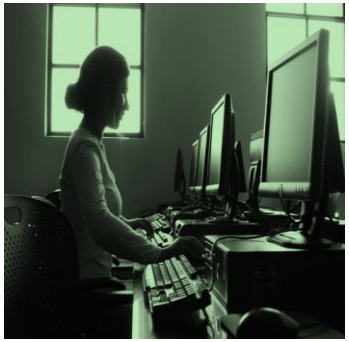
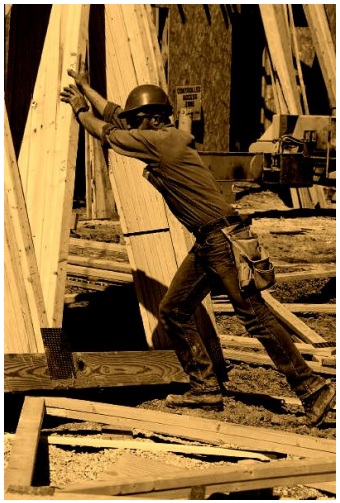
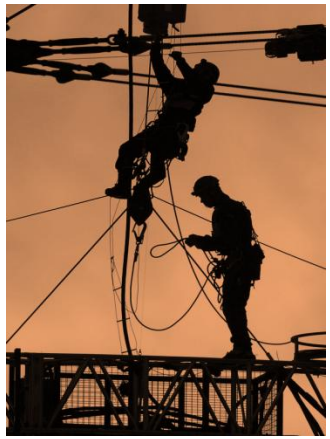
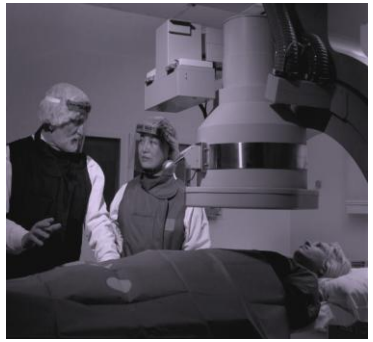
2012 Florida Division of Workers' Compensation Results and Accomplishments

JEFF ATWATER, CHIEF FINANCIAL OFFICER
FLORIDA DEPARTMENT OF FINANCIAL SERVICES

Department of Financial Services Mission Statement

To safeguard the integrity of the transactions entrusted to the Department of Financial Services and to ensure that every program within the Department delivers value to the citizens of Florida by continually improving the efficiency and cost effectiveness of internal management processes and regularly validating the value equation with our customers.

Division of Workers' Compensation Mission Statement

To actively ensure the self-execution of the workers' compensation system through educating and informing all stakeholders of their rights and responsibilities, leveraging data to deliver exceptional value to our customers and stakeholders, and holding parties accountable for meeting their obligations.

Director's Message

To All Stakeholders in the Workers' Compensation System,

In an effort to continue to provide pertinent, quality workers' compensation data, we have developed a new "Results and Accomplishments Report" which replaces the statutorily mandated Annual Report that was repealed during the 2012 Legislative Session. After your review, it is our hope that you find the information contained to be both informative and beneficial. We continue to concentrate on leveraging technology and system applications to meet our mission and continuously improve our business processes.

We welcome any suggestions and comments with regard to our new format and hope that you enjoy!

Sincerely,
Tanner Holloman

Table of Contents

Please note: All data contained in the graphics herein were extracted from the Division of Workers' Compensation resources as of 6/30/12, unless otherwise noted.

Bureau of Employee Assistance and Ombudsman Office

The Bureau of Employee Assistance and Ombudsman Office (EAO) was established pursuant to Section 440.191, F.S., to assist injured workers, employers, carriers, health care providers, and managed care arrangements in fulfilling their responsibilities under the Workers' Compensation Law. EAO is a resource for all stakeholders in the Workers' Compensation System and uses print and electronic media, one-on-one interaction with individual shareholders, and group presentations to promote the self-execution of the system.

Bureau of Employee Assistance and Ombudsman Office

To effectively fulfill its mission, EAO utilizes a team structure to focus on each specific area of its statutory responsibilities. EAO assists injured workers by:

- educating and disseminating workers' compensation information
- proactively contacting injured workers to discuss their rights and responsibilities and advise them of services available through EAO
- resolving disputes between injured workers and carriers to avoid undue expense, costly litigation or delay in the provision of benefits

EAO
Customer Service Team

The Customer Service Team assists and educates employers with questions regarding workers' compensation coverage, exemptions from coverage requirements, and drug-free workplace and safety programs.

Customer Service Call Volume FY 2011-2012	
1st Qtr	24,060
2nd Qtr	13,088
3rd Qtr	22,010
4th Qtr	22,711
Total	81,869

EAO
First Report of Injury Team

Within two business days of the Division's receipt of First Reports of Injury or Illness, the Team identifies and contacts those injured workers who have lost more than seven days of work due to job related injuries to:

- provide educational information about the Workers' Compensation System
- advise injured workers of their statutory responsibilities
- inform workers of EAO's services

EAO
First Report of Injury Team

During FY 2011-2012, the First Report of Injury Team:

- contacted 33,130 injured workers by telephone
- contacted 4,501 employers/carriers when the team was unable to reach injured workers to inquire about the status of injured workers' claims and to advise them of EAO's services
- mailed letters or responded by email to 43,241 injured workers to advise them of EAO's services and offer assistance

EAO
First Report of Injury Team

Injured Worker Contacts		
Fiscal Year	# Contacted	% Contacted
07-08	26,140	58%
08-09	25,271	63%
09-10	28,768	69%
10-11	32,140	71%
11-12	33,130	76%

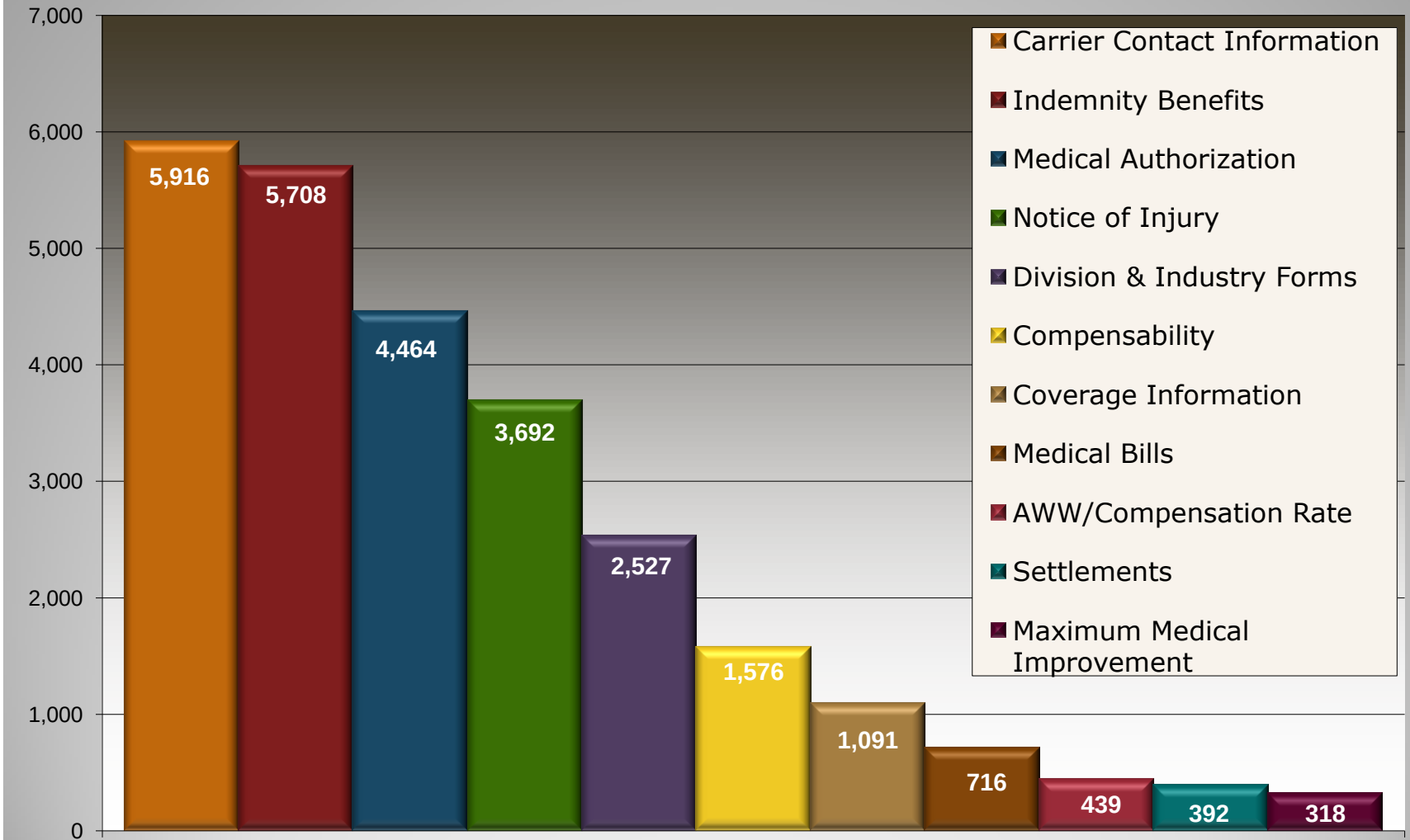
As depicted above, the increased contact success rate is attributed to EAO establishing a team dedicated to this function.

EAO
Injured Worker Helpline Team

The Injured Worker Helpline Team receives calls from all types of system stakeholders: injured workers, employers, carriers, medical providers, attorneys, and the general public.

The Team educates callers who contact the Division's toll-free telephone line about the requirements of Florida's Workers' Compensation Law and provides assistance to injured workers experiencing issues obtaining medical or indemnity benefits.

Helpline Team – Education Calls FY 2011-2012



EAO
Injured Worker Helpline Team

The Team identifies disputed issues, researches injured workers' concerns and contacts employers, carriers, medical providers, attorneys, or other appropriate parties to facilitate resolution. Disputes requiring extensive investigation are referred to the Ombudsman Team for handling.

During FY 2011-2012, the Injured Worker Helpline Team:

- provided workers' compensation educational information and assistance to 47,460 callers, including 9,459 Spanish speaking callers
- resolved 82% of the 473 disputes received

EAO Ombudsman Team

The Ombudsman Team assists injured workers in resolving complex and contentious disputes by conducting fact-finding reviews, analyzing claim files, researching case law, promoting open communication between parties, and helping them understand their statutory responsibilities.

EAO Ombudsman Team

The Ombudsman Team:

- provides early intervention services to injured workers with catastrophic or severe injuries
- assists walk-in customers in eight offices throughout Florida resolving disputes and providing workers' compensation information applicable to each injured worker's claim, including guidance on the Petition for Benefits process
- assists injured workers referred from the Governor's and CFO's Offices, legislators, and other elected officials

EAO Ombudsman Team

During FY 2011-2012, the Ombudsman Team:

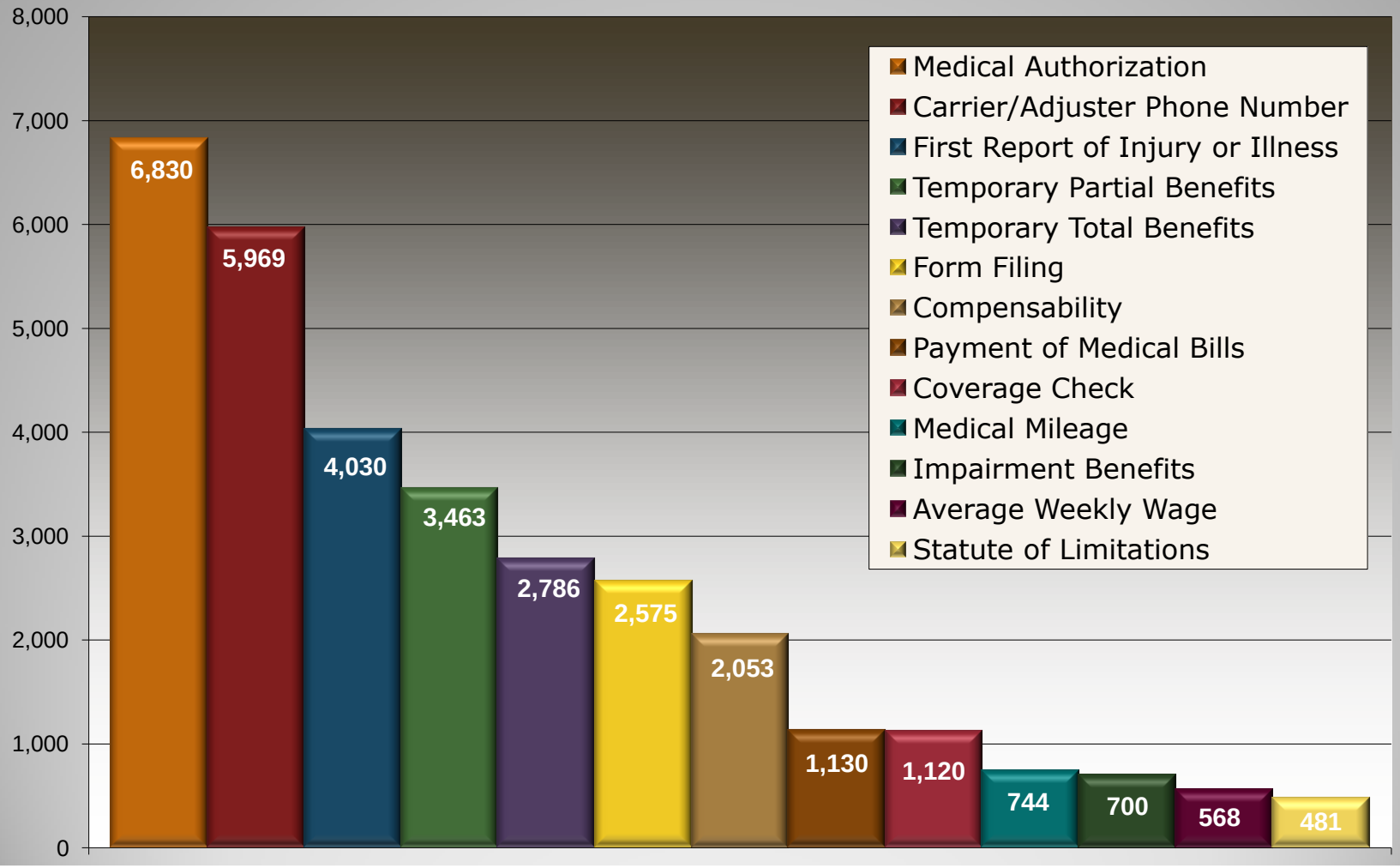
- resolved 87% of the 1,362 disputes received
- resolved 96% of the 225 medical bill disputes received, totaling $367,220 in previously unpaid medical bills
- prevented 5,084 potential disputes by educating injured workers and providing them with in-depth case specific information

System participants with questions can also contact the Team at wceao@myfloridacfo.com.

Ombudsman Intervention FY 2011-2012

Issue	Resolved	Unresolved	% Resolved
Average Weekly Wage	16	1	94%
Medical Authorization	510	73	87%
Notice of Injury	70	2	97%
Indemnity - TPD	61	24	72%
Indemnity - TTD	63	6	91%
Compensability	15	46	25%
Penalties & Interest	29	3	91%
Medical Mileage	102	2	98%
Medical Bills	215	10	96%
Impairment Income Benefits	12	2	86%
Other	60	8	88%
Total	1,153	177	87%

Issues Addressed by the Ombudsman and Helpline Teams FY 2011-2012



Bureau of Compliance

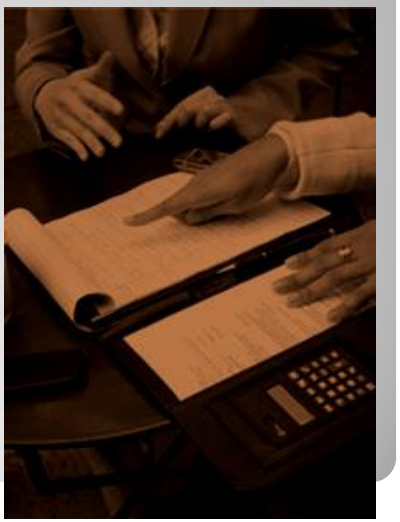
The Bureau of Compliance (BOC) accomplishes its mission to ensure employers comply with statutory obligations to obtain workers' compensation insurance coverage for employees by:

- conducting investigations and issuance of enforcement actions in accordance with Section 440.107, F.S.
- processing workers' compensation exemptions to qualified applicants in accordance with Section 440.05, F.S.
- providing educational outreach and training to employers and insurance industry representatives on workers' compensation coverage laws

Bureau of Compliance

Key Initiatives:

- leveraging data from multiple agencies to identify and target non-compliant employers
- investigated 1,929 public referrals alleging non-compliance
- conducted 68 free training sessions and 22 webinars on workers' compensation and workplace safety for over 2,000 employers statewide

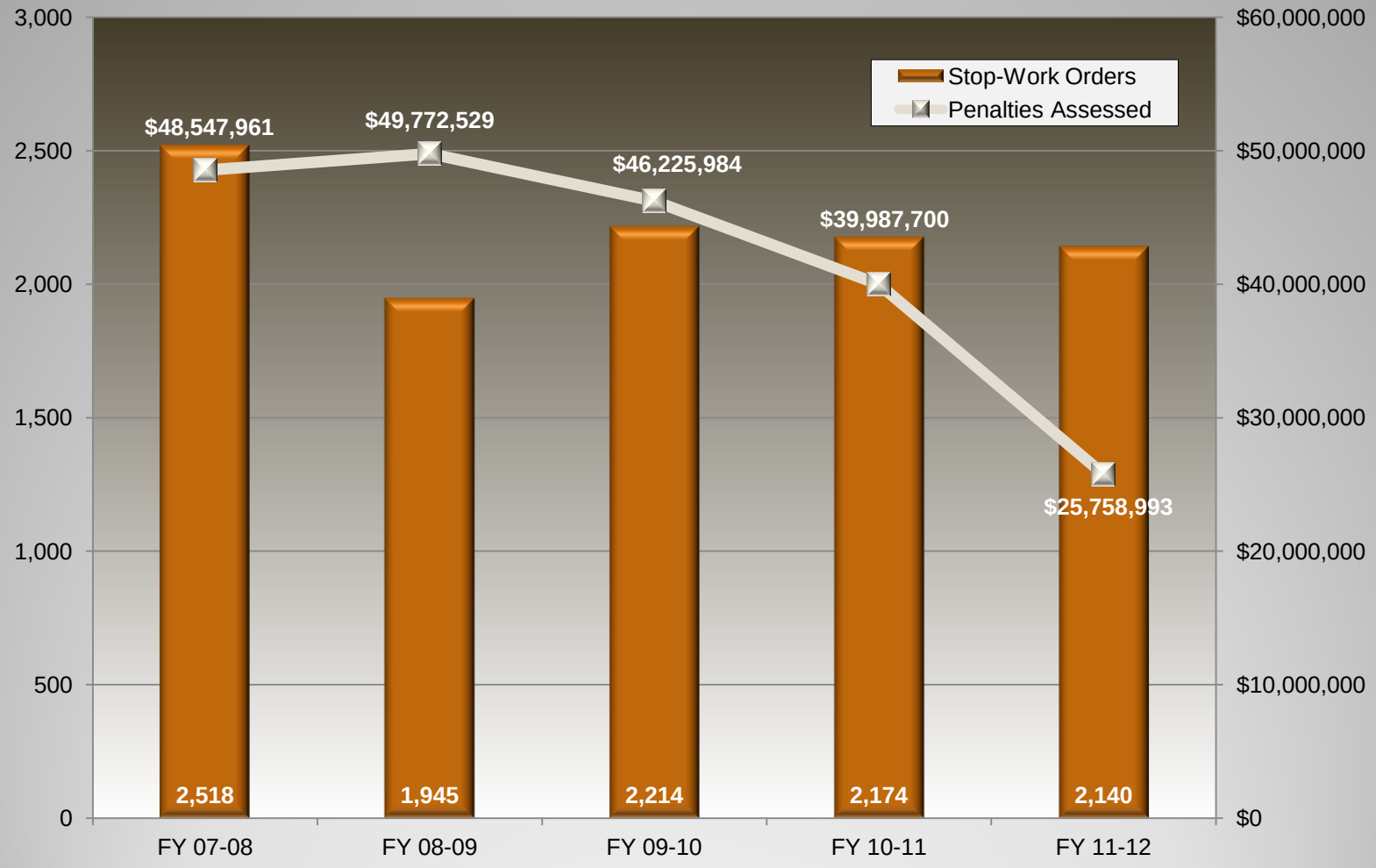


Bureau of Compliance

Investigations conducted are physical, on-site inspections of an employer's job-site or business location to determine compliance with workers' compensation coverage requirements.

