Florida Division of Workers' Compensation 2014 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 Our Stakeholders in the Florida Workers' Compensation System:

In the ongoing effort to achieve effective and efficient regulation and provide for a self-executing Florida Workers' Compensation System, the Division of Workers' Compensation continuously strives for improvement that will benefit all stakeholders. In its third year, the *"Results and Accomplishments Report"* was developed in an effort to provide meaningful workers' compensation data.

Our recommendations and modernization efforts of the Florida Workers' Compensation System were again successful during the 2014 legislative session. The passage of HB 271 included revisions to the release of stop-work orders, penalty calculations, and a simplified assessment rate calculation for the Special Disability Trust Fund (SDTF) similar to the assessment rate calculation for the Workers' Compensation Administration Trust Fund (WCATF). Employers that are issued a stop-work order now have a means to return to work sooner and in some cases are eligible for a credit against their statutory penalty based on the initial premium payment. In addition to changes in the formula for calculating the SDTF assessment rate, the law provided for the release of approximately $27 million dollars, in claim reimbursements, to carriers without affecting the 2015 rate.

Looking forward, the Division will continue to identify opportunities for meaningful improvement and welcomes any comments and suggestions relative to this report and the overall performance of the Division.

Sincerely,

Tanner Holloman

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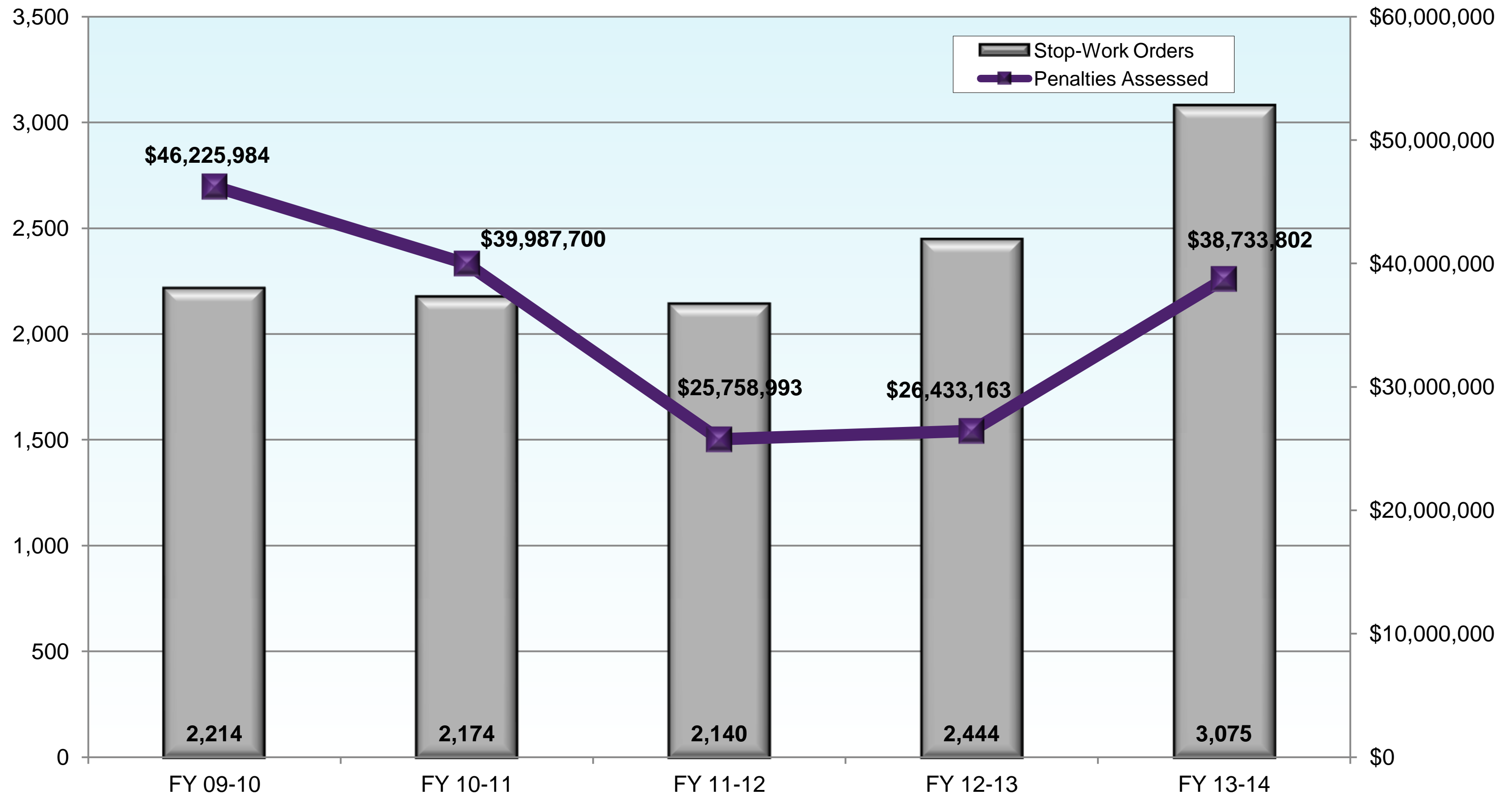
Note: All data contained herein were extracted from the Division of Workers' Compensation resources as of 6/30/14, unless otherwise noted.

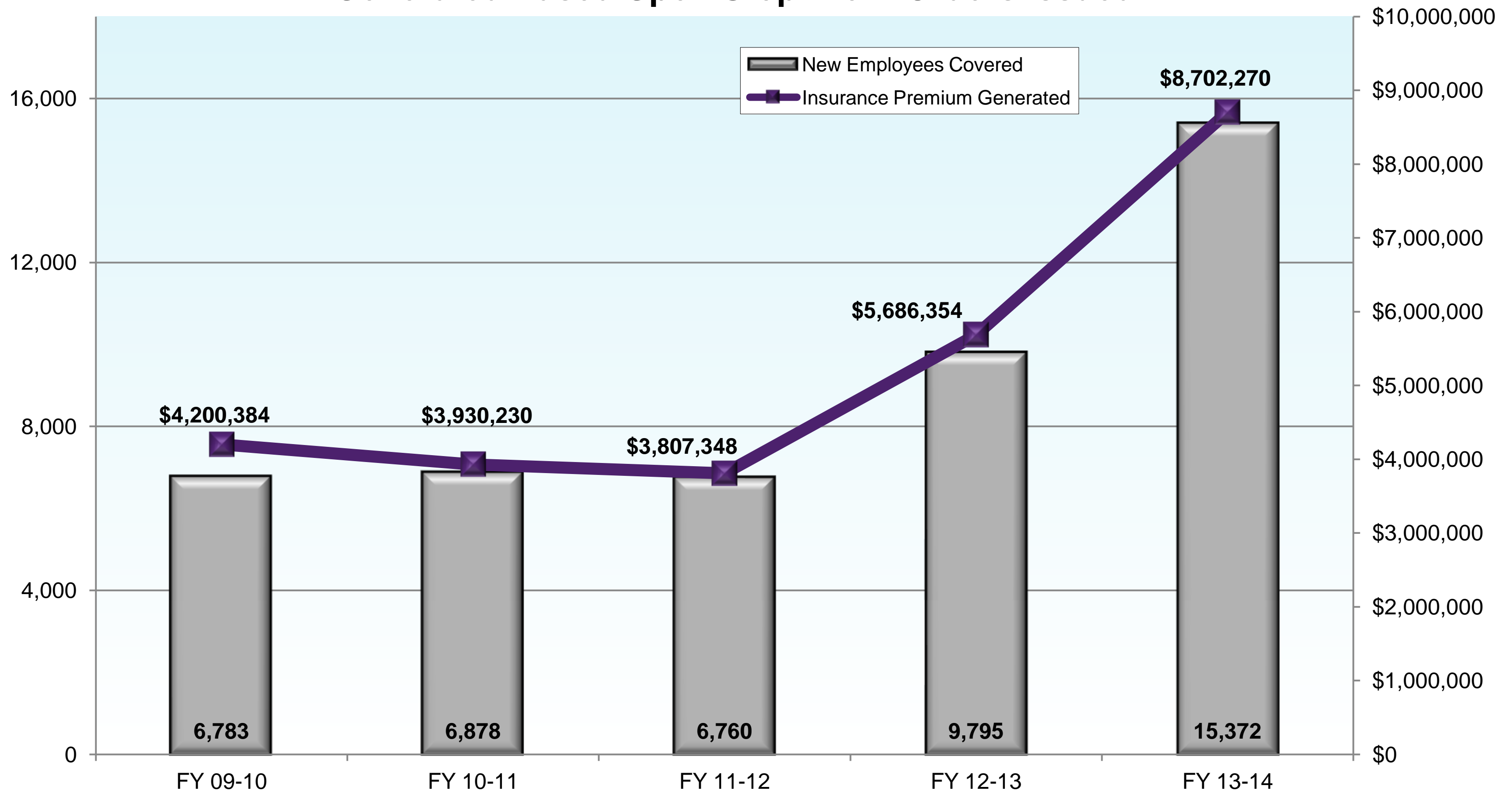
The Bureau of Compliance (BOC) is tasked with the responsibility of ensuring employers comply with statutory obligations to obtain workers' compensation insurance coverage for employees. To accomplish this mission, the BOC: conducts investigations and issues enforcement actions in accordance with Section 440.107, Florida Statutes; processes workers' compensation exemptions to qualified applicants in accordance with Section 440.05, Florida Statutes; and provides educational outreach and training to employers and insurance industry representatives on workers' compensation coverage laws.

During Fiscal Year 2013-2014, BOC: processed 99% of online exemption filings within 5 days of receipt; utilized data from various agencies to identify and successfully target non-compliant employers; investigated 1,862 public referrals alleging non-compliance; conducted 59 seminars and 25 webinars on workers' compensation and workplace safety for over 3,026 employers statewide; and increased enforcement actions by 25.8%, which led to a 56.9% increase in the number of employees covered by workers' compensation during Fiscal Year 2012-2013.

Investigators conduct physical, on-site inspections of an employer's job-site or business location to determine compliance with workers' compensation coverage requirements. The total number of investigations conducted each year continues to increase as BOC fulfills its statutory responsibilities.

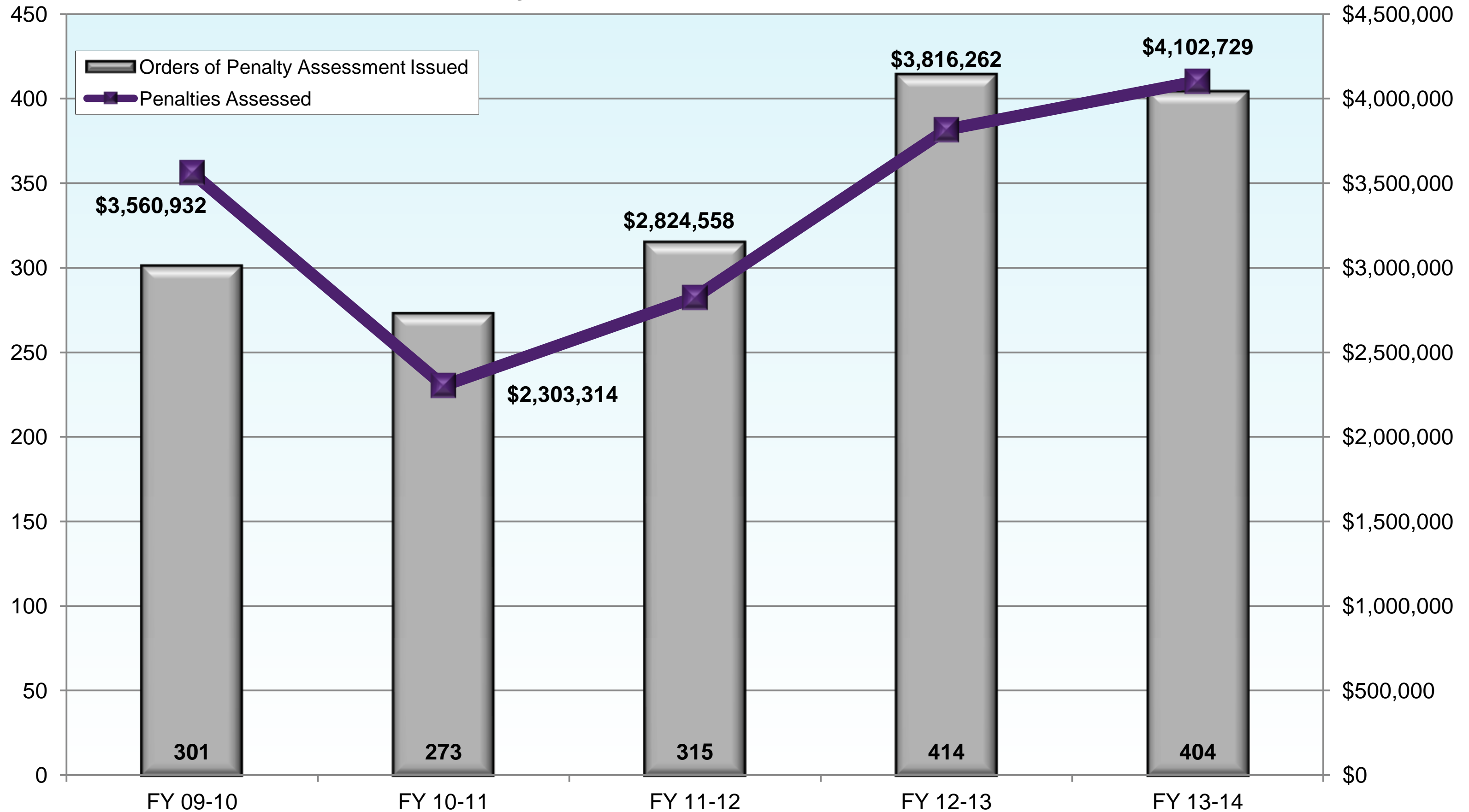
Investigations Conducted	
FY 09-10	33,235
FY 10-11	34,252
FY 11-12	34,780
FY 12-13	34,150
FY 13-14	35,294


Stop-Work Orders Issued and Penalties Assessed
Stop-Work Orders
Penalties Assessed
3,500
3,000
2,500
2,000
1,500
1,000
500
0
$60,000,000
$50,000,000
$40,000,000
$30,000,000
$20,000,000
$10,000,000
$0
$46,225,984
$39,987,700
$25,758,993
$26,433,163
$38,733,802
2,214
2,174
2,140
2,444
3,075
FY 09-10
FY 10-11
FY 11-12
FY 12-13
FY 13-14

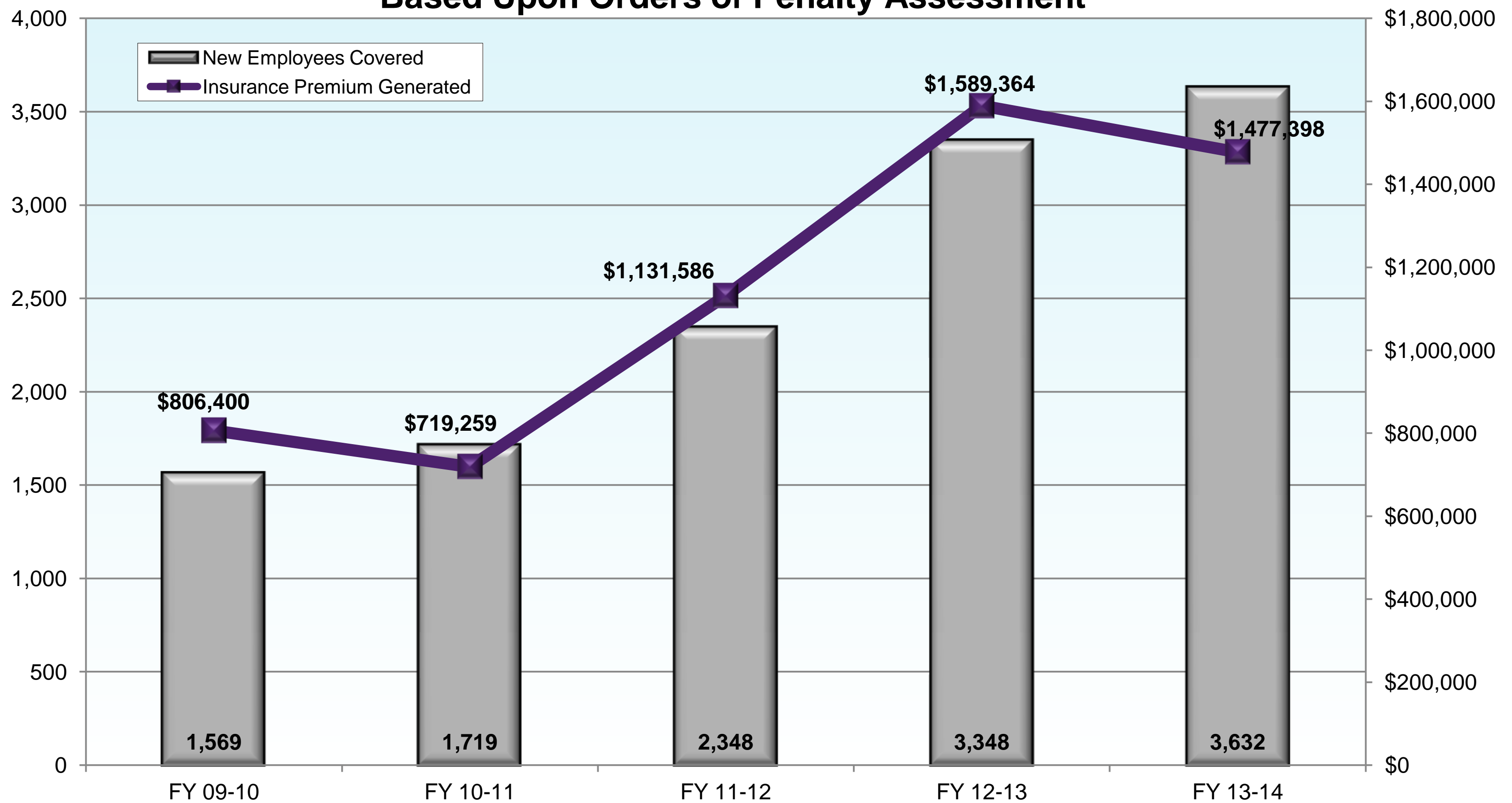


This graph illustrates the number of employees covered as a direct result of the Bureau's enforcement efforts and issuance of Stop-Work Orders and the monies added to the workers' compensation premium base that had been previously evaded.

