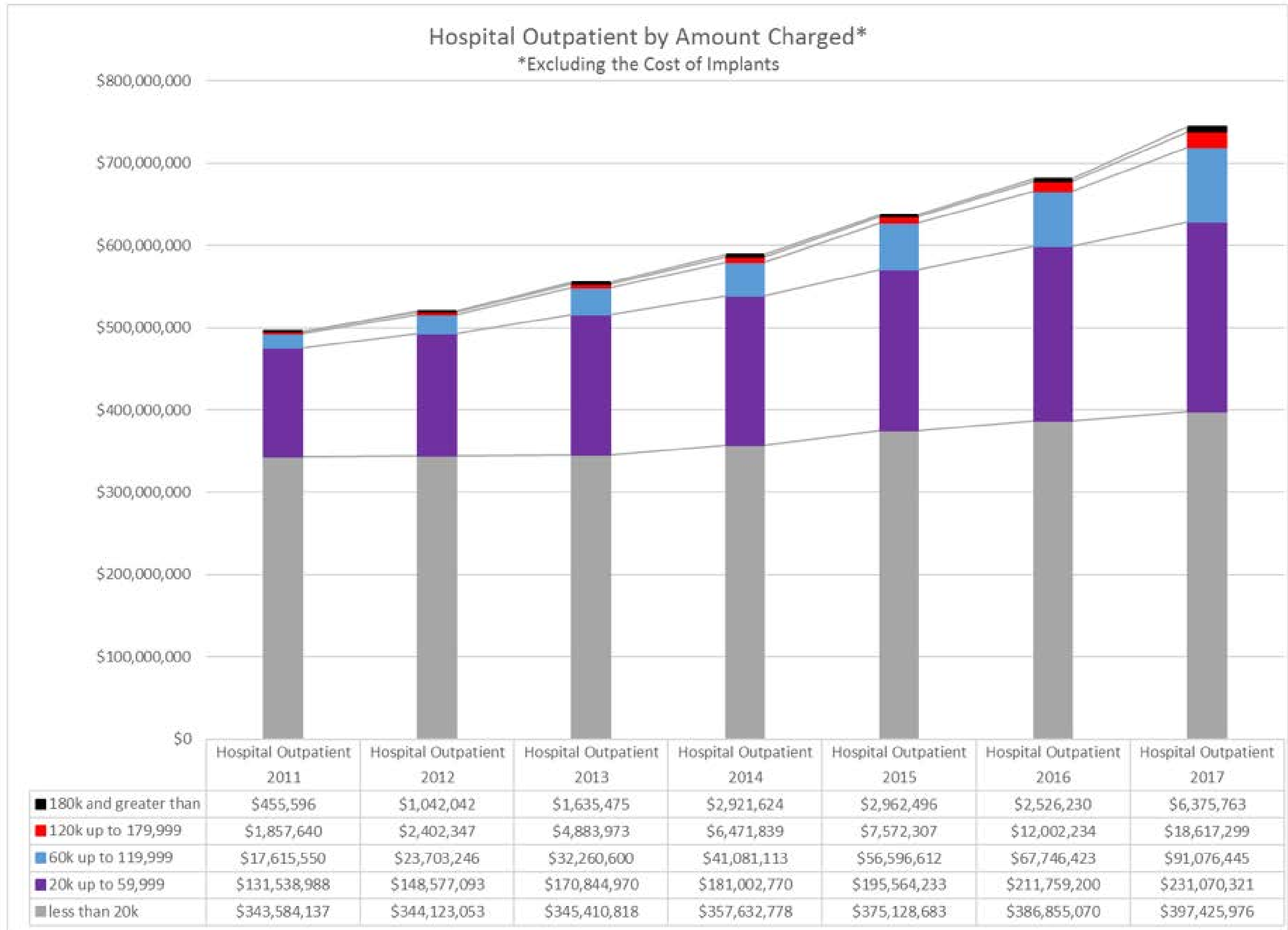
Exhibit 25 – Comparison of Florida Workers' Compensation Reimbursement and Medicare Payment Rates

*For the complete report containing the table below, please click here.

	Hospital Claims				
Category	Claims	Charges	FL WC Payment	Medicare Payment	FL WC Payment as Percent Medicare
Scheduled	13,785	$215,015,552	$104,399,716	$21,674,828	482%
Unscheduled	19,222	$97,148,165	$47,949,230	$8,091,653	593%
Not Listed	92,424	$466,582,208	$213,435,034	$37,340,883	572%
Total	125,431	$778,745,926	$365,783,980	$67,107,365	545%

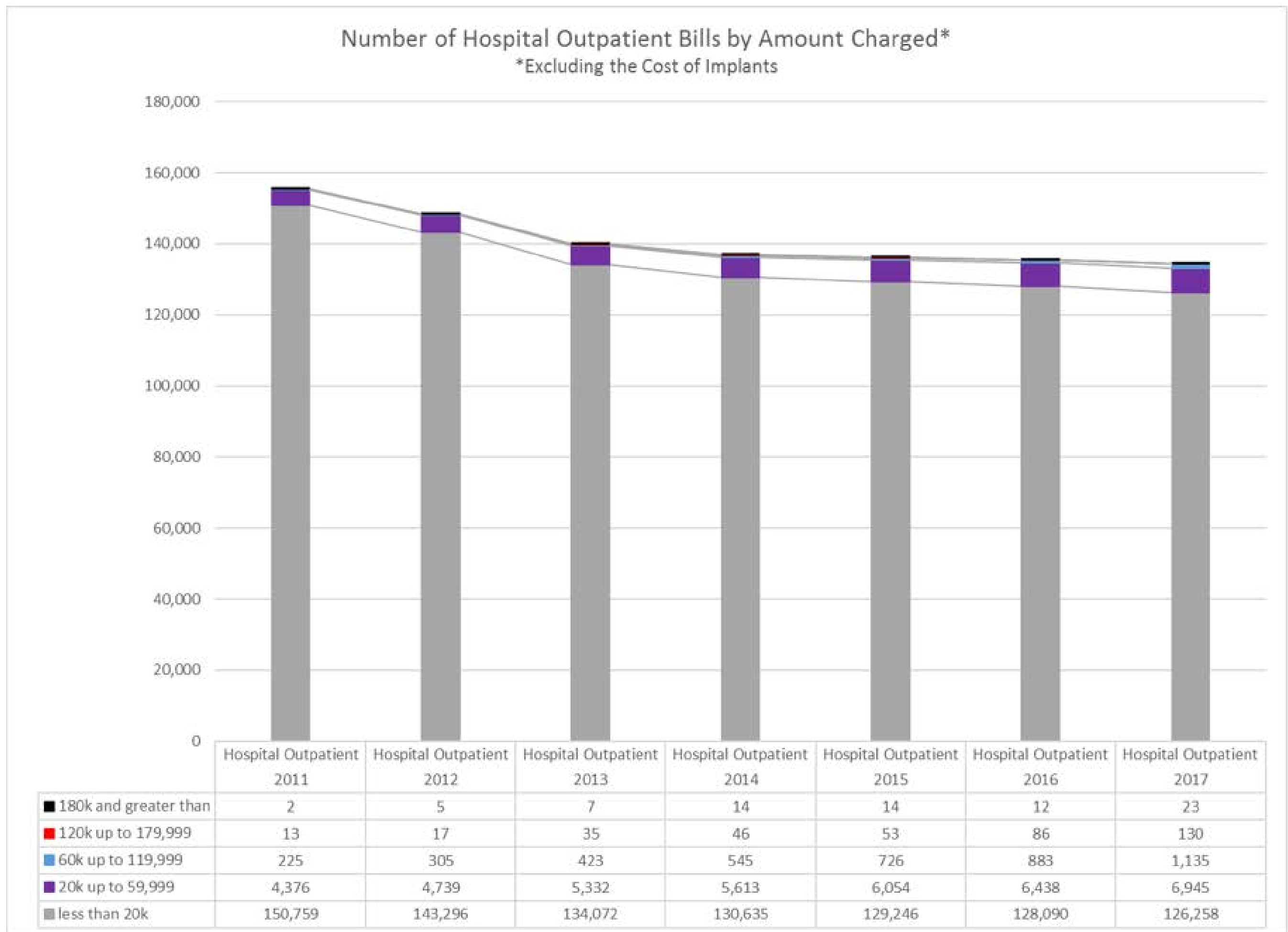
	ASC Claims				
Category	Claims	Charges	FL WC Payment	Medicare Payment	FL WC Payment as Percent Medicare
Scheduled	11,979	$227,550,785	$92,288,489	$21,982,214	420%
Unscheduled	270	$5,641,815	$2,402,922	$483,409	497%
Not Listed	21,097	$352,783,207	$134,397,192	$32,656,137	412%
Total	33,346	$585,975,807	$229,088,603	$55,121,761	416%

Exhibit 26



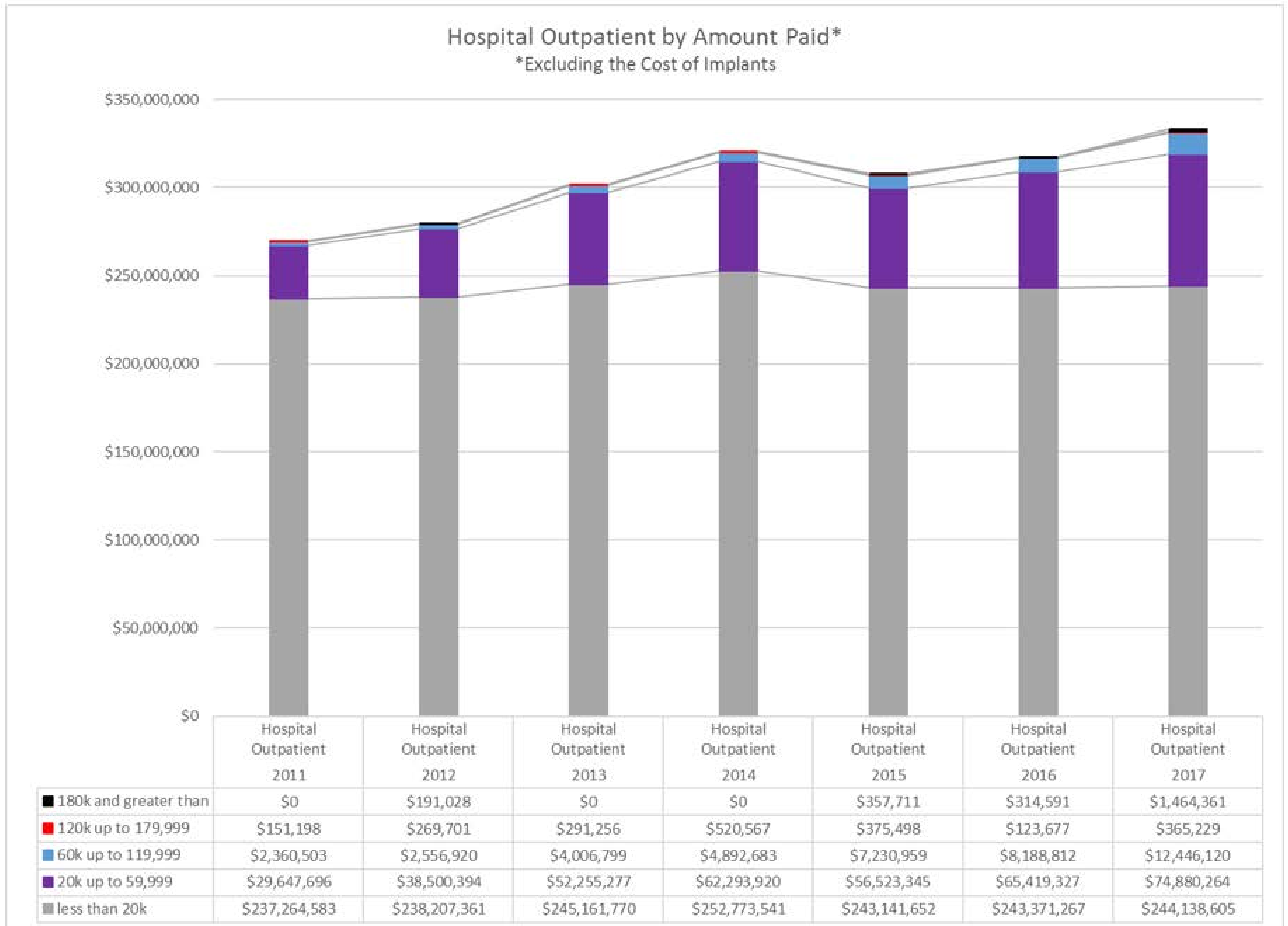
	Hospital Outpatient 2011	Hospital Outpatient 2012	Hospital Outpatient 2013	Hospital Outpatient 2014	Hospital Outpatient 2015	Hospital Outpatient 2016	Hospital Outpatient 2017
180k and greater than	$455,596	$1,042,042	$1,635,475	$2,921,624	$2,962,496	$2,526,230	$6,375,763
120k up to 179,999	$1,857,640	$2,402,347	$4,883,973	$6,471,839	$7,572,307	$12,002,234	$18,617,299
60k up to 119,999	$17,615,550	$23,703,246	$32,260,600	$41,081,113	$56,596,612	$67,746,423	$91,076,445
20k up to 59,999	$131,538,988	$148,577,093	$170,844,970	$181,002,770	$195,564,233	$211,759,200	$231,070,321
less than 20k	$343,584,137	$344,123,053	$345,410,818	$357,632,778	$375,128,683	$386,855,070	$397,425,976