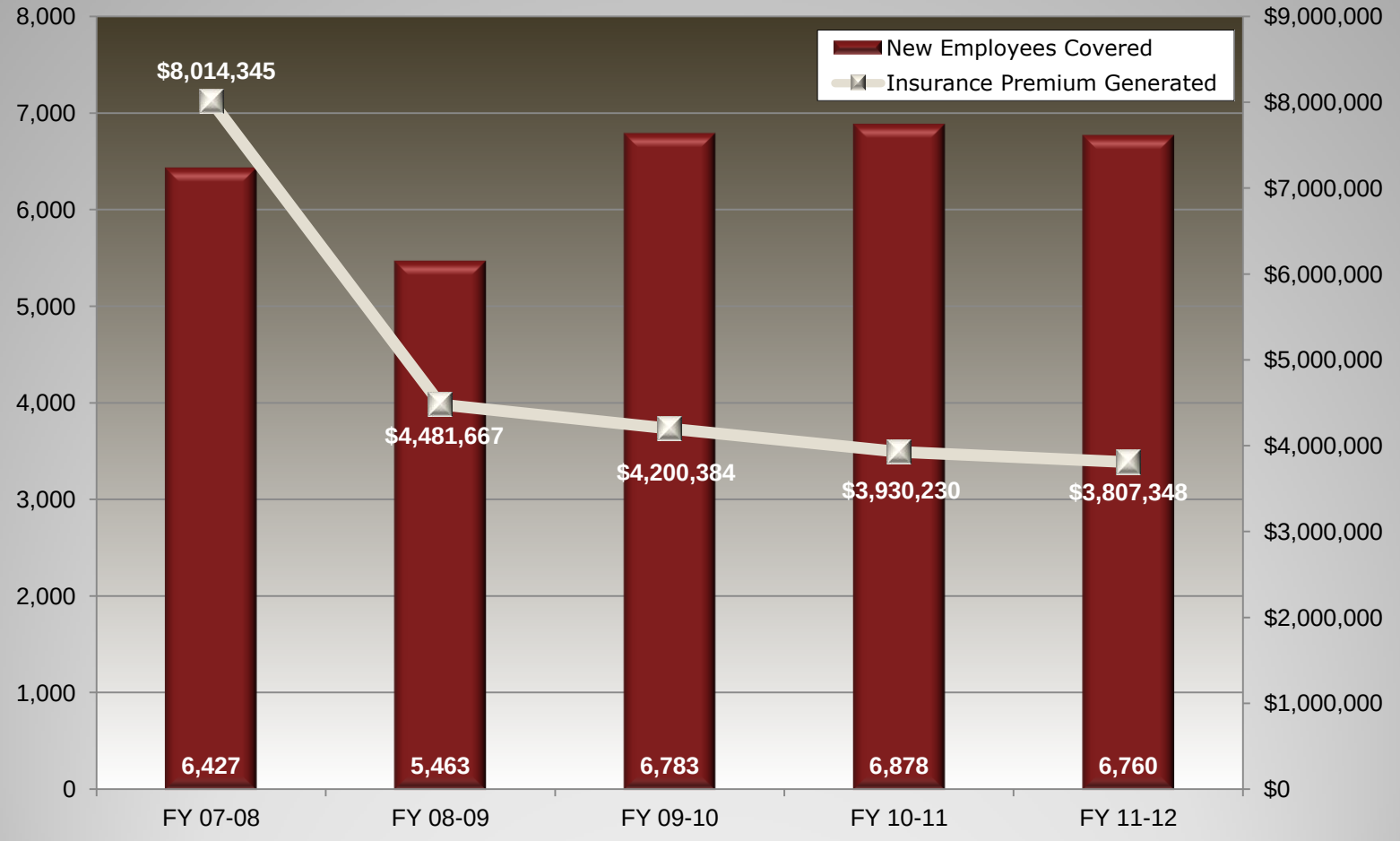
Investigations Conducted	
FY 07-08	27,674
FY 08-09	29,166
FY 09-10	33,235
FY 10-11	34,252
FY 11-12	34,780

Stop-Work Orders Issued and Penalties Assessed



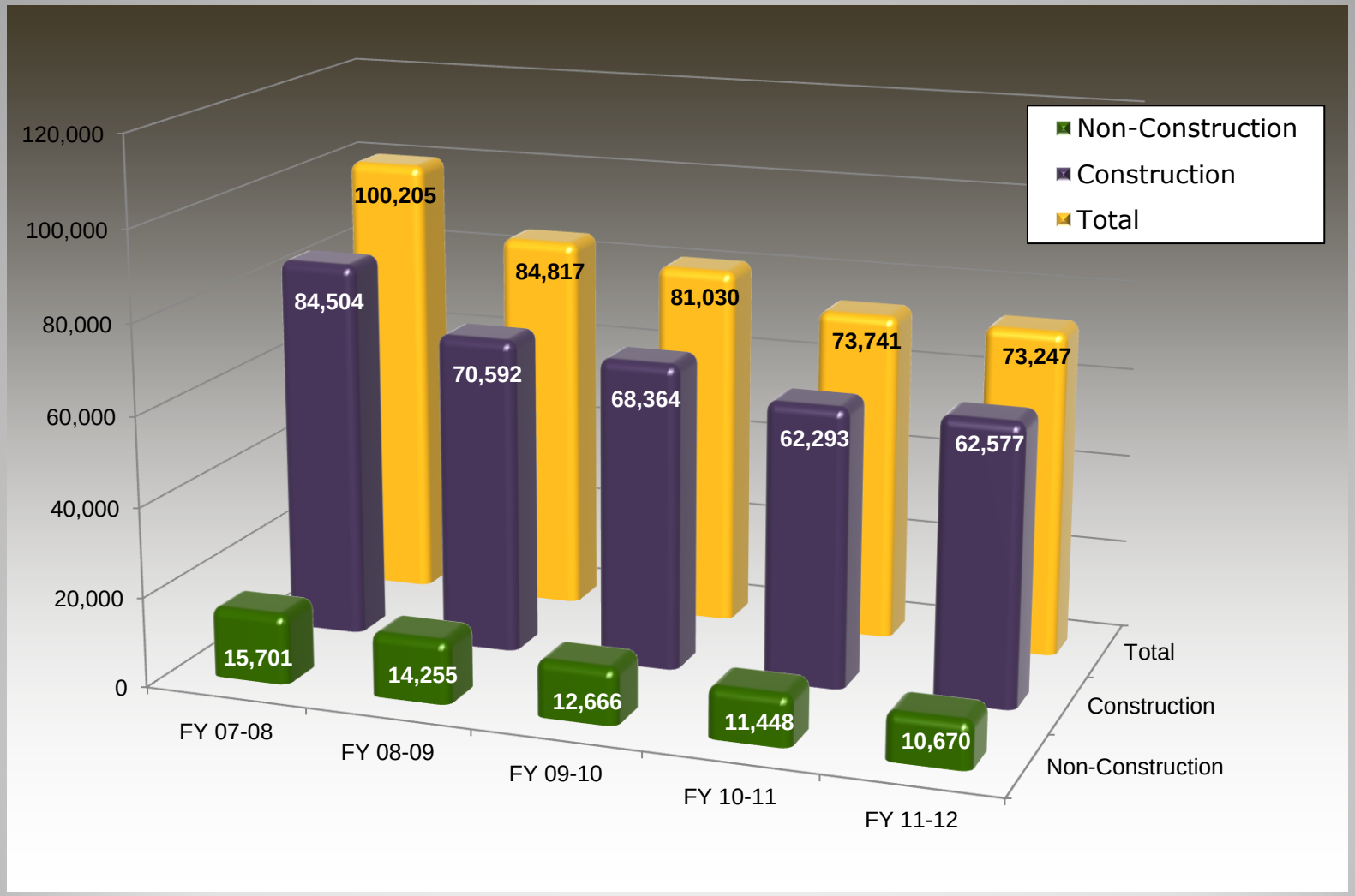
The number of Stop-Work Orders has remained relatively constant over the last five fiscal years.
The penalties assessed decreased significantly this year due to reductions in employer payrolls.

New Employees Covered and Insurance Premium Generated Based Upon Stop-Work Orders Issued



This graph illustrates the number of employees covered as a direct result of the Bureau's enforcement efforts and issuance of Stop-Work Orders and the monies added to the workers' compensation premium base that had been previously evaded.

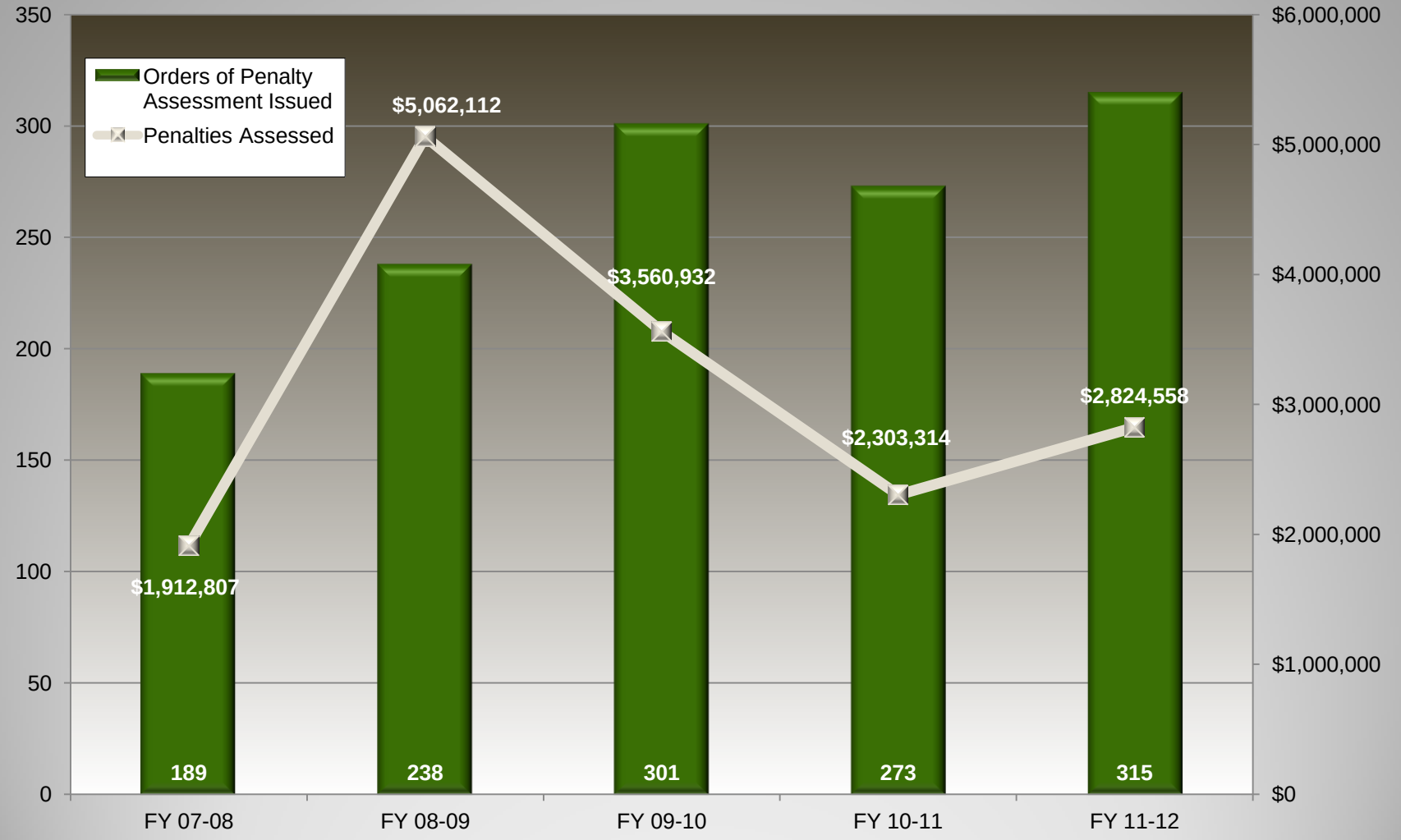
Exemption Applications Processed



Bureau of Compliance

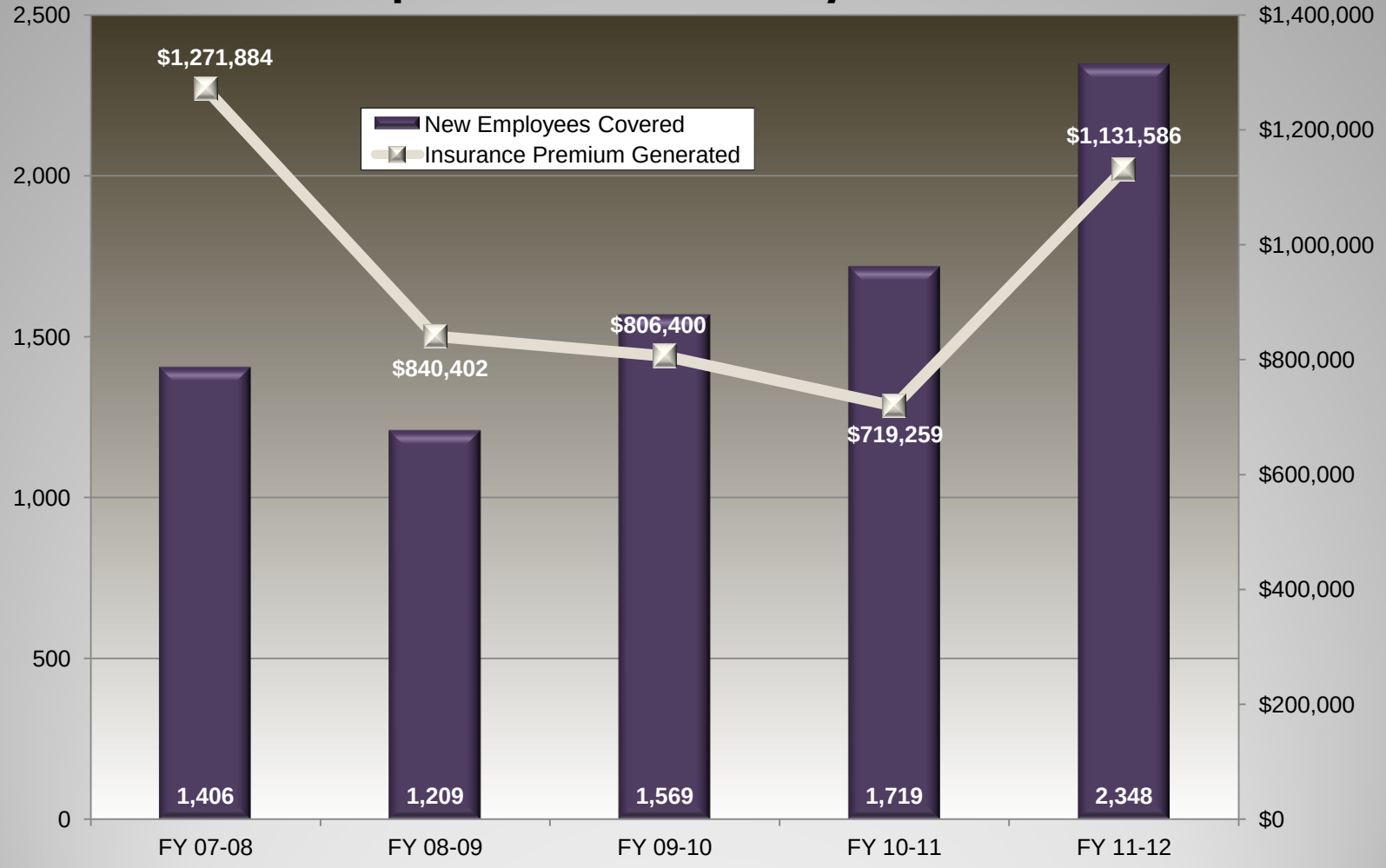
The following two graphics pertain to Orders of Penalty Assessment, when the employer obtained coverage subsequent to the commencement of an investigation, which made the issuance of the Stop-Work Order unnecessary.

Orders of Penalty Assessment and Penalties Assessed



This chart illustrates the volume of Orders of Penalty Assessments issued and penalties assessed.

New Employees Covered and Insurance Premium Generated Based Upon Orders of Penalty Assessment



This chart illustrates the new employees covered and premium generated as a result of those Orders after the employers purchased workers' compensation insurance.

Bureau of Monitoring and Audit

The Bureau of Monitoring and Audit (M&A) is responsible for ensuring that the practices of insurers and claims-handling entities meet the requirements of Chapter 440, Florida Statutes and the Florida Administrative Code.

Bureau of Monitoring and Audit

The Bureau of Monitoring and Audit's mission is to ensure the:

- timely and accurate payment of benefits to injured workers
- timely filing and payment of medical bills
- timely and accurate filing of required claims forms and other electronic data

The Bureau is also responsible for approving self-insurance programs and regulating medical services in workers' compensation.

Bureau of Monitoring and Audit

The Bureau of Monitoring and Audit consists of the following key areas:

- Audit Section
- Permanent Total Disability Section
- Penalty Section
- Self-Insurance Section
- Office of Medical Services

M&A
Audit Section

The Audit Section examines claims-handling practices of insurers, self-insurers, self-insurance funds, and other claims-handling entities pursuant to Sections 440.20, 440.185, and 440.525, Florida Statutes and the rules of the Florida Administrative Code.

M&A Audit Section

Examinations and investigations conducted by the Audit Section:

- identify patterns and practices of unreasonable delays in claims-handling
- identify untimely and inaccurate payment of benefits to injured workers
- identify untimely and inaccurate filing of required forms and reports
- enforce compliance with compensation orders of Judges of Compensation Claims

M&A
Audit Section

The Audit Section reviews Explanations of Bill Review (EOBR) for compliance with Rule 69L-7.602(5), F.A.C. which ensures complete reimbursement communications between insurers and providers.