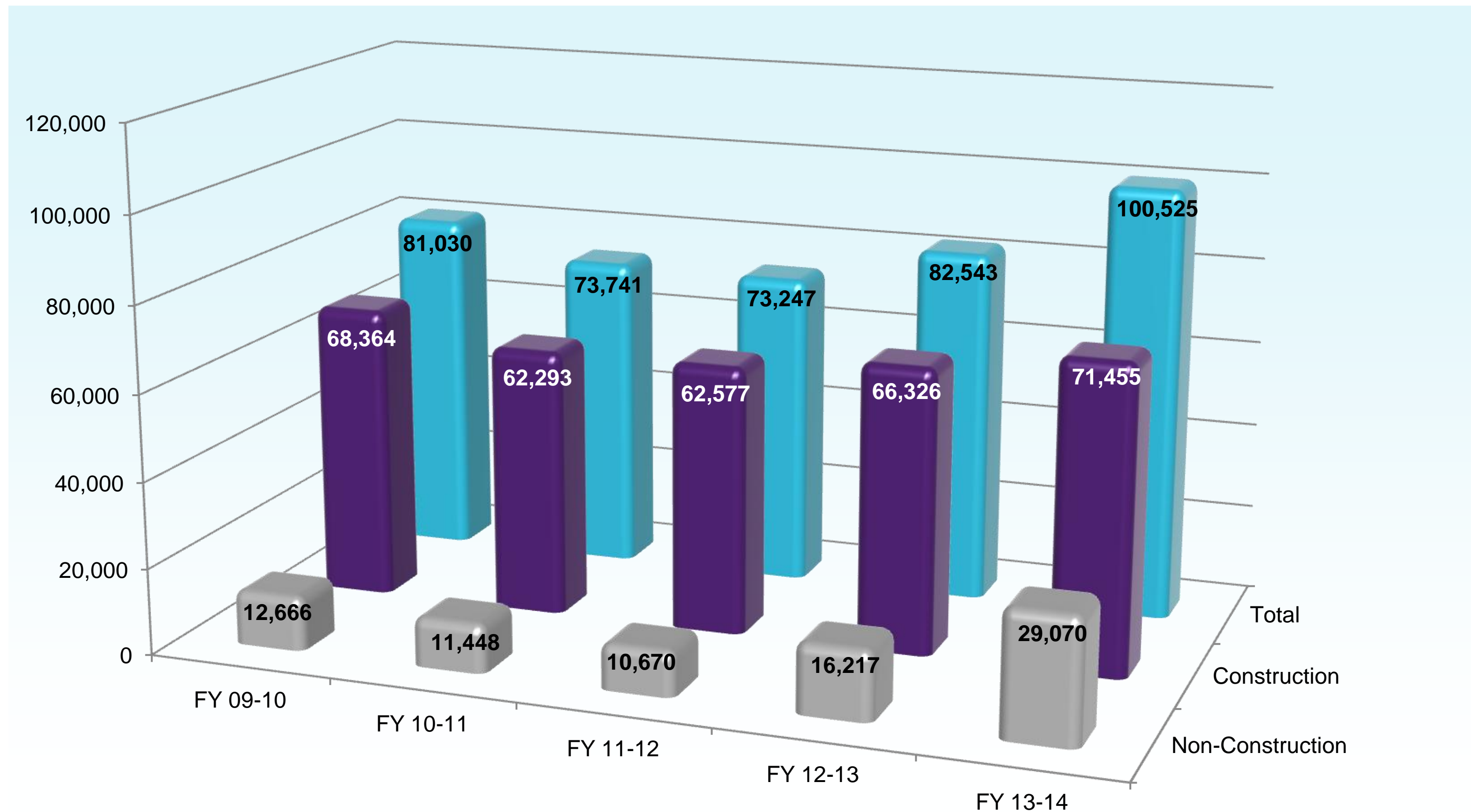
Orders of Penalty Assessment are issued when the employer obtains coverage as a result of the initiation of an investigation which negates the issuance of a Stop-Work Order.



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



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


Exemption Applications Processed
120,000
100,000
80,000
60,000
40,000
20,000
0
81,030
73,741
73,247
82,543
100,525
68,364
62,293
62,577
66,326
71,455
12,666
11,448
10,670
16,217
29,070
FY 09-10
FY 10-11
FY 11-12
FY 12-13
FY 13-14
Total
Construction
Non-Construction

The Division utilizes several available data sources to identify non-compliant employers. This effort includes the use of information and data from other state agencies. For example, by utilizing payroll and employee information provided from the Department of Revenue to cross match with the Division's policy data, the Division is able to create lists of suspected non-compliant employers. The Division also reviews policy cancellation information to identify employers whose policies have been cancelled and no subsequent coverage has been obtained. Lastly, the Division acquires county and city permitting information to identify jobsites where construction activity may be occurring.

Employers identified as potentially non-compliant via our data sources listed above, are notified of the workers' compensation requirements and the penalties for failure to secure workers' compensation. Those employers that do not secure coverage following the notification are referred for investigation.

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

EAO relies on a team structure to successfully accomplish its mission. Each team focuses on a specific area of statutory responsibility in order to effectively assist injured workers. The EAO: distributes workers' compensation information; proactively contacts injured workers to inform them of their rights and responsibilities and educates them about its services; and works to resolve disputes between injured workers and carriers to avoid unnecessary expenses, costly litigation or delay in the provision of benefits.

Customer Service Team

The Customer Service Team focuses on assisting and educating employers about the requirements of workers' compensation coverage, exemptions from coverage obligation, and drug free workplace and safety programs. This Team answers close to 93,000 calls per year.

Customer Service Call Volume FY 2013-2014	
1st Qtr	25,319
2nd Qtr	20,190
3rd Qtr	23,899
4th Qtr	23,315
Total	92,723

First Report of Injury Team

The First Report of Injury Team identifies and contacts injured workers with more than seven days of work lost due to the job injury. This contact takes place within two business days of the Division's receipt of a First Report of Injury or Illness. The First Report of Injury Team provides educational resources regarding the Workers' Compensation System, advises injured workers of their statutory responsibilities, and informs workers of EAO's various services.

During Fiscal Year 2013-2014, the Team contacted 29,732 injured workers by telephone and 3,691 employers/carriers when the team was unable to reach injured workers. These contacts were made to inquire about the status of injured workers' claims and advise of EAO's services. The Team communicated by letter or responded by email to 35,211 injured workers in an effort to give assistance and advise of EAO's services. As seen in the table below, the Team continues to have increased success rates each year.

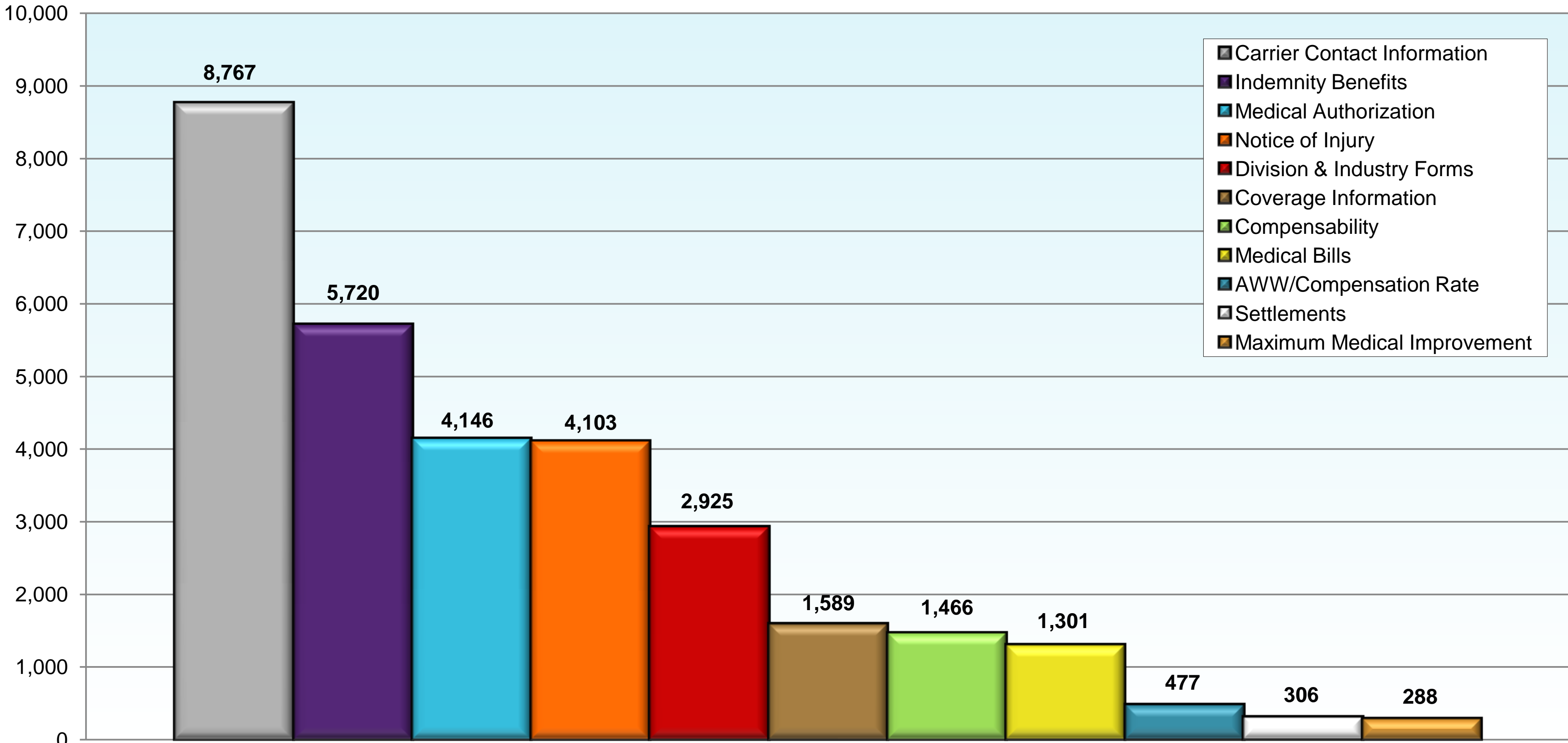
Injured Worker Contacts		
Fiscal Year	# Contacted	% Contacted
08-09	25,271	63%
09-10	28,768	69%
10-11	32,140	71%
11-12	32,966	73%
12-13	31,303	81%
13-14	29,732	82%

Injured Worker Helpline Team

The Injured Worker Helpline Team 's responsibility is to educate callers from all system stakeholders: injured workers, employers, carriers, medical providers, attorneys, and the public. Through the Division's toll-free telephone line, the Team answers questions about the requirements of Florida's Workers' Compensation Law and provides assistance to injured workers who are experiencing problems obtaining medical or indemnity benefits.

The Team fulfills it mission by identifying disputed issues, researching injured workers' concerns and contacting employers, carriers, medical providers, attorneys, or other appropriate parties to aid in resolution. All disputes requiring extensive investigation are referred to the Ombudsman Team.

During Fiscal Year 2013-2014, the Injured Worker Helpline Team handled 58,075 calls, including 8,685 Spanish speaking callers. Of the 349 disputes received, 87% were resolved by the Team.


Injured Worker Helpline Team - Education Calls FY 2013-2014
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
8,767
5,720
4,146
4,103
2,925
1,589
1,466
1,301
477
306
288
Carrier Contact Information
Indemnity Benefits
Medical Authorization
Notice of Injury
Division & Industry Forms
Coverage Information
Compensability
Medical Bills
AWW/Compensation Rate
Settlements
Maximum Medical Improvement
# of calls received

Ombudsman Team

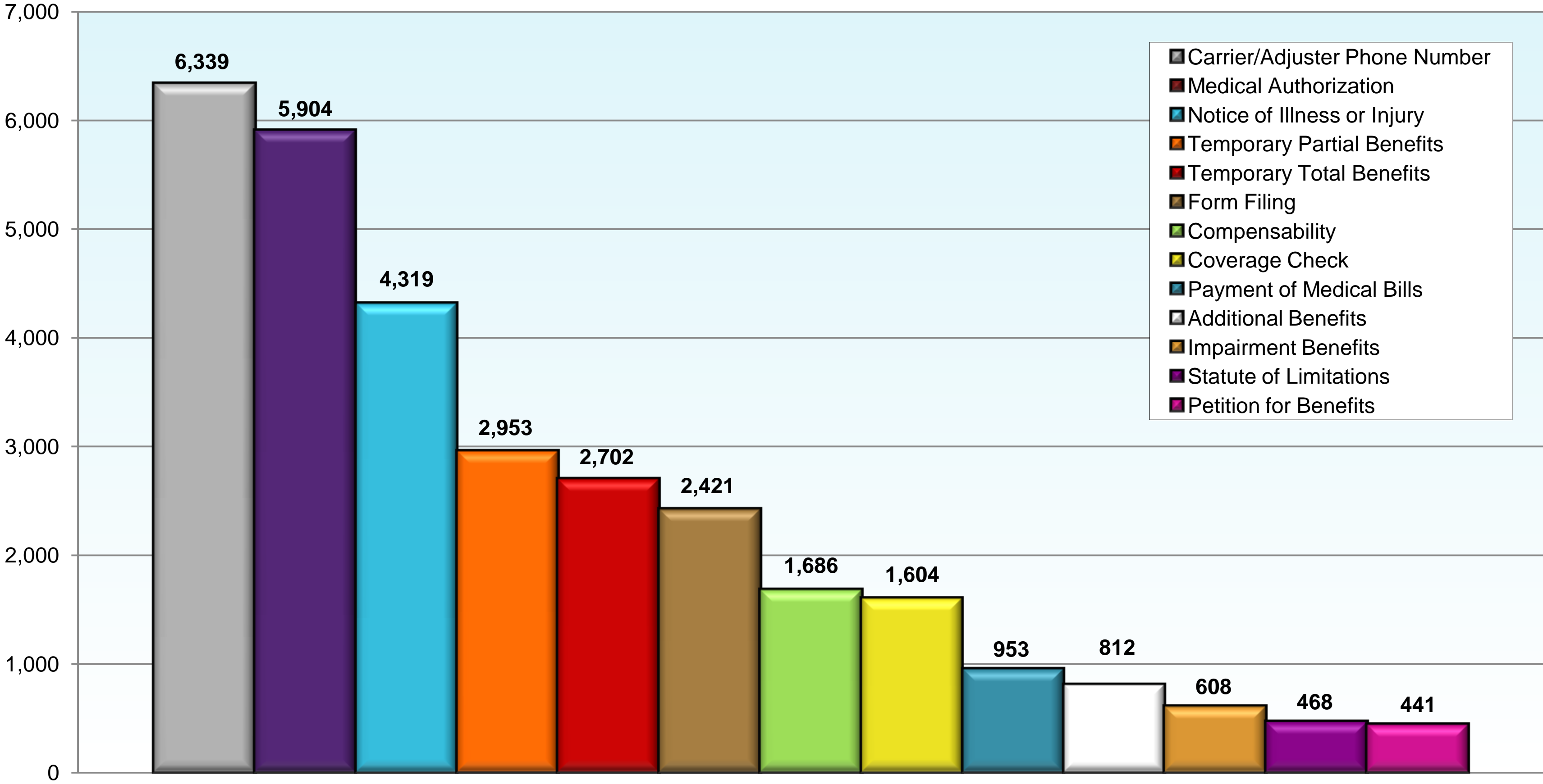
The Ombudsman Team is responsible for assisting injured workers to resolve complex disputes. In order to fulfill its role, the Team conducts fact-finding reviews, analyzes claim files, researches case law, promotes open communication between parties, and generally helps parties to understand their statutory responsibilities. The Team provides early intervention services to injured workers with catastrophic or severe injuries; assists walk-in customers in eight offices throughout Florida; assists in resolving disputes and providing workers' compensation information applicable to each injured worker's claim, including guidance on the Petition for Benefits process; and assists injured workers referred from the Governor's and CFO's Offices, legislators, and other elected officials.

During Fiscal Year 2013-2014, the Ombudsman Team was involved in resolving 88% of the 791 disputes received. The medical bill disputes totaled $121,945 in previously unpaid medical bills. The Team resolved indemnity benefit disputes totaled $387,532 . Additionally, the Ombudsman Team prevented 4,047 potential disputes by educating injured workers with in-depth, case specific information.

Contact the Ombudsman Team at wceao@myfloridacfo.com with questions.

Ombudsman Intervention
FY 2013-2014

Issue	Resolved	Unresolved	% Resolved
Average Weekly Wage	10	1	91%
Medical Authorization	385	46	89%
Notice of Injury	8	2	80%
Indemnity - TPD	32	12	72%
Indemnity - TTD	57	3	95%
Compensability	2	13	13%
Penalties & Interest	29	4	88%
Medical Mileage	69	2	97%
Medical Bills	47	2	95%
Impairment Income Benefits	9	1	90%
Other	51	6	89%
Total	699	92	88%


Issues Addressed by Ombudsman and Helpline Teams FY 2013-2014
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
6,339
5,904
4,319
2,953
2,702
2,421
1,686
1,604
953
812
608
468
441
Carrier/Adjuster Phone Number
Medical Authorization
Notice of Illness or Injury
Temporary Partial Benefits
Temporary Total Benefits
Form Filing
Compensability
Coverage Check
Payment of Medical Bills
Additional Benefits
Impairment Benefits
Statute of Limitations
Petition for Benefits

Reemployment Services Team

The Reemployment Services Team is responsible for educating injured workers about potential eligibility for reemployment services to assist in returning to appropriate gainful employment after an on-the-job injury. The Team provides services for: vocational counseling; transferable skill analysis; resume writing/development; job placement; job seeking skills; vocational evaluations; and training and education (including GED). Injured employees submit requests for screening for services through the Division's web portal. The Reemployment Services Team ensures the required documentation is received from injured workers requesting services. The Team educates carriers about reemployment services requirements under Florida's Worker's Compensation Law.

During Fiscal Year 2013-2014, the Reemployment Services Team received 266 requests for screenings through the Division's Injured Worker Web Portal. Additionally, the Team screened 337 injured workers for services and provided assistance to 196 injured workers who were eligible to return to suitable productive employment.

Contact the Reemployment Services Team via email at WCRES@myfloridacfo.com. Injured workers may apply for reemployment services by completing the online application at: https://wcres.fldfs.com/resportal/ieweb/ielogin.aspx.

The Bureau of Monitoring and Audit (M&A) is tasked with ensuring the timely and accurate payment of benefits to injured workers, timely filing and payment of medical bills, and timely and accurate filing of required claims forms and other electronic data. 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.

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

- Audit Section
- Permanent Total Disability Section
- Penalty Section
- Medical Services Section

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. Examinations and investigations are conducted by the Section to identify: patterns and practices of unreasonable delays in claims-handling; untimely and inaccurate payment of benefits to injured workers; untimely and inaccurate filing of required forms and reports; and to enforce compliance with compensation orders of Judges of Compensation Claims.