Exhibit 27



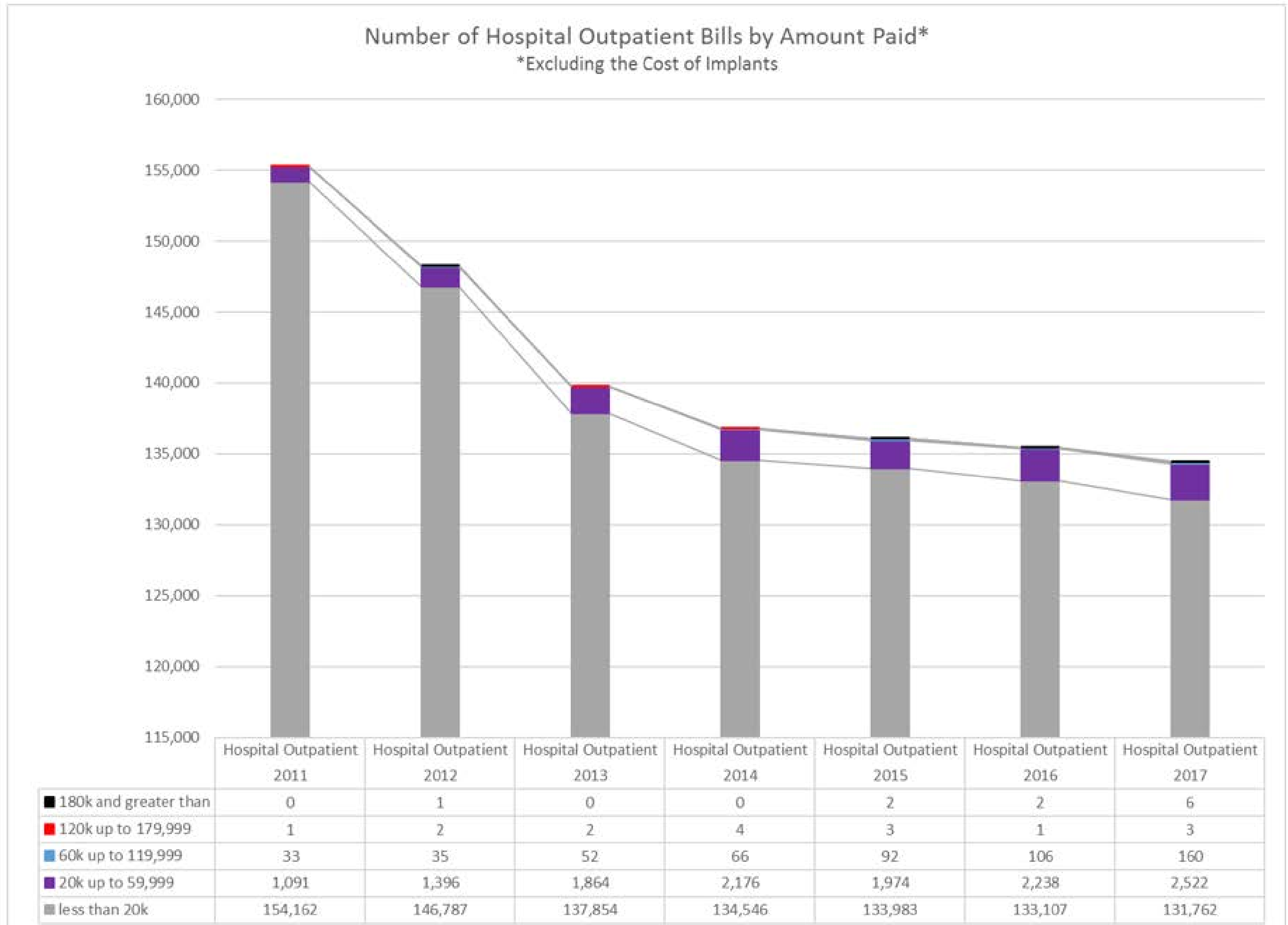
	Hospital Outpatient 2011	Hospital Outpatient 2012	Hospital Outpatient 2013	Hospital Outpatient 2014	Hospital Outpatient 2015	Hospital Outpatient 2016	Hospital Outpatient 2017
180k and greater than	2	5	7	14	14	12	23
120k up to 179,999	13	17	35	46	53	86	130
60k up to 119,999	225	305	423	545	726	883	1,135
20k up to 59,999	4,376	4,739	5,332	5,613	6,054	6,438	6,945
less than 20k	150,759	143,296	134,072	130,635	129,246	128,090	126,258

Exhibit 28



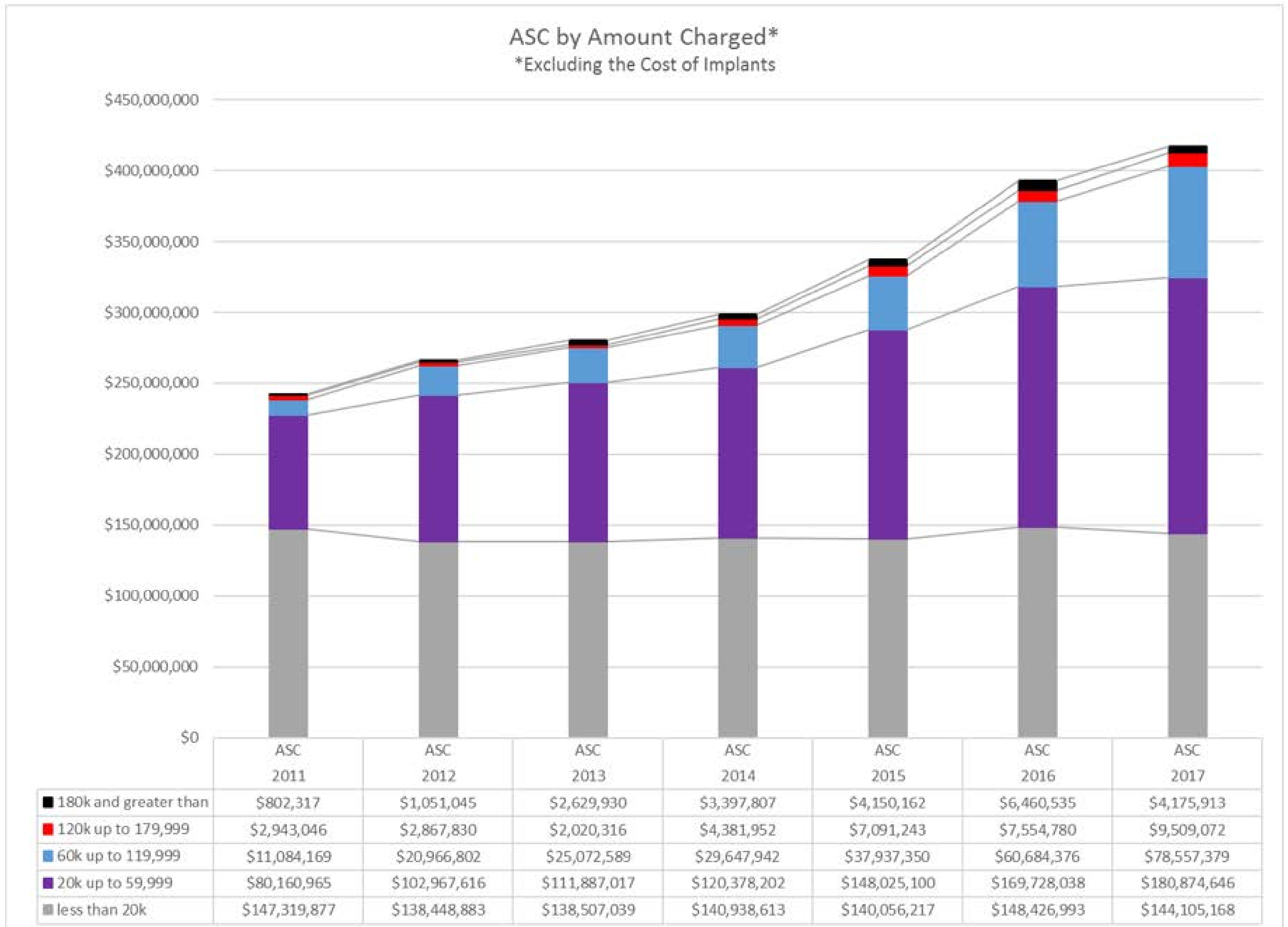
	Hospital Outpatient 2011	Hospital Outpatient 2012	Hospital Outpatient 2013	Hospital Outpatient 2014	Hospital Outpatient 2015	Hospital Outpatient 2016	Hospital Outpatient 2017
180k and greater than	$0	$191,028	$0	$0	$357,711	$314,591	$1,464,361
120k up to 179,999	$151,198	$269,701	$291,256	$520,567	$375,498	$123,677	$365,229
60k up to 119,999	$2,360,503	$2,556,920	$4,006,799	$4,892,683	$7,230,959	$8,188,812	$12,446,120
20k up to 59,999	$29,647,696	$38,500,394	$52,255,277	$62,293,920	$56,523,345	$65,419,327	$74,880,264
less than 20k	$237,264,583	$238,207,361	$245,161,770	$252,773,541	$243,141,652	$243,371,267	$244,138,605

Exhibit 29



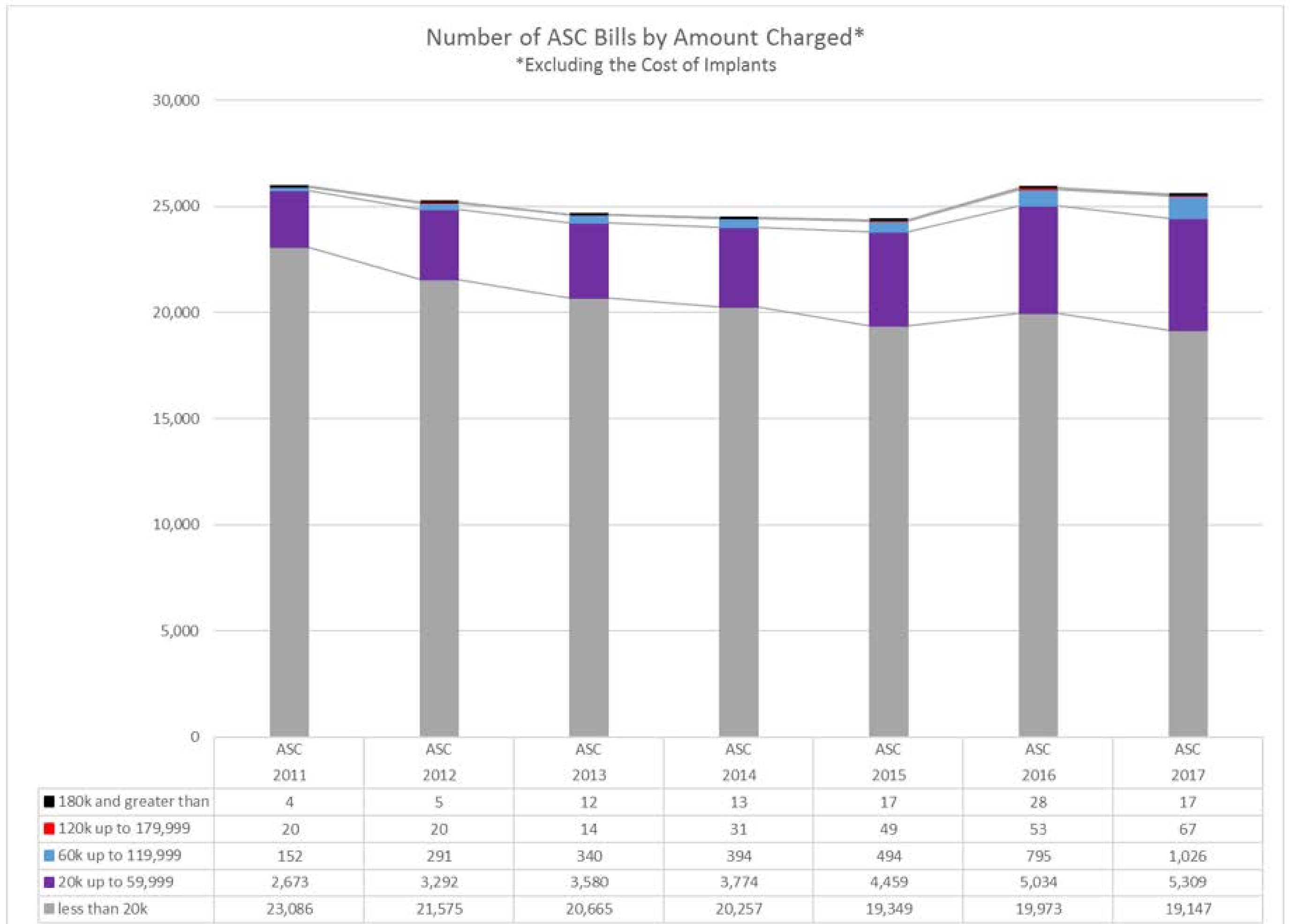
	Hospital Outpatient 2011	Hospital Outpatient 2012	Hospital Outpatient 2013	Hospital Outpatient 2014	Hospital Outpatient 2015	Hospital Outpatient 2016	Hospital Outpatient 2017
180k and greater than	0	1	0	0	2	2	6
120k up to 179,999	1	2	2	4	3	1	3
60k up to 119,999	33	35	52	66	92	106	160
20k up to 59,999	1,091	1,396	1,864	2,176	1,974	2,238	2,522
less than 20k	154,162	146,787	137,854	134,546	133,983	133,107	131,762