Overall Compliance FY 2010-2011	
Data Points Reviewed	13,769
Data Points Compliant	7,050
Overall Compliance	51%

Overall Compliance FY 2011-2012	
Data Points Reviewed	33,769
Data Points Compliant	27,915
Overall Compliance	83%

M&A Audit Section

During FY 2011-2012, the Audit Section:

- completed 70 on-site insurer audits
- examined 6,057 insurer claim files

Of the 6,057 files, 4,083 were indemnity claim files in which the reviews:

- identified 494 files with underpayments
- resulted in additional injured worker payments of $334,952 for indemnity benefits, penalties, and interest

M&A
Audit Section

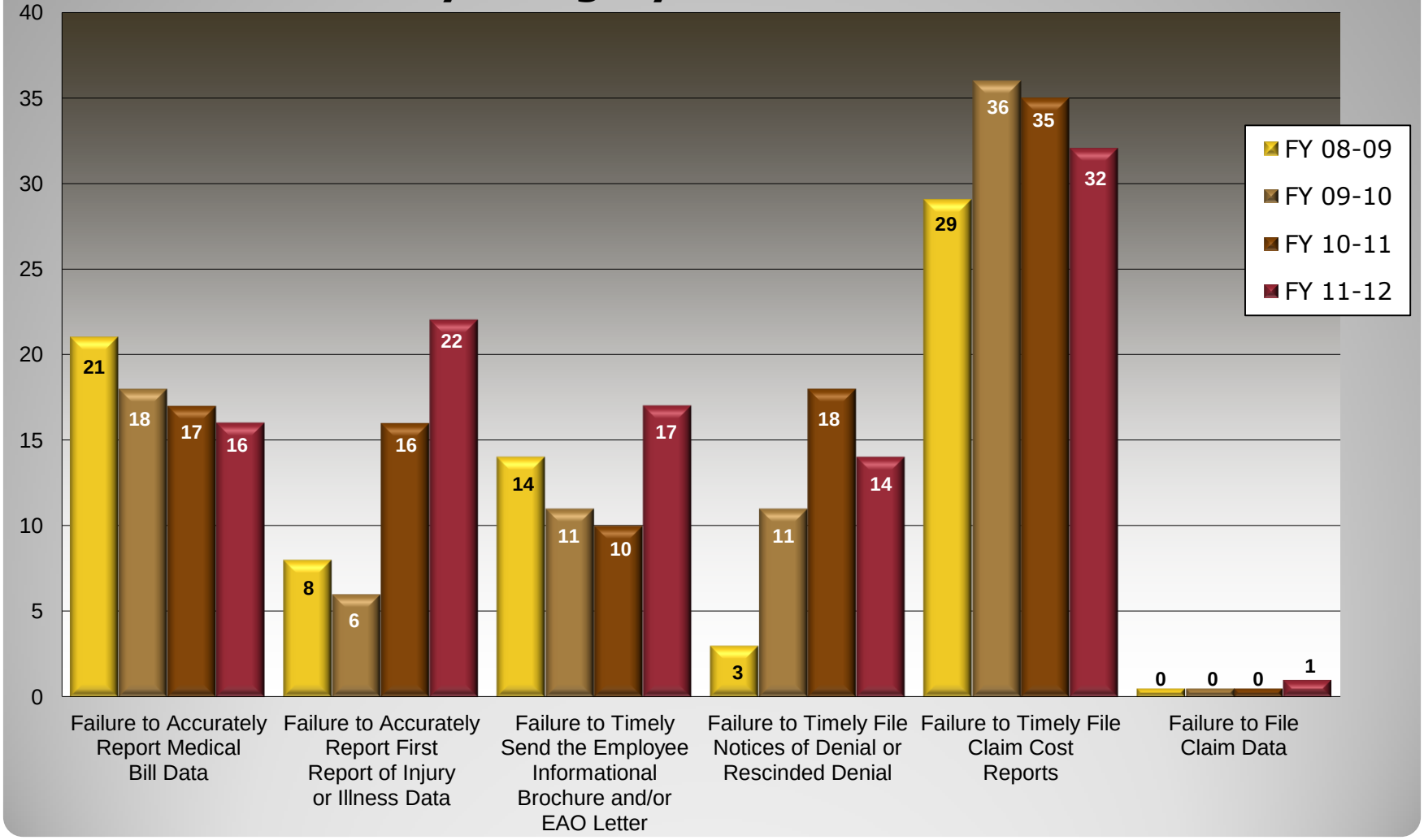
The table below illustrates penalties assessed during audits for untimely indemnity payments and untimely First Reports of Injury or Illness. These penalties were paid to the Division.

Fiscal Year	Total Amount of Penalties Issued for Late Indemnity Payments	Total Amount of Penalties Issued for Untimely First Reports of Injury or Illness
08-09	$110,150	$16,300
09-10	$78,600	$35,100
10-11	$90,400	$66,600
11-12	$87,000	$51,200

M&A
Audit Section

The graph on the next page illustrates non-willful pattern and practice penalties assessed during audits for various claims handling violations. Each pattern and practice penalty is assessed at $2,500. These penalties were paid to the Division.

Non-Willful Pattern & Practice Penalties By Category and Fiscal Year



M&A Permanent Total Disability Section

The Permanent Total Disability (PT) Section is responsible for paying permanent total supplemental benefits to eligible permanently and totally disabled workers who were injured prior to July 1, 1984.

During FY 2011-2012, the PT Section calculated, approved, and processed supplemental benefits for 1,383 claims totaling $17,484,424.

M&A
PT Section

On a continuing basis, the PT Section verifies eligibility of injured workers' entitlement to supplemental benefits by reviewing the following resources:

- Vital Statistics Report (Department of Health)
- Inmate records (Department of Corrections)
- Employee Earnings Reports
- PT Claims data electronically submitted by insurer
- Judges of Compensation Claims data

M&A
PT Section

Additionally, the PT Section verifies the accuracy and timeliness of permanent total and permanent total supplemental benefits due and paid by insurers. This includes verifying that payments are suspended, reduced, or cancelled based on statutory amendments or case law and that benefit offsets are correctly applied.

M&A
PT Section

During FY 2011-2012, the PT Section reviewed 33,279 electronic claims transactions and obtained $847,929 in past due benefits, penalties, and interest for 59 injured workers.

The PT Section works in collaboration with other Division staffing units to determine the accuracy of benefits that are due to an injured worker including:

- Special Disability Trust Fund
- Bureau of Employee Assistance and Ombudsman Office
- Audit Section

M&A Penalty Section

The Penalty Section evaluates and assesses insurer performance of timely payments of initial indemnity benefits and medical bills.

The Penalty Section also monitors the timely filing of First Reports of Injury or Illness and medical bills monthly using the Centralized Performance System (CPS). CPS is a web based application that electronically provides essential insurer performance information and trends. CPS also enables the Division and its stakeholders to monitor performance and respond to penalty assessments for untimely filing and untimely payment in real-time.

M&A Penalty Section

CPS electronically documents insurers' and claims-handling entities' communications with the Division. It also records payment information on all assessed penalties and fines. There are two components in CPS: a medical module and an indemnity module.

Both modules allow insurers to:

- monitor their performances and the performances of their third-party administrators
- compare their performance data to industry averages

M&A Penalty Section

The volume of First Reports of Injury and Illness reviewed by the Centralized Performance System is shown below.

Fiscal Year	# of First Reports Received and Reviewed
FY 08-09	57,821
FY 09-10	52,768
FY 10-11	53,285
FY 11-12	53,211

M&A Penalty Section

Performance for timely payment of initial indemnity benefits has remained relatively constant over the last four Fiscal Years. Timely filing of First Reports of Injury and Illness has increased over the same time period.

Fiscal Year	Timely Initial Benefit Payments	Timely Filing of First Reports
FY 08-09	94%	87%
FY 09-10	95%	93%
FY 10-11	95%	95%
FY 11-12	95%	95%

M&A Penalty Section

Performance Percentages of Medical Bills

Fiscal Year	Timely Medical Bill Payments	Timely Medical Bill Filings
FY 08-09	99%	99%
FY 09-10	98%	97%
FY 10-11	98%	98%
FY 11-12	99%	99%

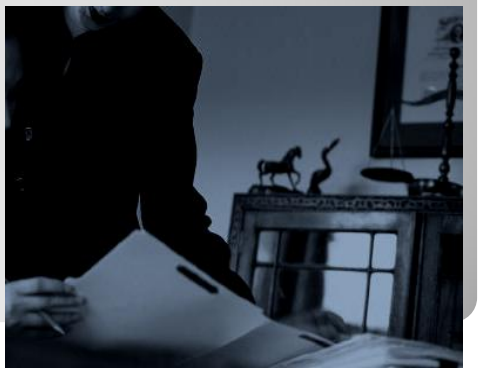
M&A
Self-Insurance Section

The Self-Insurance Section is responsible for approving self-insurance programs for governmental and private entities that have met statutory requirements and demonstrated the required financial strength to fund their Florida workers' compensation liabilities.

M&A
Self-Insurance Section

To ensure the financial stability of Florida self-insurers, the Self-Insurance Section contracts with the Florida Self-Insurers Guaranty Association (FSIGA) to review financial statements and monitor a self-insurer's ability to pay current and future workers' compensation liabilities.

The Self-Insurance Section, in conjunction with FSIGA, evaluates security deposits, grants self-insurance privileges, collects, examines, and processes self-insurance payroll, loss data, outstanding liabilities, and financial statements.



M&A Self-Insurance Section

The Self-Insurance Section conducts payroll audits of current and former self-insurers. The audits are conducted to determine the accuracy of payroll data reported annually on DFS-F2-SI-5, Self-Insurers Payroll Reports.

During FY 2011-2012, the Self-Insurance Section:

- performed 27 desk audits
- reviewed 109,542 employee payroll records
- identified $234,406,058 in underreported payroll
- identified $4,570,005 in underreported premium

M&A
Self-Insurance Section

Entities applying for self-insurance authorization pursuant to Section 440.38(1)(b),F.S., shall submit a complete application package at least ninety (90) days prior to the desired effective date of the self-insurance authorization.

For private entities, the application package shall be submitted to FSIGA, Inc.

Governmental entities shall submit their application package to the Division of Workers' Compensation.

M&A
Self-Insurance Section

During FY 2011-2012, the Self-Insurance Section:

- approved 5 entities to self-insure their workers' compensation liabilities
- processed 5 entities' notices of self-insurance cancellation

M&A
Self-Insurance Section

The Self-Insurance Section reviews applications submitted by entities requesting authorization to provide workers' compensation claims services to insurers and self-insurers. Once approved, these entities become Qualified Servicing Entities (QSEs) and must annually submit a DFS-F2-S1-23, Annual Report Form, for re-certification by March 1st to the Self-Insurance Section.

During FY 2011-2012, the Self-Insurance Section reviewed and processed:

- 97 Qualified Servicing Entities' re-certifications
- 3 Qualified Servicing Entity notifications of withdrawal from servicing self-insurers

M&A
Self-Insurance Section

Total number of active Self-Insurers and Qualified Servicing Entities as of each fiscal year's end

Fiscal Year	Self-Insurers
FY 08-09	398
FY 09-10	418
FY 10-11	410
FY 11-12	410

Fiscal Year	Qualified Servicing Entities
FY 08-09	93
FY 09-10	96
FY 10-11	100
FY 11-12	97

M&A
Office of Medical Services

Office of Medical Services (OMS) responsibilities:

- developing and adopting the various health care reimbursement manuals:
  - adopted the 2011 Reimbursement Manual for Ambulatory Surgical Centers (effective November 2011)
  - proposed the 2011 Reimbursement Manual for Health Care Providers (not ratified by the 2012 Legislature)
  - proposed the 2012 Reimbursement Manual for Hospitals (not yet final as of 8/8/2012)

M&A
Office of Medical Services

Responsibilities cont'd:

- resolving medical reimbursement disputes between providers and payors:
  - OMS received 15,010 Reimbursement Disputes during FY 2011-2012, which is an increase of over 297% from last fiscal year
  - OMS resolved 5,624 Reimbursement Disputes, an increase of approximately 57% over FY 2010-2011

M&A
Office of Medical Services

Responsibilities cont'd:

- Certifying Health Care Providers (HCPs)
  - as of June 30, 2012 there were 38,194 certified HCPs
- Certifying Expert Medical Advisors (EMAs)
  - as of June 30, 2012 there were 171 certified EMAs

M&A
Office of Medical Services

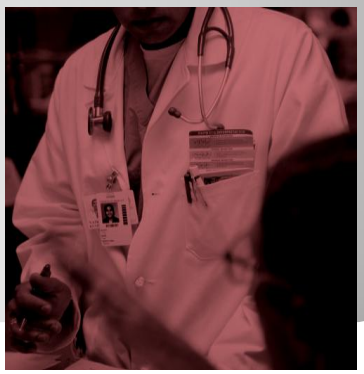
Responsibilities cont'd:

- investigating reports of provider violations:
  - adopted new Rule Chapter 69L-34, Carrier Reports of Health Care Provider Violations, effective September 2011
  - received 38 reports of alleged provider violations (16 internal DWC referrals; 22 referrals from carriers or attorneys)
  - resolved 22 of the reports; 16 remained open as of June 30, 2012

M&A
Office of Medical Services

Responsibilities cont'd:

- provides educational assistance and consultation on issues related to medical bill filing and reimbursement
- provides administrative support to the Three-Member Panel who adopts uniform schedules of maximum reimbursement allowances for physicians, hospitals, ambulatory surgical centers (ASCs), and other service providers



M&A
Office of Medical Services

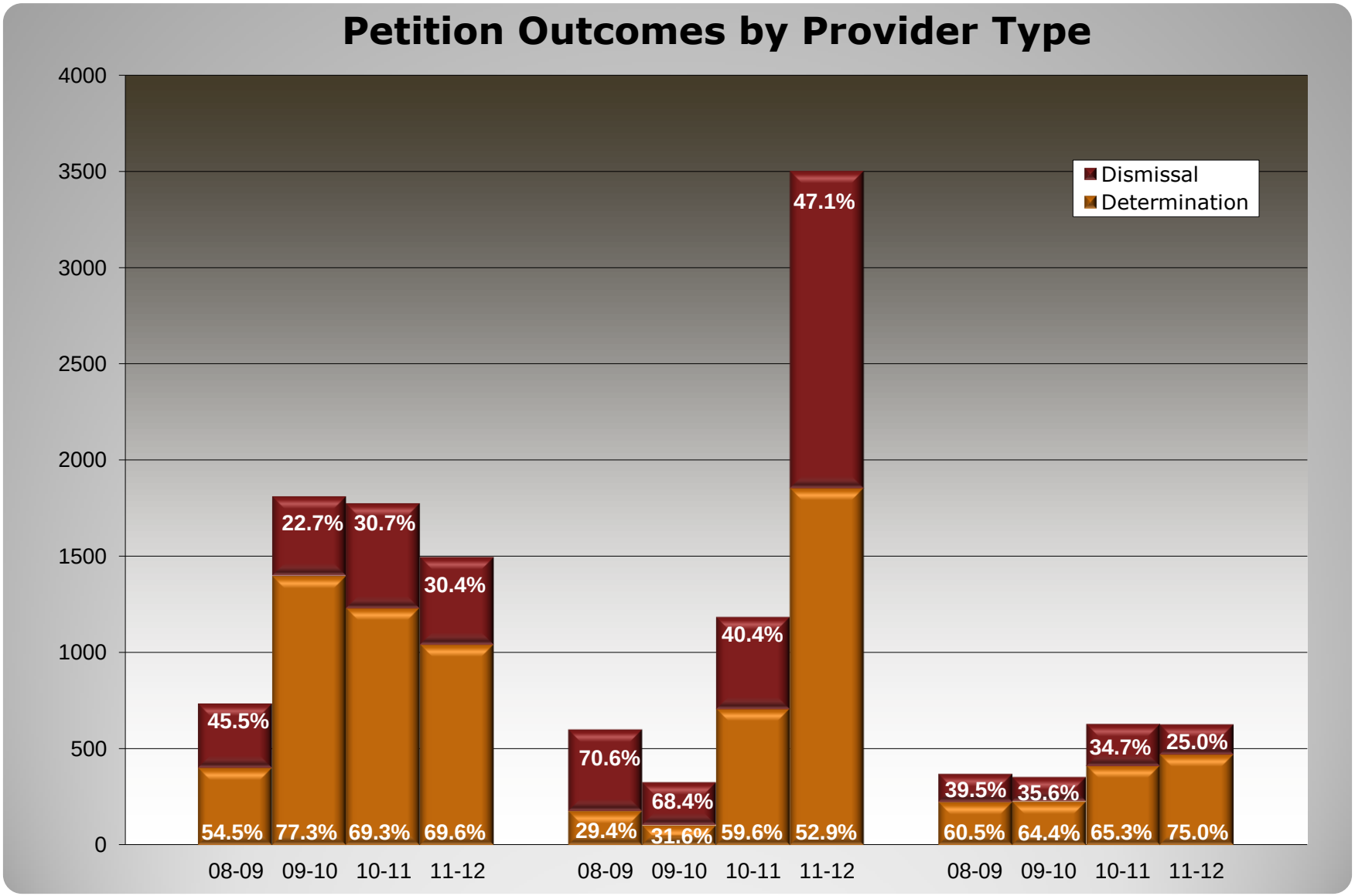
The volume of Medical Reimbursement Disputes filed by Practitioners has continued to increase dramatically (up 872% over FY 2010-2011) primarily due to disputes involving physician dispensed medication.

Petitions Submitted by Provider Type				
	FY 08-09	FY 09-10	FY 10-11	FY 11-12
Practitioner	568	296	1,308	12,718
ASC	349	373	655	687
Hospital Inpatient	244	330	436	332
Hospital Outpatient	745	1,071	1,378	1,273
Total	1,906	2,070	3,777	15,010

M&A
Office of Medical Services

- OMS resolved 5,624 Reimbursement Disputes during FY 2011-2012. This represents approximately a 57% increase over FY 2010-2011.
- OMS issued 3,365 determinations (59.8% of the time) in FY 2011-2012.
- OMS issued 2,259 dismissals (40.2% of the time) in FY 2011-2012.

Petition Outcomes by Provider Type



M&A
Office of Medical Services

Overall, the number of Reimbursement Disputes dismissed in FY 2011-2012 increased over 82% from FY 2010-2011.

Historically, the primary reason for dismissing a Reimbursement Dispute has been due to the Petitioner's failure to cure a deficiency in the petition following notice from OMS. However, in FY 2011-2012, the filing of an untimely petition was the most frequent reason for dismissal.

M&A
Office of Medical Services

A Reimbursement Dispute must be filed within 30 days from receipt of the carrier's notice of disallowance or adjustment of payment.

This past fiscal year, the number of untimely Reimbursement Disputes dismissed due to untimely filing increased 313%, from 225 to 930, and the number of withdrawals of Reimbursement Disputes increased by almost 50%.

M&A
Office of Medical Services

OMS found that the petitioner had been underpaid in 92% of all determinations issued for Fiscal Year 2011-2012. However, in most cases, the amount reimbursed to the provider did not equal the billed amount.

Determinations Issued by Reason				
	FY 08-09	FY 09-10	FY 10-11	FY 11-12
Under-Payment	715	1,635	2,181	3,095
Correct Payment	28	25	41	83
Over-Payment	19	34	28	75
Other Finding	19	2	5	3
No Additional Payment Due	9	25	90	109

Bureau of Data Quality and Collection

The Bureau of Data Quality and Collection (DQC) receives and manages large volumes of data from claims-handling entities and vendors for Claims, Medical, and Proof of Coverage data as required by Chapter 440, Florida Statutes, and various corresponding Florida administrative rules.

DQC's mission is to collect data in an efficient and effective manner in order to provide accurate, meaningful, timely and readily accessible information to all stakeholders within the workers' compensation system.

Bureau of Data Quality and Collection

DQC is responsible for collecting, storing, and retrieving information to support the Division. To ensure data quality and reliability, every electronic transaction received is evaluated through extensive program edits to ensure a high degree of accuracy prior to loading the information to the respective Division databases.

DQC develops and maintains business processes that comingle with other Division systems to facilitate the monitoring of injured worker benefits, employer coverage and compliance, and health care provider payments.

Bureau of Data Quality and Collection

Proof of Coverage EDI Data Collection

With the exception of self-insurers, every insurer is required by Administrative Rule 69L-56, F.A.C., to file policy information with the Division for the following types of filings:

- Certificates of Insurance
- Notices of Reinstatement
- Endorsements
- Cancellations

Bureau of Data Quality and Collection

One hundred percent of all workers' compensation Proof of Coverage (POC) data is collected and inspected via Electronic Data Interchange (EDI). EDI is the structured transmission of data between organizations by electronic means. It is used to transfer electronic documents or business data from one computer system to another computer system, i.e. from one trading partner to another trading partner, without human intervention.

Bureau of Data Quality and Collection

POC EDI data is used to populate several online Division databases, including:

- Proof of Coverage database which provides information that can be used to verify if an employer currently has workers' compensation coverage in force; to view a prior policy period; or to validate if a person has a workers' compensation exemption.
- Construction Policy Tracking database which provides the policy status of every subcontractor a contractor has chosen to track. Features include the electronic notification of any changes to a subcontractor's coverage status.

Bureau of Data Quality and Collection

Proof of Coverage Accepted Filings				
	FY 08-09	FY 09-10	FY 10-11	FY 11-12
New Policies	244,766	248,448	253,998	262,301
Reinstatements	87,369	86,885	80,306	79,958
Endorsements	221,491	249,438	225,425	208,553
Cancellations	161,195	167,873	155,987	157,405
Total	714,821	752,644	715,716	708,217

If you have any questions or require assistance regarding the electronic reporting of Proof of Coverage information, contact the Bureau of Data Quality and Collection via email at poc.edi@myfloridacfo.com.