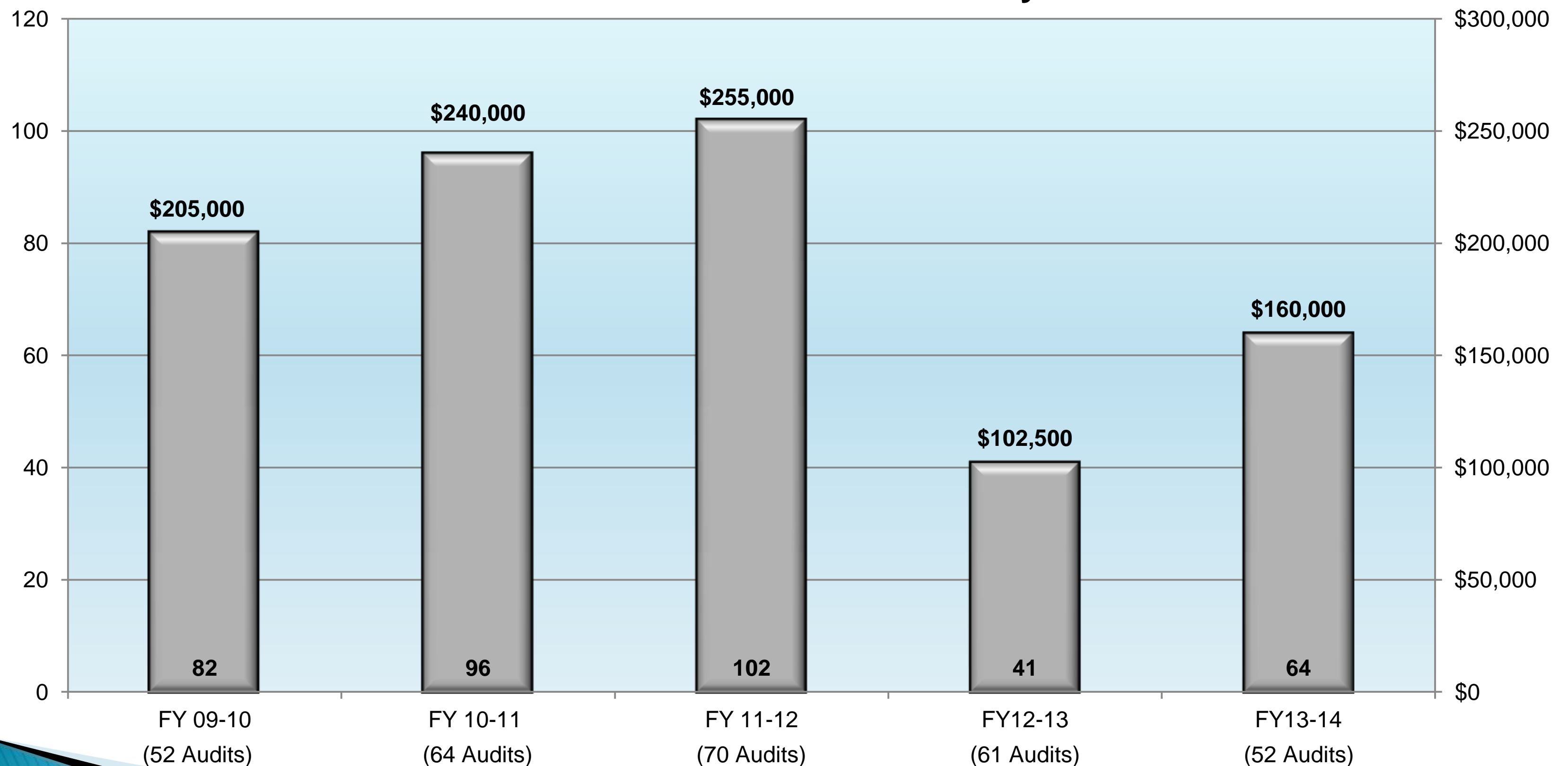
The Audit Section completed 52 on-site insurer audits and examined 4,598 insurer claim files during Fiscal Year 2013-2014. The Section discovered 533 indemnity claim files with underpayments resulting in $262,612 of additional injured worker payments for indemnity benefits, penalties, and interest.

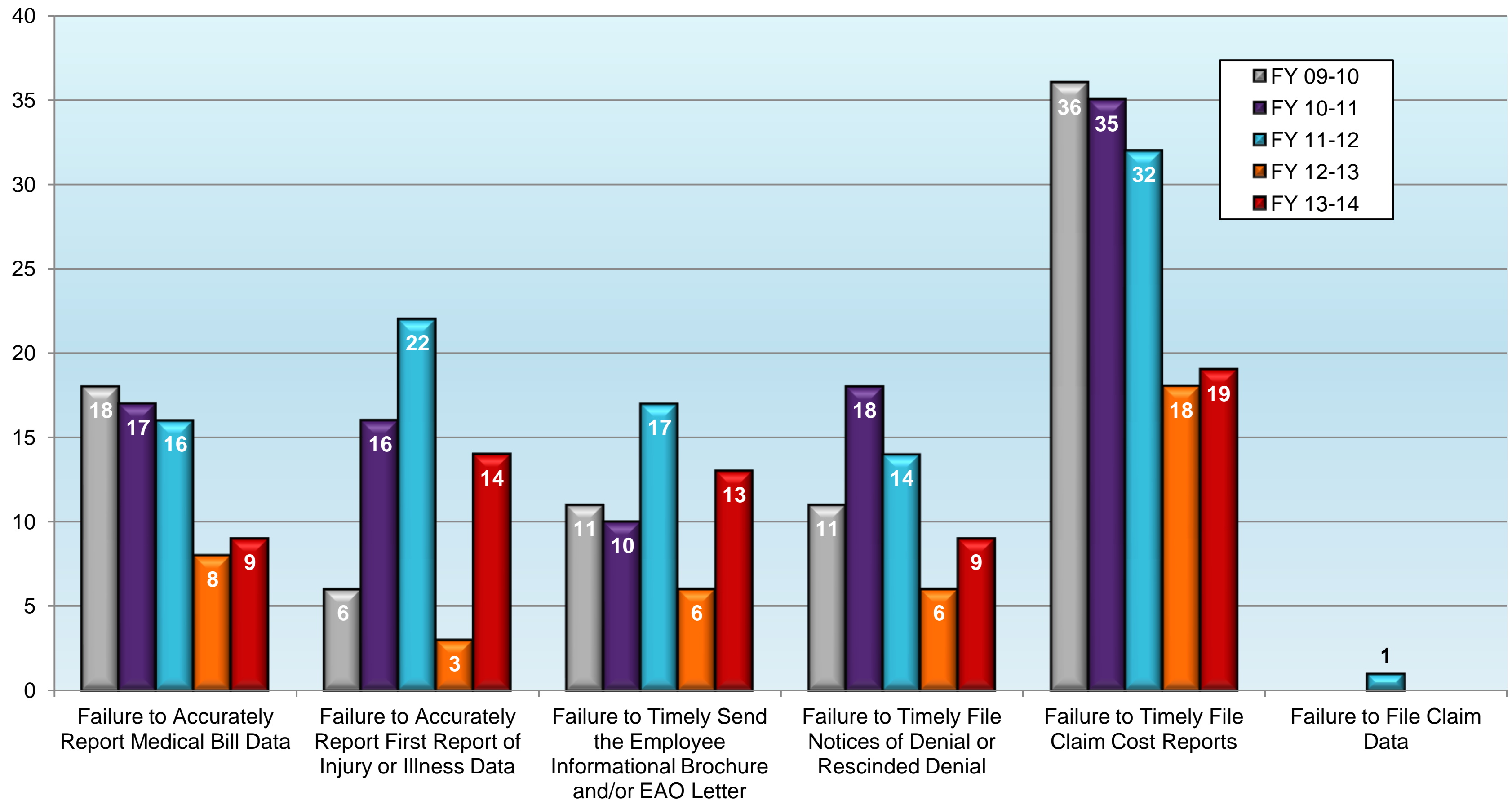
The table below illustrates penalties assessed during audits for untimely indemnity payments and untimely First Reports of Injury or Illness and paid to the Division.

Fiscal Year	Total Amount of Penalties Issued for Untimely Indemnity Payments	Total Amount of Penalties Issued for Untimely First Reports of Injury or Illness
09-10	$78,600	$35,100
10-11	$90,400	$66,600
11-12	$87,000	$51,200
12-13	$64,200	$27,500
13-14	$70,850	$25,800

The next 2 graphs illustrate non-willful pattern and practice penalties assessed during audits for various claims-handling violations that were paid to the Division. Each pattern and practice penalty is assessed at $2,500.

Fiscal Year 2013-2014 saw an increase in assessed non-willful pattern and practice penalties over Fiscal Year 2012-2013. Audits have enabled the industry to improve claims-handling practices.




Non-Willful Pattern & Practice Penalties
by Category and Fiscal Year
40
35
30
25
20
15
10
5
0
FY 09-10
FY 10-11
FY 11-12
FY 12-13
FY 13-14
18
17
16
8
9
6
16
22
3
14
11
10
17
6
13
11
18
14
6
9
36
35
32
18
19
1
Failure to Accurately Report Medical Bill Data
Failure to Accurately Report First Report of Injury or Illness Data
Failure to Timely Send the Employee Informational Brochure and/or EAO Letter
Failure to Timely File Notices of Denial or Rescinded Denial
Failure to Timely File Claim Cost Reports
Failure to File Claim Data

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 Fiscal Year 2013-2014, the PT Section calculated, approved, and processed supplemental benefits for 1,188 claims totaling $16,318,210.

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; and Judges of Compensation Claims data. Additionally, this 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.

Throughout Fiscal Year 2013-2014, the PT Section reviewed 27,398 electronic claims transactions. 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, and the Audit Section.

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.

Fiscal Year	# of First Reports Received and Reviewed by CPS
09-10	52,768
10-11	53,285
11-12	53,211
12-13	51,690
13-14	52,344

Fiscal Year	Timely Initial Benefit Payments	Timely Filing of First Reports
09-10	95%	93%
10-11	95%	95%
11-12	95%	95%
12-13	95%	95%
13-14	95%	95%

Fiscal Year	Timely Medical Bill Payments	Timely Medical Bill Filings
09-10	98%	97%
10-11	98%	98%
11-12	99%	99%
12-13	98%	96%
13-14	99%	98%

Medical Services Section

The Medical Services Section is responsible for establishing medical reimbursement rules and policy, implementing the Three Member Panel's uniform schedules for Maximum Reimbursement Allowances (MRAs), and resolving medical reimbursement disputes between providers and payers. This Section also provides educational assistance and consultation on issues related to medical bill filing and reimbursements, and 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.

The Medical Services Section received 10,483 Reimbursement Disputes during Fiscal Year 2013-2014. This Section issued 5,454 determinations (52%) and 4,971 dismissals (47%). Reimbursement Disputes must be filed within 45 days from the provider's receipt of the carrier's notice of disallowance or adjustment of payment.

Petitions Submitted by Provider Type by FY

	09-10	10-11	11-12	12-13	13-14
Practitioner	296	1,308	12,718	7,819	8,483
ASC	373	655	687	737	665
Hospital Inpatient	330	436	332	350	266
Hospital Outpatient	1,071	1,378	1,273	1,303	1,069
Total	2,070	3,777	15,010	10,209	10,483

Petitions Determination Outcomes by Provider Type by FY

	09-10	10-11	11-12	12-13	13-14
Practitioner	102	706	1,853	2,573	3,992
ASC	226	412	471	584	512
Hospital Inpatient	216	286	218	217	183
Hospital Outpatient	1,177	941	823	966	767
Total	1,721	2,345	3,365	4,340	5,454

Petitions Dismissal Outcomes by Provider Type by FY

	09-10	10-11	11-12	12-13	13-14
Practitioner	221	478	1,647	2,605	4,432
ASC	125	219	157	216	173
Hospital Inpatient	112	133	109	140	96
Hospital Outpatient	298	411	346	448	270
Total	756	1,241	2,259	3,409	4,971

During Fiscal Year 2013-2014, the number of Reimbursement Disputes dismissed due to untimely filing decreased by 26% from 1,283 last year to 951. In Fiscal Year 2012-2013, the primary reason for dismissing a Reimbursement Dispute was untimely filing of petition. However, in Fiscal Year 2013-2014, withdrawal by Petitioner was the most frequent reason for dismissal. The number of petitions withdrawn in Fiscal Year 2013-2014 increased by 110% over Fiscal Year 2012-2013. There were 2,448 petitions withdrawn in Fiscal Year 2013-2014 compared to 1,167 withdrawn in Fiscal Year 2012-2013.

Petitions Dismissals Issued By Reason by FY

	09-10	10-11	11-12	12-13	13-14
Failure to Cure Deficiency	237	507	547	617	998
Untimely Filed	230	255	930	1,283	951
Petition Withdrawn	199	295	437	1,167	2,448
Other Reason	15	19	28	41	88
Lack of Jurisdiction	45	92	131	191	202
Non-HCP	4	30	13	4	2
Managed Care	4	9	137	80	274
Not-Ripe for Resolution	20	34	32	25	8
Improper Service	0	0	0	0	0
Not Reported	0	0	4	1	0

Though nominal in actual numbers, the number of correct payments found continues to increase. Overpayments remain virtually unchanged from Fiscal Year 2012-2013; however, the number of determinations of no additional payment due has doubled since last year.

The Medical Services Section discovered that the petitioner had been underpaid in 86% of all determinations issued for Fiscal Year 2013-2014**.** However, in most cases, the amount reimbursed to the provider rarely equaled the billed amount. Therefore, the amount found to be due was typically less than the billed charge.

Determinations Issued by Reason per FY

	09-10	10-11	11-12	12-13	13-14
Under-Payment	1,635	2,181	3,095	3,871	4,699
Correct Payment	25	41	83	118	127
Over-Payment	34	28	75	96	97
Other Finding	2	5	3	10	16
No Additional Payment Due	26	90	109	244	515

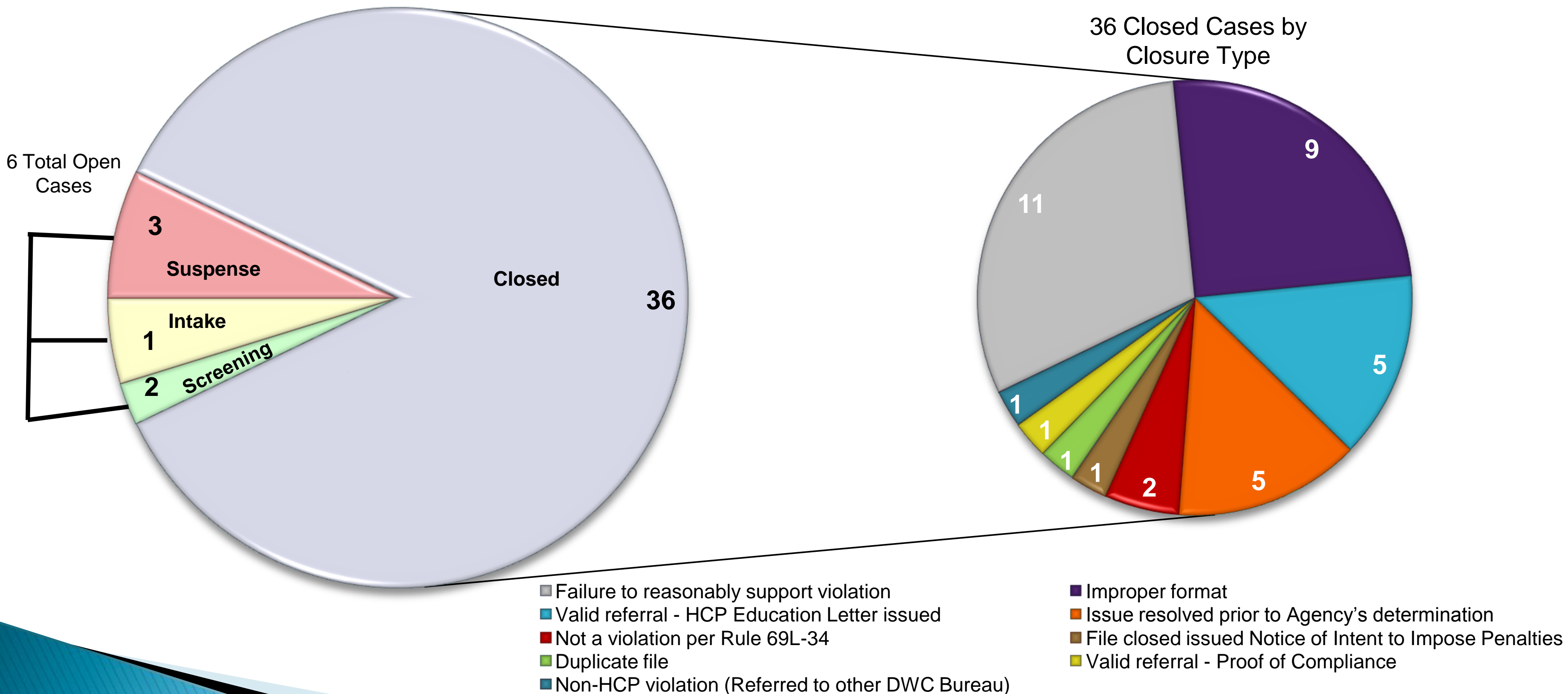
The Medical Services Section is responsible for certifying Expert Medical Advisors (EMAs). As of June 30, 2014 there were 126 certified EMAs.

The Section also has the responsibility of investigating reports of provider violations. In Fiscal Year 2013-2014, the Medical Services Section processed 42 reports which included 8 reports carried over from FY 2012-2013. Out of the 42 reports processed, 1 was an internal Division of Workers' Compensation referral, and 41 were referrals from insurers, attorneys, or other. The table below illustrates the end of year case status for reports of provider violations processed during Fiscal Year 2013-2014. Open cases are carried over into the next fiscal year for further processing.

Reports of Provider Violations Case Statuses as of June 30, 2014

Status	Number of Cases
Open	6
Closed	36

The chart below describes the distribution of the various provider violation case outcomes for those cases closed during Fiscal Year 2013-2014. The most common reason for closure was the failure of the entity making the report of violation to reasonably support the report with documentation of a violation.



Bureau of Financial Accountability

The Bureau of Financial Accountability houses the Division's largest monetary transaction programs and safeguards its assets by developing and implementing a broad range of financial accountability measures. The Bureau's programs work to implement and build upon its internal checks and balances while maintaining effective financial controls that focus on managing the daily functions of cash receipts, revenue, and warrant payments. Included in these controls is a series of comprehensive reconciliation processes that balance each cash receipt and cash payment process.

The Bureau of Financial Accountability has the following monetary programs:

- Assessments Section
- Financial Accountability Section
- Self-Insurance Section
- Special Disability Trust Fund Section

Assessments Section

The Assessments Section calculates, collects, audits, and reconciles quarterly assessment payments by insurance companies, assessable mutual insurance companies, self-insurance funds, and individual self-insurers for the Special Disability Trust Fund (SDTF) and the Workers' Compensation Administration Trust Fund (WCATF). The section also calculates the annual assessment rate for both the SDTF and the WCATF.

