2016 RESULTS AND ACCOMPLISHMENTS REPORT

JEFF ATWATER | CHIEF FINANCIAL OFFICER | 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 Stakeholders and other Interested Parties of Florida's Workers' Compensation System:

On behalf of all Division employees who contribute to the outputs of the Division, we are pleased to present the Division of Workers' Compensation 2016 Results and Accomplishments Report. This report contains pertinent data and information about Florida's workers' compensation system and the regulatory activities of the Division for Fiscal Year 2015-2016. A primary and consistent challenge of the Division is to ensure that we engage stakeholders of Florida's vast workers' compensation system in search of innovative means to improve upon the self-execution of our system.

Our energy and effort towards educating and informing stakeholders of their rights and responsibilities, and holding parties accountable for meeting their obligations are cornerstones of our regulatory efforts and our Mission Statement. We continue to leverage technology and data to fulfill our statutory duties in the most cost-effective manner available to the division.

In this year's report you will learn about a value-added report that was developed to provide insurers a comprehensive analysis of their performance. The Insurer Regulatory Report, developed by multiple program areas of the Division, details audit performance and includes comparison data regarding an insurer's past and current level of execution, and benchmarks their overall industry performance. In addition, you will also note that we have realized an approximate 43% decrease in medical reimbursement disputes submitted to the Division.

As we move towards 2017, we would like to pledge and assure all stakeholders that the Division stands ready to provide whatever support is necessary to ensure a healthy and viable system.

We welcome any suggestions and comments, as we continue to search for meaningful ways to improve the performance of your workers' compensation system for all stakeholders.

Sincerely,

E. Tanner Holloman

Tanner Holloman, Director
Division of Workers' Compensation

Andrew Sabolic

Andrew Sabolic, Assistant Director
Division of Workers' Compensation

DIVISION OF WORKERS' COMPENSATION
2016 RESULTS & ACCOMPLISHMENTS REPORT

Note: All data contained herein were extracted from the Division of Workers' Compensation resources as of 6/30/16, unless otherwise noted.

BUREAU OF MONITORING & AUDIT

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.

A new initiative for Fiscal Year 2015-2016 was the Insurer Regulatory Report. These reports are issued to insurers selected for audits. The reports detail past performance of the insurer and compare it to the industry performance, and they contain data from other bureaus within the Division of Workers' Compensation. A sample report is available at the link below.

Insurer Regulatory Report

M&A also conducted additional audit training through on-site or webinar sessions. These sessions offer guidance regarding claim handling and compliance with statutes and rules. 32 of these training sessions were held in Fiscal Year 2015-2016.

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

- Audit Section
- Permanent Total Disability Section
- Centralized Performance System Section (CPS)
- 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 50 on-site insurer audits and examined 5,809 insurer claim files during Fiscal Year 2015-2016. The bureau conducted several audits requiring two or more audit teams due to multiple locations of the insurer's claims. In addition, two of these multi-location audits were conducted over a period of two weeks. This is equivalent to 12 additional M&A audits.

The Audit Section discovered 17.52% of the reviewed indemnity claim files contained underpayments resulting in $337,727 of additional injured worker payments for indemnity benefits, penalties, and interest.