Exhibit 30



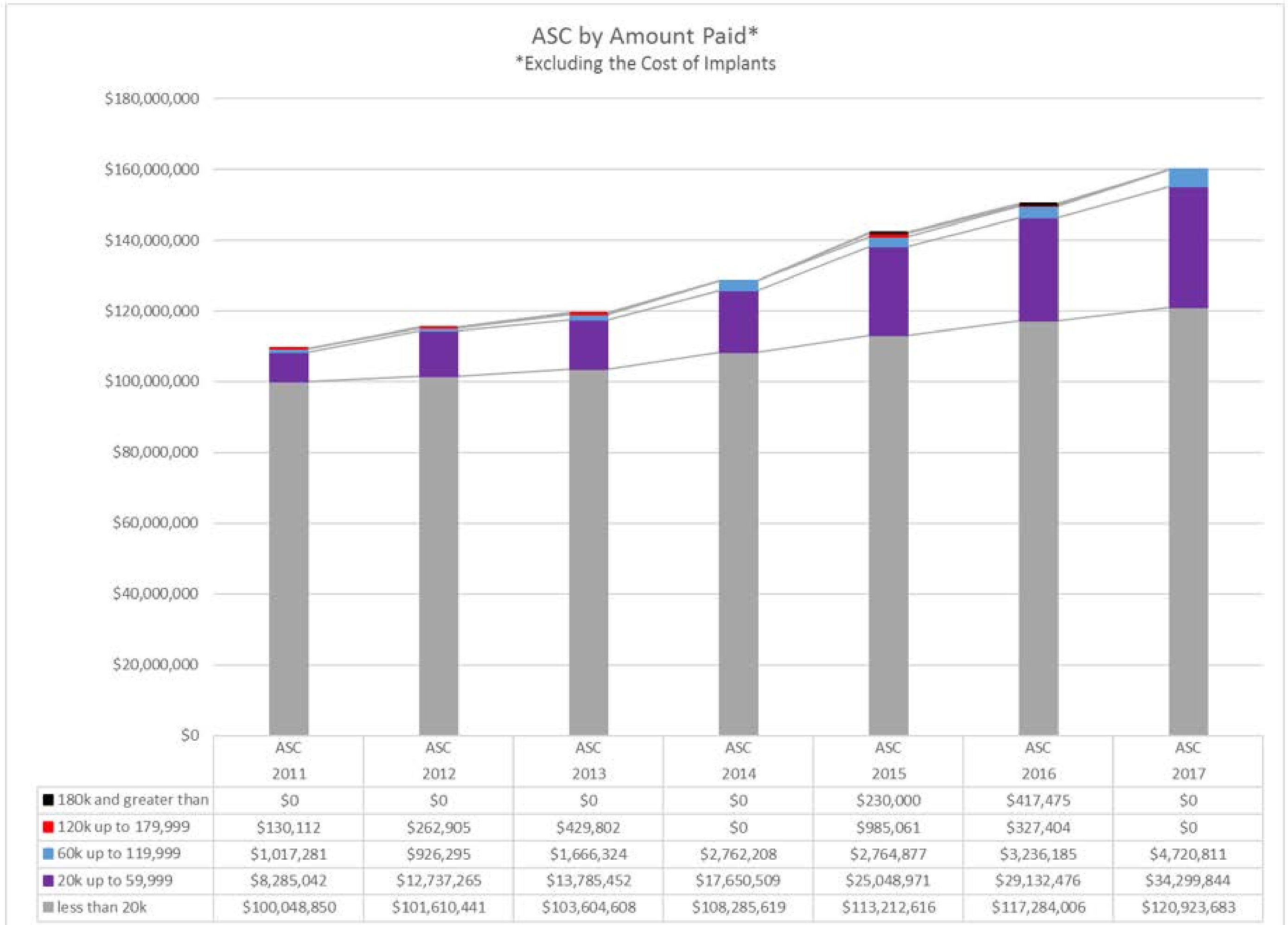
	ASC 2011	ASC 2012	ASC 2013	ASC 2014	ASC 2015	ASC 2016	ASC 2017
180k and greater than	$802,317	$1,051,045	$2,629,930	$3,397,807	$4,150,162	$6,460,535	$4,175,913
120k up to 179,999	$2,943,046	$2,867,830	$2,020,316	$4,381,952	$7,091,243	$7,554,780	$9,509,072
60k up to 119,999	$11,084,169	$20,966,802	$25,072,589	$29,647,942	$37,937,350	$60,684,376	$78,557,379
20k up to 59,999	$80,160,965	$102,967,616	$111,887,017	$120,378,202	$148,025,100	$169,728,038	$180,874,646
less than 20k	$147,319,877	$138,448,883	$138,507,039	$140,938,613	$140,056,217	$148,426,993	$144,105,168

Exhibit 31



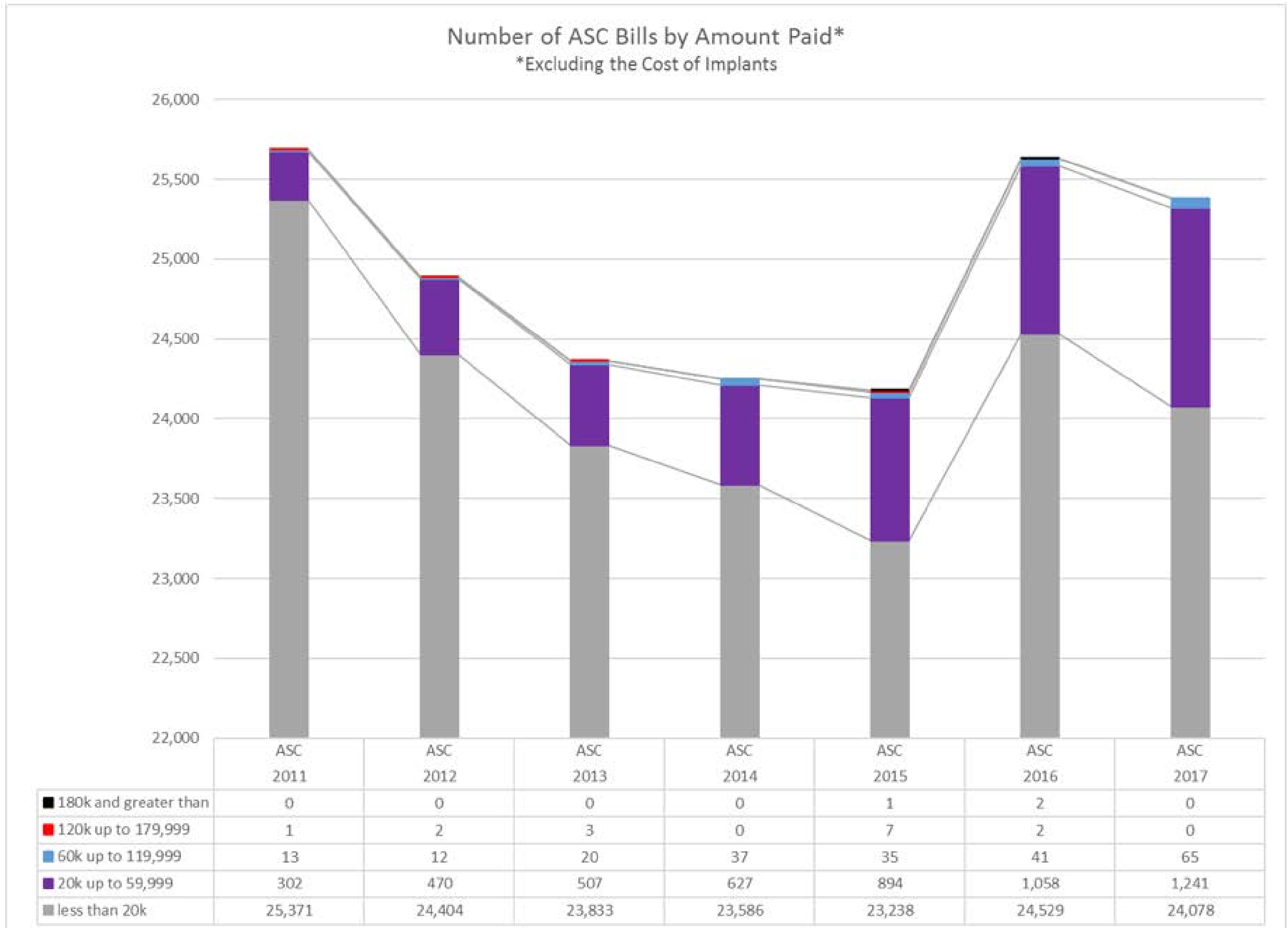
	ASC 2011	ASC 2012	ASC 2013	ASC 2014	ASC 2015	ASC 2016	ASC 2017
180k and greater than	4	5	12	13	17	28	17
120k up to 179,999	20	20	14	31	49	53	67
60k up to 119,999	152	291	340	394	494	795	1,026
20k up to 59,999	2,673	3,292	3,580	3,774	4,459	5,034	5,309
less than 20k	23,086	21,575	20,665	20,257	19,349	19,973	19,147

Exhibit 32



	ASC 2011	ASC 2012	ASC 2013	ASC 2014	ASC 2015	ASC 2016	ASC 2017
180k and greater than	$0	$0	$0	$0	$230,000	$417,475	$0
120k up to 179,999	$130,112	$262,905	$429,802	$0	$985,061	$327,404	$0
60k up to 119,999	$1,017,281	$926,295	$1,666,324	$2,762,208	$2,764,877	$3,236,185	$4,720,811
20k up to 59,999	$8,285,042	$12,737,265	$13,785,452	$17,650,509	$25,048,971	$29,132,476	$34,299,844
less than 20k	$100,048,850	$101,610,441	$103,604,608	$108,285,619	$113,212,616	$117,284,006	$120,923,683

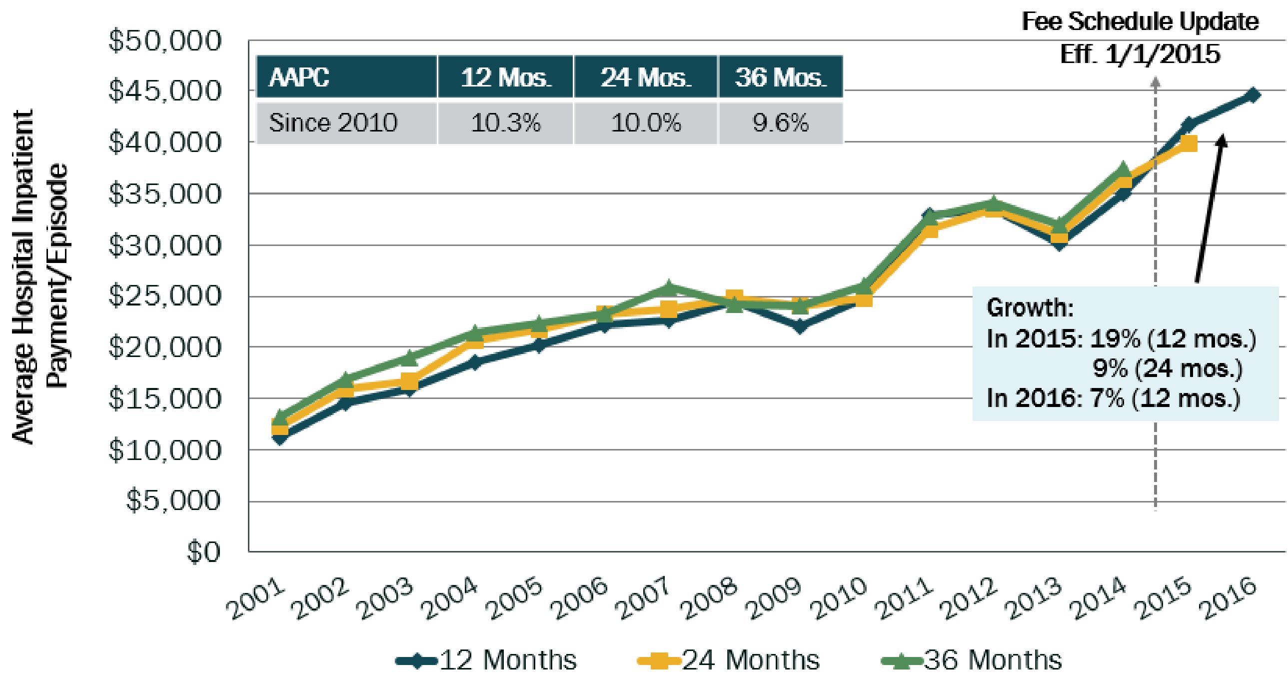
Exhibit 33



	ASC 2011	ASC 2012	ASC 2013	ASC 2014	ASC 2015	ASC 2016	ASC 2017
180k and greater than	0	0	0	0	1	2	0
120k up to 179,999	1	2	3	0	7	2	0
60k up to 119,999	13	12	20	37	35	41	65
20k up to 59,999	302	470	507	627	894	1,058	1,241
less than 20k	25,371	24,404	23,833	23,586	23,238	24,529	24,078

Exhibit 34

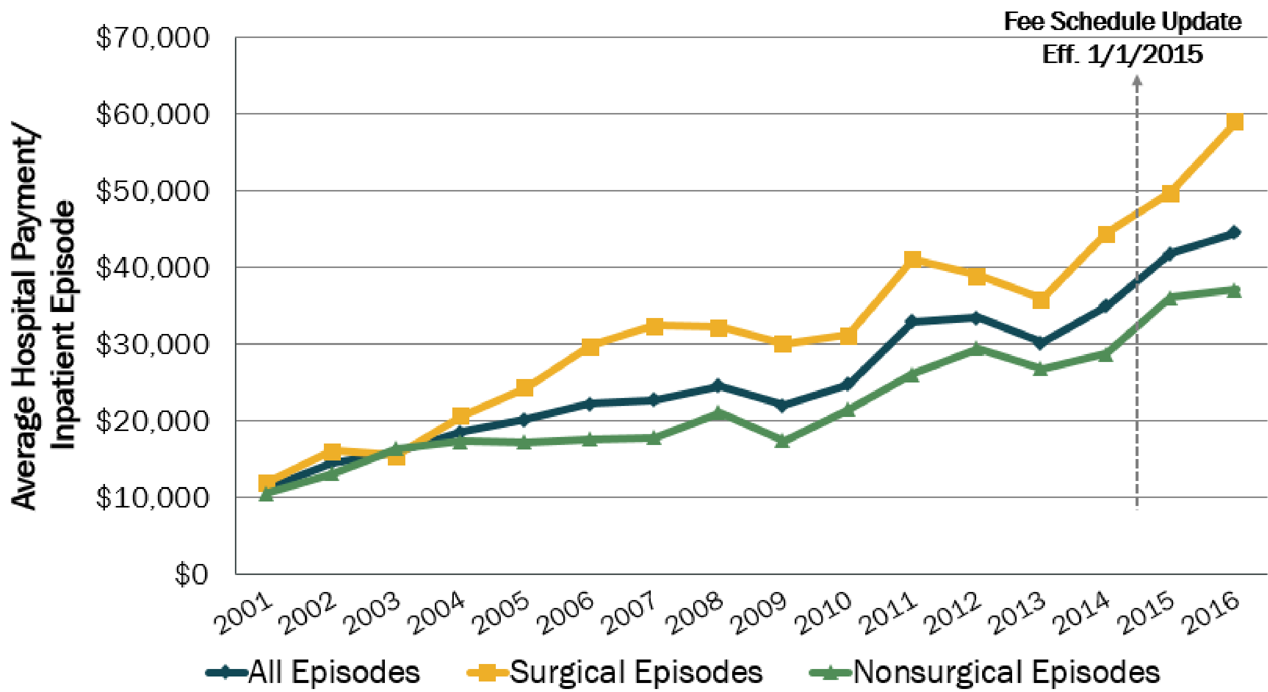
Hospital Inpatient Payments Per Episode In FL Grew Rapidly Since 2010, Incl. Two Years After FS Update