Bureau of Data Quality and Collection

Medical EDI Data Collection

The Florida Workers' Compensation Medical Services Billing, Filing, and Reporting Rule, 69L-7.602, F.A.C., was last amended on January 12, 2010. The amended rule introduced new electronic reporting requirements, updated unique codes that denote insurer payment/non-payment decisions for each rendered service, and added additional data elements in order to strengthen the collection of workers' compensation medical data.

Electronic Medical Bills Accepted	
Fiscal Year	Bills Accepted
FY 08-09	4,161,200
FY 09-10	4,014,501
FY 10-11	3,884,341
FY 11-12	3,834,451

Bureau of Data Quality and Collection

The amended rule requires that nursing home facilities, ambulatory surgical centers, and home health agencies begin reporting their billing information to the Division electronically via the DWC-90. The national paper equivalent of this form is the UB-04 CMS-1540.

To assist electronic medical submitters with the management of rejected bills, and to allow comparison benchmarking among the industry, DQC generates monthly report cards that denote the primary reasons for initial medical bill rejection.

If you have any questions or require assistance regarding Medical EDI reporting, contact the Bureau of Data Quality and Collection via email at MedicalDataManagementTeam@myfloridacfo.com.

Bureau of Data Quality and Collection

Claims EDI Data Collection

Claims EDI data populates the Division's main accident database and several online web databases. This data is collected pursuant to Rule 69L-56, F.A.C.

DQC conducted six EDI Webinar training classes in FY 2011-2012 on the fundamentals of EDI Claims, FL EDI Requirement Tables, Missing SA Process, Claims EDI MTC CB, and EDI Basic Overview Training.

If you have any questions or require assistance regarding the reporting of Claims EDI data, contact the Bureau of Data Quality and Collection via email at claims.edi@myfloridacfo.com.

Bureau of Data Quality and Collection

Accepted Claims Forms			
Fiscal Year	EDI	Paper	Total
FY 08-09	308,255	226,189	534,444
FY 09-10	485,403	10,696	496,099
FY 10-11	526,908	6,316	533,224
FY 11-12	500,613	2,223	502,836

Bureau of Data Quality and Collection

Public Records Requests and Subpoenas

Florida's Public Records Law and Civil Rules of Procedure require the release of certain information for public inspection upon request.

Once a request is received, documents must be identified, located, printed, and assembled from various mediums and inspected for confidentiality pursuant to Chapter 119, F.S., and appropriate administrative rules. To ensure quality and excellence, multiple quality reviews are performed prior to the release of records.

Bureau of Data Quality and Collection

During FY 2011-2012, DQC responded to 3,450 public records requests that resulted in 23,150 documents being produced. On average, public records requests were invoiced, or documents provided if no charge, within two business days of receipt. Documents are mailed upon requestor's pre-payment as authorized by Section 119.07, F.S., if applicable.

In the past year, DQC processed 4,029 subpoenas, which necessitated the retrieval of 228,619 documents. On average, subpoenas were mailed within three business days from receipt of payment.

Public Record Requests may be submitted via email to the Division at DWCPublicRecordsRequest@myfloridacfo.com.

Bureau of Data Quality and Collection

Records Privacy Requests

Florida's public records law requires most workers' compensation accident information to be released to any party upon request. The Florida Legislature created Section 119.071(4)(d), Florida Statutes to afford certain occupational classes (e.g., law enforcement personnel, correctional officers, firefighters, judges, etc.) the ability to request an agency to exempt their personal information (i.e., home address and home telephone number) from public records release.

During FY 2011-2012, DQC marked 1,445 workers' compensation profile records exempt from public records inspection under Section 119.071(4)(d), Florida Statutes.

Bureau of Data Quality and Collection

The average turn-around time to process Records Privacy Requests is less than 2 business days. This quick turn-around timeframe can be attributed to the creation of enhanced on-line educational information made available on the Division's website, including revised forms designed to expedite the request process. DQC further instituted a follow-up email process that notifies the requestor of the status of his/her exemption request.

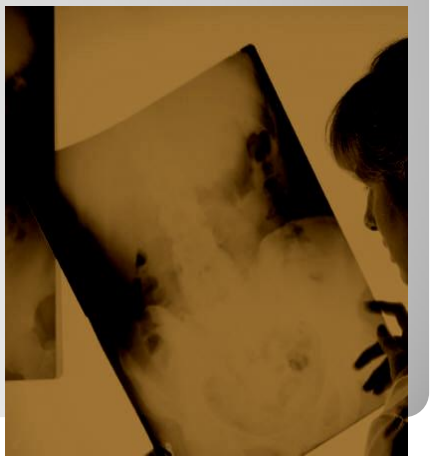
A complete listing of qualified occupations can be found at http://www.myfloridacfo.com/wc/employee/records.html.

If you have any questions or require assistance regarding Records Privacy, please contact DQC via email at DWCRecordsPrivacy@myfloridacfo.com.

Special Disability Trust Fund

The Special Disability Trust Fund (SDTF) was created by the Florida Legislature in 1955 to encourage employers to hire and reemploy individuals with a pre-existing permanent physical disability.

If the employee experienced a new injury subsequent to being hired and that work-related injury resulted in a greater permanent impairment, the SDTF would reimburse the employer for excess costs.



Special Disability Trust Fund

The cost of operating the SDTF, including reimbursements to carriers, is funded through annual assessments on workers' compensation premiums written by insurance companies and the imputed premium calculated by the Division for individual self-insured employers.

Legislative changes in 1997 resulted in the SDTF being prospectively abolished and statutorily prohibited from accepting any new claims for dates of accident after December 31, 1997. However, in accordance with the statute, insurers and individual self-insured employers continue to be assessed to fund the run-off claims.

Special Disability Trust Fund

Presently, the SDTF has three primary business processes:

- review all filed Proofs of Claim to determine if the claim meets eligibility requirements for reimbursement of benefits paid by the carrier and subsequently notify the carrier whether the claim has been accepted or denied
- determine eligibility for reimbursement by the Fund through auditing Reimbursement Requests and supporting documentation submitted by the carrier on claims that have been accepted
- issue accurate reimbursements

Special Disability Trust Fund

What's Next?

The Fund has been working to leverage the Medical EDI data submitted to the Division to create a new Computer Assisted Auditor Tool for use in evaluating and reviewing Reimbursement Requests submitted to the Fund.

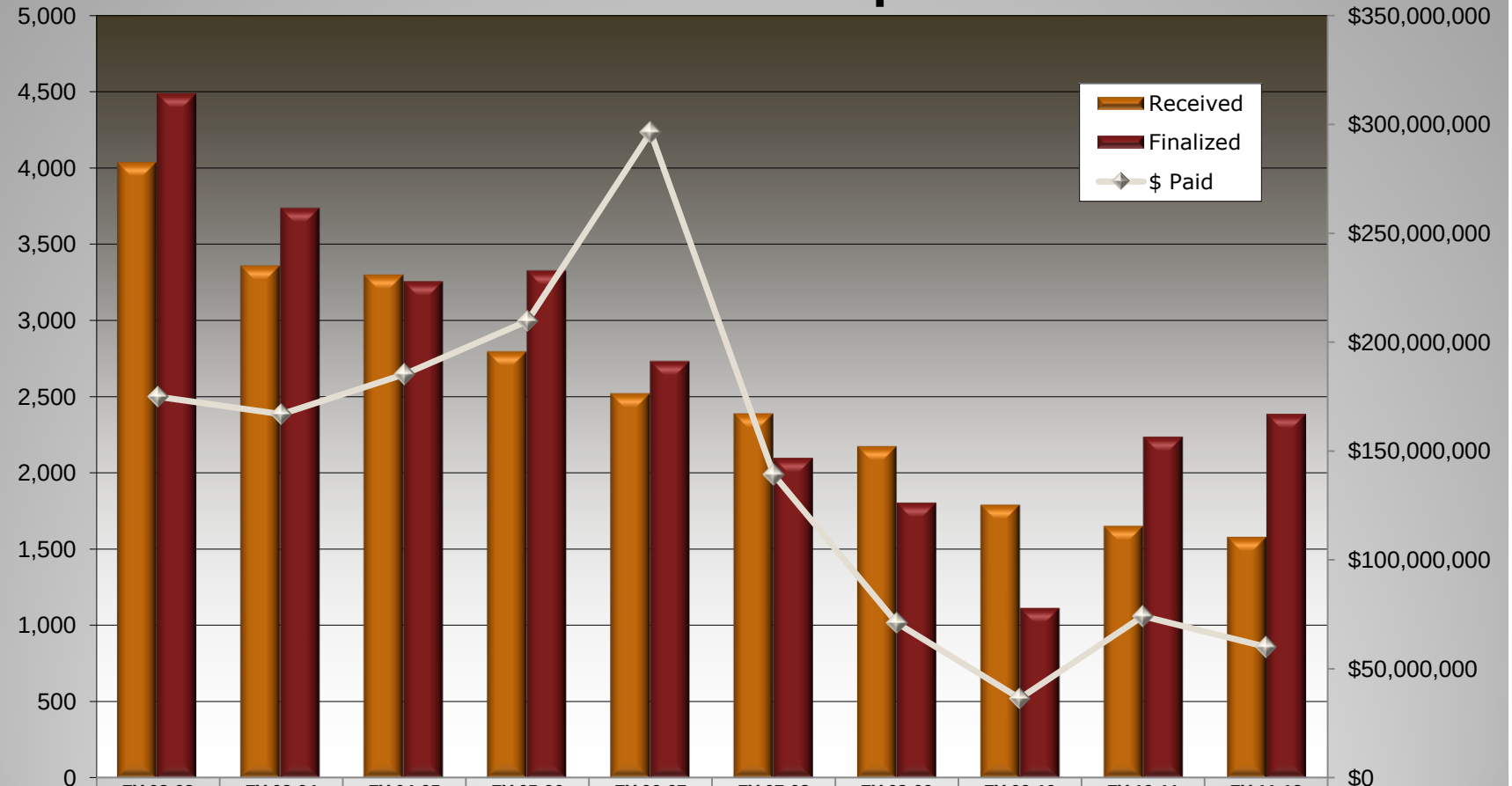
The next step will be to integrate this system into an electronic web portal to be used in the submission, review, and approval of Reimbursement Requests. The Fund will be able to utilize electronic data presently collected by the Division for use in this process, which will prevent the need for resubmission of some data by the carrier.

Special Disability Trust Fund

Implementation of such a system will:

- dramatically reduce the paper used
- allow for and encourage more fluid communication between the Fund and its customers
- reduce the time between submission and final disposition of requests
- provide educational information

Reimbursement Requests



	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10	FY 10-11	FY 11-12
Received	4,028	3,351	3,292	2,789	2,516	2,384	2,170	1,787	1,650	1,578
Finalized	4,486	3,735	3,255	3,326	2,732	2,099	1,805	1,116	2,237	2,387
$ Paid	$174,953,139	$166,980,684	$185,319,701	$209,781,409	$296,412,026	$139,121,165	$71,113,533	$36,443,562	$74,158,800	$60,137,393

Number of Reimbursement Requests received vs. number finalized and monies reimbursed annually

Assessments Unit

In Fiscal Year 2011-2012, the Assessments Unit collected:

- over $44 million in assessments for The Workers' Compensation Administration Trust Fund (WCATF)
- over $39 million for The Special Disability Trust Fund (SDTF)

Both trust funds are supported by quarterly assessments. These assessments are based on insurance carriers' Florida workers' compensation net insurance premiums, as required by statute.

Each quarter, the Unit notified and provided all carriers with the necessary information to report premiums.

Assessments Unit

The Assessments Unit subsequently collected, audited, and reconciled the quarterly assessments of 369 insurance companies and self-insurance funds.

The Unit calculated imputed premium of 411 individual self-insured companies (premium that the self-insurer would have paid had they not chosen to self-insure). This process utilized the required company payroll, volume discounts, approved credits, and experience modifications in determining that premium for which the assessment was applied.

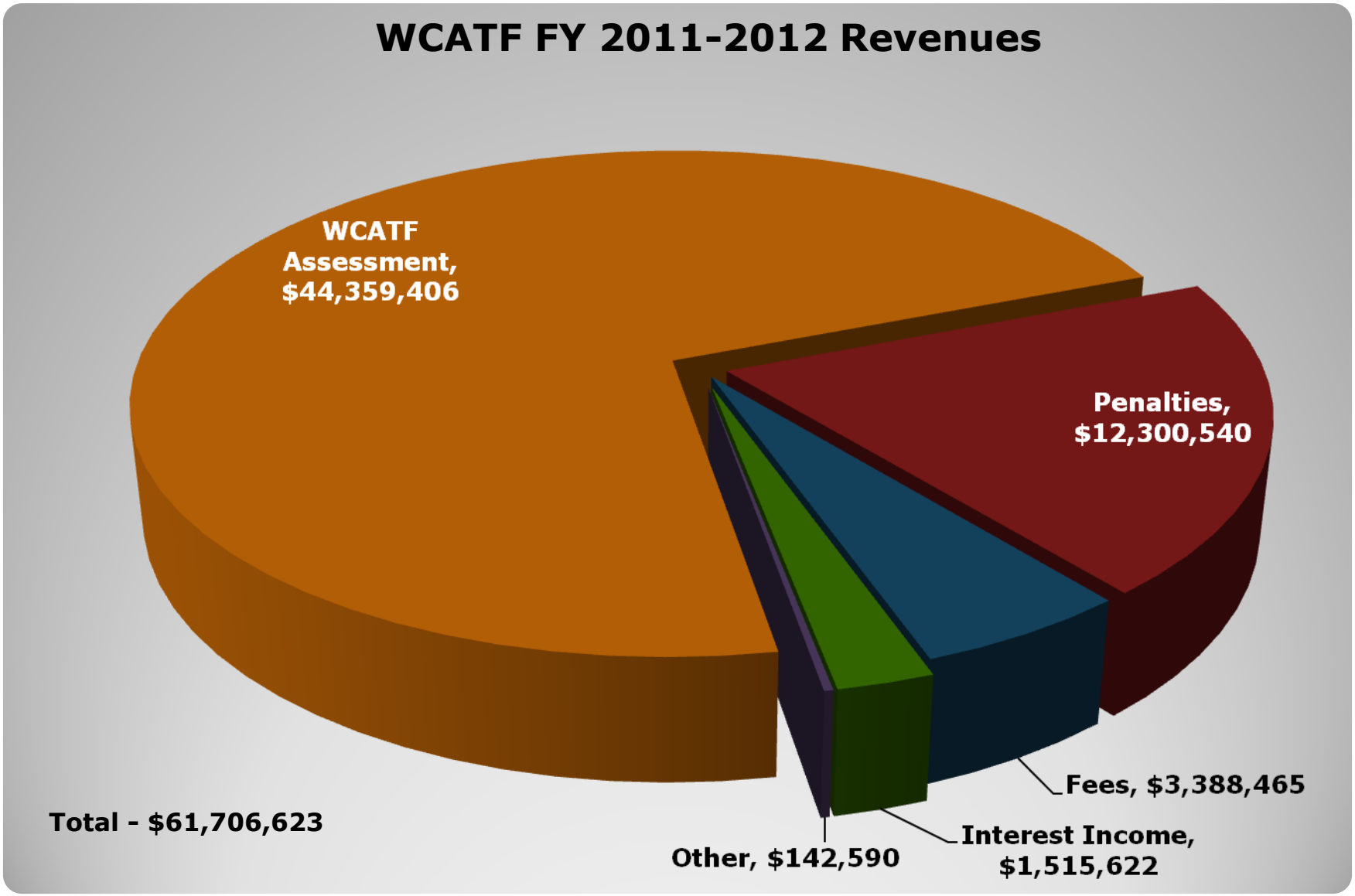
Assessments Unit

The Assessments Unit received a 2012 Davis Productivity Certificate of Commendation for eliminating $13,930 in annual Certified Mail and Return Receipt mail costs by sending Quarterly Premium Reports via receipt email.

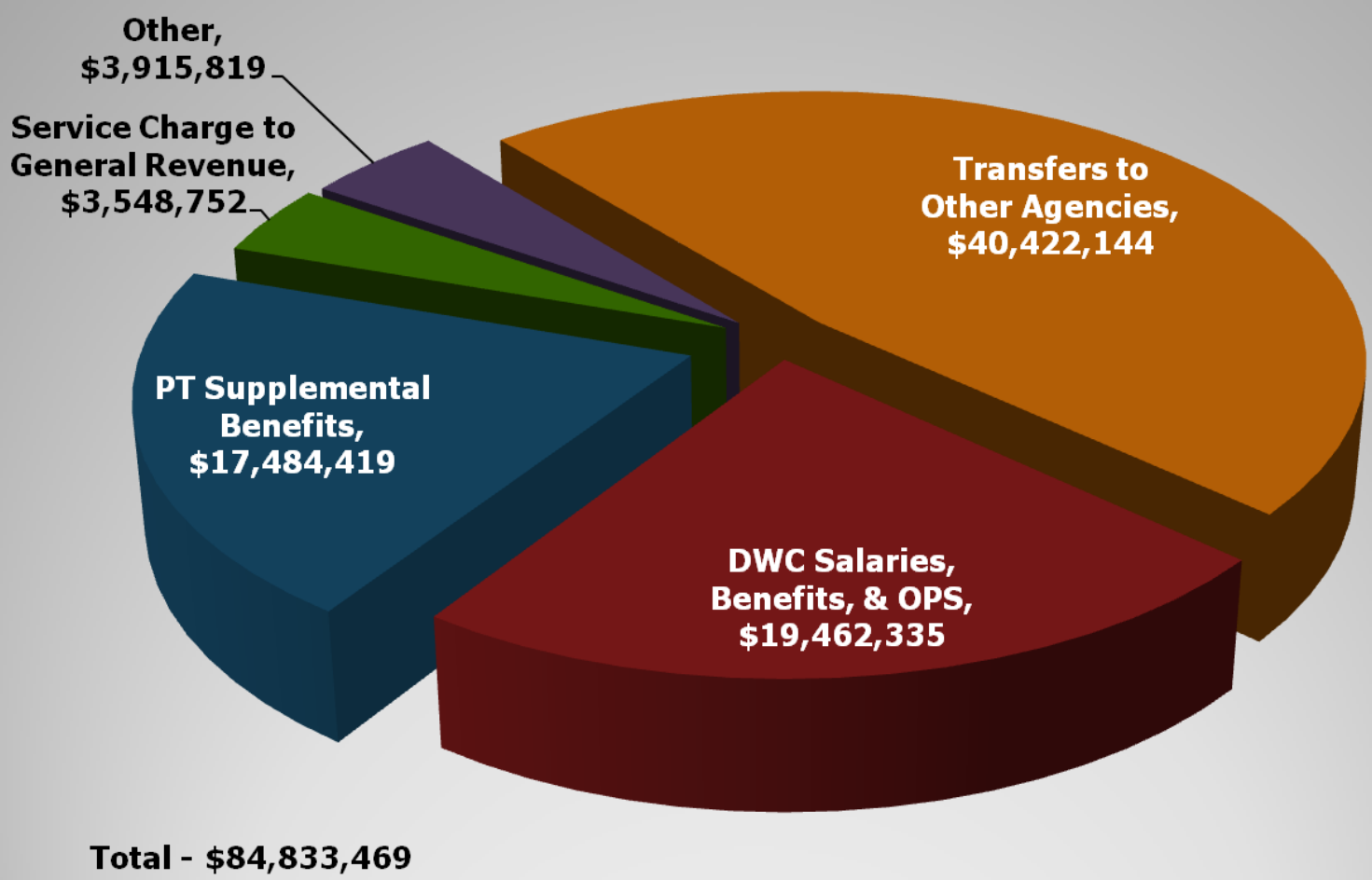
What's Next?

In an effort to improve efficiency and cost effectiveness, the Unit is pursuing opportunities to allow insurance carriers and individual self-insurers to report and pay their assessments on-line.