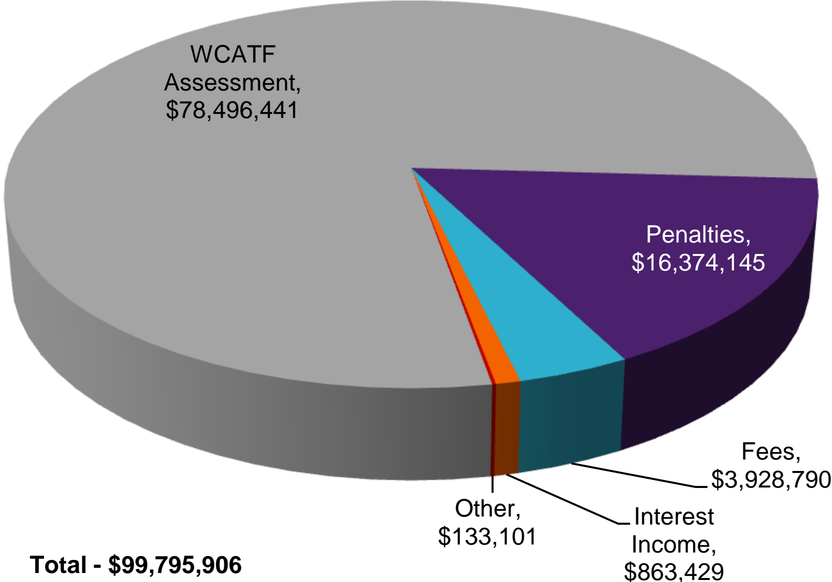
In Fiscal Year 2013-2014, the Assessments Section collected over $78 million in assessments for the Workers' Compensation Administration Trust Fund (WCATF) and over $46 million for the Special Disability Trust Fund (SDTF).

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 Assessments Section notified and provided all carriers with the necessary information to report premiums.

The Assessments Section subsequently collected, audited, and reconciled the quarterly assessments of 367 insurance companies and self-insurance funds. This Section also calculated the imputed premium of 406 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 the premium for which the assessment was applied.

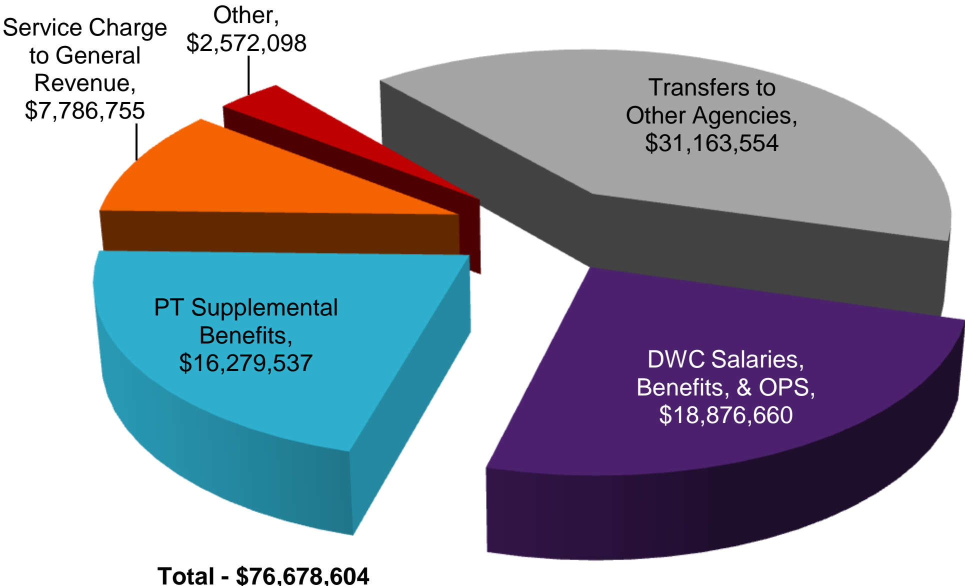
In an effort to improve efficiency and cost effectiveness, the Assessments Section has developed a product that allows insurance carriers to report their assessments on-line. This application is called START – **S**ystem for **T**racking **A**ssessments, **R**econciliations and **T**ransactions. The individual self-insurers phase is being developed.

Workers' Compensation Administration Trust Fund (WCATF) Revenues for FY 2013-2014

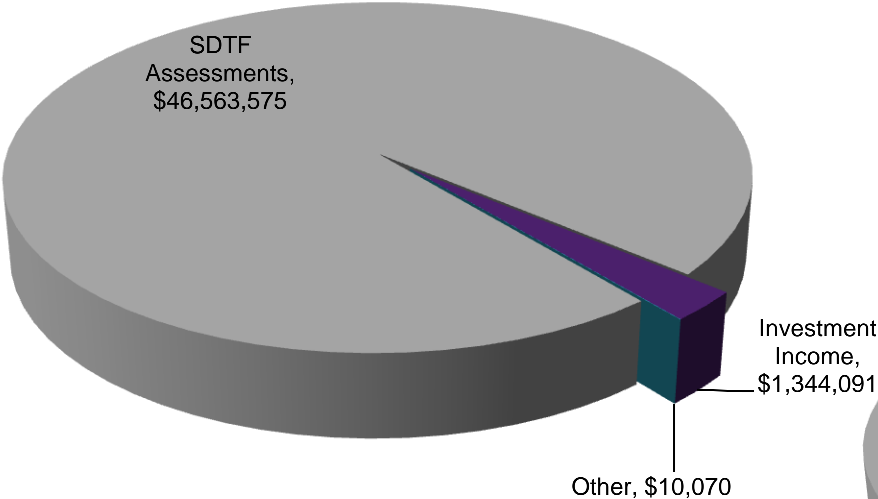


Total - $99,795,906

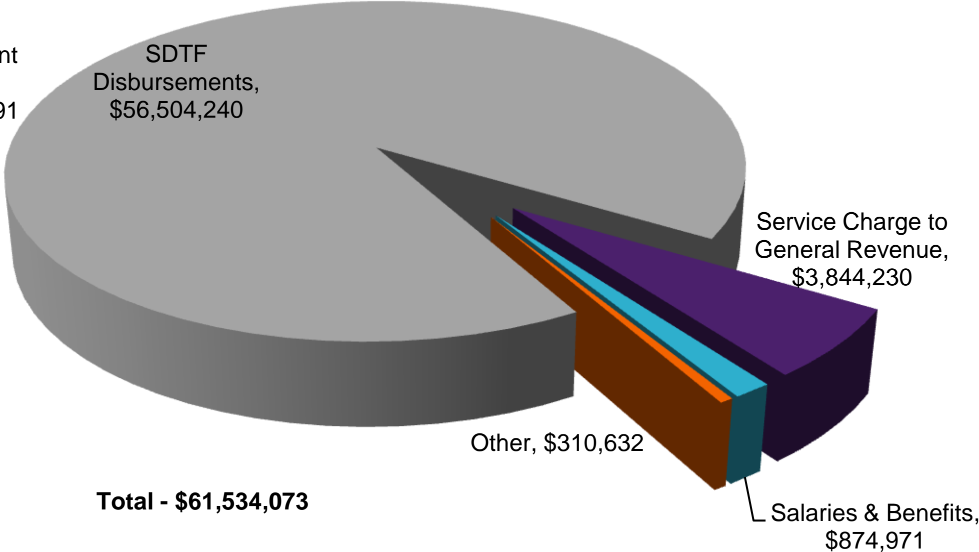
Workers' Compensation Administration Trust Fund (WCATF) Expenses for FY 2013-2014



Total - $76,678,604



Total - $47,917,736



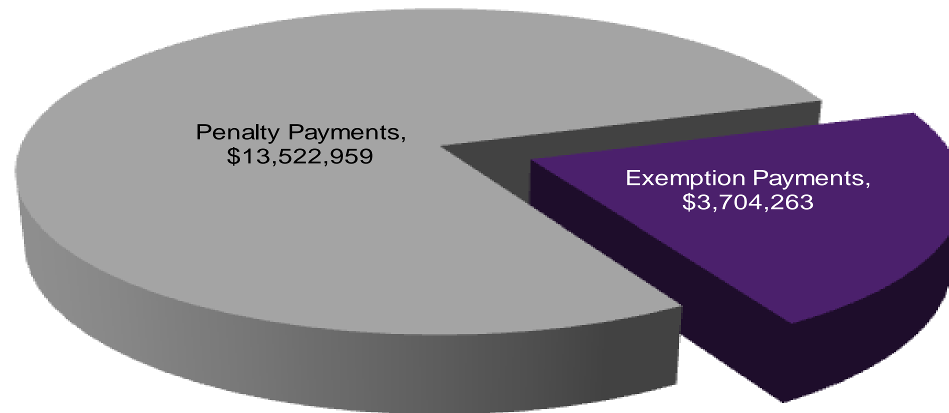
Total - $61,534,073

Financial Accountability Section

The Financial Accountability Section monitors the receipt of all payments related to Notices of Election to be Exempt and employer penalty payments. The Section oversees the process of reinstating Stop-Work Orders to employers who default on payments, referring delinquent accounts to the collection agency, and filing liens against those employers.

The Financial Accountability Section (FAS) supports the activities pursuant to Section 440.107, Florida Statutes, by performing the following functions: collects and monitors revenues associated with payments from corporate officers in the construction industry who elect to exempt themselves from workers' compensation benefits; collects and monitors revenues associated with corporate officers who were out of compliance with the workers' compensation laws and have been assessed a penalty; and monitors monthly penalty payments associated with corporate officers who have been assessed a penalty and have entered a Periodic Payment Agreement Schedule (PPA).

Financial Accountability Section Revenues
FY 2013-2014



Total - $17,227,222

Penalty Payment Count Break-Down by Payment Category for Fiscal Year 2013-2014:

Payment Count Break-Down	Totals	Average Monthly Count	Average % of Total Count
Payment In Full	1,208	101	3%
Down Payments	1,468	122	4%
PPA Payments	31,943	2,662	91%
Collection Payments	321	27	1%
TOTALS	34,940		

Payment Amount Break-Down	Totals	Average Monthly Amount	Average % of Total Amount
Payment In Full	$2,781,854	$231,821	20%
Down Payments	$2,481,218	$206,768	18%
PPA Payments	$8,080,194	$673,349	59%
Collection Payments	$179,693	$14,974	1%
TOTALS	$13,522,959		

Self-Insurance Section

The Self-Insurance Section regulates private, individual self-insurers to ensure they have the financial strength required to pay workers' compensation claims. The Self-Insurance Section also regulates governmental individual self-insured employers to ensure timely reporting of Payroll and Loss Data. This Section promulgates experience modifications for all active individually self-insured employers and issues notices of violation for late filing of forms, reports and assessments.

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. 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; and collects, examines ,and processes self-insurance payroll, loss data, outstanding liabilities, and financial statements.

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 Self-Insurers Payroll Reports (DFS-F2-SI-5). During Fiscal Year 2013-2014, the Self-Insurance Section performed 15 desk audits, reviewed 19,079 employee payroll records, identified $30,591,912 in underreported payroll, and $1,624,326 in under reported premium.

Entities applying for self-insurance authorization pursuant to Section 440.38(1)(b), Florida Statutes, shall submit a complete application package at least 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.

During Fiscal Year 2013-14, the Self-Insurance Section monitored 399 active self-insurers (Governmental and Private). There were 2 new self-insurers approved and 10 active self-insurers that voluntarily terminated their self-insurance privileges.

During Fiscal Year 2013-14, the Self-insurance Section monitored 95 active Qualified Servicing Entities that serviced claims for Self-Insurers and Commercial Carriers. All 95 Qualified Servicing Entities were re-certified. Three of the approved Qualified Servicing Entities withdrew from providing claims-handling services for self-insurers and commercial carriers.

Fiscal Year	Self-Insurers
10-11	410
11-12	410
12-13	404
13-14	399

Fiscal Year	Qualified Servicing Entities
10-11	100
11-12	97
12-13	97
13-14	95

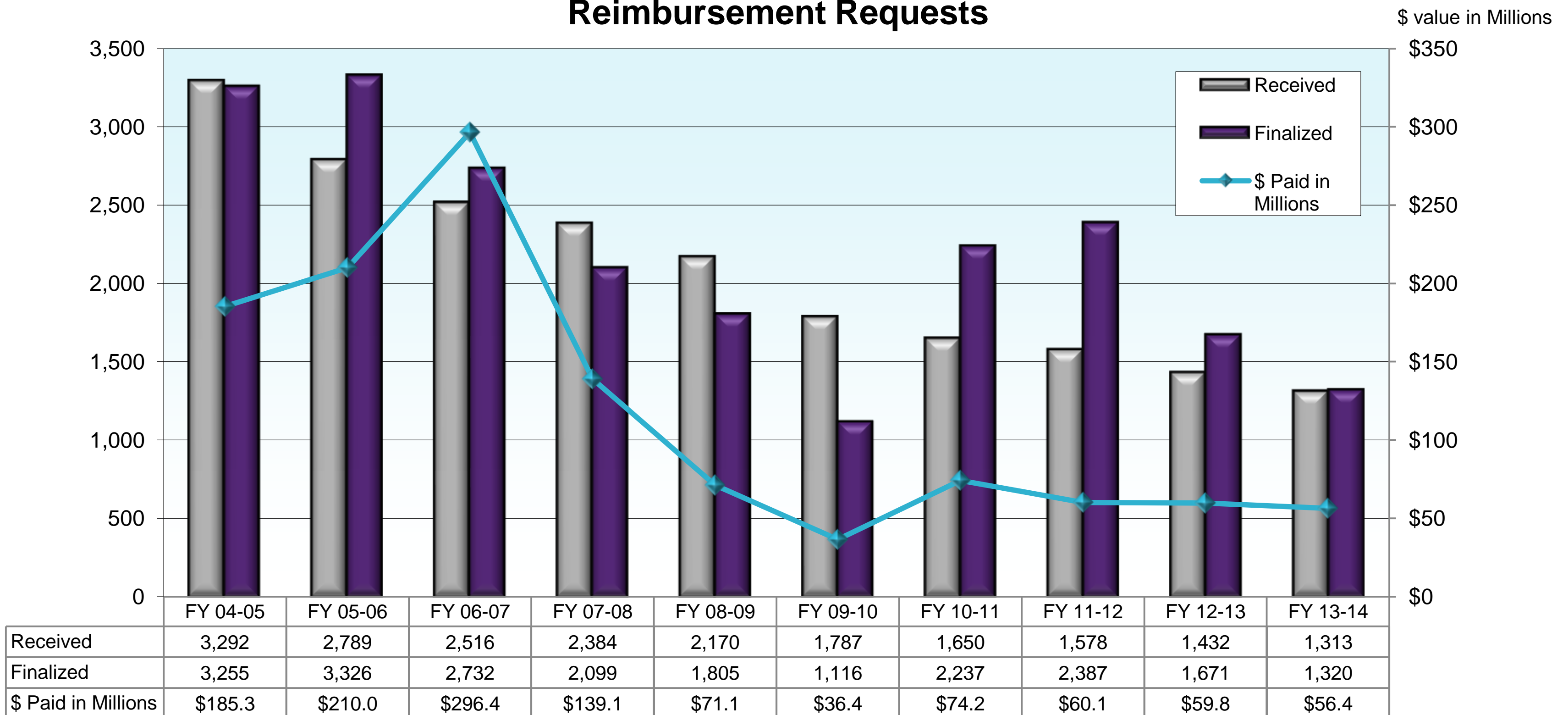
Special Disability Trust Fund Section

The Special Disability Trust Fund Section (SDTFS) reviews all Proofs of Claim filed to determine if the claims meet eligibility requirements for reimbursement of benefits paid by the carriers. The SDTFS then determines eligibility for reimbursement by the Fund through the audit of submitted requests for issuance of accurate reimbursements. Additionally, the Fund is responsible for the disbursement of Permanent Total Supplemental Benefits to certain injured workers.

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. 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.

Presently, the SDTFS has three primary business processes: (1) 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; (2) determine eligibility for reimbursement by the Fund through auditing Reimbursement Requests and supporting documentation submitted by the carrier on claims that have been accepted; and (3) issue accurate reimbursements.

The Fund has created a new Computer Assisted Auditor Tool Suite which leverages the Medical EDI data submitted to the Division 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. Implementation of such a system will: dramatically reduce the paper submissions; allow for and encourage more fluid communication between the Fund and its customers; reduce the time between submission and final disposition of requests; and provide educational information.



	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 13-14
Received	3,292	2,789	2,516	2,384	2,170	1,787	1,650	1,578	1,432	1,313
Finalized	3,255	3,326	2,732	2,099	1,805	1,116	2,237	2,387	1,671	1,320
$ Paid in Millions	$185.3	$210.0	$296.4	$139.1	$71.1	$36.4	$74.2	$60.1	$59.8	$56.4

The Bureau of Data Quality and Collection's (DQC) mission is to efficiently and effectively collect and store data in order to provide accurate, meaningful, timely, and readily accessible information to all stakeholders within the workers' compensation system. DQC is responsible for facilitating data distribution to other Division bureaus and managing high 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 also provides real-time feedback to data submitters.

Each electronic transaction received by DQC undergoes extensive program edits to ensure data quality, reliability, and high degree of accuracy before being loaded to the appropriate Division databases. DQC is responsible for developing, improving and maintaining 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.

Proof of Coverage EDI Data Collection

With the exception of self-insurers, every insurer is required by Rule 69L-56, Florida Administrative Code, to file policy information with the Division for Certificates of Insurance, Notices of Reinstatement, Endorsements, and Cancellations. Proof of Coverage (POC) data is collected and inspected 100% 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.

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; and "Construction Policy Tracking" database which provides the policy status of every subcontractor a contractor has chosen to track. The Construction Policy Tracking database also sends electronic notifications of any changes to a subcontractor's coverage status.

Questions or assistance regarding the electronic reporting of Proof of Coverage information can be sent to poc.edi@myfloridacfo.com.

Proof of Coverage Accepted Filings

	FY 10-11	FY 11-12	FY 12-13	FY 13-14
New Policies	253,998	262,301	267,264	271,617
Reinstatements	80,306	79,958	78,089	83,449
Endorsements	225,425	208,553	246,040	389,596
Cancellations	155,987	157,405	150,321	156,300
Total	715,716	708,217	741,714	900,962

Medical EDI Data Collection

The Medical EDI section collects and monitors medical billing data and manages submitter accounts which includes resolving data acceptance issues and other medical EDI related inquiries. All workers' compensation medical bills are required to be filed with the Division in accordance with Rule 69L-7.710, F.A.C. and the date-appropriate Florida Medical EDI Implementation Guide (MEIG).

To assist with the electronic filing of medical bills, the Medical Data Management System (MDMS) web site was developed. Small insurers with a low volume of workers' compensation medical bills may utilize the MDMS web site to comply with the mandate for electronic submission of the DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, and DFS-F5-DWC-90 medical bills (no more than 200 per month including all four form types). Monthly report cards are generated that identify the primary reasons for initial medical bill rejection. The report cards also allow Medical EDI submitters to track their rejection rates and compare their rates with that of the industry.

For information on setting up an MDMS web account or assistance regarding Medical EDI reporting, email the Medical Data Management Team at MedicalDataManagementTeam@myfloridacfo.com.

Electronic Medical Bills Accepted	
Fiscal Year	**Bills Accepted**
FY 10-11	3,884,341
FY 11-12	3,834,451
FY 12-13	3,929,214
FY 13-14	3,969,831

Claims EDI Data Collection

Claims EDI data is collected pursuant to Rule 69L-56, Florida Administrative Code and is used to populate the Division's primary accident database, as well as several online web databases. As of Fiscal Year 2013-2014, one hundred percent of claims data is submitted via EDI.