Claims With > 7 Days Of Lost Time At Various Claim Maturities, Not Adjusted For Injury/Industry Mix

© WCRI 2018

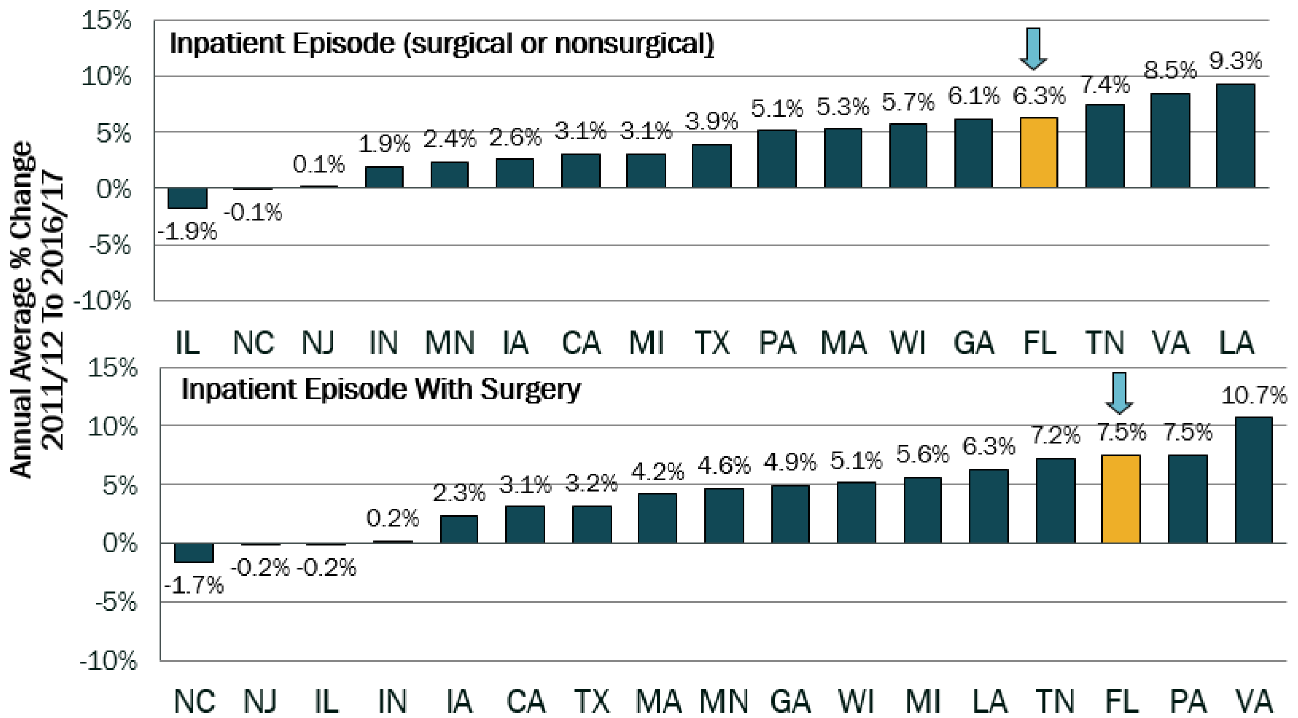
Exhibit 35



Claims With > 7 Days Of Lost Time At 12 Months Of Experience With Hospital Inpatient Episodes, Not Adjusted For Injury/Industry Mix

© WCRI 2018

Exhibit 36



Hospital Payments/Inpatient Episode, Claims With > 7 Days Of Lost Time At 12 Months Of Experience, Not Adjusted For Injury/Industry Mix

© WCRI 2018

Exhibit 37

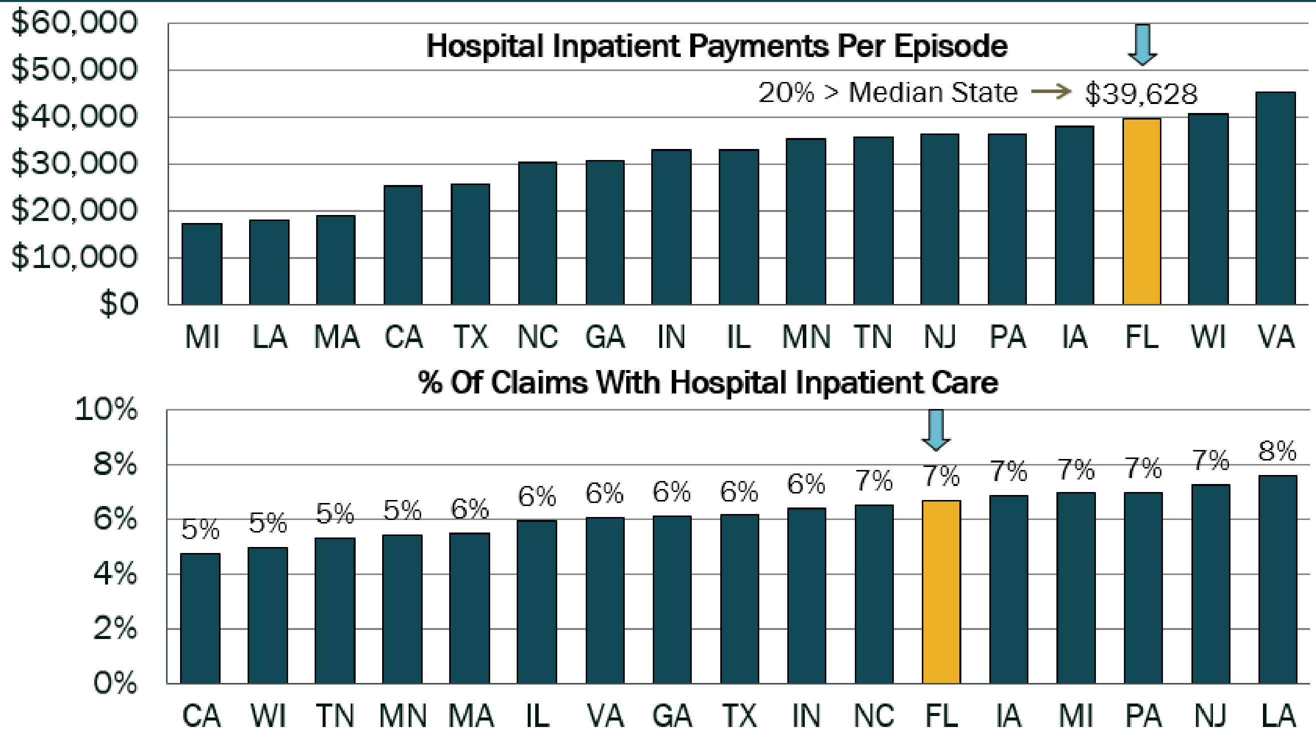


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Exhibit 38

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

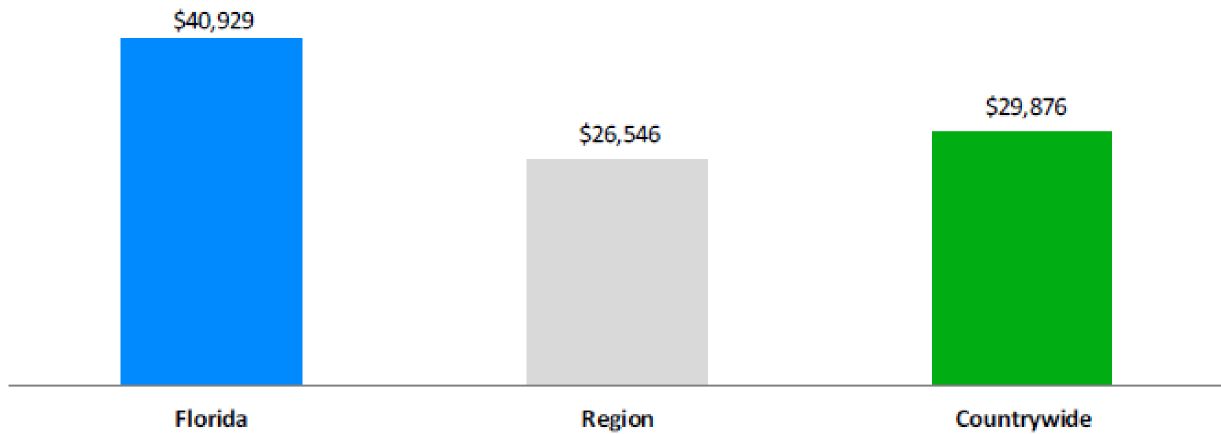
Hospital Inpatient Payments as a Percentage of Medicare

Medical Cost Category	Florida	Region	Countrywide
Hospital Inpatient	346%	176%	191%

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 39

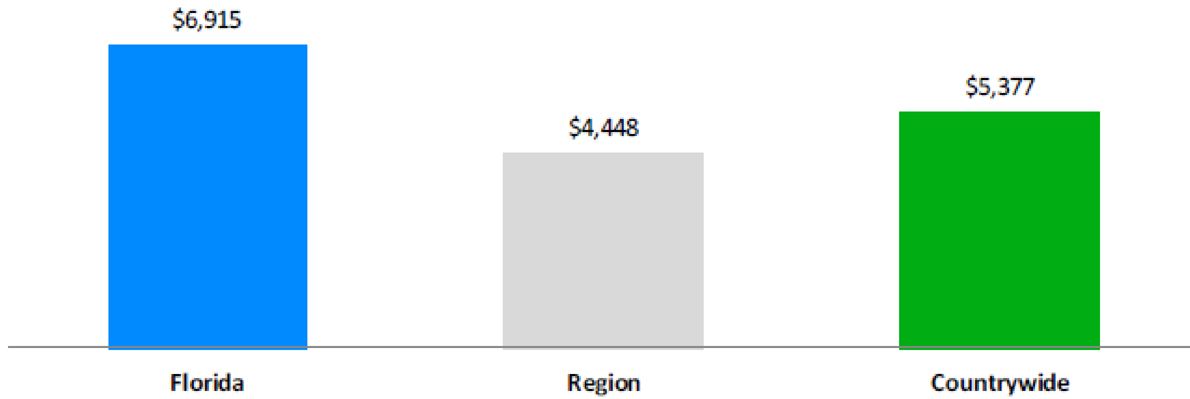
REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT



Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 40

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT



Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 41

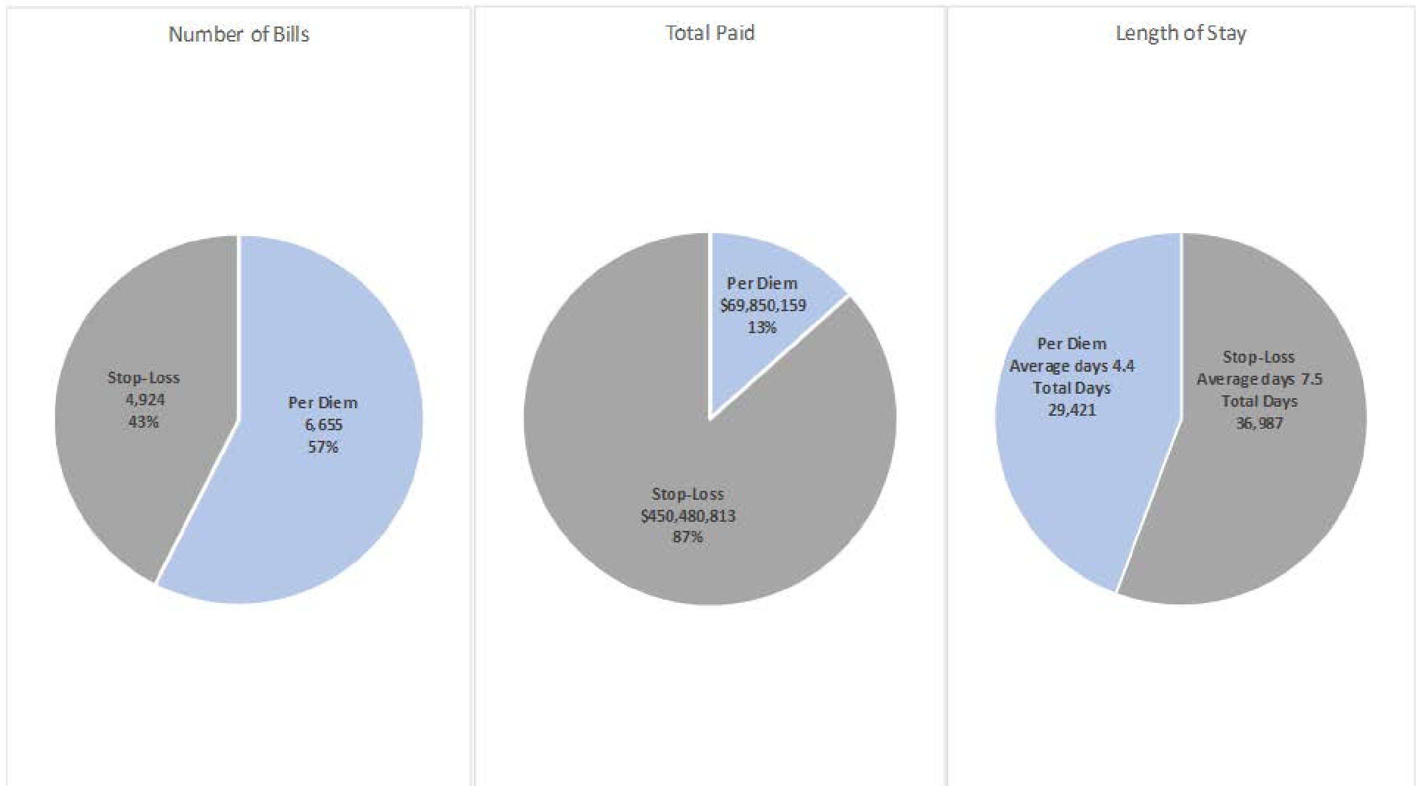
REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