WCATF FY 2011-2012 Revenues

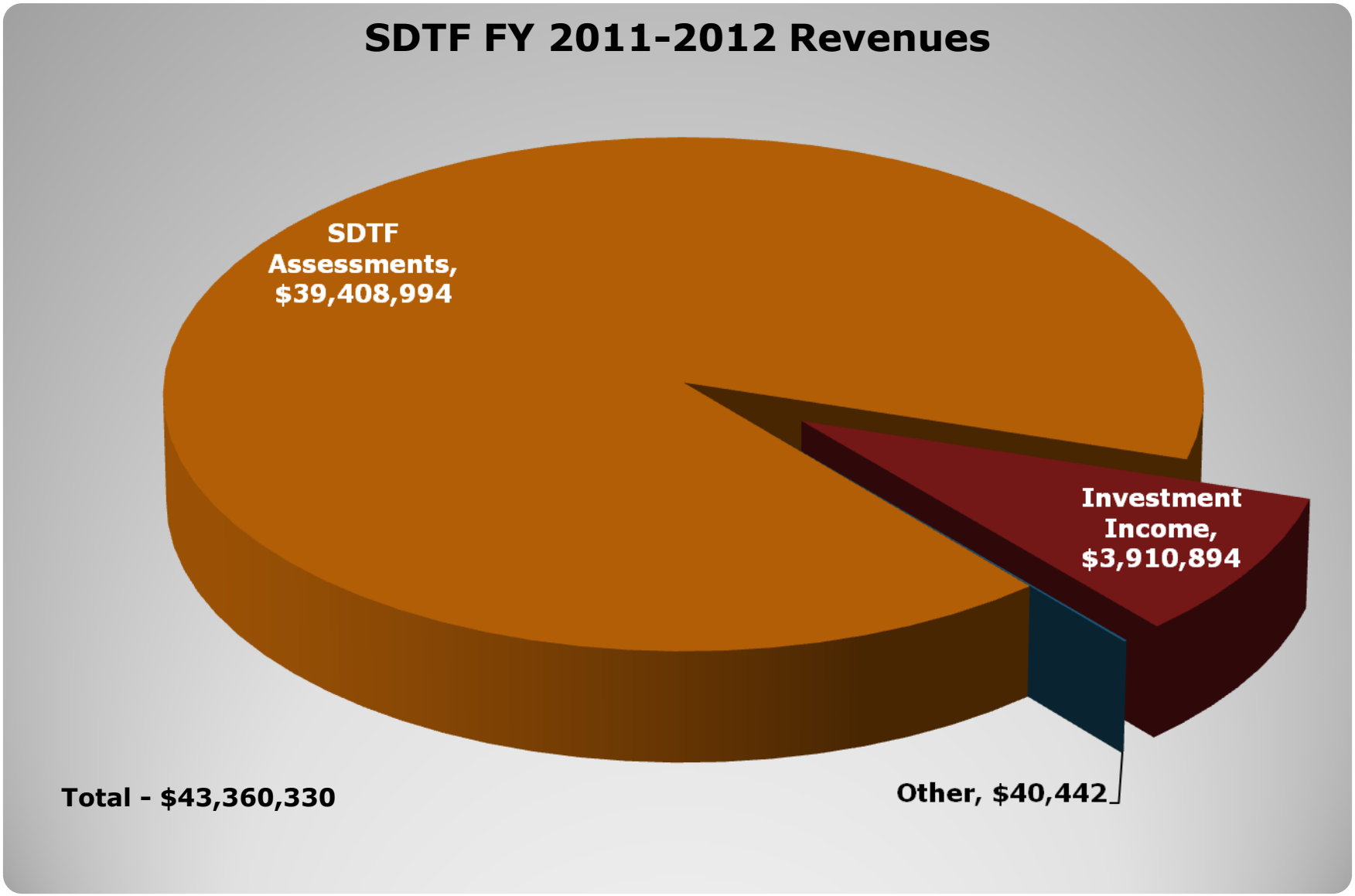


WCATF FY 2011-2012 Expenses

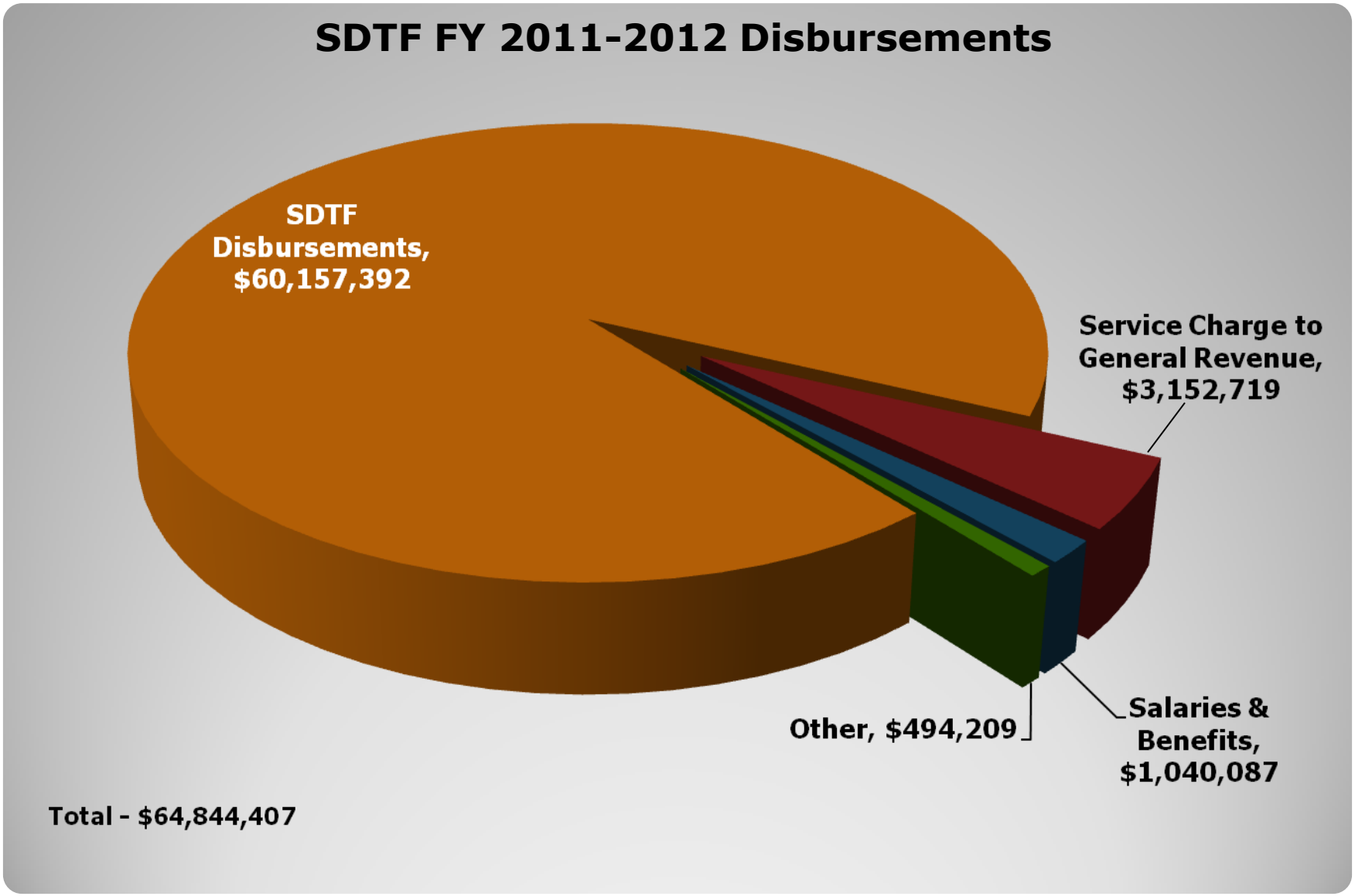


Total - $84,833,469

SDTF FY 2011-2012 Revenues



SDTF FY 2011-2012 Disbursements

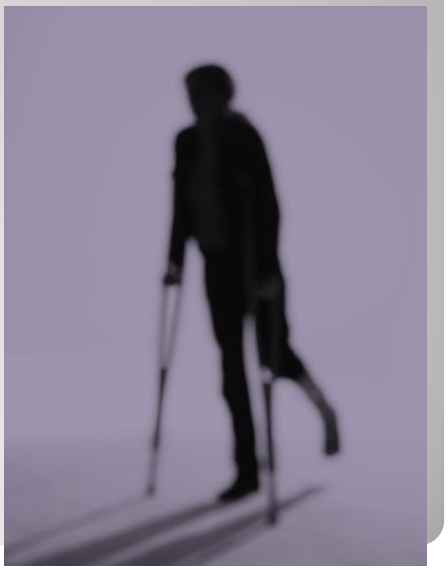


Lost-Time Claims Data

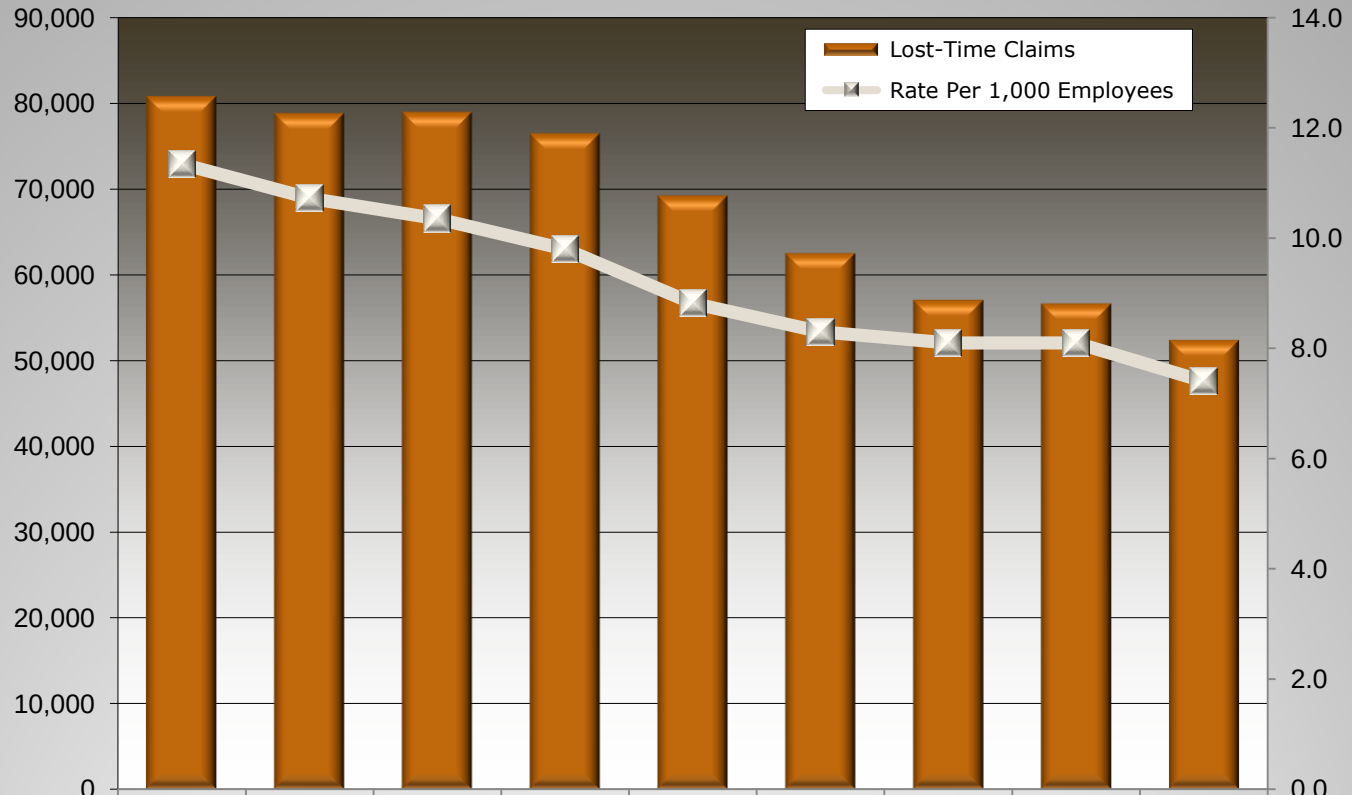
Under Florida's workers' compensation statute, workers sustaining a compensable injury are entitled to receive medically necessary treatment. If the injury results in disability for more than seven days, the injured worker is entitled to payment for a portion of lost wages. Additional benefits are paid for injuries resulting in a permanent impairment. Payment of survivor dependent benefits and funeral expenses may be provided for injuries resulting in workplace fatalities.

Lost-Time Claims Data

The injured worker's prior earnings, the nature and extent of the injury, the length of the healing period, and the worker's ability to return to work are all factors upon which benefit payments for lost wages or permanent impairments depend. If an injured worker's disability results in a benefit payment(s) for lost wages, a permanent impairment, or a settlement, it is considered to be a Lost-Time case.



Lost-Time Claims and Lost-Time Claim Rate**



	2003	2004	2005	2006	2007	2008	2009*	2010*	2011*
Lost-Time Claims	80,705	78,741	78,893	76,362	69,150	62,431	56,964	56,557	52,312
Rate Per 1,000 Employees	11.3	10.7	10.4	9.8	8.8	8.3	8.1	8.1	7.4

*Preliminary data

**Lost-time claim frequencies as of 6/30/12, based on the most recent information from insurers about determinations & dispositions.

Source: DWC Integrated Database as of 6/30/12 & the Agency for Workforce Innovation, 2002-2012 Statewide Quarterly Census of Employment and Wages (excluding federal government employment) released July 2012

Lost-Time Claims Data

Top Ten Industrial Classifications for 2011* Lost-Time Claims	
	Number of Claims
Administrative, Support, Waste Management, Remediation	**6,457**
Retail Trade	**6,444**
Health Care & Social Assistance	**5,180**
Public Administration	**4,838**
Construction	**4,777**
Accommodation & Food Services	**4,506**
Manufacturing	**3,552**
Transportation & Warehousing	**3,320**
Educational Services	**3,105**
Wholesale Trade	**1,753**

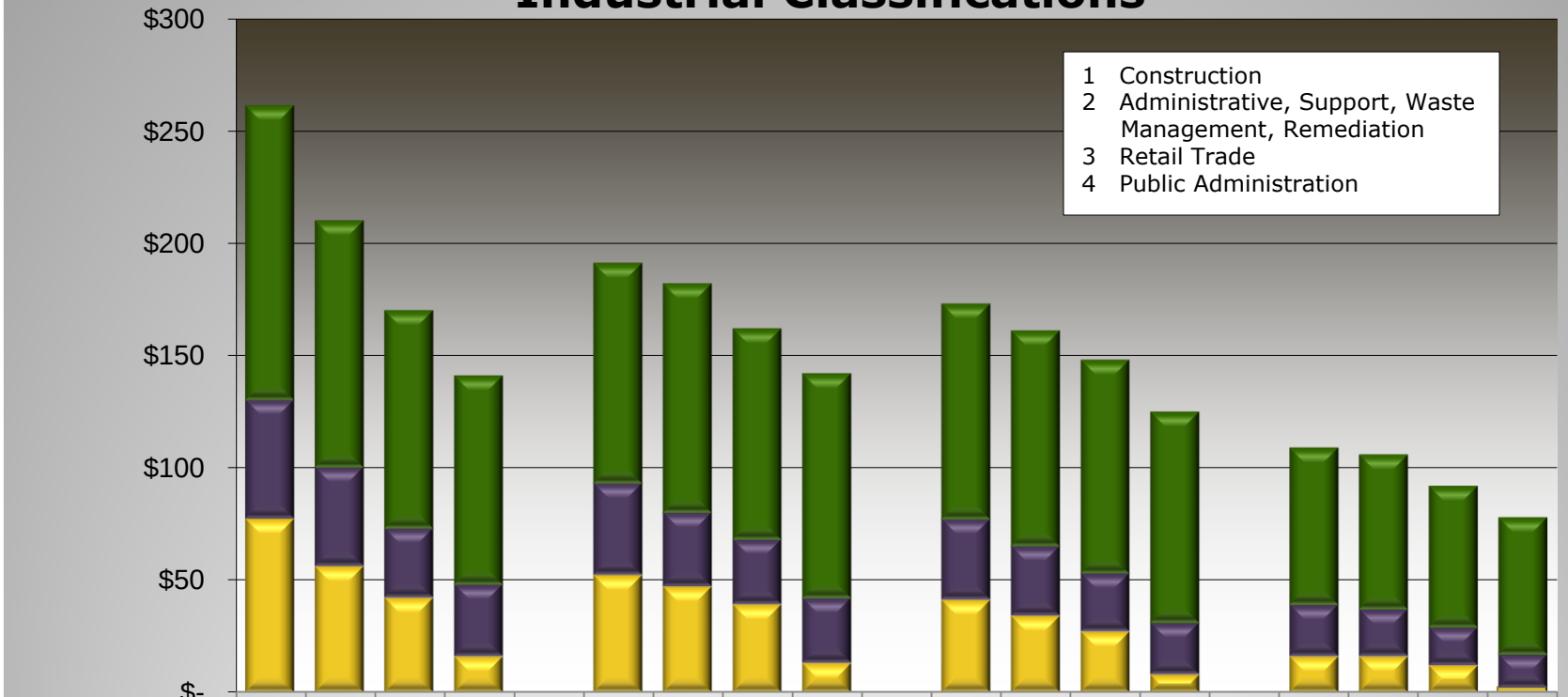
*Preliminary data

Lost-Time Claims Data

The following chart illustrates the total benefit payments for the four industrial classifications whose benefit payments for medical, indemnity, and settlement benefits are the highest. Historically, Construction has consistently incurred the highest benefit payments of all the industrial classifications.

Differences regarding claim development reveal the priority of medical services early in the life of a claim and the increasing importance of settlements as claims progress.

Benefit Payments for the Four Leading Industrial Classifications



	2008				2009*				2010*				2011*			
Injury Yr	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Medical	$131	$110	$97	$93	$98	$102	$94	$100	$96	$96	$95	$94	$70	$69	$63	$61
Indemnity	$53	$44	$31	$32	$41	$33	$29	$29	$36	$31	$26	$23	$23	$21	$17	$15
Settlement	$77	$56	$42	$16	$52	$47	$39	$13	$41	$34	$27	$8	$16	$16	$12	$2

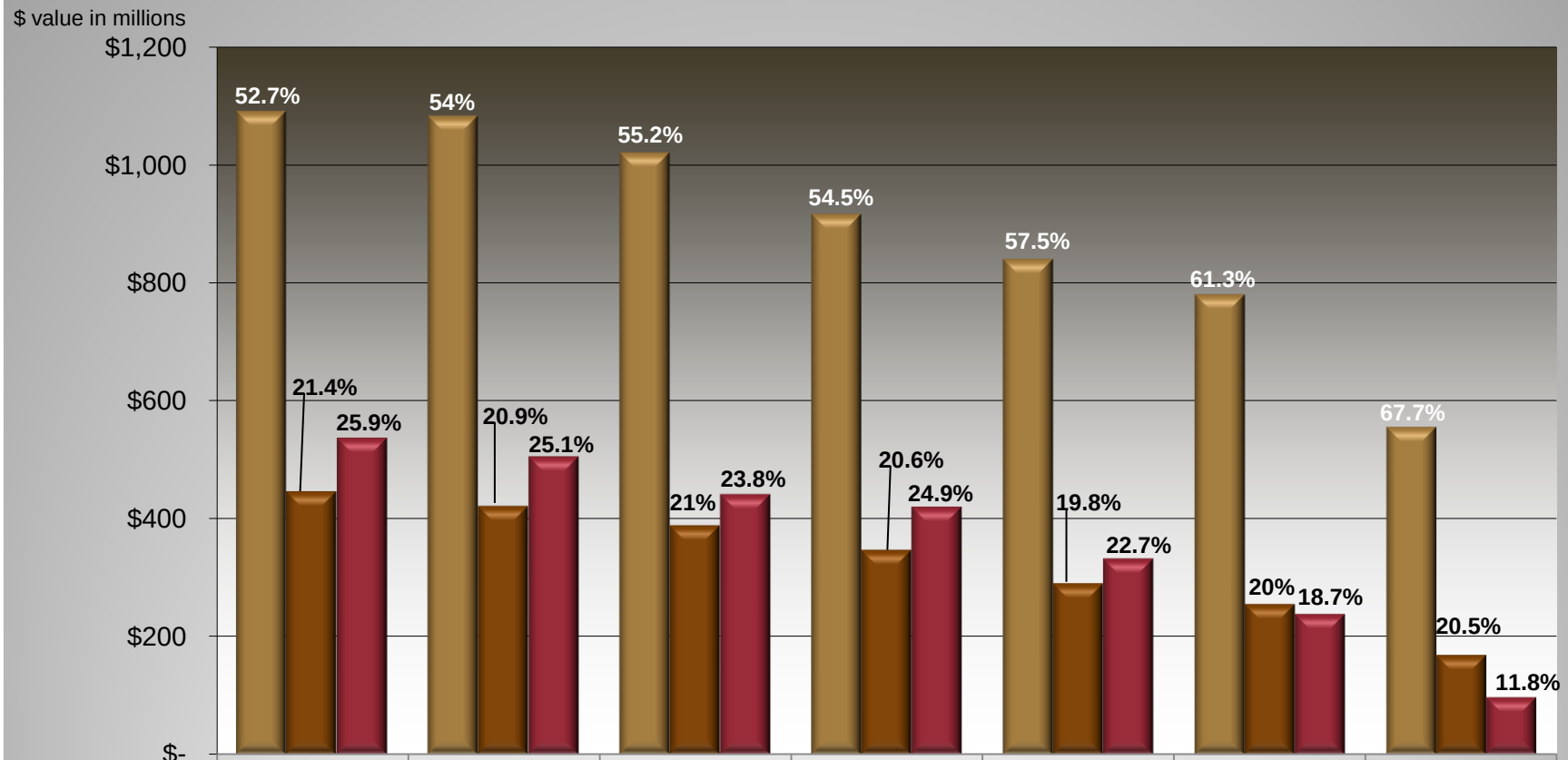
*Preliminary data

Each illustrated year represents a different level of data maturity, with only the earliest year, 2008, deemed mature. This offers a perspective for comparing the impact of claim development on benefit payments.