In an effort to reduce the overall error rejection percentages of claims EDI filings, the Claims EDI Team took a more active approach by providing Triage Assistance. Triage Assistance consists of action plans with timelines, teleconferences, on-site visits, and webinars. Personalized sessions are available upon request. During Fiscal Year 2013-2014, the Team conducted 24 Training Sessions consisting of EDI Webinars and/or Triage sessions along with a 2 day industry-wide training class held in Orlando, Florida for individual trading partners covering:

- Claims EDI Warehouse Demonstration Insurer Access View
- Reporting Return to Work Information MTC S1 (Suspension - RTW) vs. FROI or SROI 02 (Change)
- Reinstatement of Benefits (MTC RB and MTC ER)
- Top Errors Affecting Claim Administrators and How to Correct Them
- Proper Reporting of Claim Type 'L' (Medical Only to Lost Time)

For questions or assistance regarding Claims EDI data, contact the Claims EDI Team by email at claims.edi@myfloridacfo.com.

Accepted Claims Forms			
Fiscal Year	EDI	Paper	Total
10-11	526,908	6,316	533,224
11-12	500,613	2,223	502,836
12-13	474,780	422	475,202
13-14	469,652	0	469,652

Records Management Section

Chapter 119, Florida Statutes, Florida's Public Records Law and Civil Rules of Procedure require the release of certain information for public inspection upon request. Upon receipt of a request, documents must be identified, located, printed, assembled from multiple mediums, inspected for confidentiality, and redacted. Each request undergoes multiple quality reviews prior to the release of records.

During Fiscal Year 2013-2014, DQC processed 4,459 subpoenas and 2,602 public records requests. Subpoenas were invoiced , on average, in less than 2 business days of receipt . Public records requests were invoiced, or documents provided if no charge, on average, in less than 2 business days of receipt. Documents are redacted and released upon receipt of payment, as authorized by Section 119.07, Florida Statutes, if applicable. Public record requests may be submitted via email to the Division at DWCPublicRecordsRequest@myfloridacfo.com.

The Records Management Section assists Division Bureaus by converting paper files and microfilm documents to electronic records by scanning, indexing and verifying documents. During Fiscal Year 2013-2014, this Section processed 3,657,134 pages of documents.

Records Privacy Requests

Most workers' compensation accident information is releasable to any party upon request under Florida's public records law. Section 119.071(4)(d), Florida Statutes, provides exemption of personal information for certain occupational classes (e.g., law enforcement personnel, correctional officers, firefighters, judges, etc.). The employee or employer may request an agency exempt personal information (i.e., home address, telephone number, and date of birth) from public records release if a person's occupation qualifies. In Fiscal Year 2013-2014, the Records Management Section processed 1,474 requests for workers' compensation profiles to be exempt from public records inspection under Section 119.071(4)(d), Florida Statutes. For a list of qualifying occupations and educational information, visit http://www.myfloridacfo.com/division/WC/employee/records.htm.

Records privacy requests are processed in two or less business days on average and a follow-up email process allows notification to the requestor of the status of the exemption request. Questions regarding records privacy can be emailed to DWCRecordsPrivacy@myfloridacfo.com.

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.

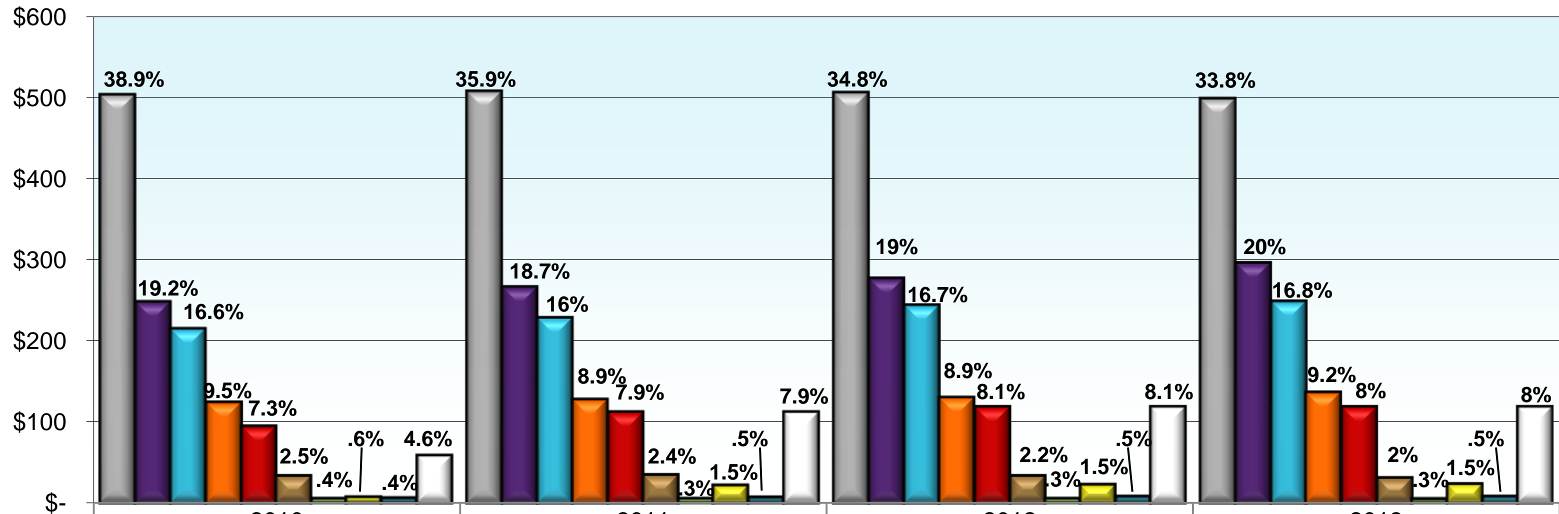
Medical bill reimbursement amounts may be based on prices negotiated by the claim administrator or the maximum reimbursement allowance approved by the Three-Member Panel and contained in reimbursement manuals adopted by the Division of Workers' Compensation. Prescription reimbursement amounts are based 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. When medical bills are received, the Division screens them by applying hundreds of edits that reject bills which do not meet Division requirements. The submitter is notified immediately if the submitted bill failed the edits and was subsequently rejected. Rejected medical bills are not considered timely filed until corrected, re-submitted, and accepted by the Division.

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 Division yearly reports due to payment disputes being resolved or adjustments to previously submitted medical bill data.

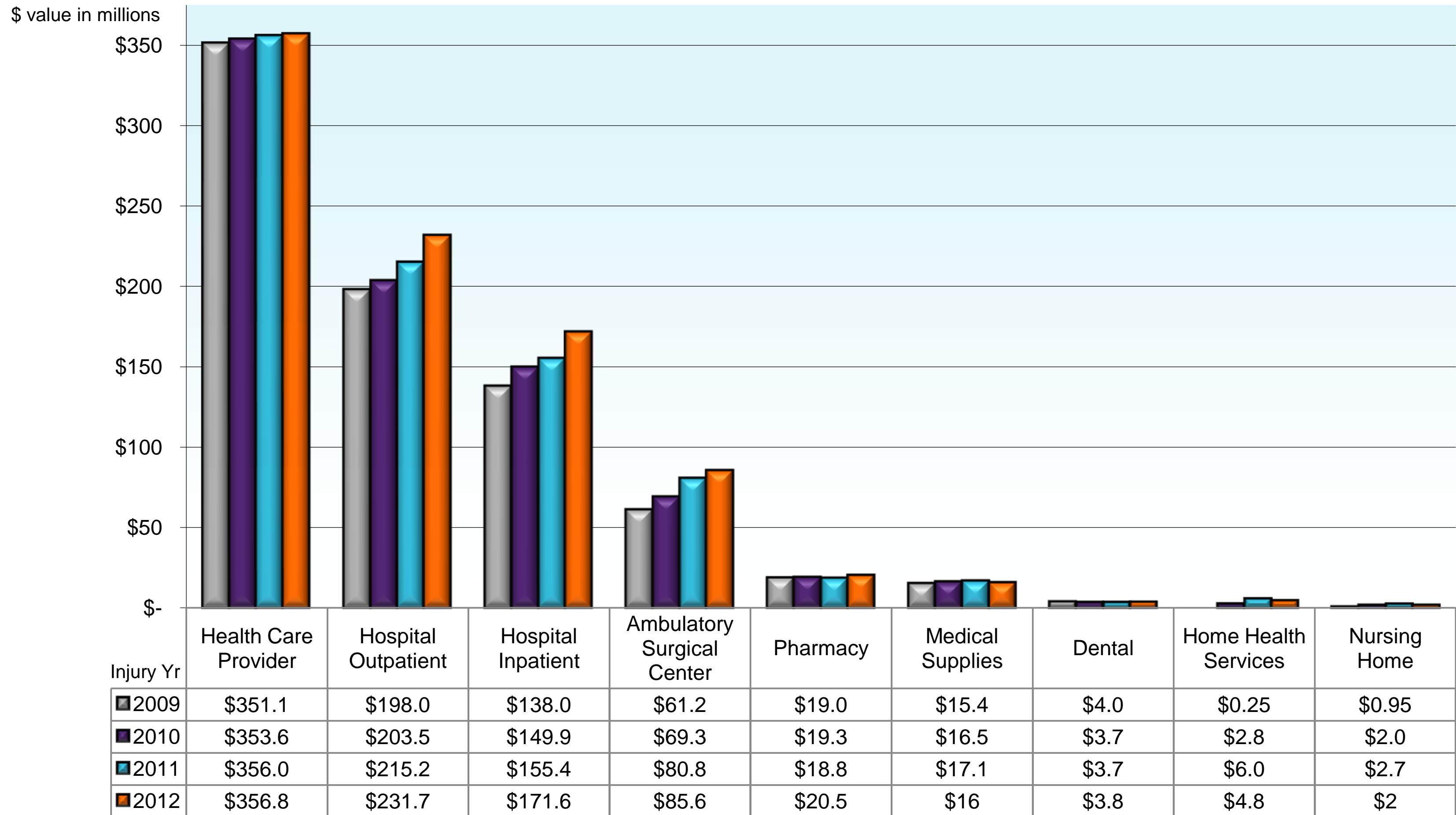
Medical Payments* by Cost Type and Distribution

$ value in millions



	2010	2011	2012	2013
Health Care Provider	$503.8	$508.0	$506.6	$498.9
Hospital Outpatient	$247.7	$265.6	$276.5	$295.6
Hospital Inpatient	$214.0	$227.3	$242.7	$247.6
Pharmacy	$123.0	$126.6	$129.0	$135.4
Ambulatory Surgical Center	$94.1	$111.6	$117.8	$117.8
Medical Supplies	$32.5	$33.7	$32.5	$30.2
Dental	$4.9	$4.9	$4.9	$4.6
Home Health Services	$7.4	$20.8	$21.7	$22.2
Nursing Home	$5.6	$6.5	$7.2	$7.5
Unknown/Other	$58.8	$111.6	$117.8	$117.8

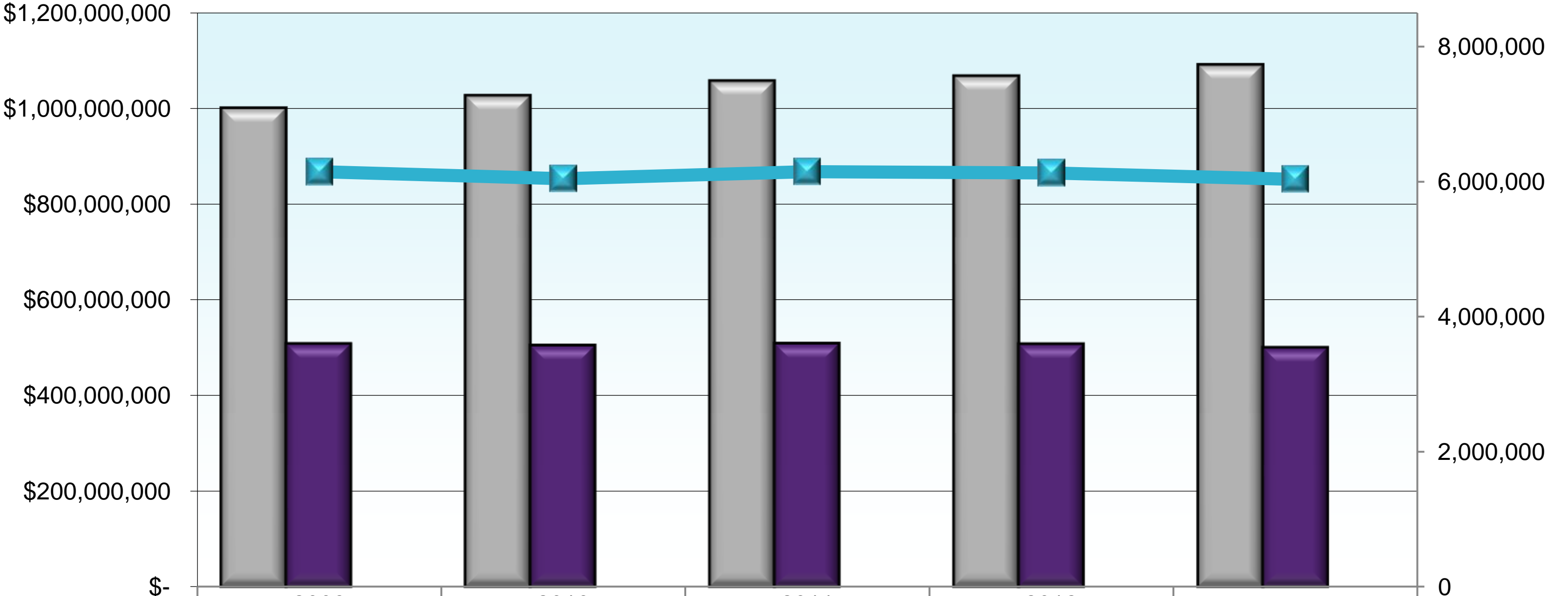
*Excludes bills received beyond six months of the end of the calendar year of service.



Injury Yr	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental	Home Health Services	Nursing Home
2009	$351.1	$198.0	$138.0	$61.2	$19.0	$15.4	$4.0	$0.25	$0.95
2010	$353.6	$203.5	$149.9	$69.3	$19.3	$16.5	$3.7	$2.8	$2.0
2011	$356.0	$215.2	$155.4	$80.8	$18.8	$17.1	$3.7	$6.0	$2.7
2012	$356.8	$231.7	$171.6	$85.6	$20.5	$16	$3.8	$4.8	$2

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

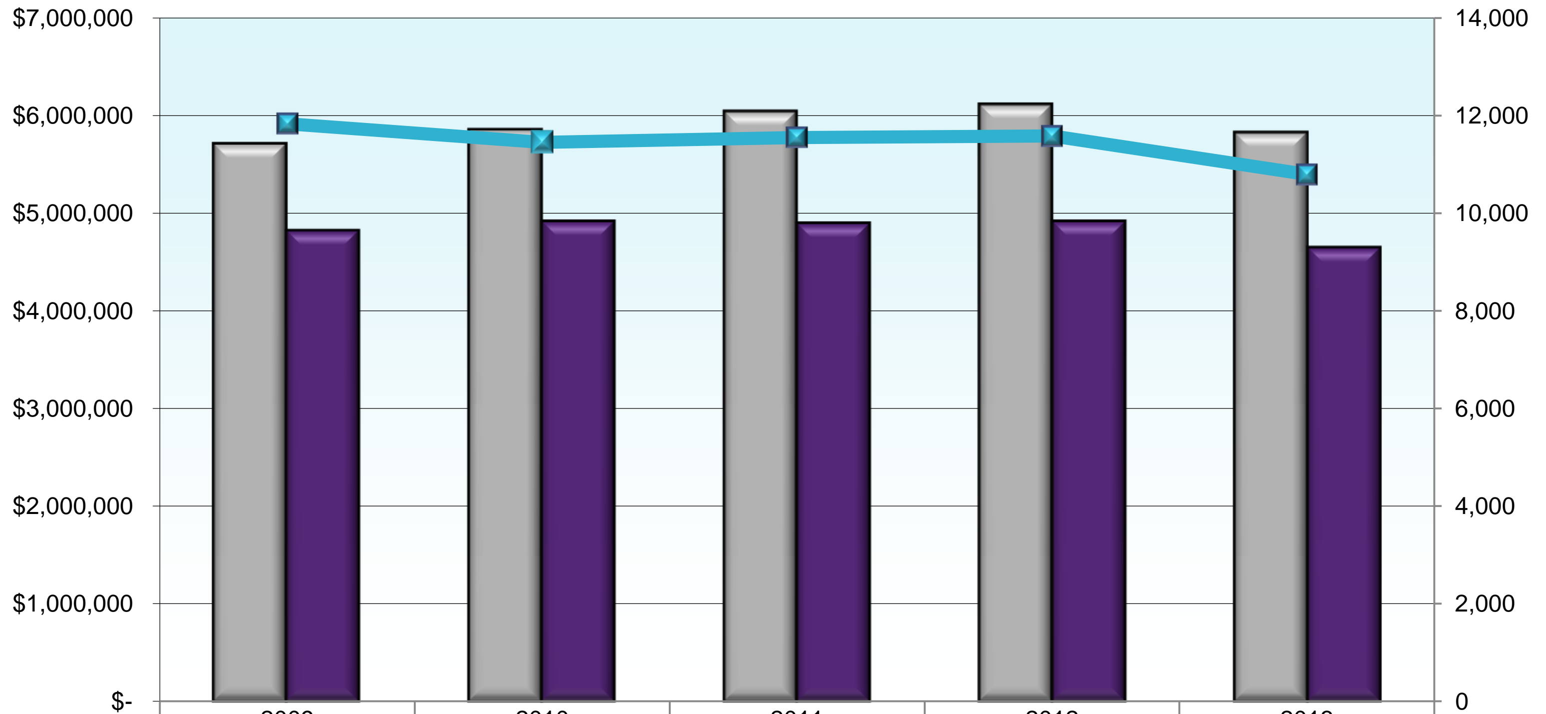
Total Charges and Total Paid for Health Care Provider Services



	2009	2010	2011	2012	2013
Charges	$998,762,054	$1,024,977,348	$1,055,950,603	$1,065,963,358	$1,089,132,422
Paid	$507,105,360	$503,752,351	$508,038,148	$506,662,637	$498,912,819
Avg Chg Per Line Item	$162.50	$169.61	$171.78	$173.92	$180.45
Avg Paid Per Line Item	$82.51	$83.36	$82.64	$82.67	$82.66
Total Line Items	6,146,192	6,043,122	6,147,276	6,128,940	6,035,578