		Median Amount Paid per Stay		
Diagnosis Group	**Paid Share**	**Florida**	**Region**	**Countrywide**
Fracture of lower leg, including ankle	8.9%	$27,401	$17,016	$18,514
Intracranial injury	7.4%	$40,292	$19,000	$21,210
Hip/pelvis fracture/major trauma	5.5%	$29,684	$16,381	$19,257
Lumbosacral intervertebral disc disorders	3.9%	$33,243	$21,684	$25,084
Lumbar spine degeneration	3.8%	$51,892	$27,839	$30,504
Fracture of rib(s), sternum and thoracic spine	3.1%	$32,570	$12,701	$16,118
Fracture of forearm	2.8%	$30,172	$17,912	$19,044
Fracture of lumbar spine and pelvis	2.7%	$25,770	$15,901	$18,820
Fracture of skull and facial bones	2.1%	$17,815	$20,331	$20,885
Fracture of foot and toe, except ankle	1.8%	$15,400	$13,174	$15,120

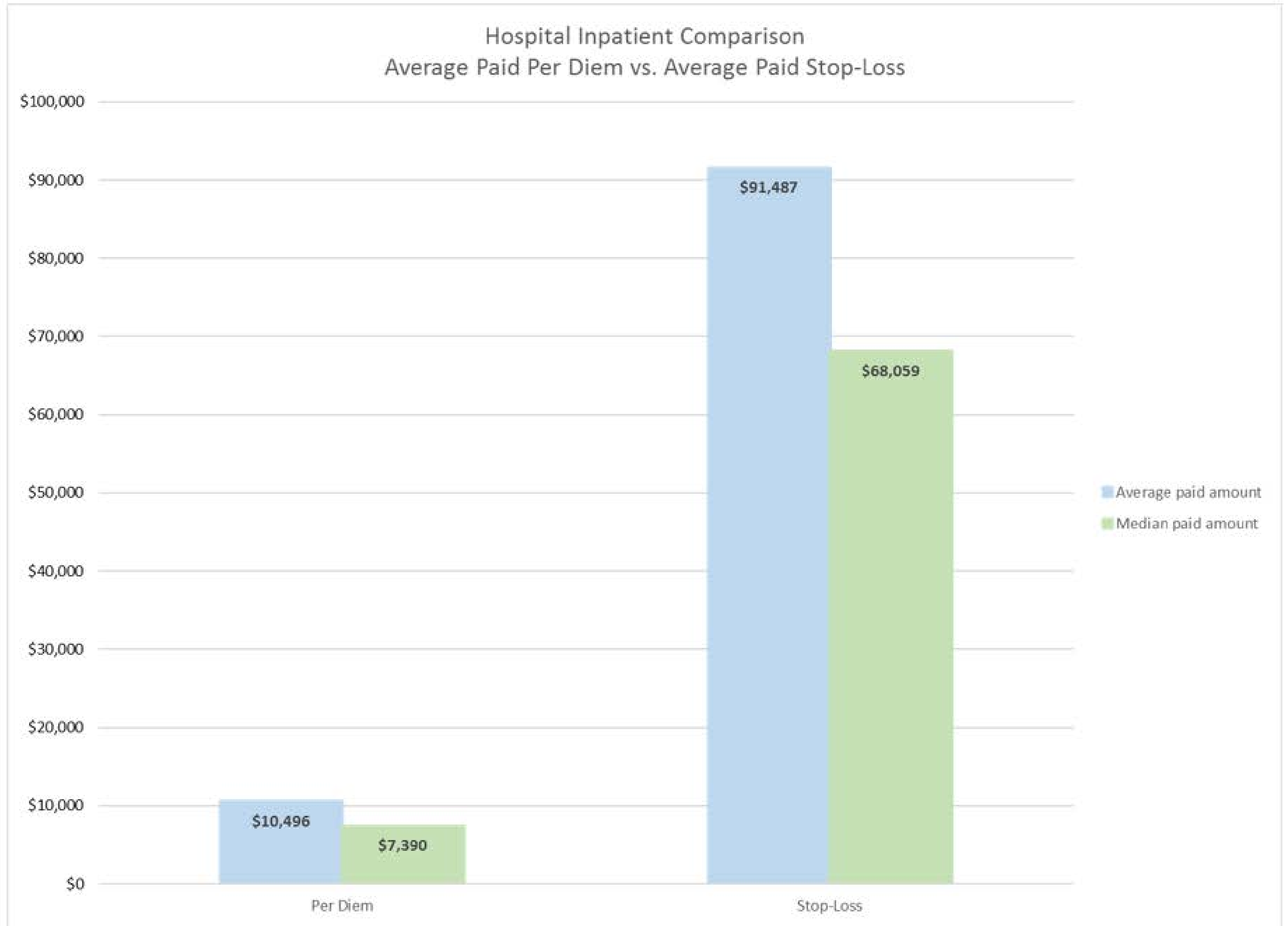
Source: NCCI's Medical Data Call for Service Years 2016 and 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 42



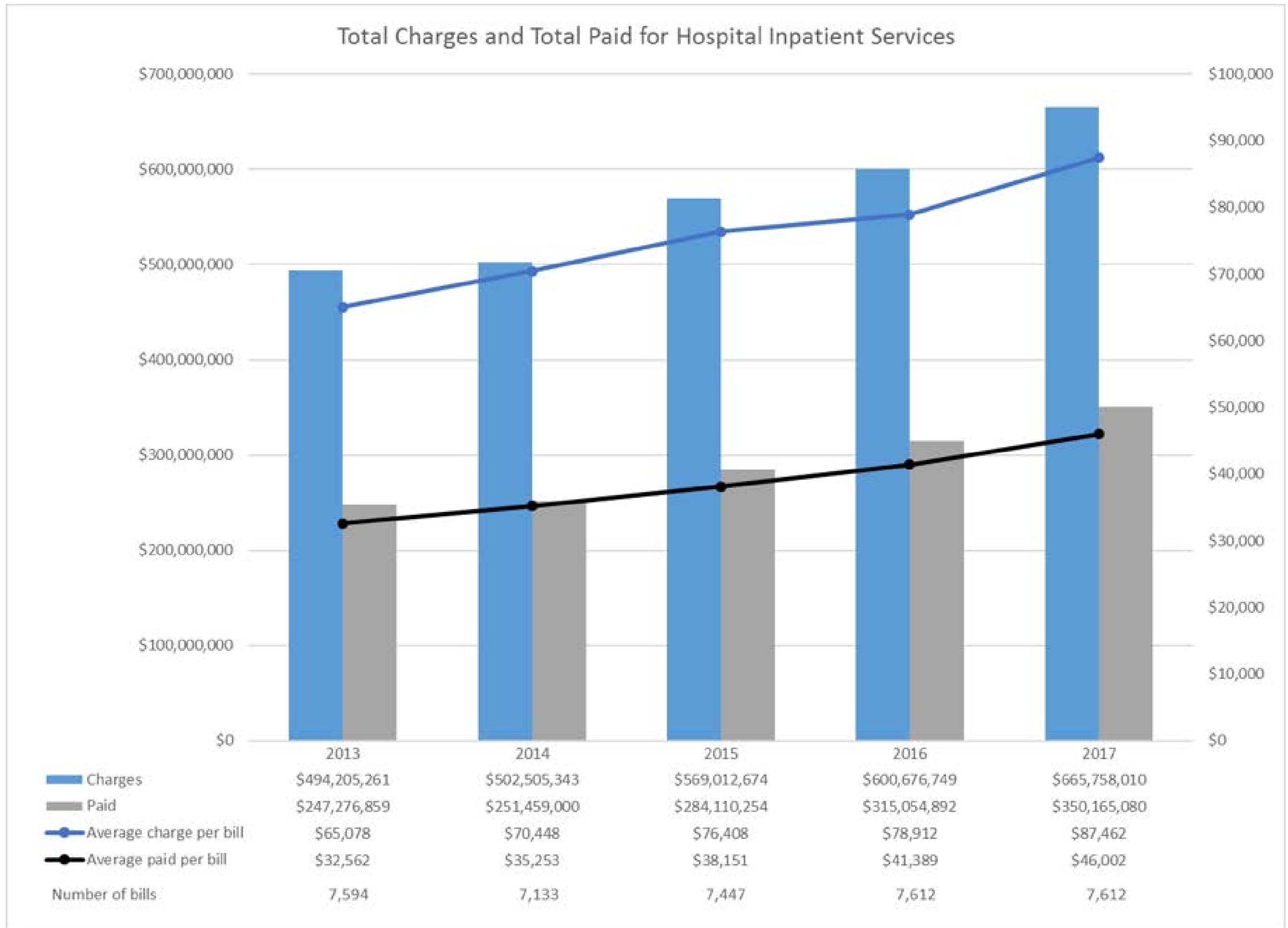
Data from bills reported to the Division with dates of service from 7/1/16 and 12/31/17

Exhibit 43



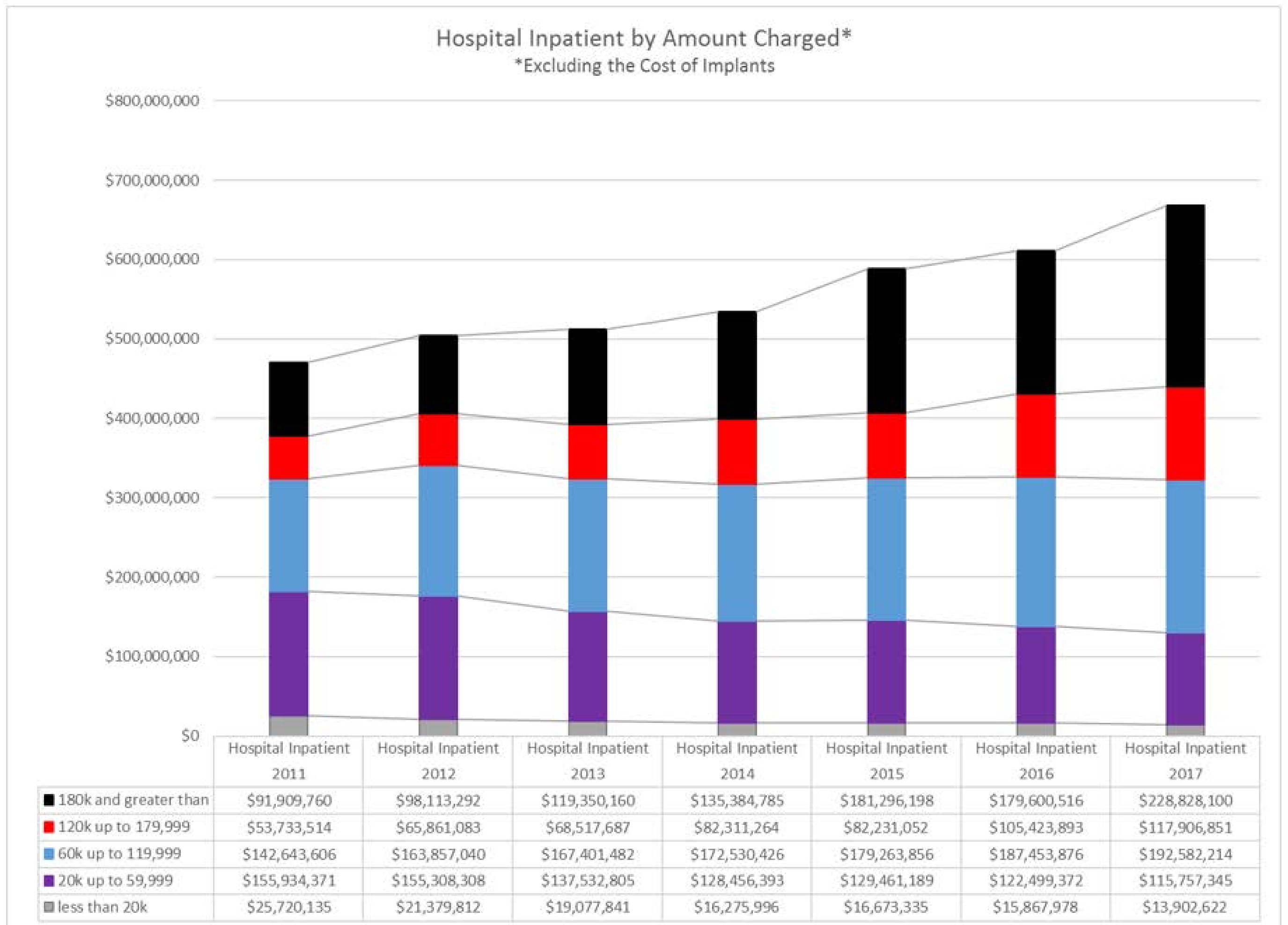
Data from bills reported to the Division with dates of service from 7/1/16 and 12/31/17