Lost-Time Claims Data

Treatment for a work-related injury, as deemed medically necessary, may involve services of physicians, physical therapists, chiropractors, dentists, or other health care providers; services of hospitals, ambulatory surgical centers, or skilled nursing facilities; and medicines, supplies, equipment, and related items such as prosthetic devices or implants. Medical benefits continue throughout the period of recovery.

Medical, Indemnity and Settlement Costs for Lost-Time Claims



	2005	2006	2007	2008	2009*	2010*	2011*
Medical	$1,089.5	$1,081.5	$1,019.8	$915.3	$839.1	$779.4	$554.6
Indemnity	$444.0	$419.0	$386.7	$345.0	$289.0	$253.7	$168.2
Settlements	$535.3	$503.4	$439.8	$418.5	$331.3	$237.6	$96.9

*Preliminary data
Amounts unadjusted for inflation

Lost-Time Claims Data

Medical Payments for Lost-Time Claims				
Calendar Year	Health Care Provider, Dental, Ambulatory Surgical Center	Hospital	Pharmacy	All Other Medical
2005	39.8%	34.1%	7.9%	18.2%
2006	39.7%	35.7%	6.9%	17.7%
2007	39.3%	35.2%	6.5%	19.0%
2008	41.2%	34.3%	5.7%	18.8%
2009*	41.8%	35.6%	5.0%	17.6%
2010*	41.7%	36.9%	4.4%	17.0%
2011*	40.4%	39.2%	3.4%	17.0%

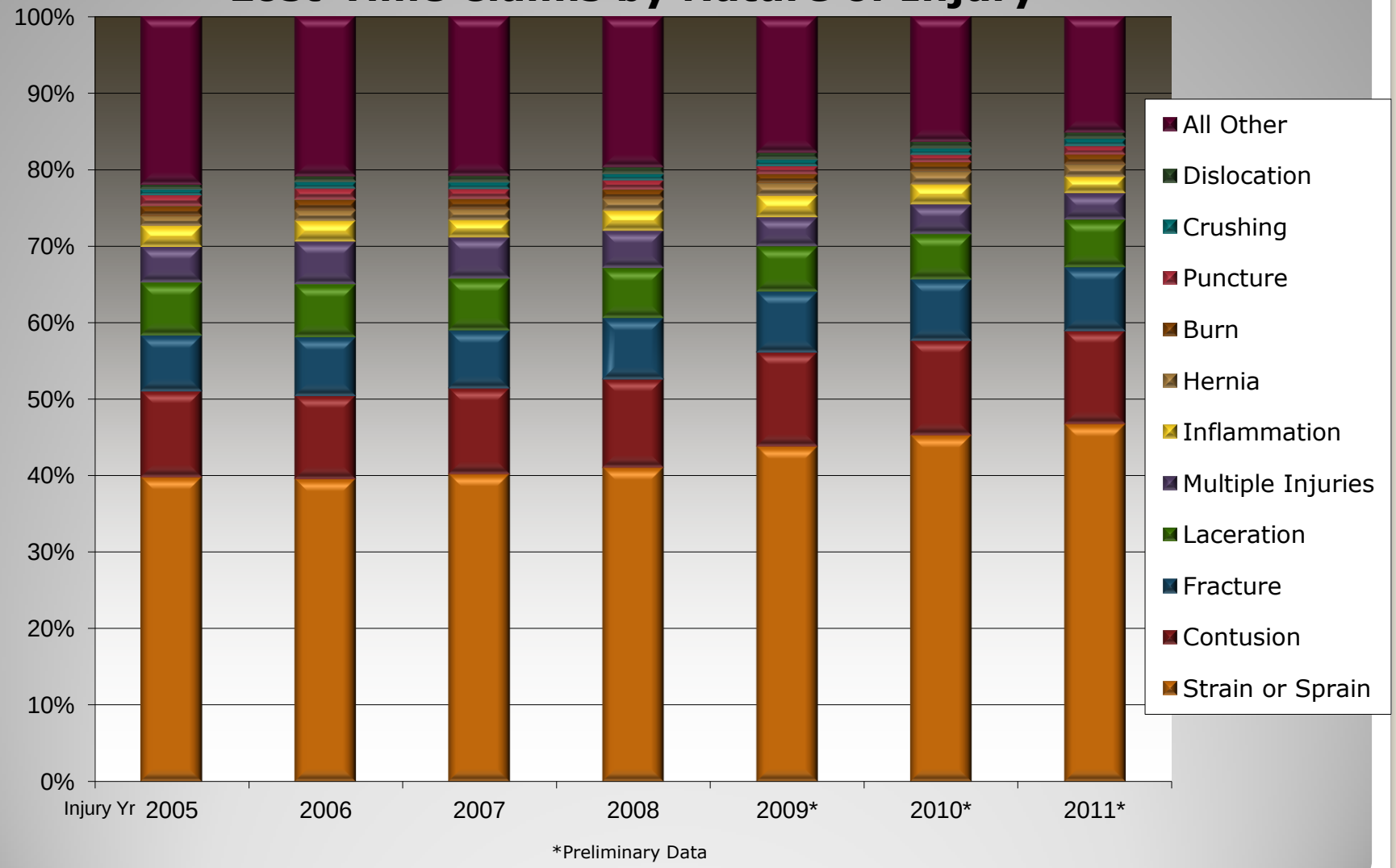
*Preliminary data

Nature, Cause, and Body Location of Injury

As part of the First Report of Injury or Illness, employers or claim administrators provide information on the nature, cause, and body part of each workplace injury. The following charts summarize that information to depict recent and historical patterns of lost-time injuries.

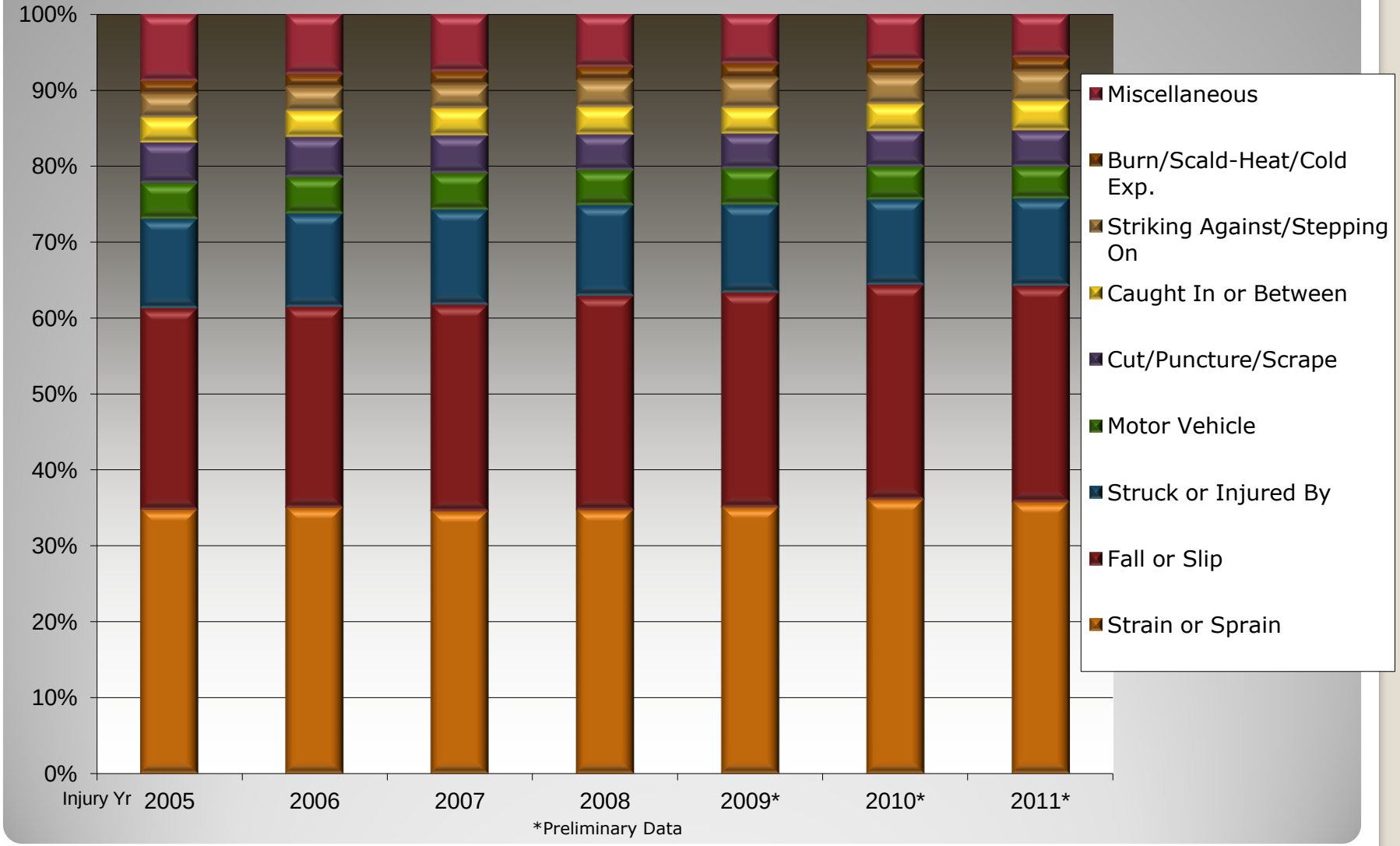
Because the information is reported on the First Report of Injury or Illness, it may not correspond to a diagnosis made by a health care professional. Additionally, the figures may change slightly over time due to preliminary reporting of data.

Lost-Time Claims by Nature of Injury

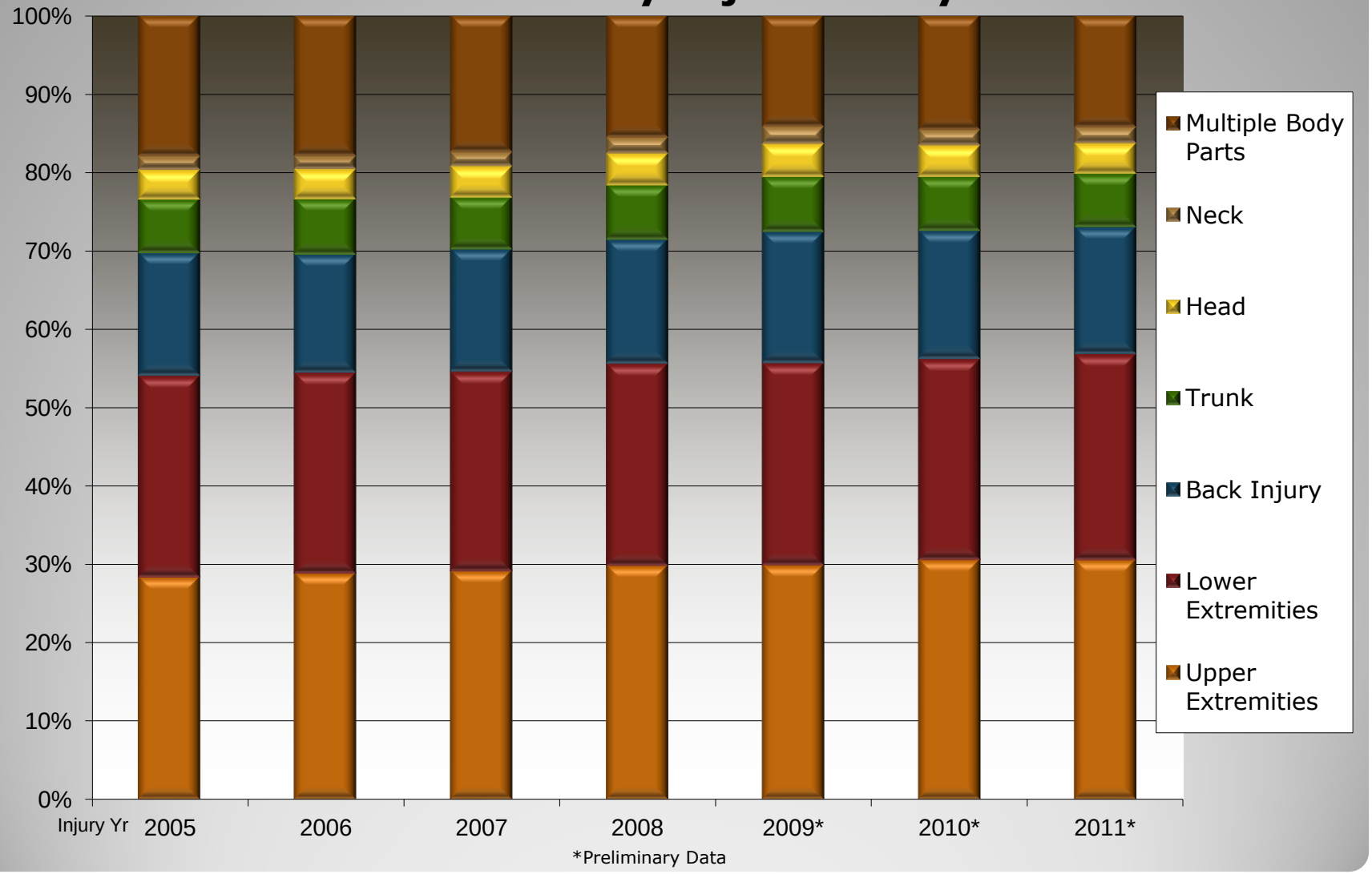


*Preliminary Data

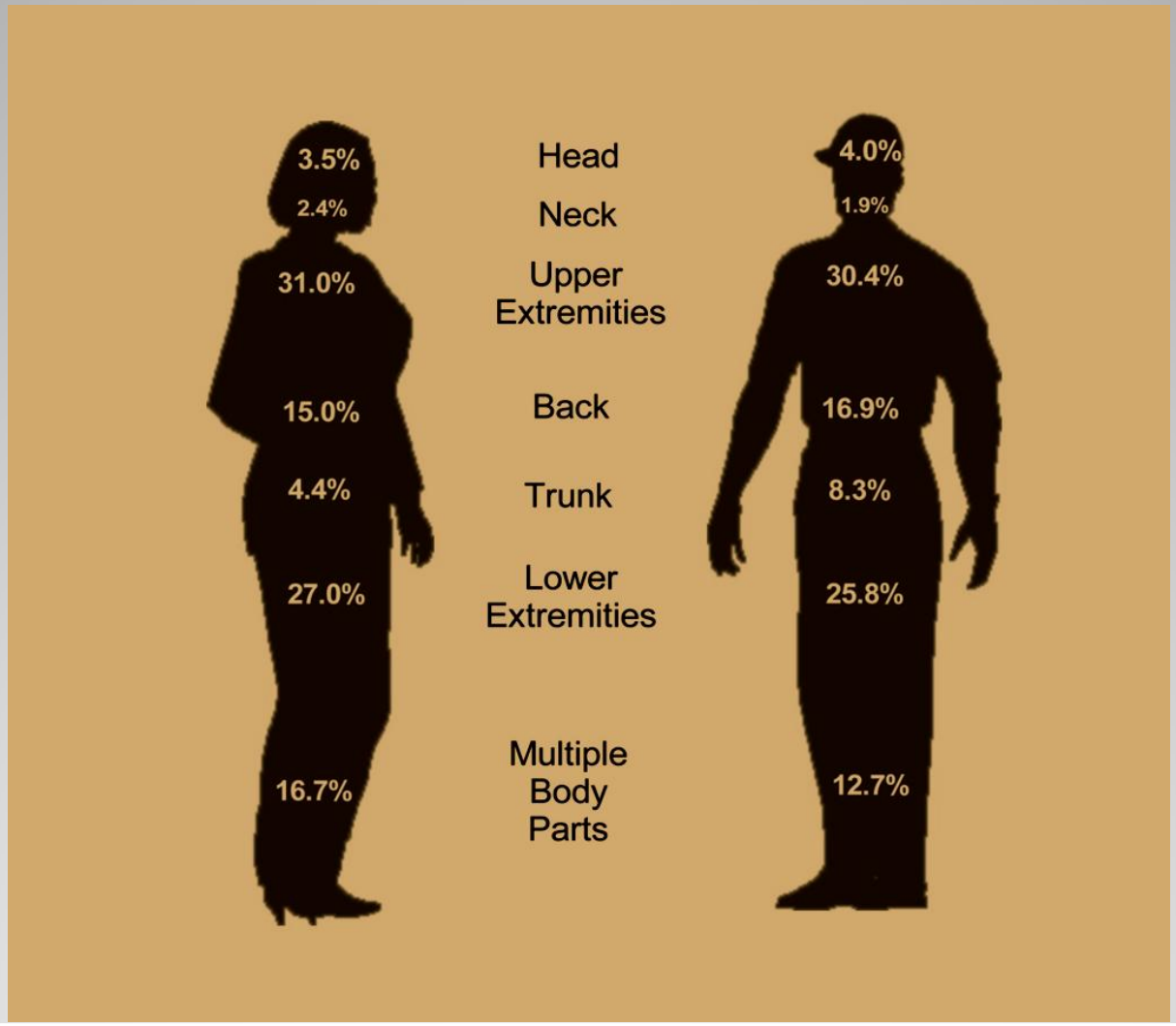
Lost-Time Claims by Cause of Injury



Lost-Time Claims by Injured Body Part



Injury Body Location by Gender for 2011 Lost-Time Claims



Medical Data

The Bureau of Data Quality and Collection receives nearly four million medical bill records each year via electronic submission, which is the largest volume of data electronically received by the Division.

Reporting of medical data begins with a workplace injury that required medical care from a physician, hospital, ambulatory surgical center (ASC), pharmacy, or other health care provider. The providers then submit medical bills to the applicable claim administrator for services rendered using the applicable medical claim forms (or electronic equivalents). The claim administrator or contracted medical bill review vendor adjudicates the medical bill.

Medical Data

Medical bill reimbursement amounts may be based on prices negotiated by the claim administrator, managed care contracts, or the maximum reimbursement allowance contained in reimbursement manuals adopted by the Three-Member Panel.

Prescription reimbursement amounts are based on prices negotiated by the claim administrator, managed care contracts, or the statutory formula contained in Chapter 440, Florida Statutes.

Adjudication results and information about the medical services provided are transmitted via proprietary electronic formats to the Division, as required by administrative rule.