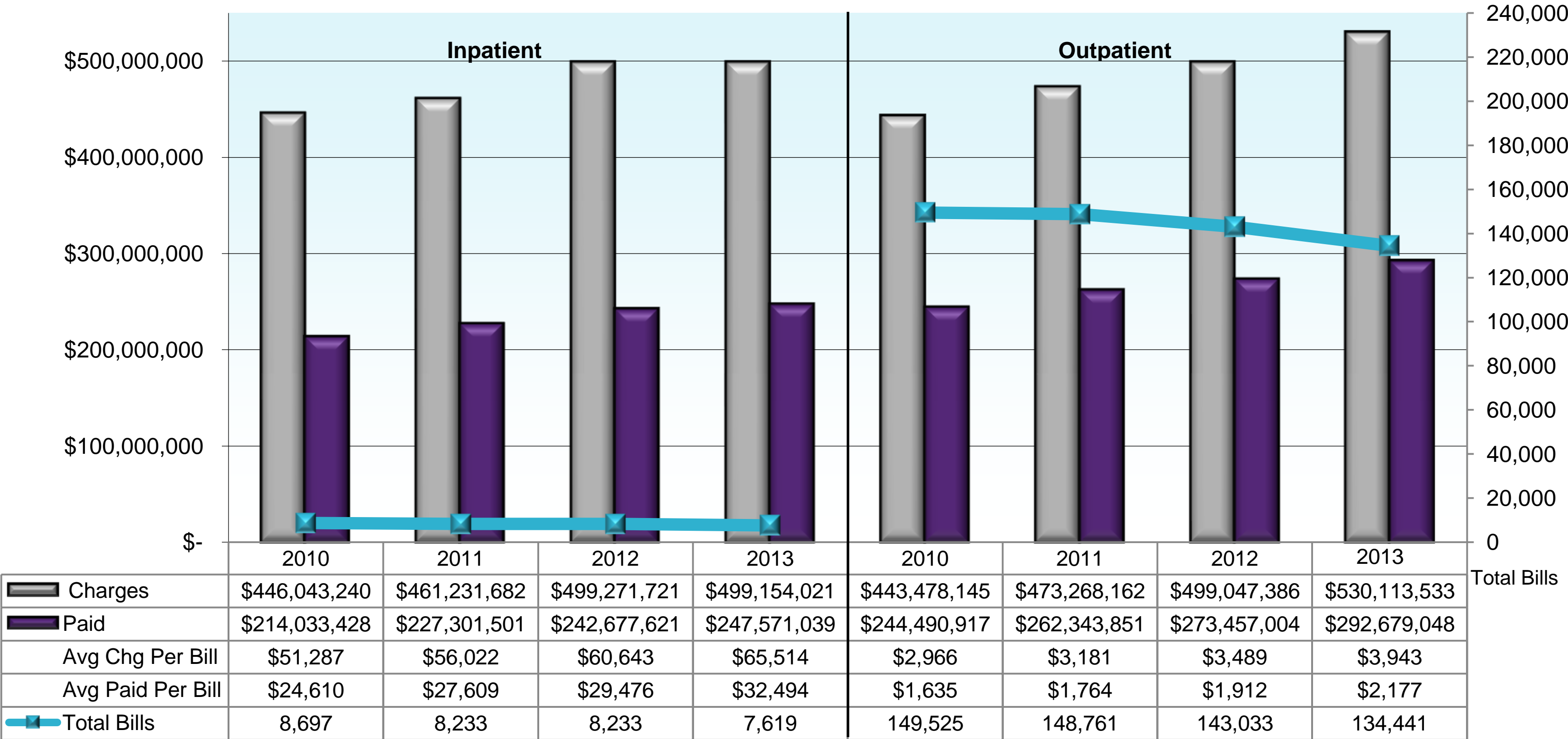
Note: Only bills with payment amount >$0 are included. Prescription drugs & supplies are included when dispensed by a health care provider.

Total Charges and Total Paid for Dental Services



	2009	2010	2011	2012	2013
Charges	5,710,535	5,854,252	6,041,692	6,115,054	5,824,367
Paid	4,812,797	4,908,907	4,887,736	4,906,953	4,638,318
Avg Chg Per Line Item	$483	$511	$523	$528	$540
Avg Paid Per Line Item	$407	$429	$423	$424	$430
Total Line Items	11,833	11,452	11,552	11,581	10,793

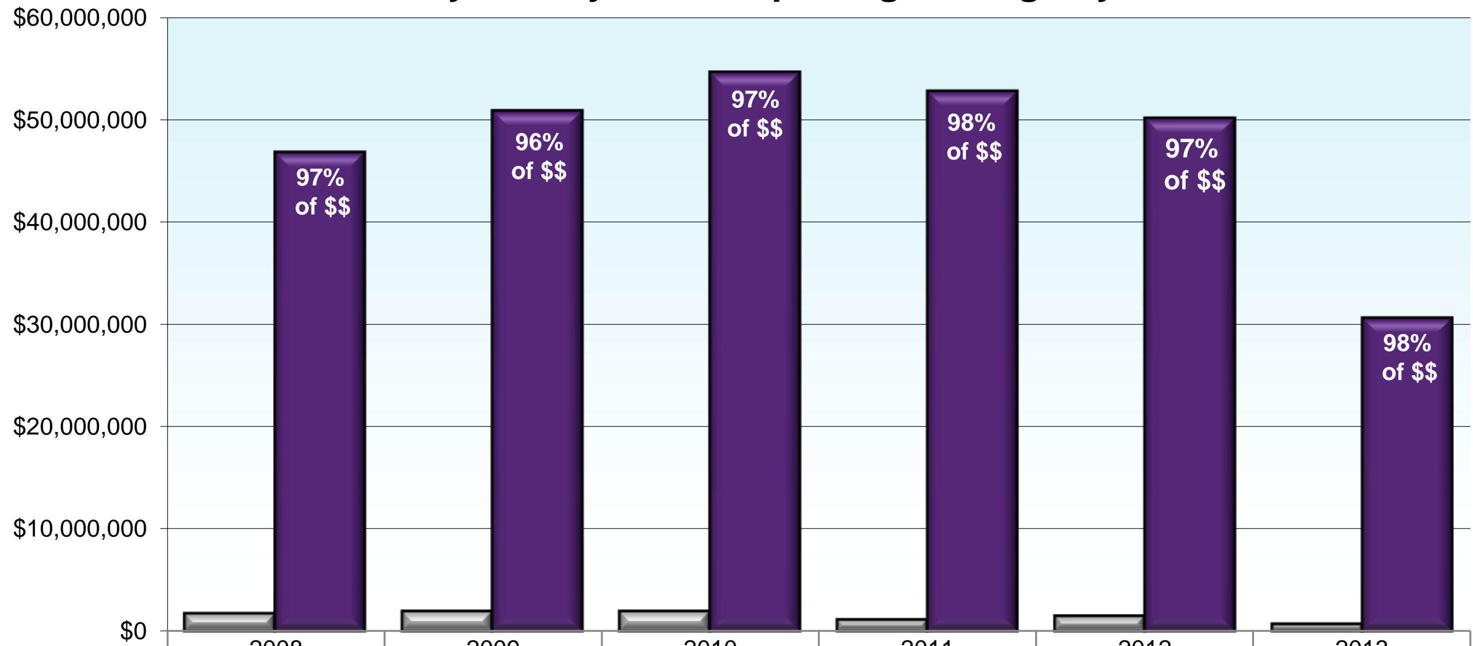
Note: Only bills with payment amount >$0 are included.



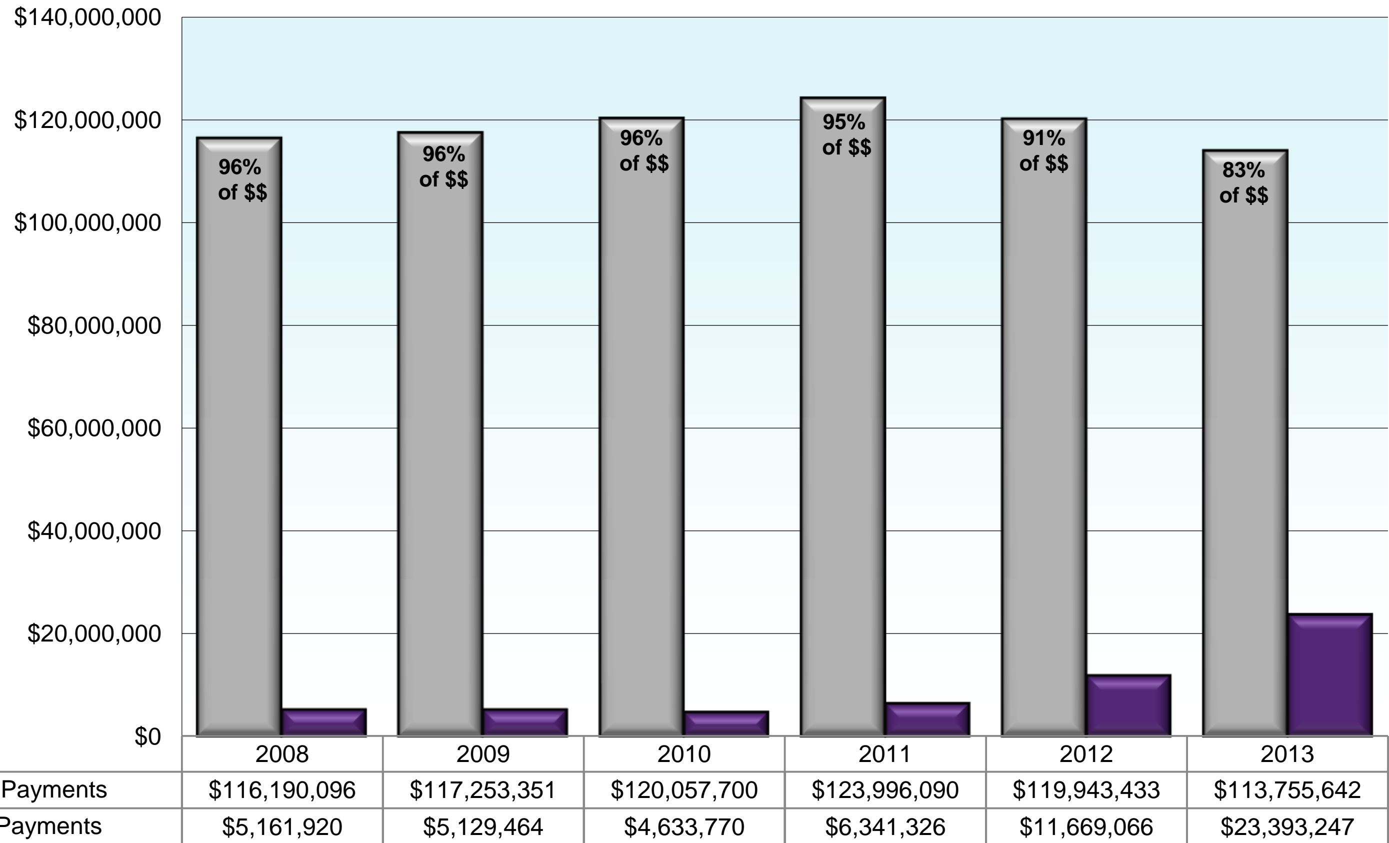
	Inpatient 2010	Inpatient 2011	Inpatient 2012	Inpatient 2013	Outpatient 2010	Outpatient 2011	Outpatient 2012	Outpatient 2013
Charges	$446,043,240	$461,231,682	$499,271,721	$499,154,021	$443,478,145	$473,268,162	$499,047,386	$530,113,533
Paid	$214,033,428	$227,301,501	$242,677,621	$247,571,039	$244,490,917	$262,343,851	$273,457,004	$292,679,048
Avg Chg Per Bill	$51,287	$56,022	$60,643	$65,514	$2,966	$3,181	$3,489	$3,943
Avg Paid Per Bill	$24,610	$27,609	$29,476	$32,494	$1,635	$1,764	$1,912	$2,177
Total Bills	8,697	8,233	8,233	7,619	149,525	148,761	143,033	134,441

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

Pharmacy vs. Physician Repackaged Drug Payments

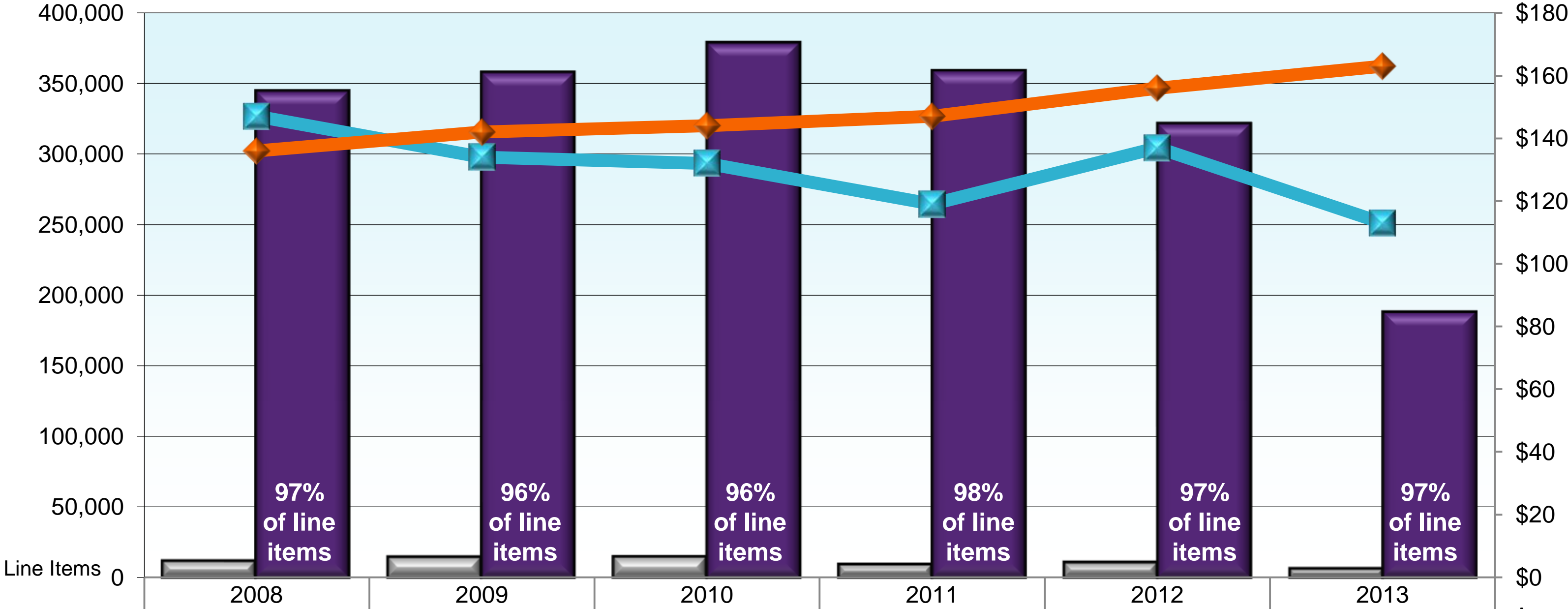


	2008	2009	2010	2011	2012	2013
Pharmacy Repackaged Total Payments	$1,655,418	$1,883,399	$1,866,837	$1,071,158	$1,421,189	$684,832
Physician Repackaged Total Payments	$46,748,580	$50,789,715	$54,527,237	$52,684,976	$50,051,562	$30,599,651



	2008	2009	2010	2011	2012	2013
Pharmacy Nonrepackaged Total Payments	$116,190,096	$117,253,351	$120,057,700	$123,996,090	$119,943,433	$113,755,642
Physician Nonrepackaged Total Payments	$5,161,920	$5,129,464	$4,633,770	$6,341,326	$11,669,066	$23,393,247

Pharmacy vs. Physician Repackaged Drugs

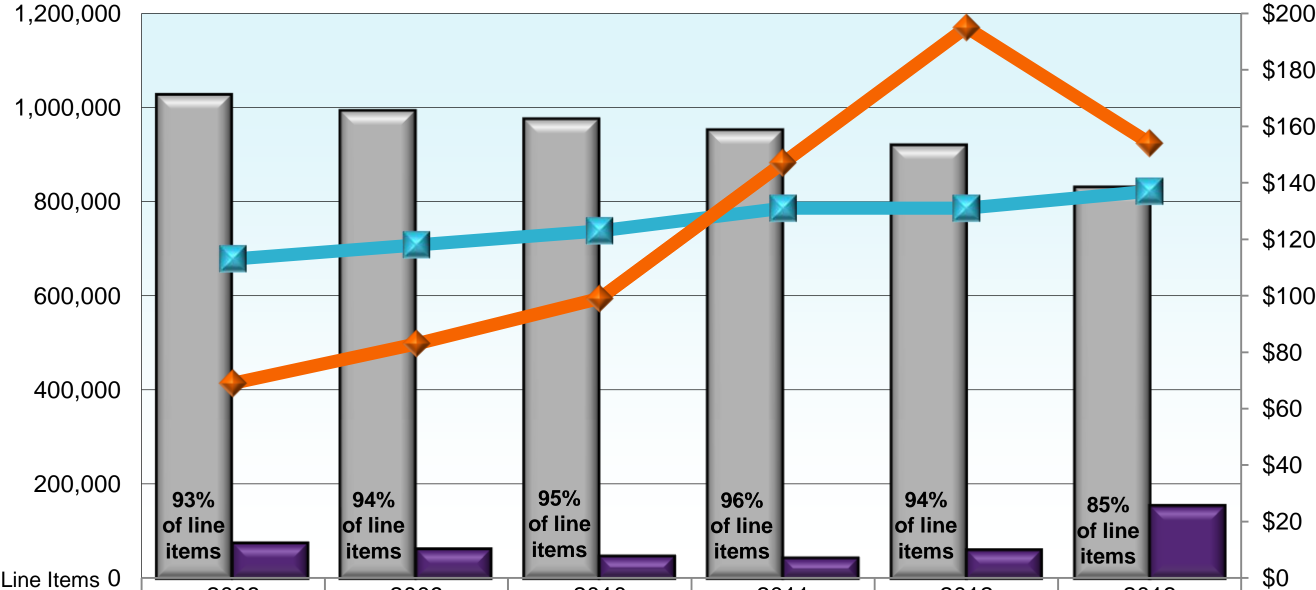


	2008	2009	2010	2011	2012	2013
Pharmacy Repackaged Line Items	11,226	14,058	14,132	8,977	10,382	6,076
Physician Repackaged Line Items	344,307	357,557	378,356	358,506	321,232	188,069
Pharmacy Repackaged Avg $ Per Line Item	$147	$134	$132	$119	$137	$113
Physician Repackaged Avg $ Per Line Item	$136	$142	$144	$147	$156	$163

Avg Paid per Line Item

Graph compares drugs billed on DWC-10 forms (dispensed by pharmacies) to drugs billed on DWC-9 forms (dispensed by physicians).
Reference to line items also means per prescription.