Exhibit 44



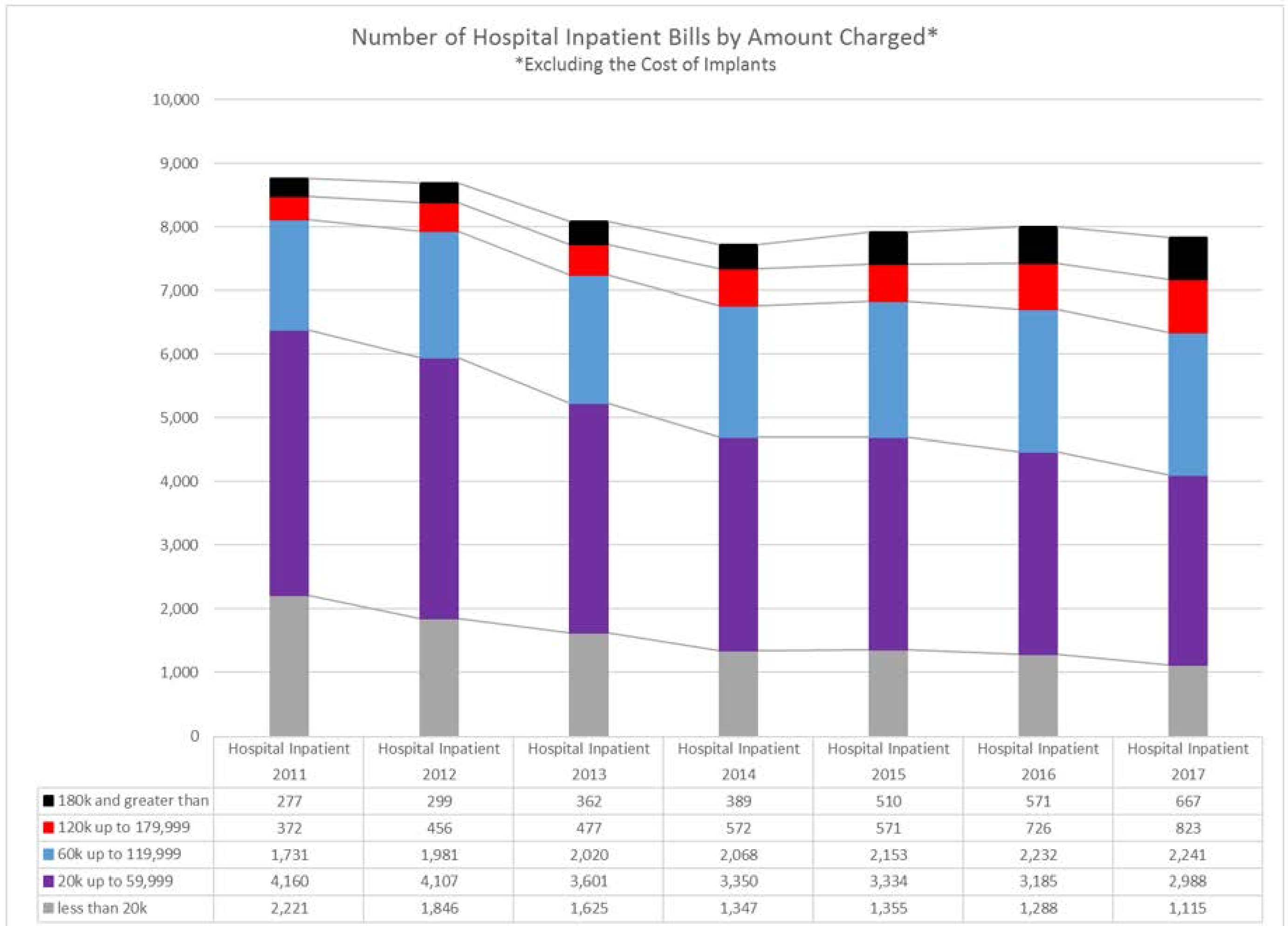
	2013	2014	2015	2016	2017
Charges	$494,205,261	$502,505,343	$569,012,674	$600,676,749	$665,758,010
Paid	$247,276,859	$251,459,000	$284,110,254	$315,054,892	$350,165,080
Average charge per bill	$65,078	$70,448	$76,408	$78,912	$87,462
Average paid per bill	$32,562	$35,253	$38,151	$41,389	$46,002
Number of bills	7,594	7,133	7,447	7,612	7,612

Exhibit 45



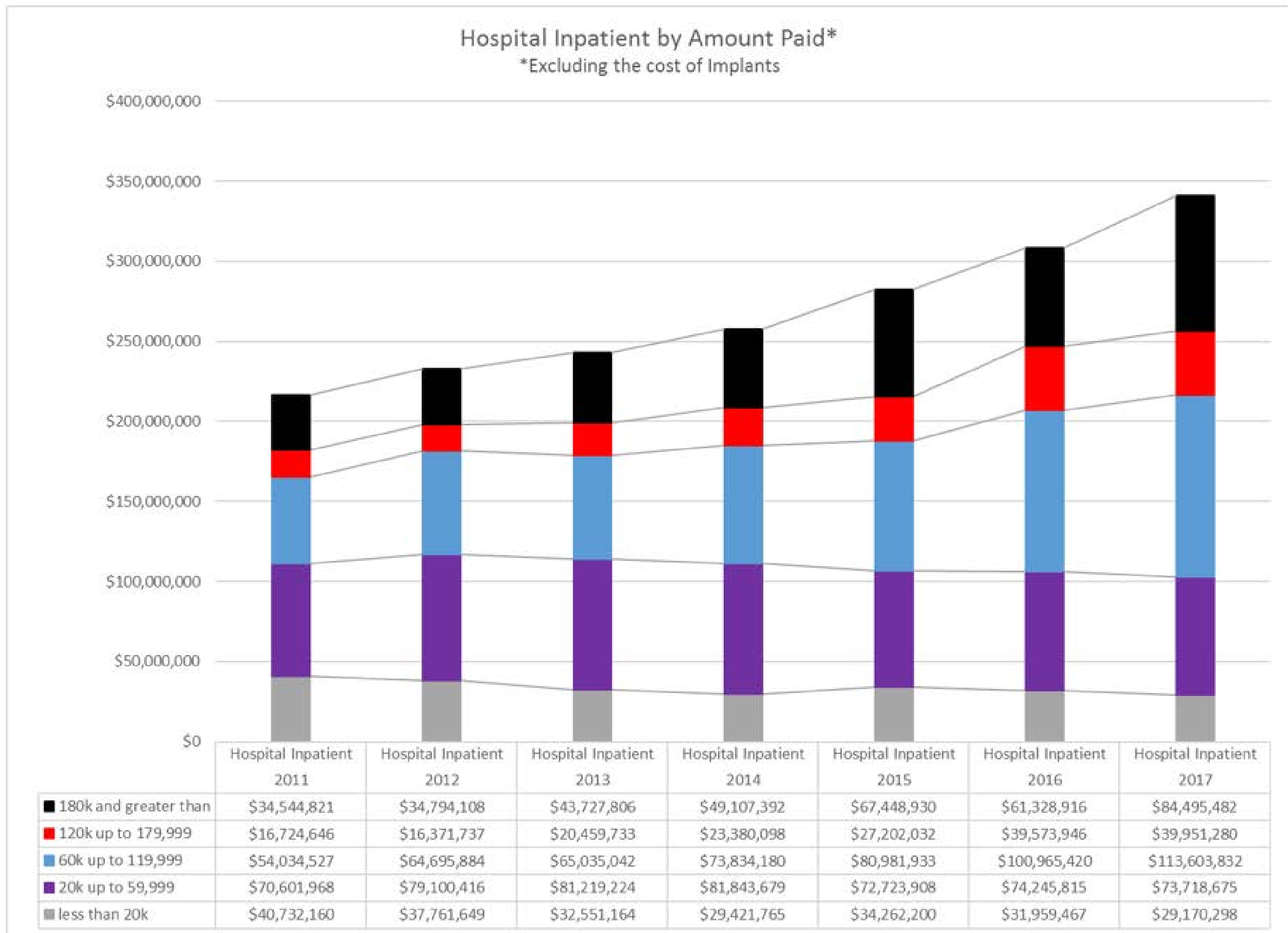
	Hospital Inpatient 2011	Hospital Inpatient 2012	Hospital Inpatient 2013	Hospital Inpatient 2014	Hospital Inpatient 2015	Hospital Inpatient 2016	Hospital Inpatient 2017
180k and greater than	$91,909,760	$98,113,292	$119,350,160	$135,384,785	$181,296,198	$179,600,516	$228,828,100
120k up to 179,999	$53,733,514	$65,861,083	$68,517,687	$82,311,264	$82,231,052	$105,423,893	$117,906,851
60k up to 119,999	$142,643,606	$163,857,040	$167,401,482	$172,530,426	$179,263,856	$187,453,876	$192,582,214
20k up to 59,999	$155,934,371	$155,308,308	$137,532,805	$128,456,393	$129,461,189	$122,499,372	$115,757,345
less than 20k	$25,720,135	$21,379,812	$19,077,841	$16,275,996	$16,673,335	$15,867,978	$13,902,622

Exhibit 46



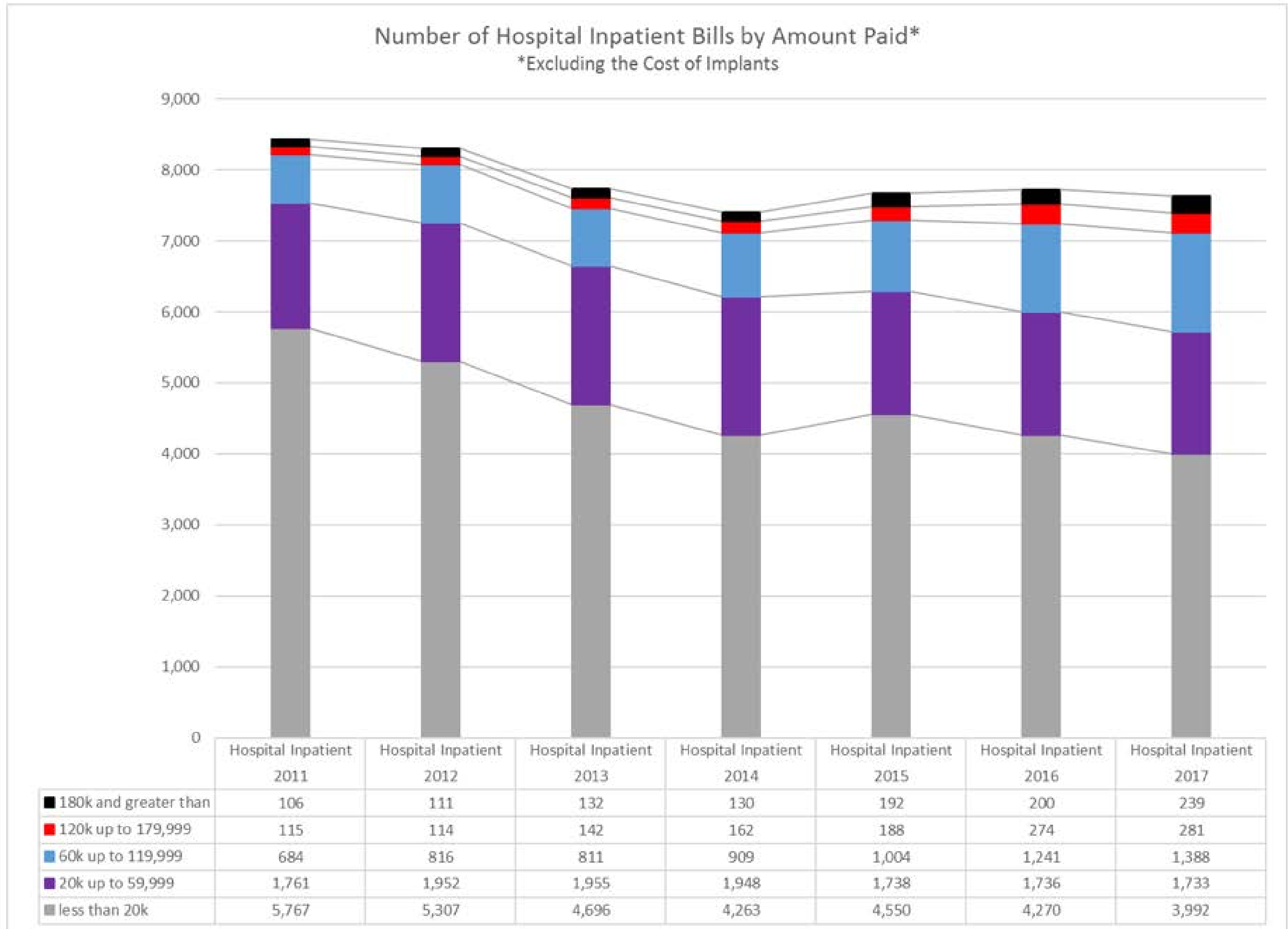
	Hospital Inpatient 2011	Hospital Inpatient 2012	Hospital Inpatient 2013	Hospital Inpatient 2014	Hospital Inpatient 2015	Hospital Inpatient 2016	Hospital Inpatient 2017
180k and greater than	277	299	362	389	510	571	667
120k up to 179,999	372	456	477	572	571	726	823
60k up to 119,999	1,731	1,981	2,020	2,068	2,153	2,232	2,241
20k up to 59,999	4,160	4,107	3,601	3,350	3,334	3,185	2,988
less than 20k	2,221	1,846	1,625	1,347	1,355	1,288	1,115