Medical Data

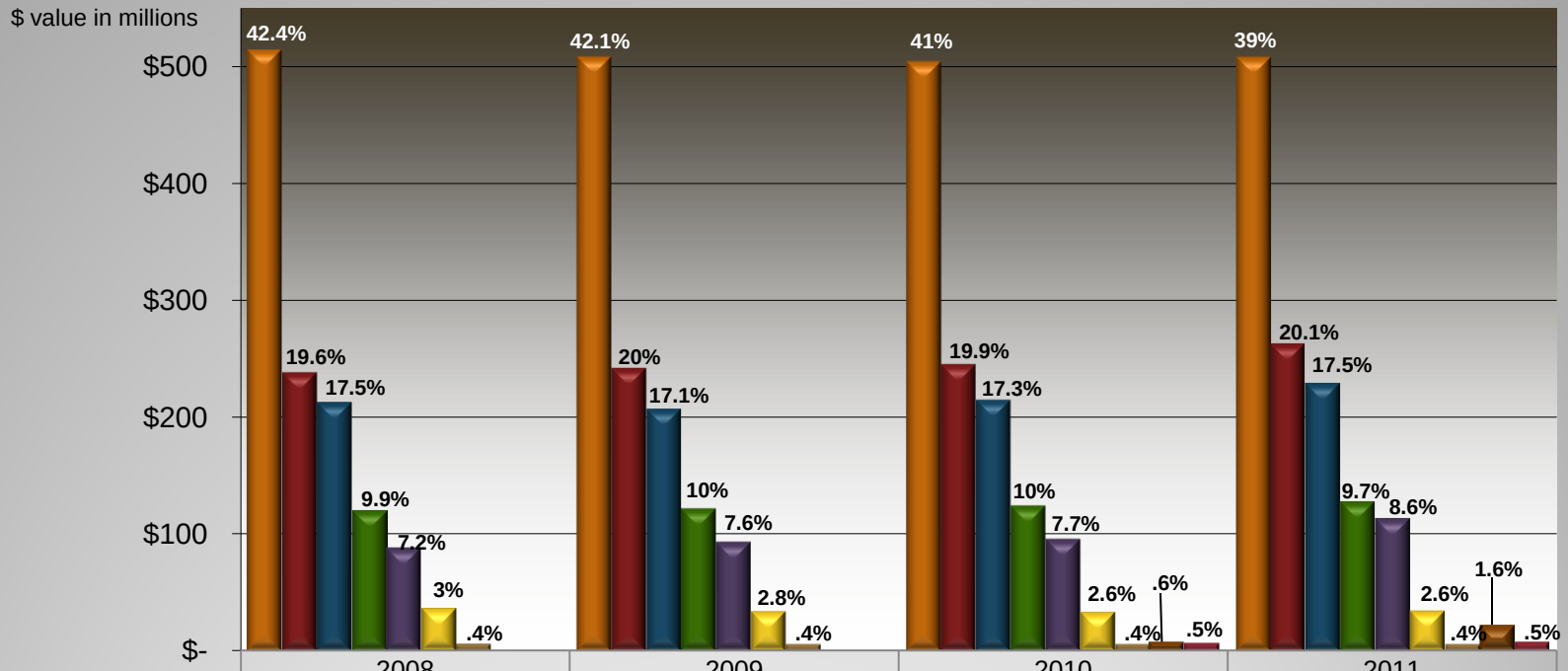
When medical bills are received, the Division screens them by applying hundreds of edits that reject bills that do not meet Division requirements. The submitter is notified immediately if the submitted bill failed the edits and subsequently rejected. Rejected medical bills are not considered timely filed until corrected, re-submitted, and accepted by the Division.

Medical Data

The following charts pertain to both lost-time and medical only claims. Data aggregation is by calendar year of the date of service, rather than injury year. The data for each year is restricted to medical bills received and accepted by the Division no later than six months after the end of that year.

Payment totals may differ in comparison to previous Annual Reports data due to payment disputes being resolved or adjustments to previously submitted medical bill data.

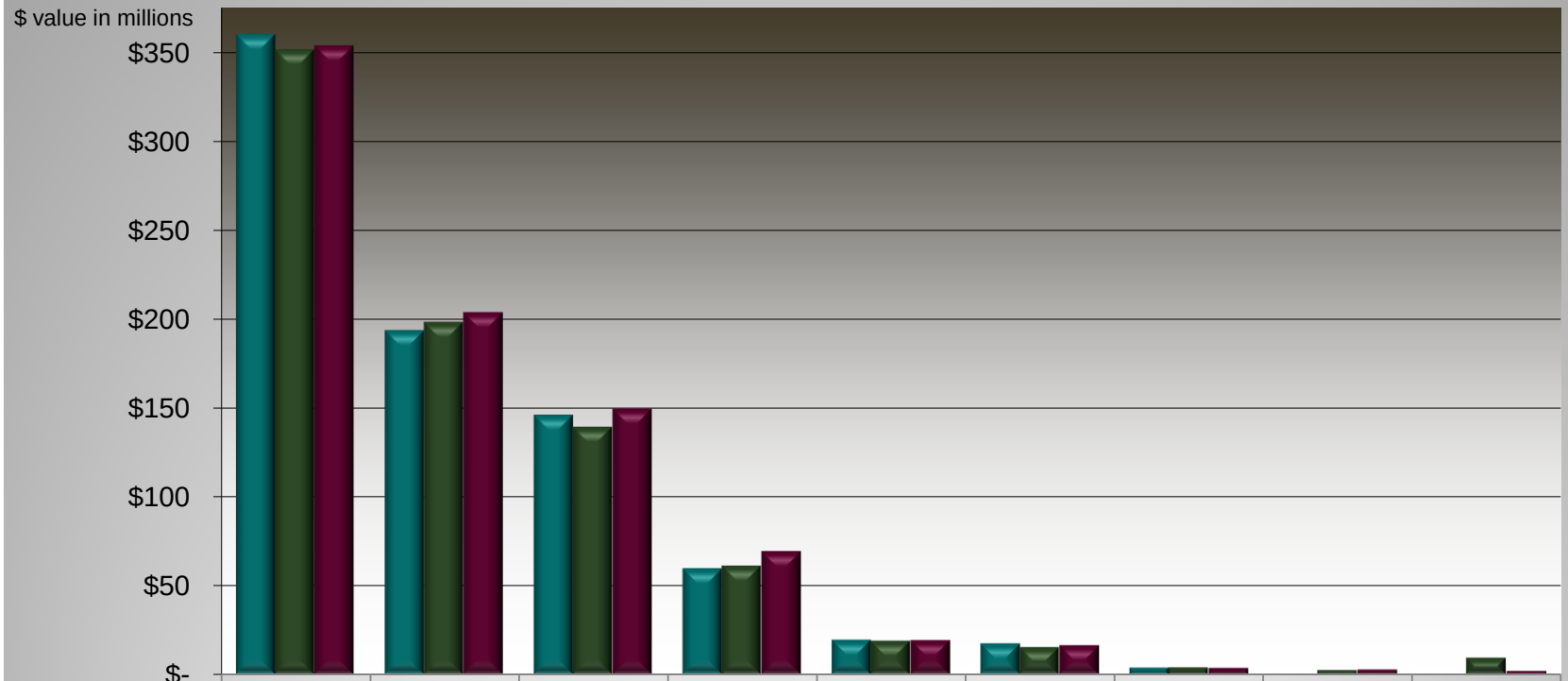
Medical Payments* by Cost Type and Distribution



	2008	2009	2010	2011
Health Care Provider	$513.60	$507.80	$503.80	$507.40
Hospital Outpatient	$237.60	$241.50	$244.70	$262.10
Hospital Inpatient	$211.90	$206.30	$213.80	$228.10
Pharmacy	$119.50	$120.50	$122.90	$126.50
Ambulatory Surgical Center	$86.90	$92.01	$94.20	$111.70
Medical Supplies	$36.00	$33.30	$32.60	$33.70
Dental	$5.20	$4.80	$4.90	$4.90
Home Health Services	n/a	n/a	$7.40	$20.80
Nursing Home	n/a	n/a	$5.60	$6.50

*Excludes bills received beyond six months of the end of the calendar year of service.

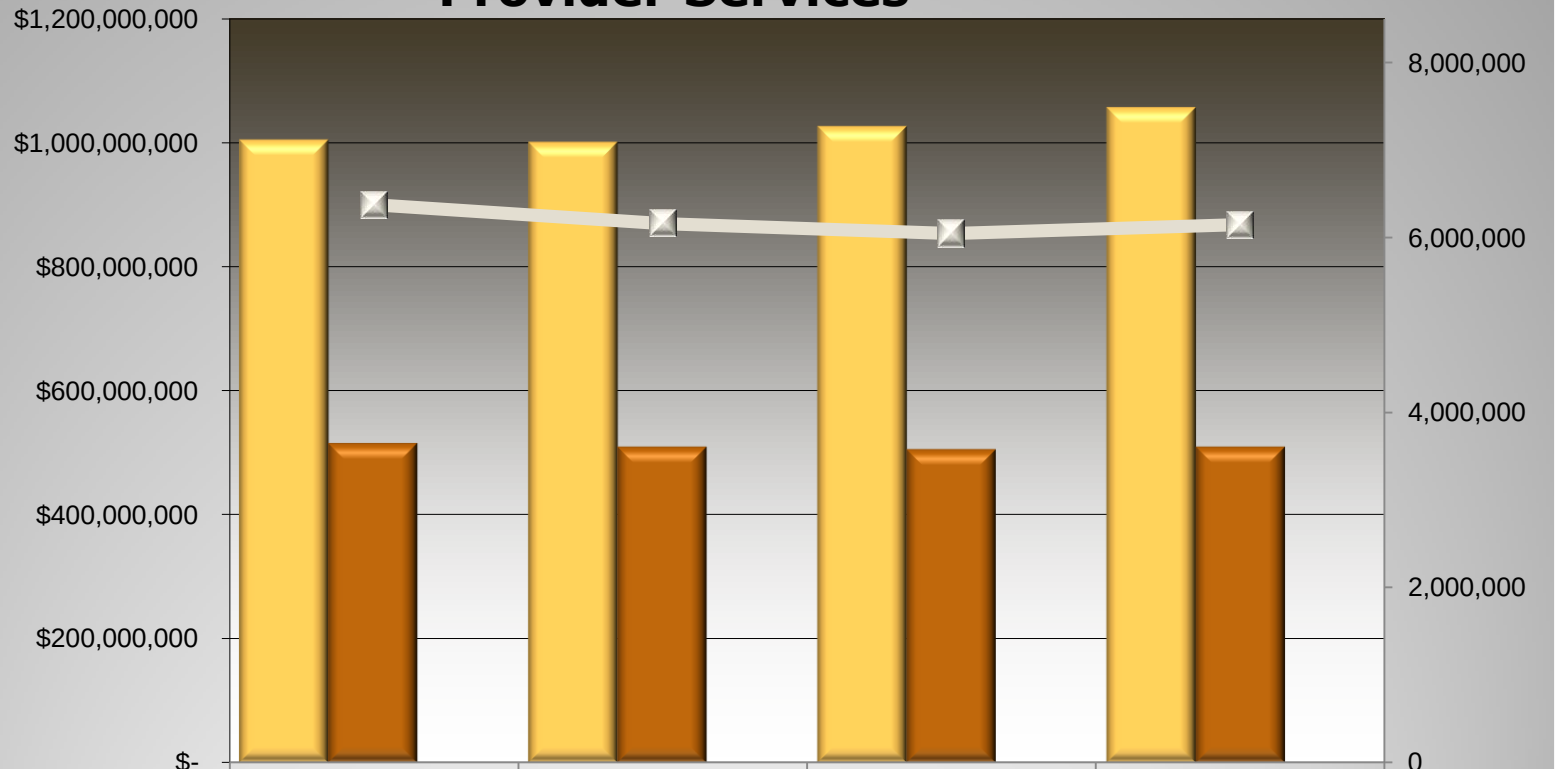
Total Medical Paid* for Services Provided Within 12 Months of Injury



Injury Yr	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental	Home Health Services	Nursing Home
2008	$359.7	$193.4	$145.9	$59.7	$19.5	$17.5	$3.8	n/a	n/a
2009	$351.1	$198.0	$139.1	$61.2	$19.0	$15.4	$4.0	$2.5	$9.5
2010	$353.6	$203.7	$149.5	$69.3	$19.3	$16.5	$3.7	$2.8	$2.0

*Excludes bills received beyond six months of the end of the calendar year of service.

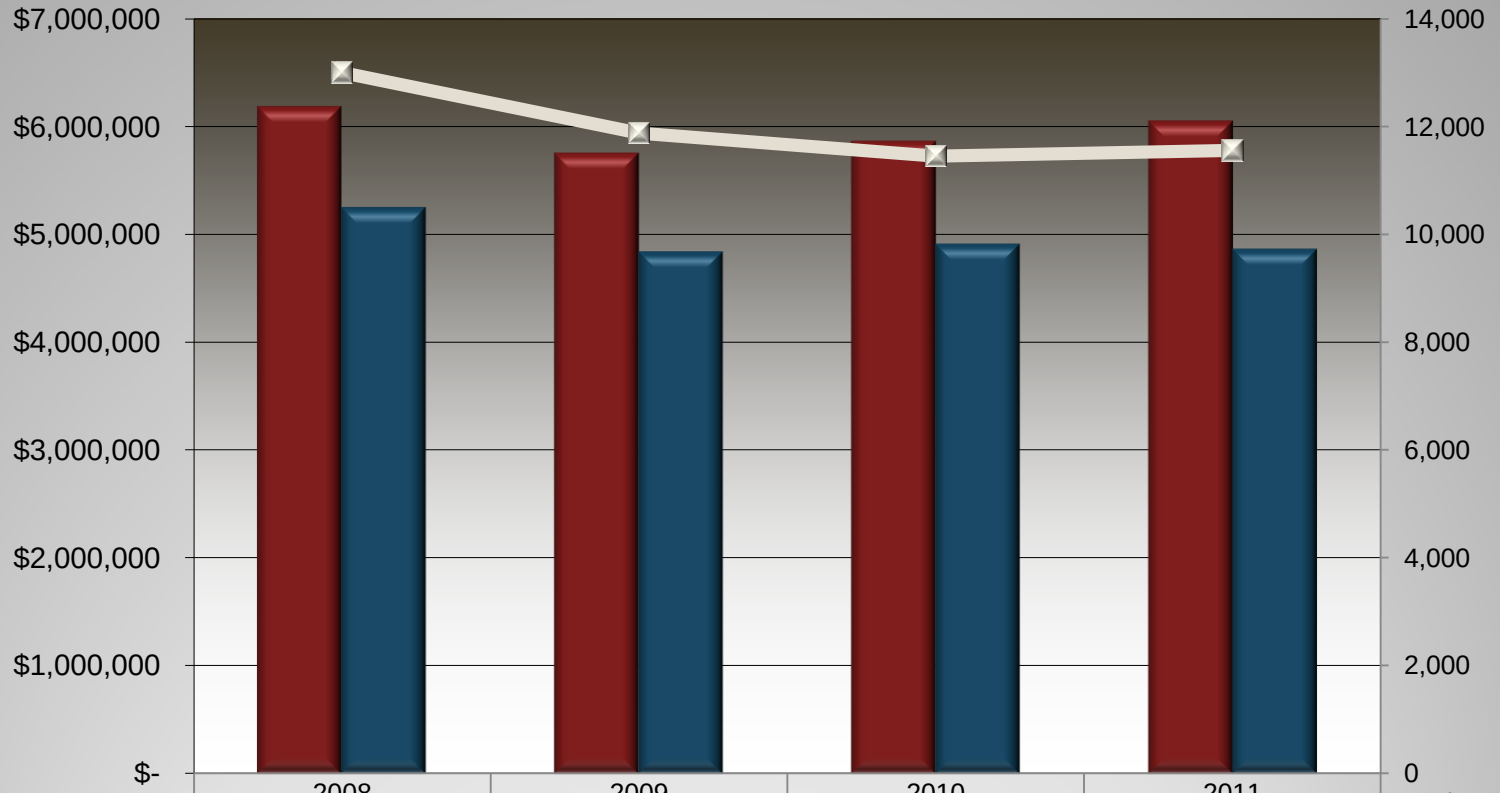
Total Charges and Total Paid for Health Care Provider Services



	2008	2009	2010	2011
Charges	$1,003,799,370	$1,000,184,934	$1,025,182,236	$1,055,728,682
Paid	$513,550,424	$507,815,029	$503,773,398	$507,424,729
Avg Charge/Per Line Item	$157.48	$162.37	$169.62	$171.77
Avg Paid/Per Line Item	$80.57	$82.44	$83.35	$82.56
Total Line Items	6,374,162	6,159,786	6,044,068	6,146,296

Note: Only bills with payment amount >$0 are included. Prescription drugs & supplies are included when dispensed by a health care provider.

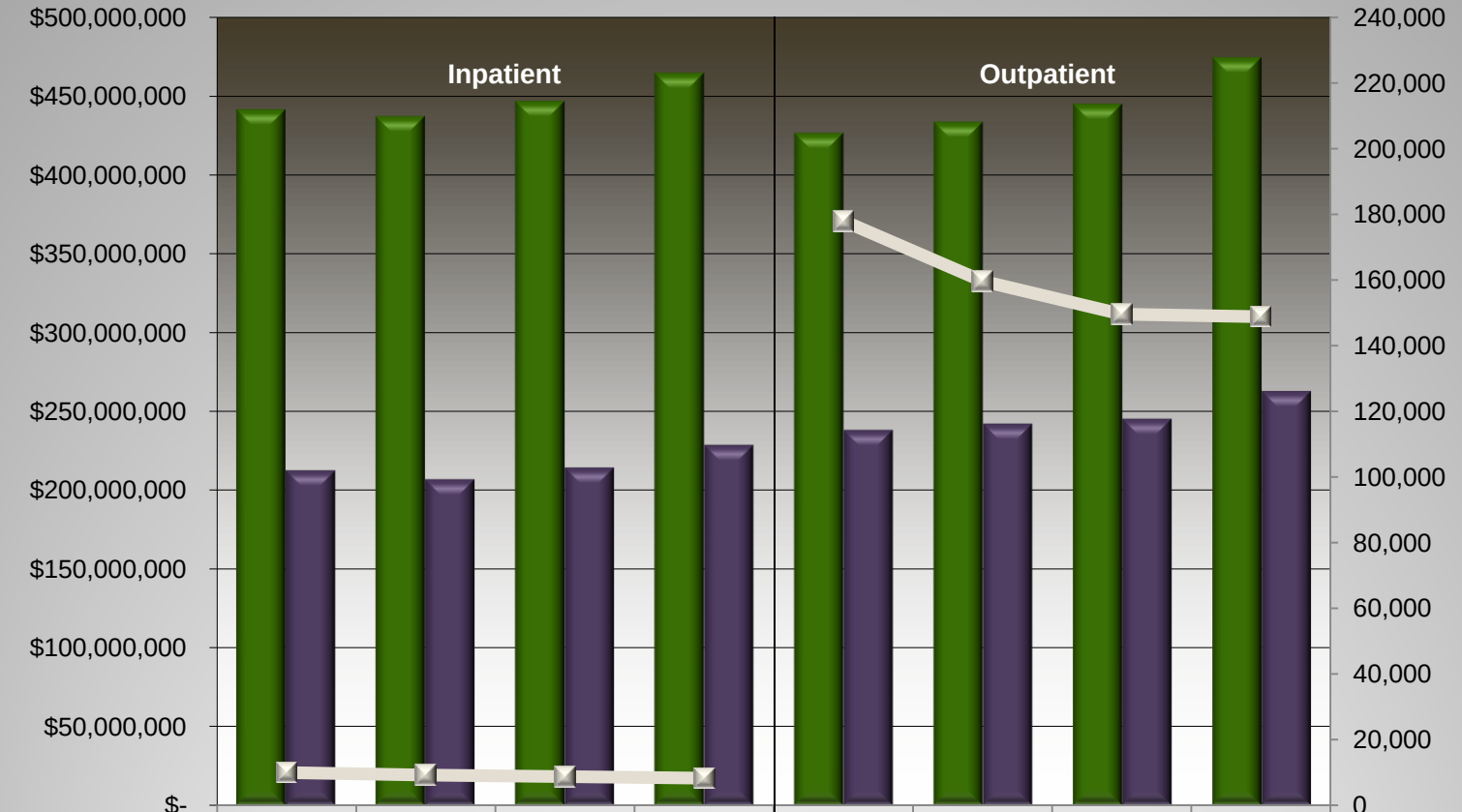
Total Charges and Total Paid for Dental Services



	2008	2009	2010	2011
Charges	$6,177,335	$5,744,138	$5,856,300	$6,040,963
Paid	$5,246,847	$4,837,921	$4,909,270	$4,860,450
Avg Chg Per Line Item	$475	$483	$511	$523
Avg Paid Per Line Item	$404	$407	$429	$420
Total Line Items	13,002	11,882	11,453	11,559

Note: Only bills with payment amount >$0 are included.