Pharmacy vs. Physician Nonrepackaged Drugs



	2008	2009	2010	2011	2012	2013
Pharmacy Nonrepackaged Line Items	1,024,752	991,002	973,247	950,132	918,589	829,543
Physician Nonrepackaged Line Items	74,582	61,838	46,995	43,094	59,806	151,891
Pharmacy Nonrepackaged Avg $ Paid Per Line Item	$113.00	$118.00	$123.00	$131.00	$131.00	$137.00
Physician Nonrepackaged Avg $ Paid Per Line Item	$69.00	$83.00	$99.00	$147.00	$195.00	$154.00

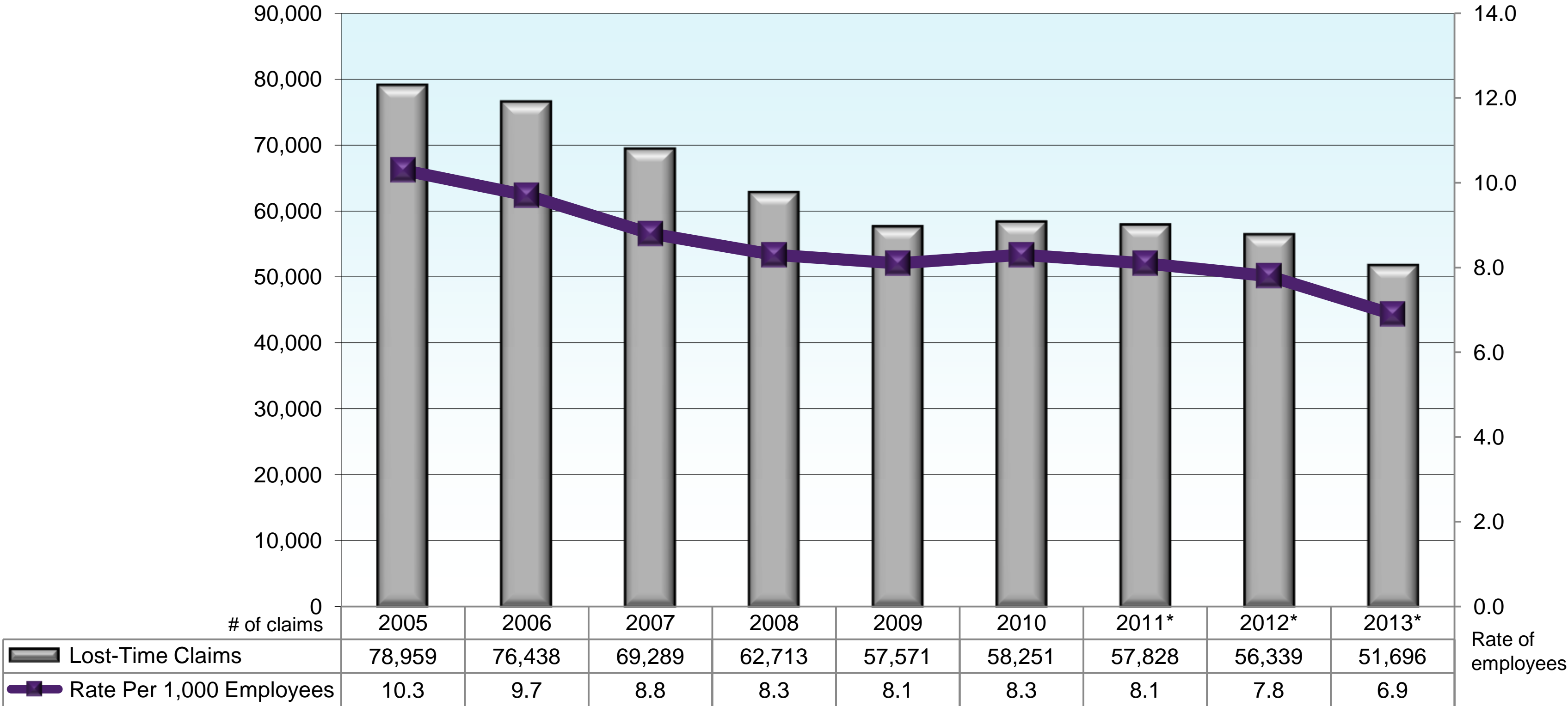
Graph compares drugs billed on DWC-10 forms (dispensed by pharmacies) to drugs billed on DWC-9 forms (dispensed by physicians).
Reference to line items also means per prescription.

Workers sustaining a compensable injury are entitled to receive medically necessary treatment under Florida's workers' compensation statute. If the injury results in disability for more than seven ays, the injured worker is entitled to payment for a portion of lost wages. Injuries resulting in permanent impairment result in additional benefits being paid to the injured employee. When an injury results in a workplace fatality, survivor dependent benefits and funeral expenses may be paid.

Multiple factors are considered when determining if benefit payments for lost wages or permanent impairments are due: 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. To be deemed a Lost-Time case, an injured worker's disability must result in a benefit payment(s) for lost wages, a permanent impairment, or a settlement.

Top Ten Industrial Classifications for 2013 Lost-Time Claims

	Number of Claims
Administrative, Support, Waste Management, Remediation	6,617
Retail Trade	5,839
Construction	5,016
Health Care & Social Assistance	4,917
Accommodation & Food Services	4,570
Public Administration	4,293
Manufacturing	3,780
Transportation & Warehousing	3,264
Educational Services	3,078
Wholesale Trade	1,906



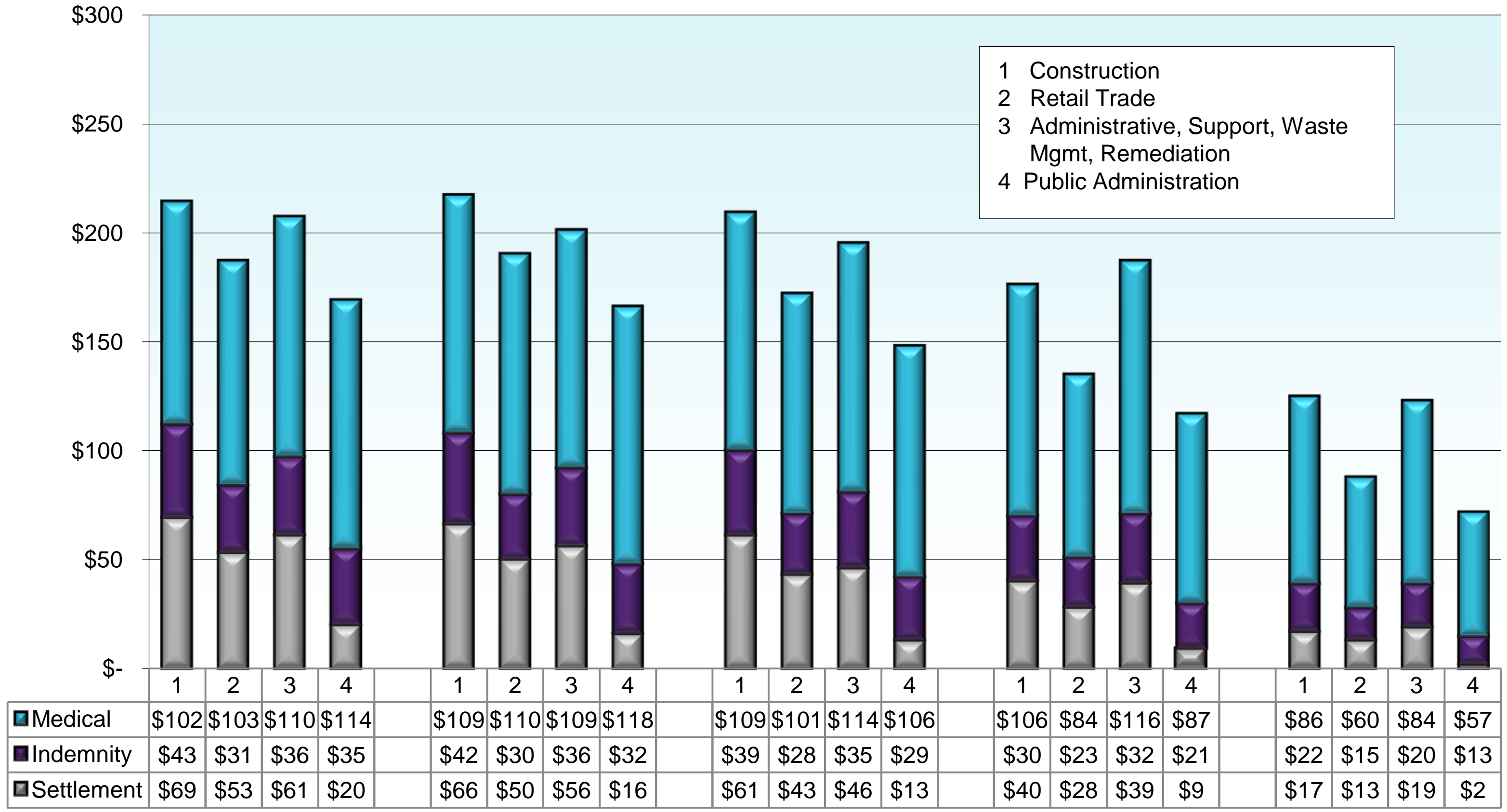
	2005	2006	2007	2008	2009	2010	2011*	2012*	2013*
Lost-Time Claims	78,959	76,438	69,289	62,713	57,571	58,251	57,828	56,339	51,696
Rate Per 1,000 Employees	10.3	9.7	8.8	8.3	8.1	8.3	8.1	7.8	6.9

*Preliminary Data

Source: Florida Department of Economic Opportunity, Current Employment Statistics, Office of Labor Market Statistics, March 2014

**Lost-time claim frequencies as of 6/30/14, based on the most recent information from insurers about determinations & dispositions.

The chart below illustrates the total benefit payments for the four industrial classifications whose benefit payments for medical, indemnity, and settlement benefits are the highest. Each year represents a different level of data maturity with 2009 and 2010 being deemed mature.



Injury Yr	2009 1	2009 2	2009 3	2009 4	2010 1	2010 2	2010 3	2010 4	2011* 1	2011* 2	2011* 3	2011* 4	2012* 1	2012* 2	2012* 3	2012* 4	2013* 1	2013* 2	2013* 3	2013* 4
Medical	$102	$103	$110	$114	$109	$110	$109	$118	$109	$101	$114	$106	$106	$84	$116	$87	$86	$60	$84	$57
Indemnity	$43	$31	$36	$35	$42	$30	$36	$32	$39	$28	$35	$29	$30	$23	$32	$21	$22	$15	$20	$13
Settlement	$69	$53	$61	$20	$66	$50	$56	$16	$61	$43	$46	$13	$40	$28	$39	$9	$17	$13	$19	$2

Medically necessary treatment for a work-related injury may involve: the 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. Until recovery of the injured employee is achieved, medical benefits continue.

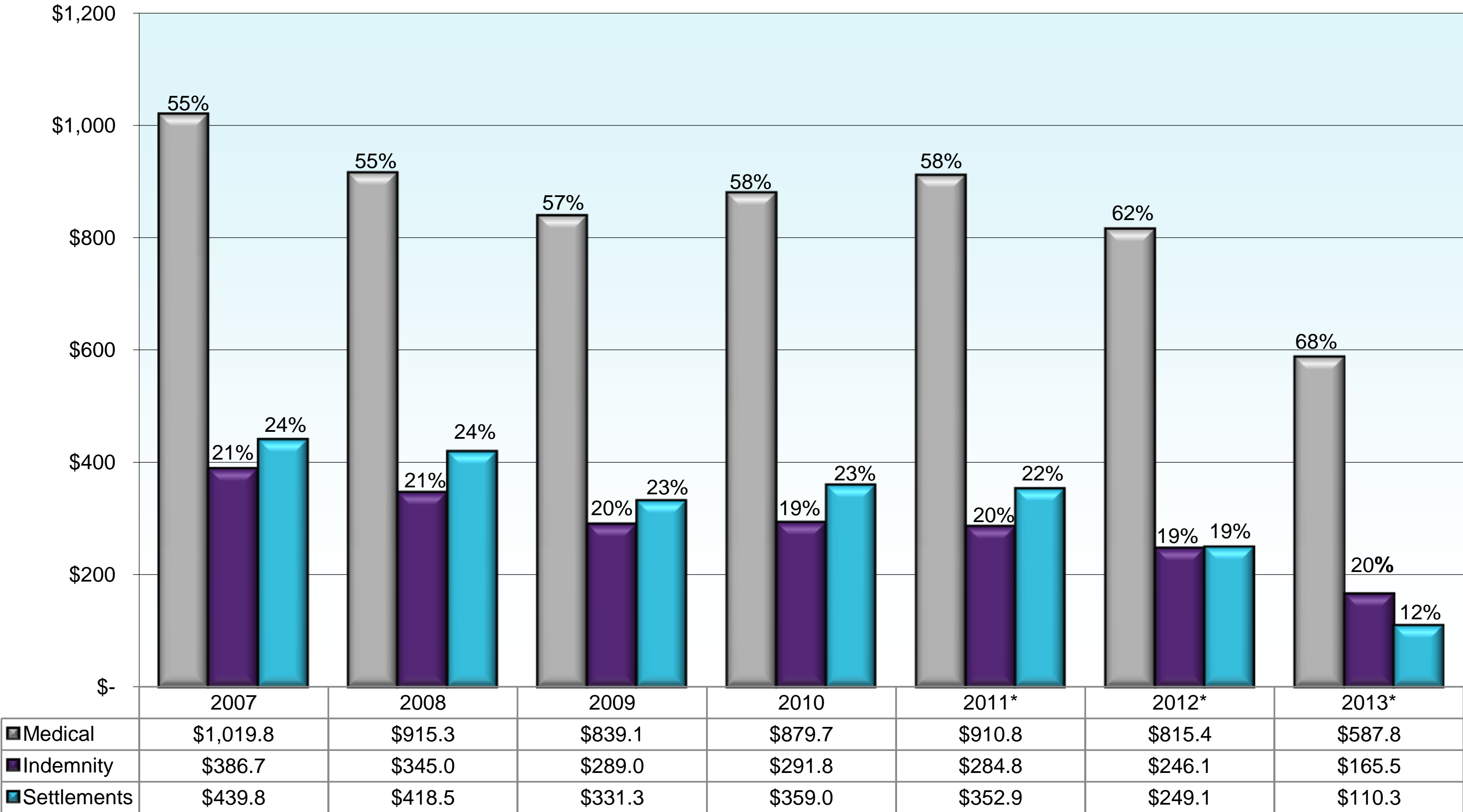
Medical Payments for Lost-Time Claims

Calendar Year	Health Care Providers, Dental, Ambulatory Surgical Center	Hospital	Pharmacy	All Other Medical
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	33.6%	44.6%	5.1%	16.7%
2011*	30.9%	47.0	4.8%	17.3%
2012*	30.3%	50.1%	4.2%	15.4%
2013*	27.5%	53.6%	3.2%	15.7%

*Preliminary data

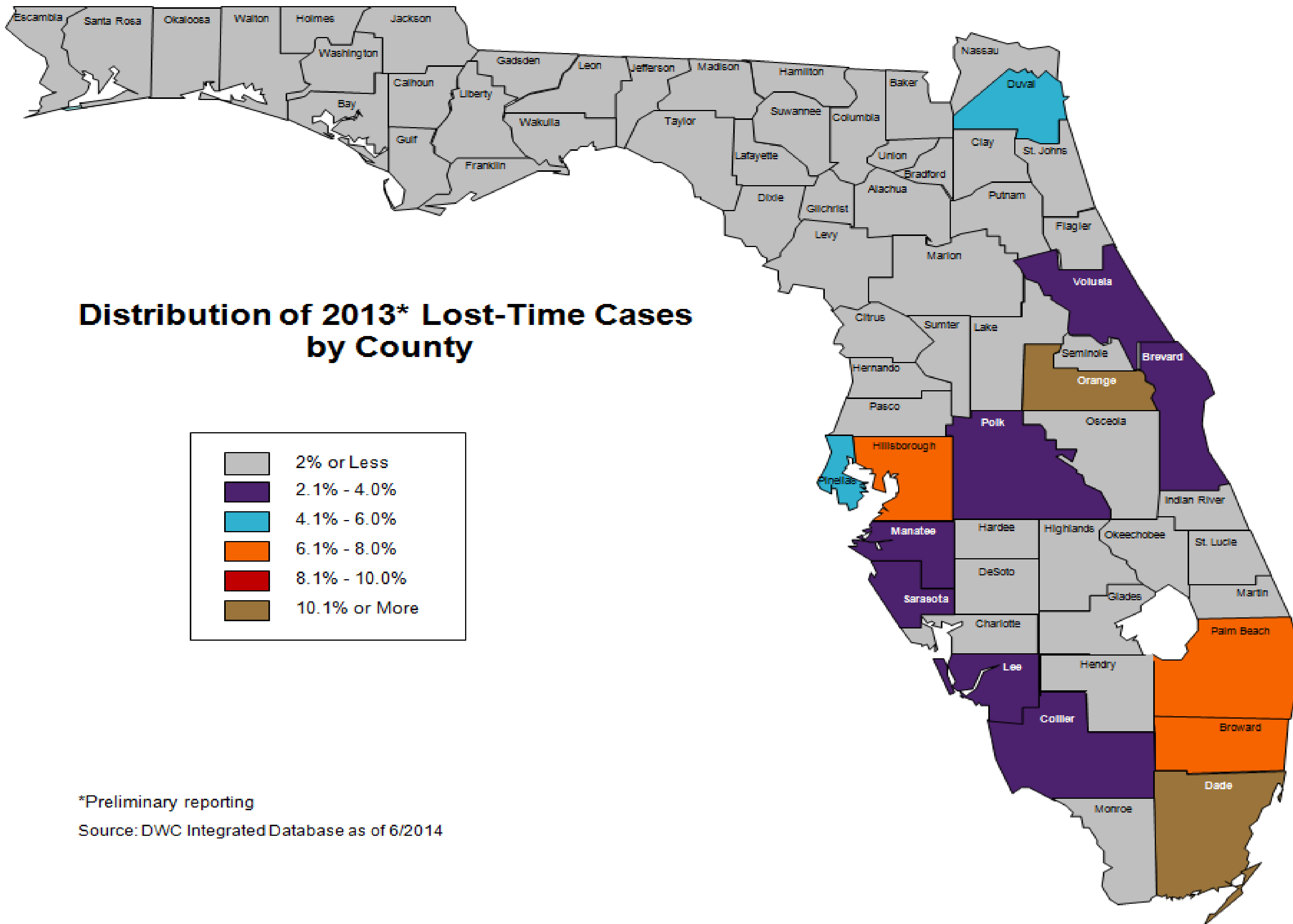
Medical, Indemnity, and Settlement Costs for Lost-Time Claims