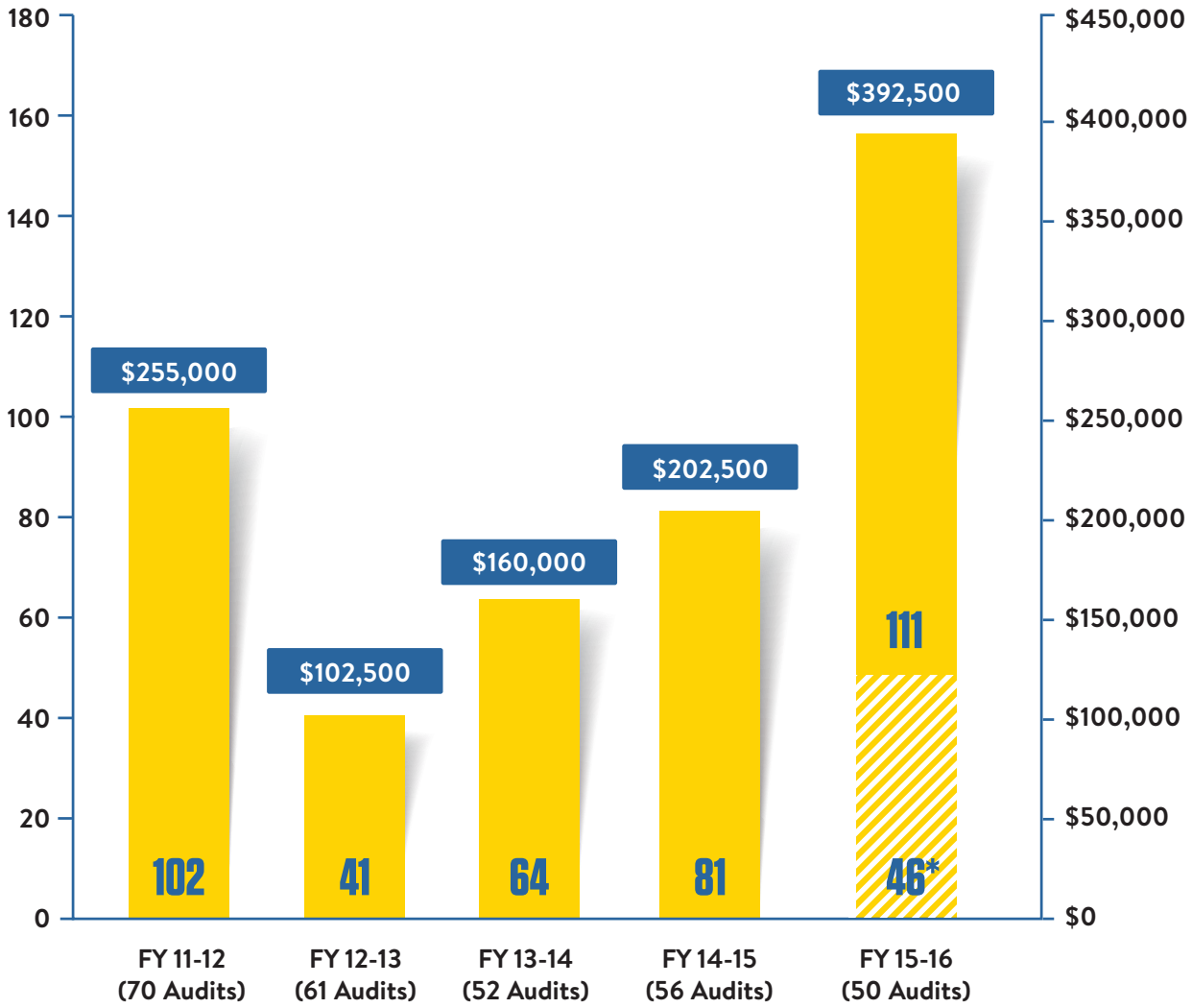
The table below illustrates penalties assessed during audits for untimely indemnity payments and untimely First Reports of Injury or Illness on denied claims that were not processed through CPS.

Fiscal Year	Total Number of Untimely Indemnity Payments	Total Amount of Penalties Issued for Untimely Indemnity Payments	Total Number of Untimely First Reports of Injury or Illness	Total Amount of Penalties Issued for Untimely First Reports of Injury or Illness
11-12	2,268	$87,000	318	$51,200
12-13	1,619	$64,200	219	$27,500
13-14	1,836	$70,850	277	$25,800
14-15	2,013	$83,300	359	$60,300
15-16	2,771	$99,400	558	$78,900