Total Charges and Total Paid by Hospital Bill Type



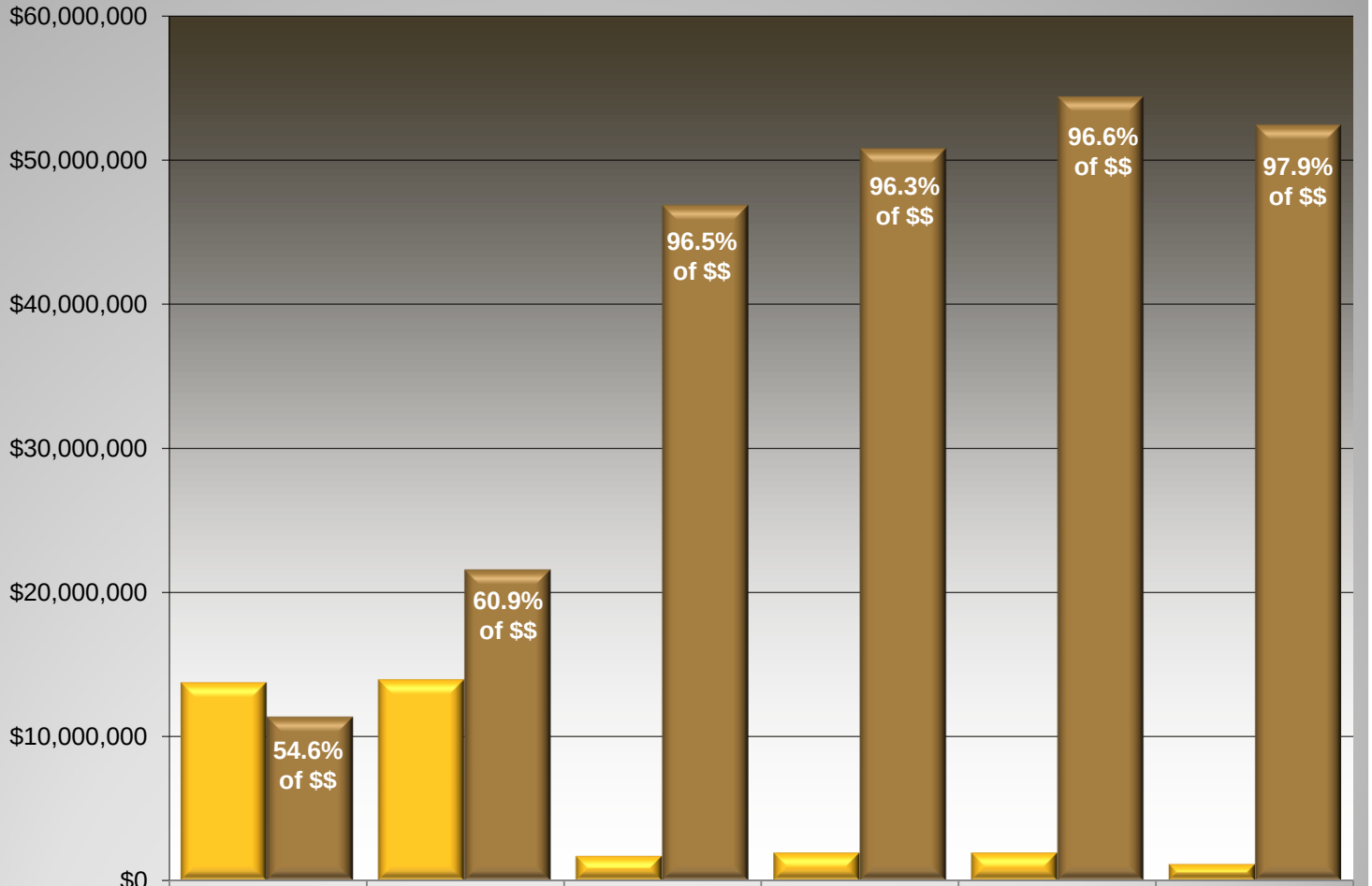
	Inpatient				Outpatient			
	2008	2009	2010	2011	2008	2009	2010	2011
Charges	$441,411,615	$437,028,262	$446,642,882	$464,565,741	$426,387,875	$433,460,408	$444,854,330	$474,421,498
Paid	$211,855,514	$206,266,586	$213,791,230	$228,064,193	$237,586,284	$241,520,183	$244,640,002	$262,085,591
Avg Charge/Bill	$44,610	$47,544	$51,356	$56,304	$2,396	$2,715	$2,974	$3,188
Avg Paid/Bill	$21,410	$22,440	$24,582	$27,641	$1,335	$1,513	$1,635	$1,761
Total Bills	9,895	9,192	8,697	8,251	177,938	159,671	149,598	148,809

Note: Only bills with payment amount >$0 are included.

Medical Data

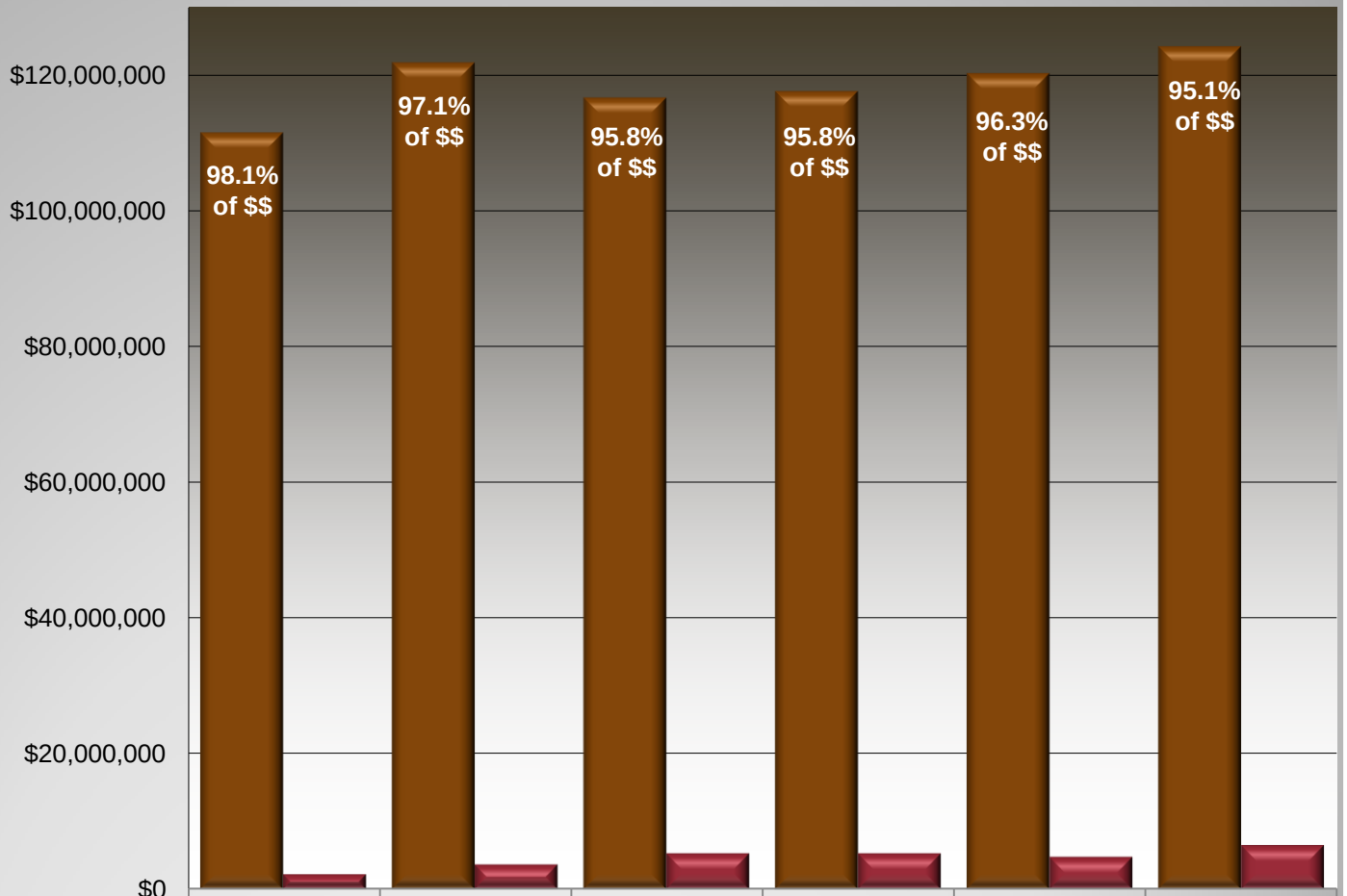
The following three charts compare drugs billed on DWC-10 forms (dispensed by pharmacies) to drugs billed on DWC-9 forms (dispensed by physicians). The reference to each line item also means per prescription.

Pharmacy vs. Physician Repackaged Drug Payments



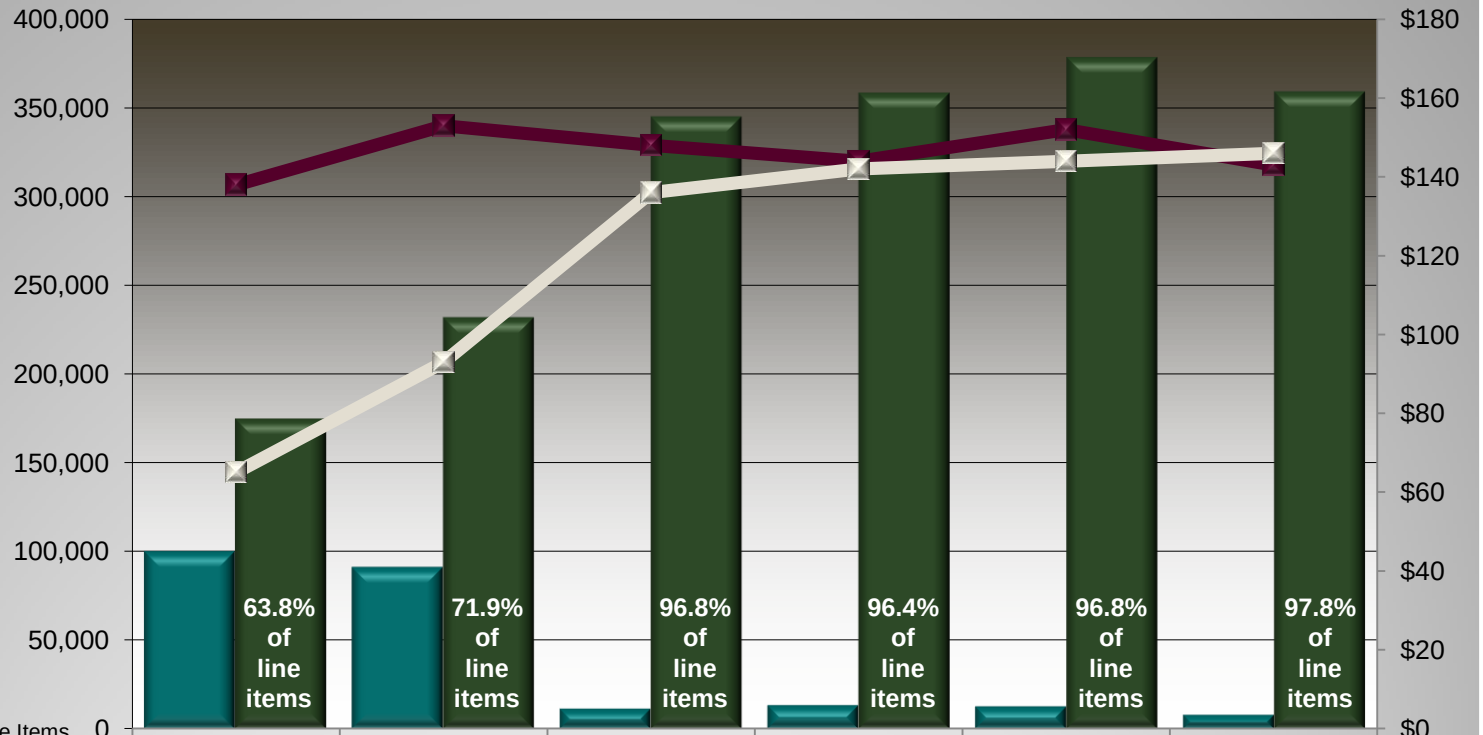
	2006	2007	2008	2009	2010	2011
Pharmacy Repackaged Total Payments	$13,668,058.84	$13,871,993.50	$1,689,552.89	$1,929,485.82	$1,927,952.07	$1,133,483.99
Physician Repackaged Total Payments	$11,359,962.38	$21,565,750.37	$46,834,571.96	$50,754,717.87	$54,357,929.06	$52,400,461.43

Pharmacy vs. Physician Nonrepackaged Drug Payments



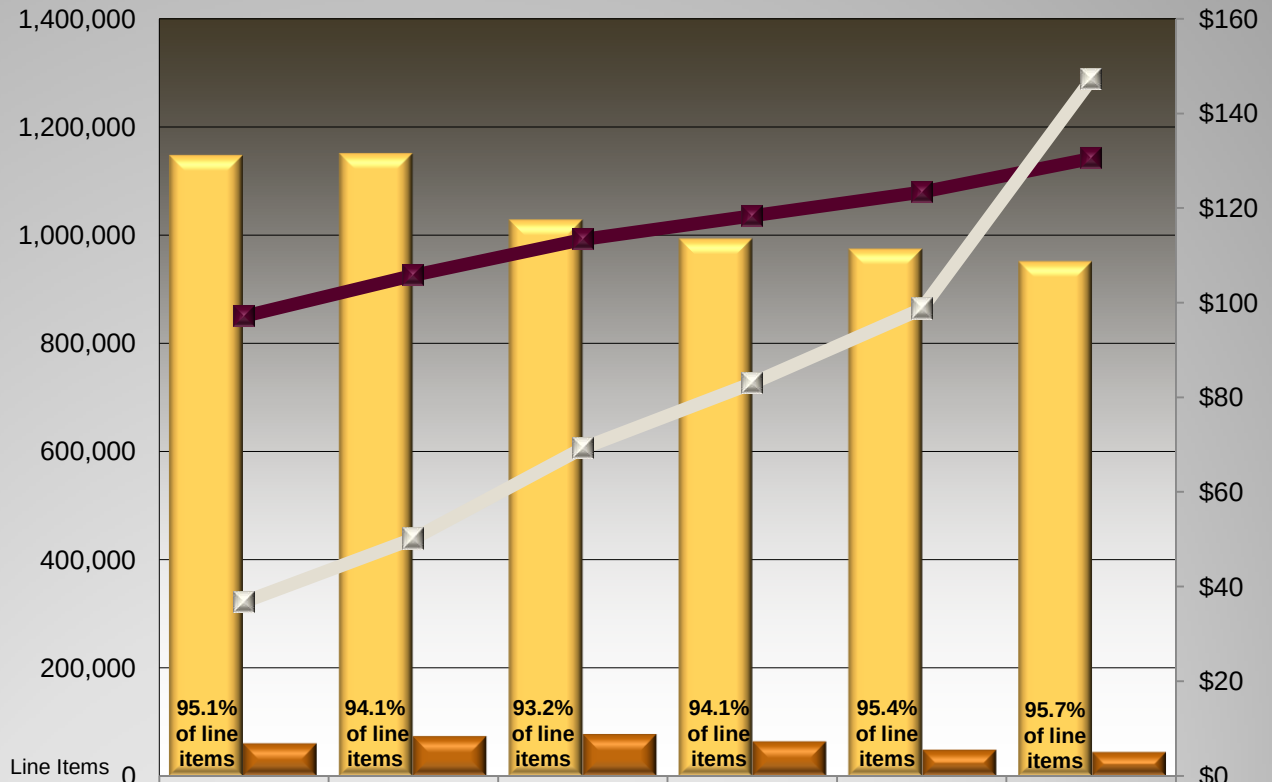
	2006	2007	2008	2009	2010	2011
Pharmacy Nonrepackaged Total Payments	$111,330,312.34	$121,632,090.71	$116,463,276.45	$117,428,303.46	$120,067,745.04	$123,998,513.22
Physician Nonrepackaged Total Payments	$2,149,796.11	$3,581,951.08	$5,169,333.97	$5,143,651.86	$4,640,892.98	$6,344,811.09

Pharmacy vs. Physician Repackaged Drugs



	2006	2007	2008	2009	2010	2011
Pharmacy Repackaged Line Items	99,245	90,498	11,378	13,372	12,685	7,901
Physician Repackaged Line Items	174,816	231,793	344,793	358,036	378,233	358,912
Pharmacy Repackaged Avg $ Paid per Line Item	$138.00	$153.00	$148.00	$144.00	$152.00	$143.00
Physician Repackaged Avg $ Paid per Line Item	$65.00	$93.00	$136.00	$142.00	$144.00	$146.00

Pharmacy vs. Physician Nonrepackaged Drugs



	2006	2007	2008	2009	2010	2011
Pharmacy Nonrepackaged Line Items	1,146,410	1,149,801	1,027,169	992,262	973,336	950,222
Physician Nonrepackaged Line Items	58,542	71,459	74,631	61,981	47,018	43,103
Pharmacy Nonrepackaged Avg Paid Per Line Item	$97.11	$105.79	$113.38	$118.34	$123.36	$130.49
Physician Nonrepackaged Avg Paid Per Line Item	$36.72	$50.13	$69.27	$82.99	$98.70	$147.20

DWC Contacts

Director's Office: (850) 413-1600
Tanner Holloman, Director
Andrew Sabolic, Assistant Director

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Stephen Yon, Bureau Chief

Bureau of Compliance: (850) 413-1609
Robin Delaney, Bureau Chief

Bureau of Monitoring and Audit: (850) 413-1608
Pam Macon, Bureau Chief

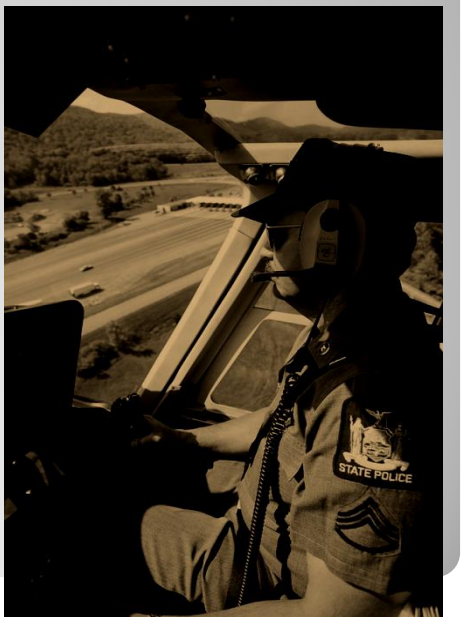
Bureau of Data Quality and Collection: (850) 413-1607
Linda Yon, Bureau Chief

DWC Contacts

Special Disability Trust Fund: (850) 413-1604
Kelly Fitton, Manager

Assessments:(850) 413-1753
Mark Reichmuth, Assessments Unit Supervisor

Office of Medical Services:(850) 413-1608
Eric Lloyd, Program Administrator



DWC Hotlines

Hotlines:

Reporting Deaths: (800) 219-8953

Compliance Fraud Referral Hotline: (800) 742-2214

Employee Assistance Office Hotline: (800) 342-1741

Customer Service Center: (850) 413-1601

DWC Website Information

Contact information for Bureau of Compliance and Bureau of Employee Assistance and Ombudsman District Offices may be found on the Division's website at:
http://www.myfloridacfo.com/wc/dist_offices.html

The Division of Workers' Compensation website home page is located at:
http://myfloridacfo.com/wc and provides direct information access for all stakeholders in the Workers' Compensation System. The website organizes items of interest by stakeholder group with tabs for Employer, Insurer, Employee, and Provider.