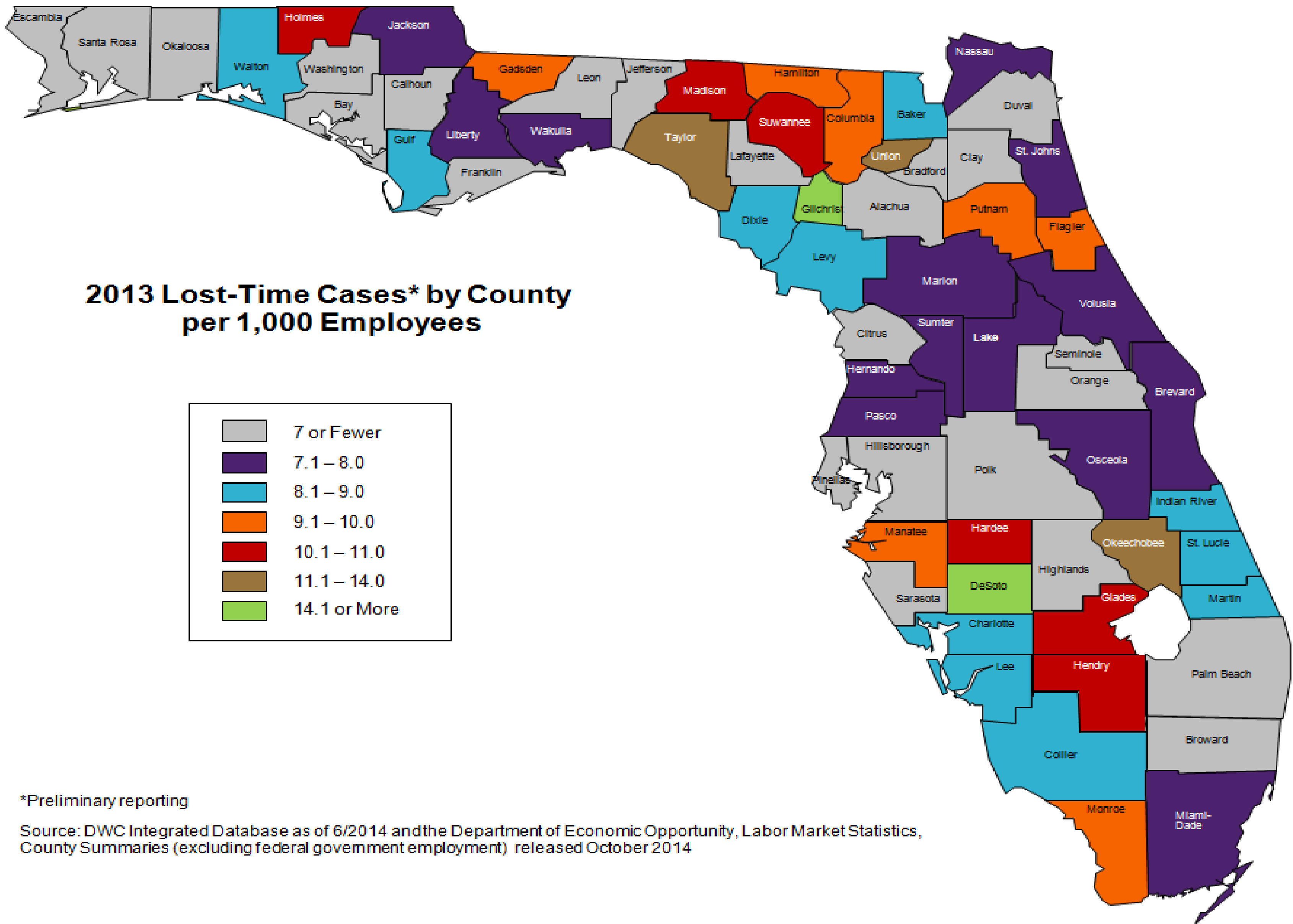
$ value in millions



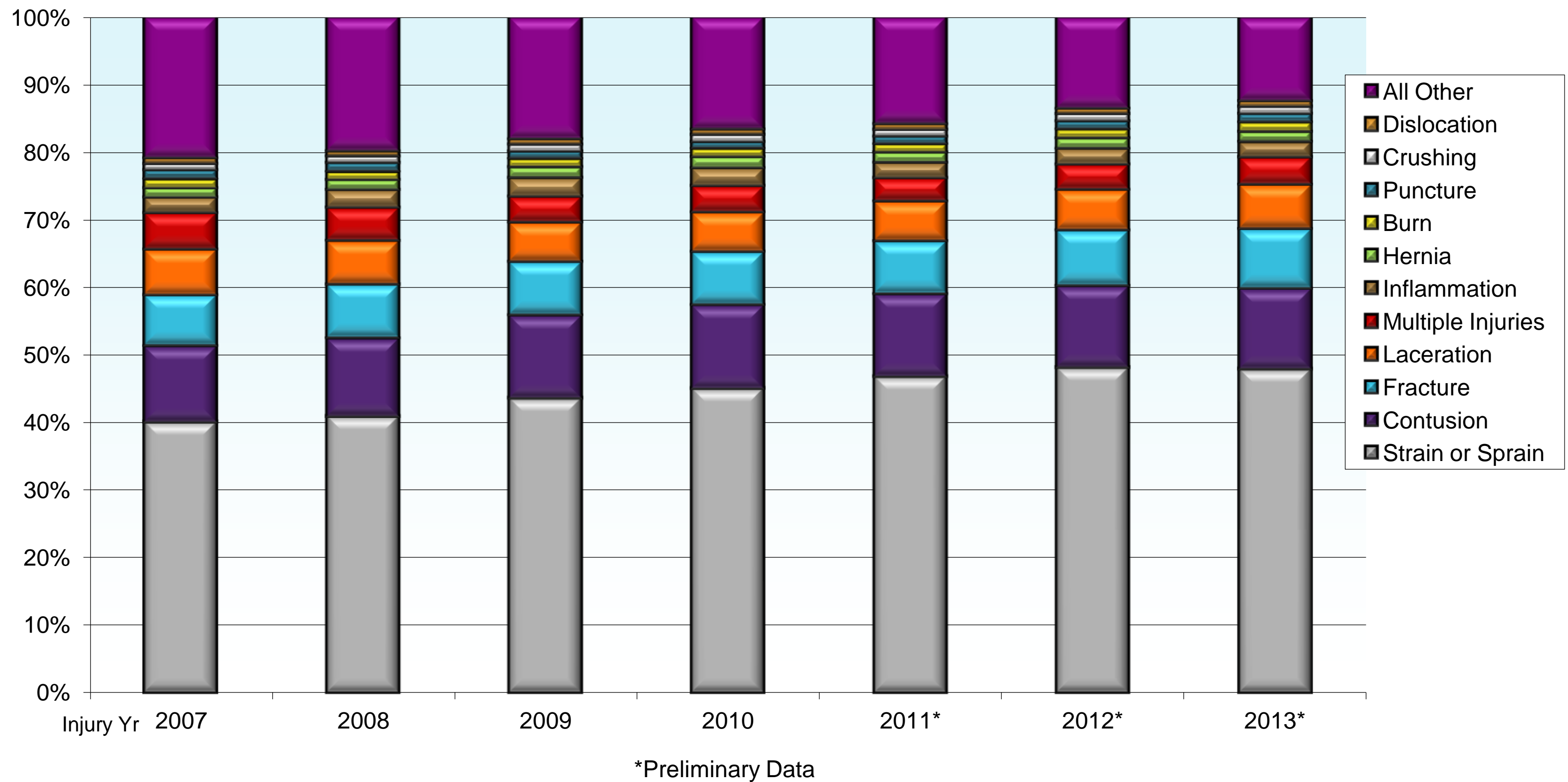
	2007	2008	2009	2010	2011*	2012*	2013*
Medical	$1,019.8	$915.3	$839.1	$879.7	$910.8	$815.4	$587.8
Indemnity	$386.7	$345.0	$289.0	$291.8	$284.8	$246.1	$165.5
Settlements	$439.8	$418.5	$331.3	$359.0	$352.9	$249.1	$110.3

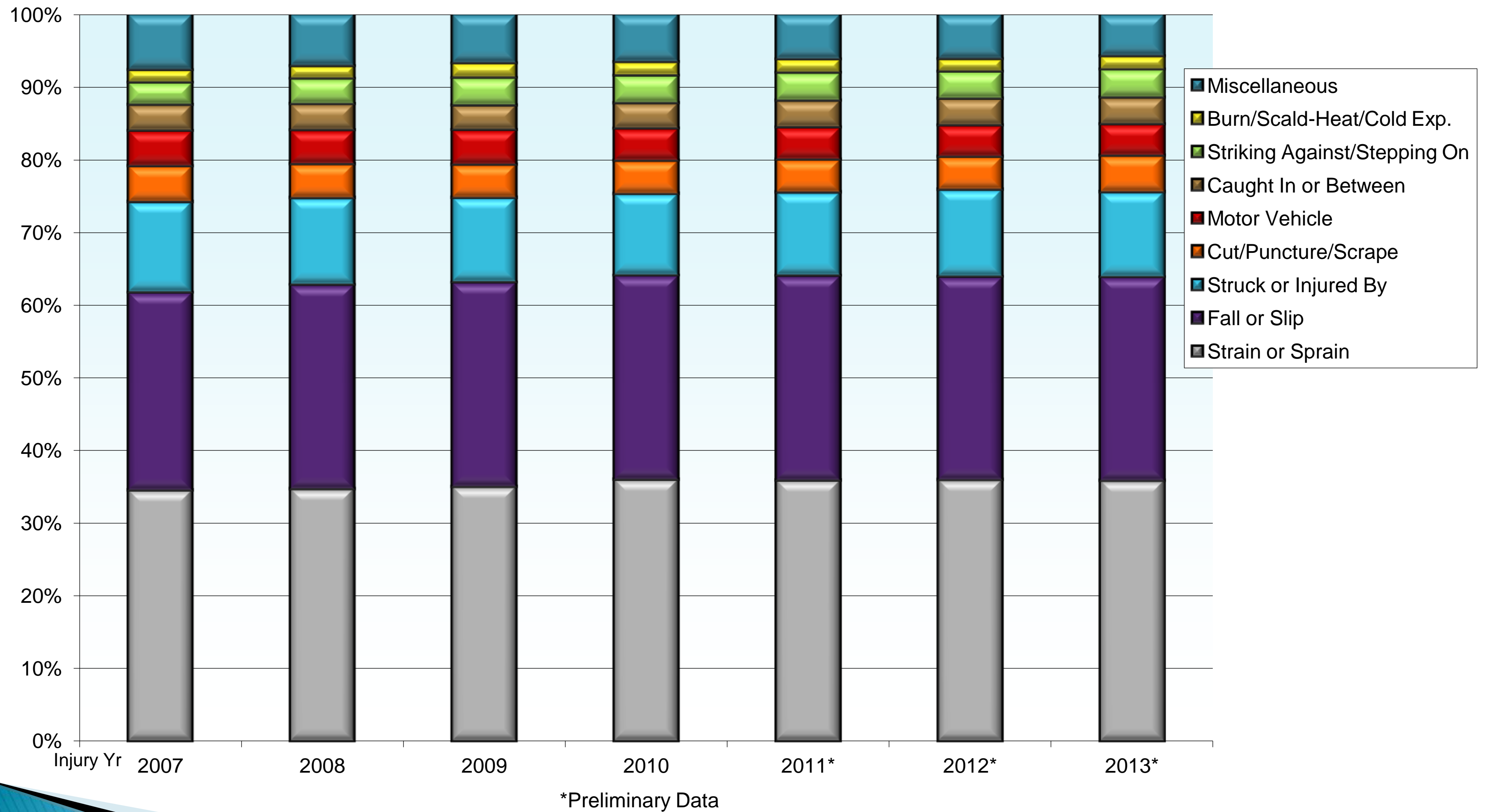
*Preliminary data, amounts unadjusted for inflation

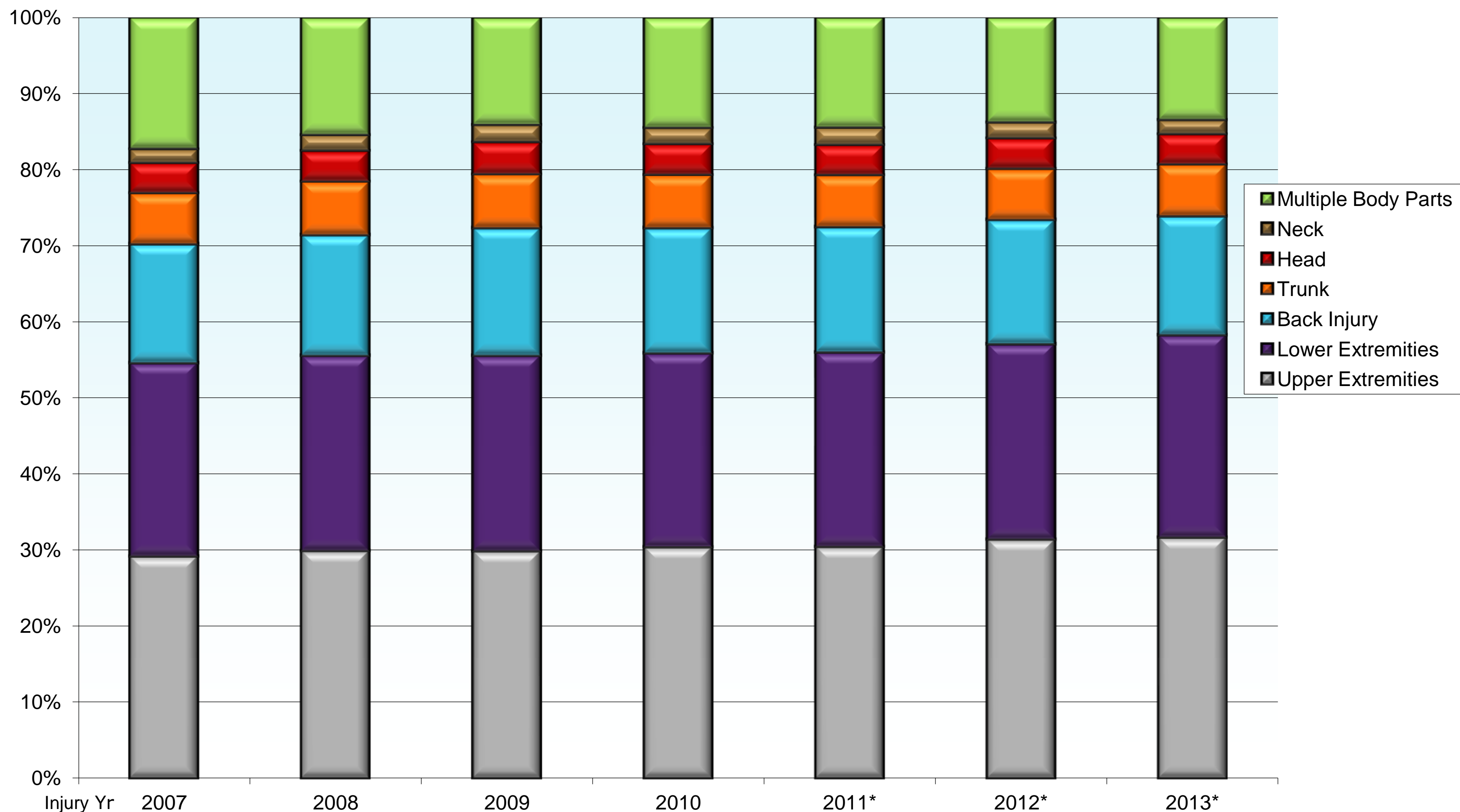

Distribution of 2013* Lost-Time Cases by County
2% or Less
2.1% - 4.0%
4.1% - 6.0%
6.1% - 8.0%
8.1% - 10.0%
10.1% or More
*Preliminary reporting
Source: DWC Integrated Database as of 6/2014
Escambia
Santa Rosa
Okaloosa
Walton
Holmes
Jackson
Washington
Bay
Calhoun
Gulf
Liberty
Franklin
Gadsden
Wakulla
Leon
Jefferson
Madison
Taylor
Hamilton
Suwannee
Lafayette
Dixie
Columbia
Baker
Union
Bradford
Gilchrist
Alachua
Levy
Nassau
Duval
Clay
St. Johns
Putnam
Flagler
Marion
Volusia
Citrus
Sumter
Lake
Seminole
Brevard
Orange
Hernando
Pasco
Polk
Osceola
Pinellas
Hillsborough
Manatee
Hardee
Highlands
Okeechobee
Indian River
St. Lucie
DeSoto
Sarasota
Glades
Martin
Charlotte
Palm Beach
Lee
Hendry
Collier
Broward
Dade
Monroe


2013 Lost-Time Cases* by County per 1,000 Employees
7 or Fewer
7.1 – 8.0
8.1 – 9.0
9.1 – 10.0
10.1 – 11.0
11.1 – 14.0
14.1 or More
Escambia
Santa Rosa
Okaloosa
Walton
Holmes
Washington
Jackson
Bay
Calhoun
Gulf
Liberty
Gadsden
Franklin
Leon
Wakulla
Jefferson
Madison
Taylor
Hamilton
Suwannee
Lafayette
Columbia
Dixie
Gilchrist
Baker
Union
Bradford
Nassau
Duval
Clay
St. Johns
Alachua
Putnam
Flagler
Levy
Marion
Volusia
Citrus
Sumter
Lake
Seminole
Orange
Hernando
Brevard
Pasco
Hillsborough
Pinellas
Polk
Osceola
Indian River
Manatee
Hardee
Okeechobee
St. Lucie
Highlands
DeSoto
Sarasota
Glades
Martin
Charlotte
Lee
Hendry
Palm Beach
Broward
Collier
Monroe
Miami-Dade
*Preliminary reporting
Source: DWC Integrated Database as of 6/2014 and the Department of Economic Opportunity, Labor Market Statistics, County Summaries (excluding federal government employment) released October 2014

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.

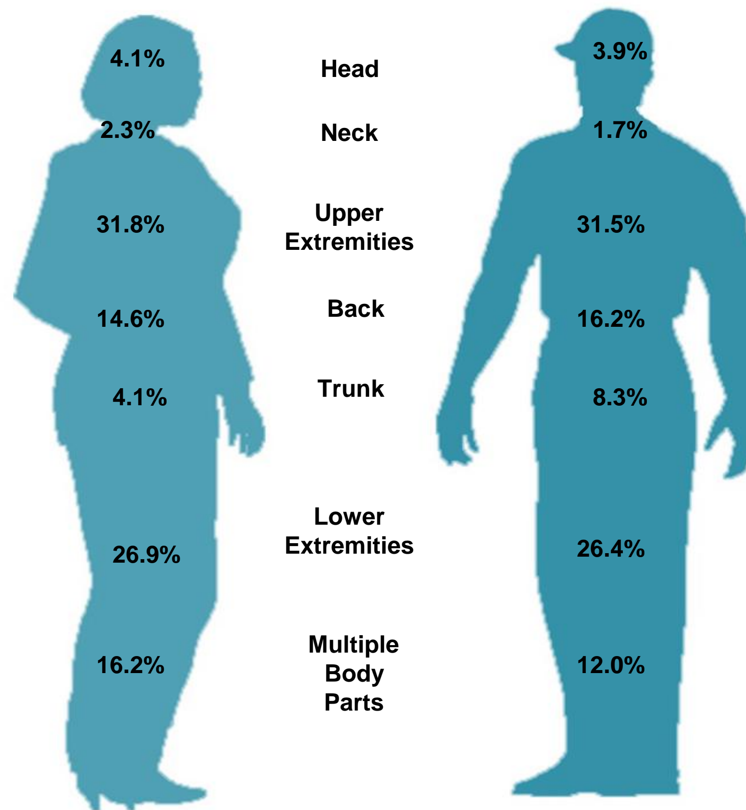



Lost-Time Claims by Cause of Injury
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Injury Yr
2007
2008
2009
2010
2011*
2012*
2013*
Miscellaneous
Burn/Scald-Heat/Cold Exp.
Striking Against/Stepping On
Caught In or Between
Motor Vehicle
Cut/Puncture/Scrape
Struck or Injured By
Fall or Slip
Strain or Sprain
*Preliminary Data



*Preliminary Data

Injury Body Location by Gender for 2013 Lost-Time Claims



DWC Contacts

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Andrew Sabolic, Asst. Director/Acting Bureau Chief

Bureau of Compliance: (850) 413-1609

Robin Delaney, Bureau Chief

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

Websites:

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/division/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.

DWC Organizational Chart