Exhibit 47



	Hospital Inpatient 2011	Hospital Inpatient 2012	Hospital Inpatient 2013	Hospital Inpatient 2014	Hospital Inpatient 2015	Hospital Inpatient 2016	Hospital Inpatient 2017
180k and greater than	$34,544,821	$34,794,108	$43,727,806	$49,107,392	$67,448,930	$61,328,916	$84,495,482
120k up to 179,999	$16,724,646	$16,371,737	$20,459,733	$23,380,098	$27,202,032	$39,573,946	$39,951,280
60k up to 119,999	$54,034,527	$64,695,884	$65,035,042	$73,834,180	$80,981,933	$100,965,420	$113,603,832
20k up to 59,999	$70,601,968	$79,100,416	$81,219,224	$81,843,679	$72,723,908	$74,245,815	$73,718,675
less than 20k	$40,732,160	$37,761,649	$32,551,164	$29,421,765	$34,262,200	$31,959,467	$29,170,298

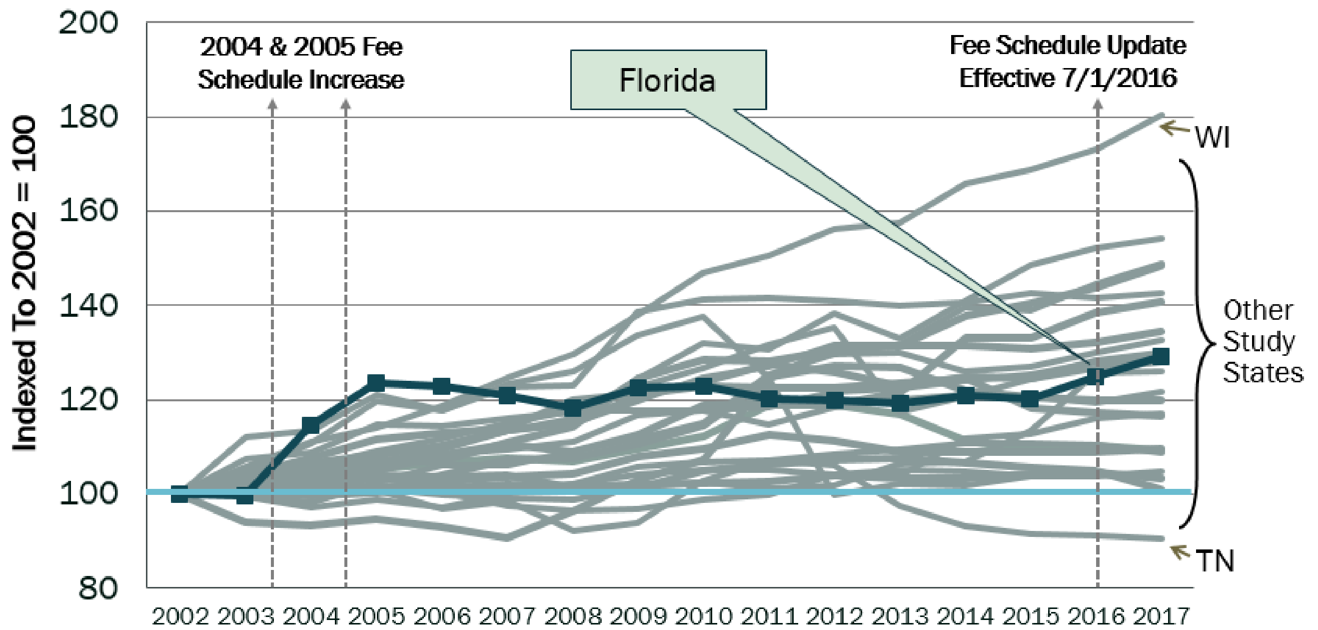
Exhibit 48



	Hospital Inpatient 2011	Hospital Inpatient 2012	Hospital Inpatient 2013	Hospital Inpatient 2014	Hospital Inpatient 2015	Hospital Inpatient 2016	Hospital Inpatient 2017
180k and greater than	106	111	132	130	192	200	239
120k up to 179,999	115	114	142	162	188	274	281
60k up to 119,999	684	816	811	909	1,004	1,241	1,388
20k up to 59,999	1,761	1,952	1,955	1,948	1,738	1,736	1,733
less than 20k	5,767	5,307	4,696	4,263	4,550	4,270	3,992

Exhibit 49

Overall Prices Paid For Professional Services In FL Grew 7% From 2015 To 2017 Following FS Update

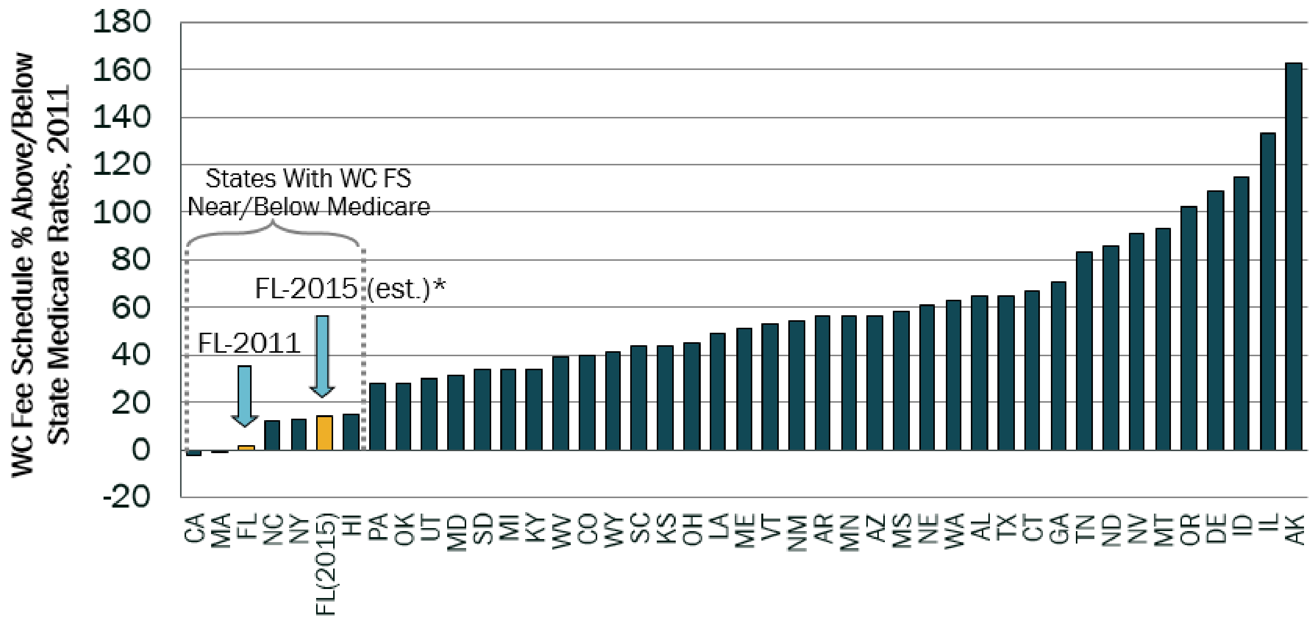


Prices Paid For Nonhospital (professional) Services In Calendar Year 2002 To 2017 (2017 data is January through June). Source: *WCRI Medical Price Index For Workers' Compensation, 10th Edition* (2018)

© WCRI 2018

Exhibit 50

FL Professional FS Rates Likely Remain Lower Than Most States After The Update In July 2016



* 2015 rates are estimated based on the Florida Workers' Compensation Health Care Provider Reimbursement Fee Schedule, 2015 Edition, which became effective July 1, 2016.

Source: WCRI FlashReport: *Evaluation Of The 2015 Professional Fee Schedule Update For Florida* (2015)

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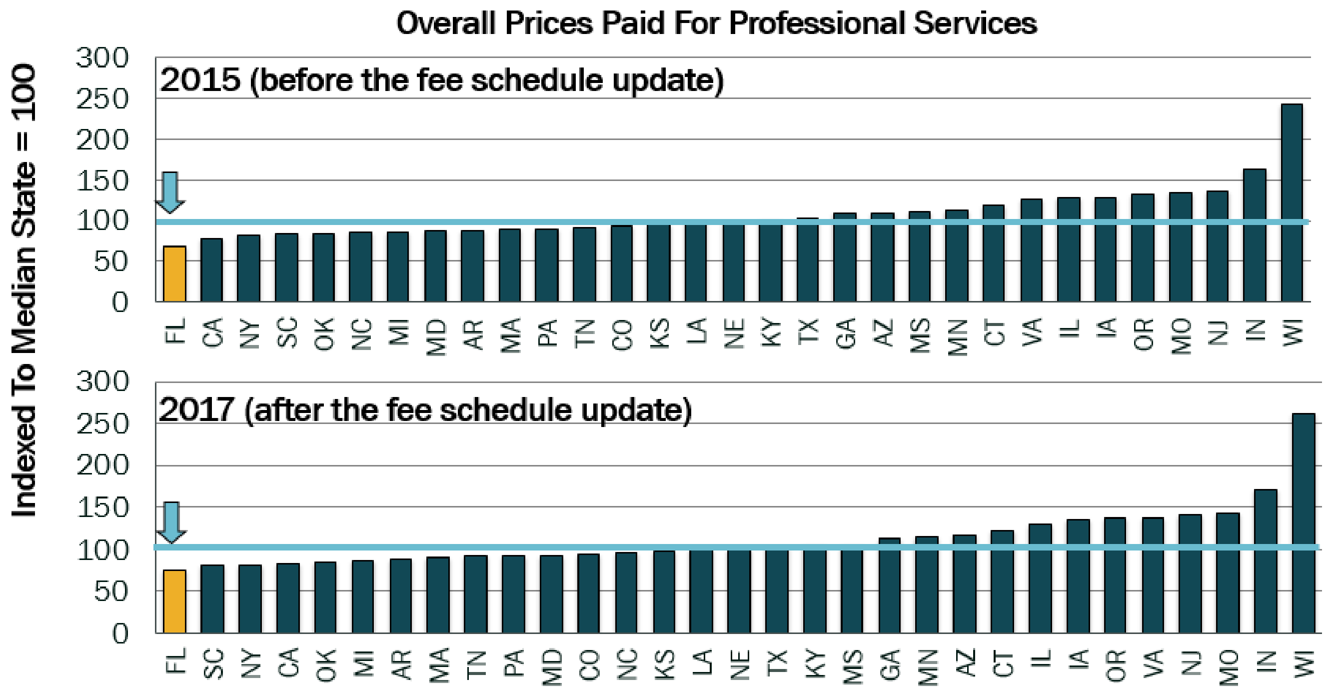
Exhibit 51

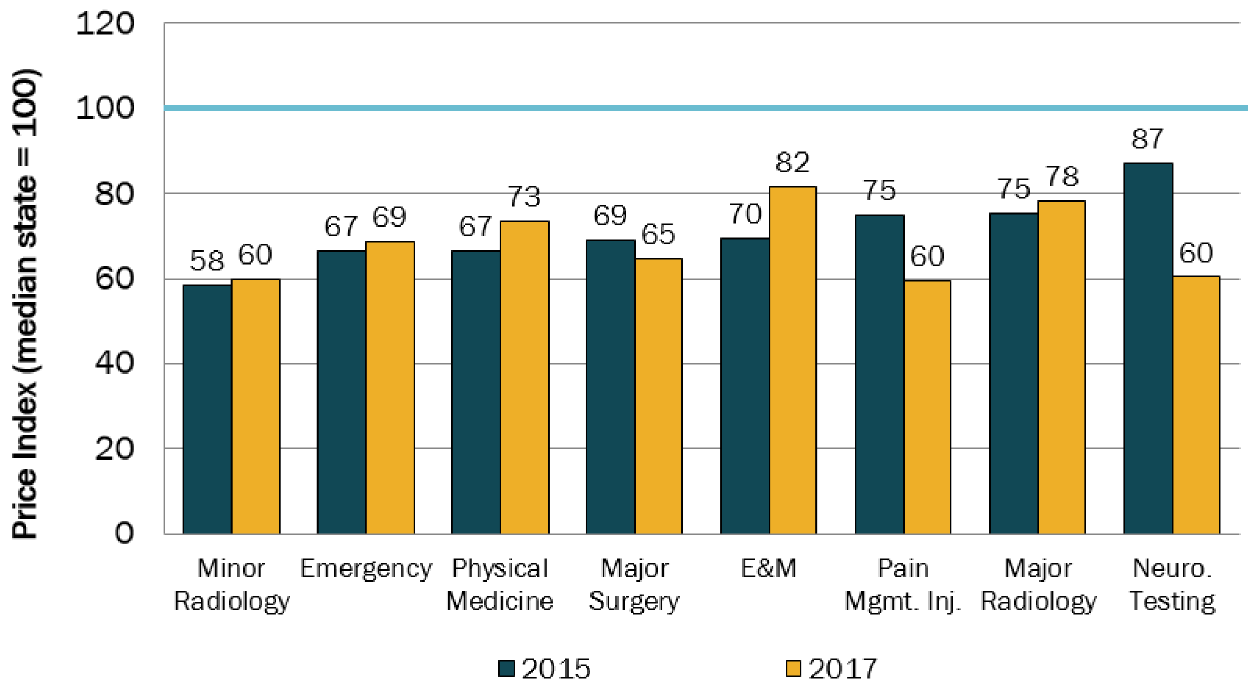
FL Overall Prices Paid For Professional Services Remained The Lowest Of Study States In 2017



Prices Paid For Professional Services, 2017 Data Covers January Through June
Source: *WCRI Medical Price Index For Workers' Compensation, 10th Edition* (2018)

© WCRI 2018

Exhibit 52



Prices Paid For Professional Services, 2017 Data Covers January Through June
Source: *WCRI Medical Price Index For Workers' Compensation, 10th Edition* (2018)

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Exhibit 53

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Medical Cost Distributions by Payment Share

Medical Cost Category	Florida[1]	Countrywide[2]	Difference (percentage points)
Physician	29.8%	39.9%	-10.1
Hospital Outpatient	17.2%	19.0%	-1.8
Hospital Inpatient	20.6%	12.8%	7.8
Ambulatory Surgical Centers	9.6%	6.9%	2.7
Drugs	14.3%	9.5%	4.8
DME, Supplies & Implants	6.8%	7.5%	-0.7
Other	1.7%	4.4%	-2.7
Total	**100.0%**	**100%**	**0.0**

[1] Source: Derived from data provided by the Florida Division of Workers' Compensation for Service Year 2017.
[2] Source: NCCI Medical Data Call for Service Year 2017. Countrywide includes data from the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 54

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

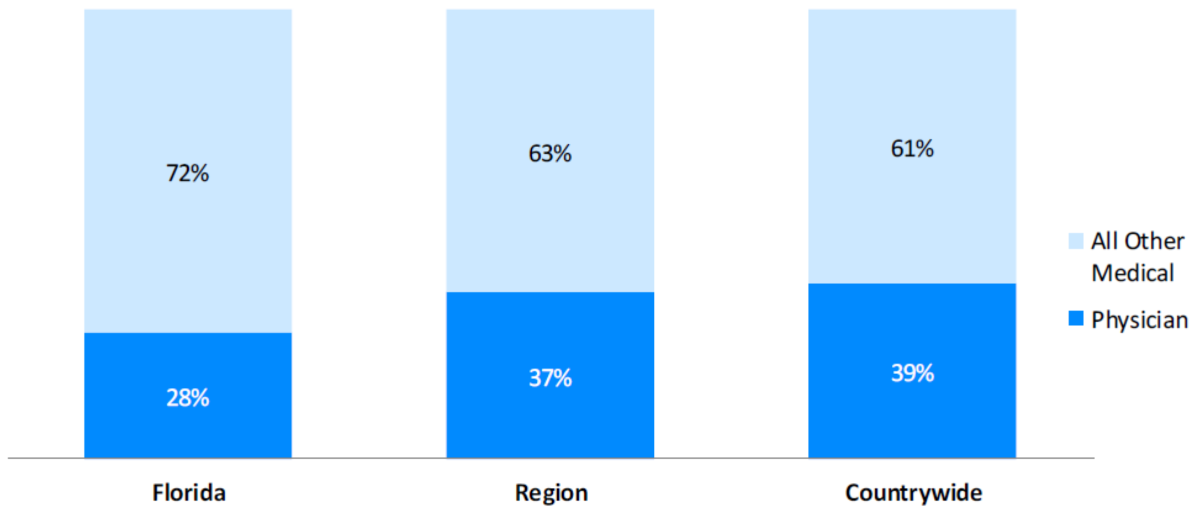
Physician Payments as a Percentage of Medicare

Physician Service Category	Florida	Region	Countrywide
Surgery	155%	234%	275%
Radiology	154%	216%	236%
General and Physical Medicine	87%	124%	131%
Evaluation and Management	102%	135%	141%
All Physician Services	**110%**	**154%**	**167%**

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 55

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

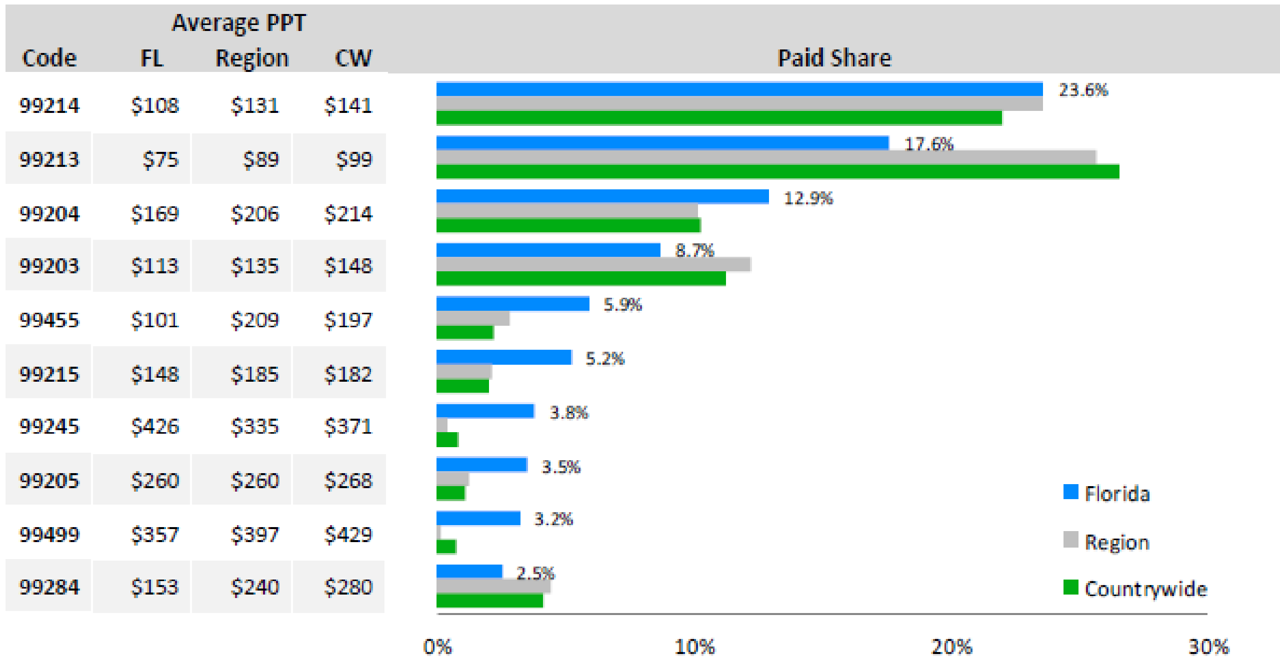


Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 56

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Top 10 Evaluation and Management Procedure Codes by Amount Paid



Code	Average PPT FL	Average PPT Region	Average PPT CW
99214	$108	$131	$141
99213	$75	$89	$99
99204	$169	$206	$214
99203	$113	$135	$148
99455	$101	$209	$197
99215	$148	$185	$182
99245	$426	$335	$371
99205	$260	$260	$268
99499	$357	$397	$429
99284	$153	$240	$280

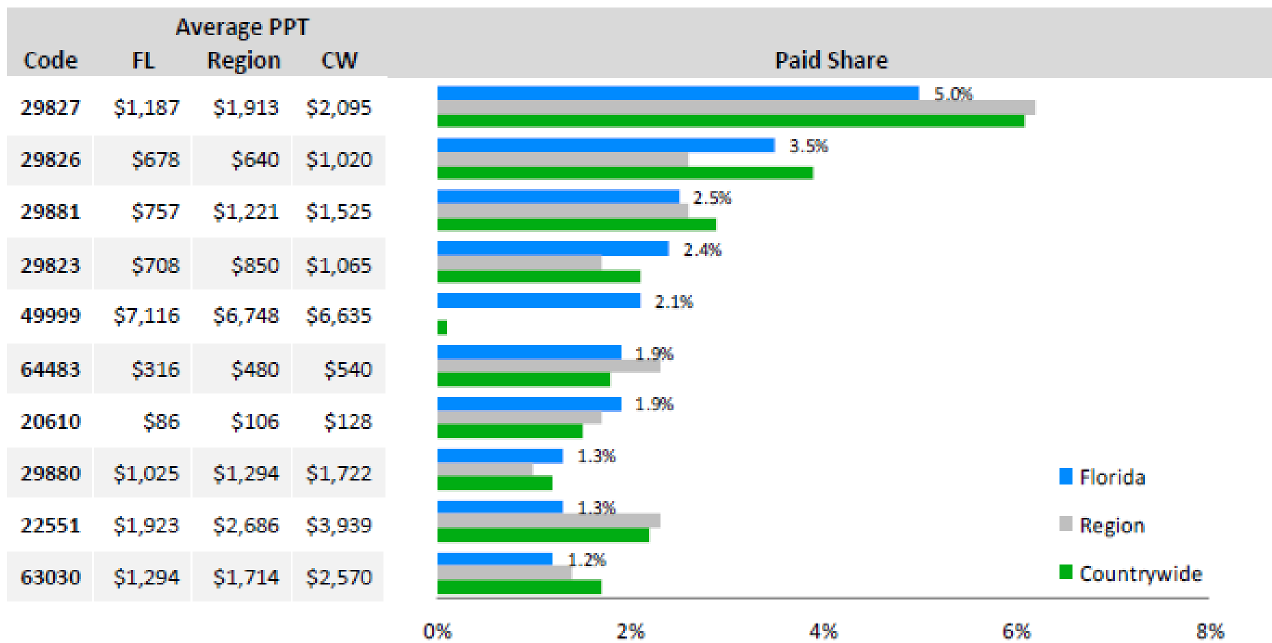
Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99455	Work related or medical disability examination by the treating physician.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99245	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99499	Unlisted evaluation and management service
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 57

REQUESTED 2018 FLORIDA MEDICAL REPORT CHARTS
FOR THE STATE OF FLORIDA'S 2019 BIENNIAL REPORT

Top 10 Surgery Procedure Codes by Amount Paid



Code	Average PPT FL	Average PPT Region	Average PPT CW
29827	$1,187	$1,913	$2,095
29826	$678	$640	$1,020
29881	$757	$1,221	$1,525
29823	$708	$850	$1,065
49999	$7,116	$6,748	$6,635
64483	$316	$480	$540
20610	$86	$106	$128
29880	$1,025	$1,294	$1,722
22551	$1,923	$2,686	$3,939
63030	$1,294	$1,714	$2,570

Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release when performed
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
29823	Arthroscopy, shoulder, surgical; debridement extensive
49999	Unlisted procedure, abdomen, peritoneum and omentum
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral including any meniscal shaving), including debridement/shaving of articular cartilage
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AL, AR, GA, KY, LA, MS, NC, SC, TN, VA, and WV. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Exhibit 58

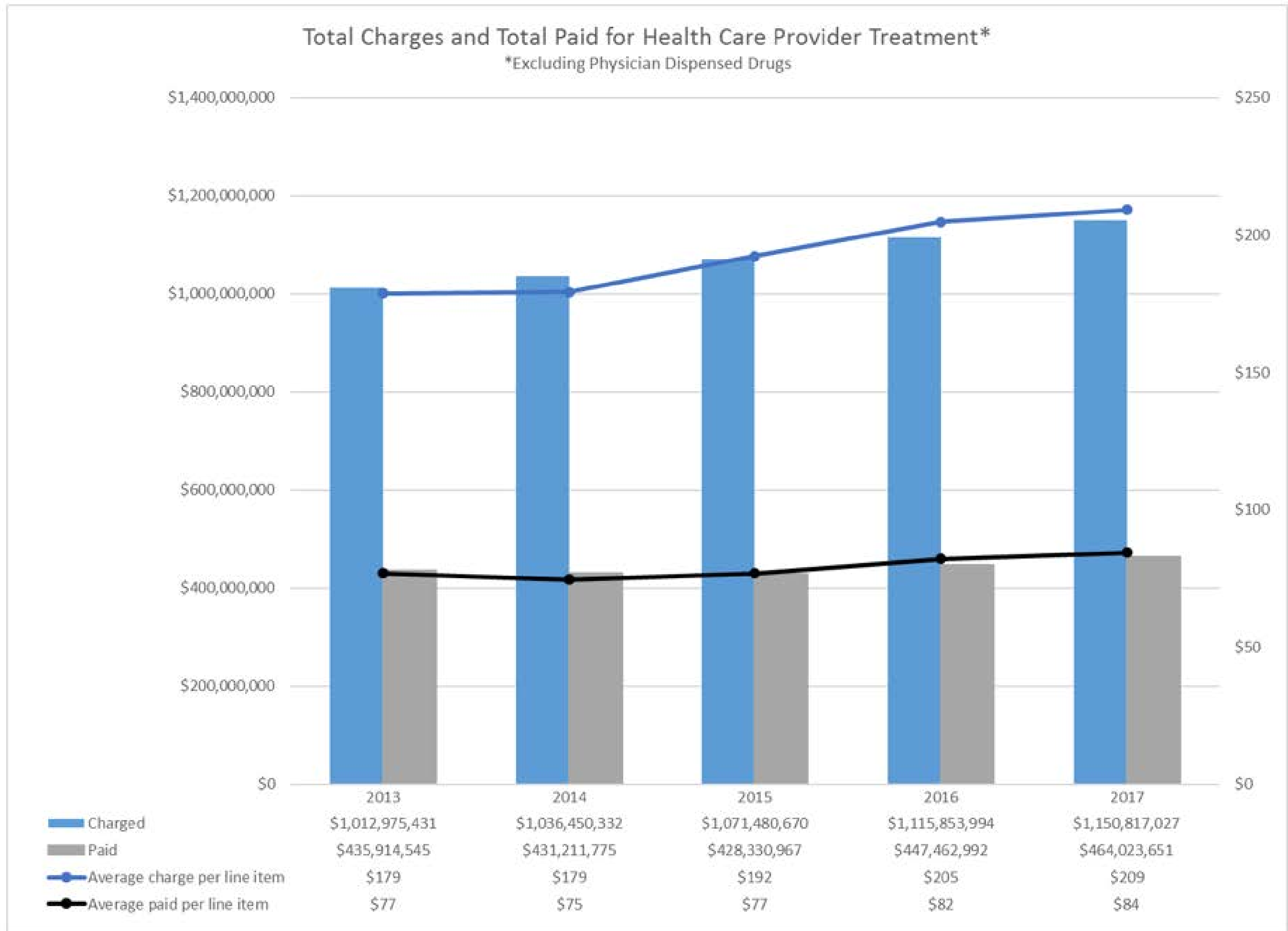


Exhibit 59