NON-WILLFUL PATTERN AND PRACTICE PENALTIES BY FISCAL YEAR

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

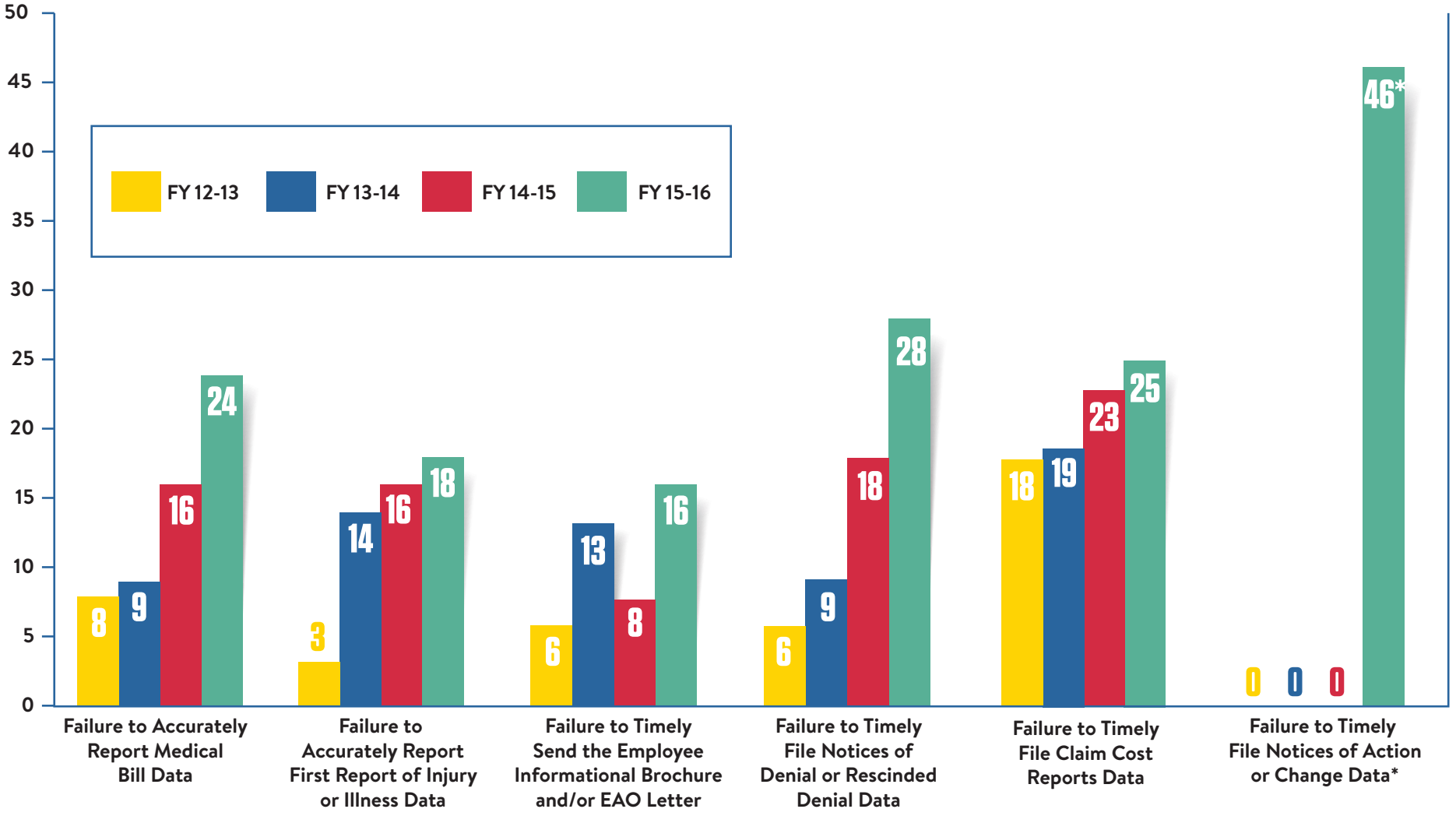
Fiscal Year 2015-2016 saw an increase in assessed non-willful pattern and practice penalties over Fiscal Year 2014-2015. The five-year average of the number of non-willful pattern and practice penalties is 89, while the total five-year average of monetary penalties is $222,500.



*Please note that FY 15-16 was the first year M&A began assessing Pattern and Practice Penalties for Untimely Notices of Action or Change. 46 of the 157 penalties were assessed for Untimely Notices of Action or Change.

A Notice of Action or Change provides the injured worker and the division with claim status changes.

NON-WILLFUL PATTERN & PRACTICE PENALTIES BY CATEGORY AND FISCAL YEAR



* Please note that penalties for untimely Notices of Action or Change were not assessed until FY 15-16.

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 2015-2016, the PT Section calculated, approved, and processed supplemental benefits for 987 claims totaling $14,624,725.

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 insurers, 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 2015-2016, the PT Section reviewed 28,993 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.

CENTRALIZED PERFORMACE SYSTEM SECTION

The Centralized Performance System (CPS) Section evaluates and assesses insurer performance of timely payments of initial indemnity benefits and medical bills. The Section also monitors the timely filing of First Reports of Injury or Illness and medical bills monthly using 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
11-12	53,211
12-13	51,690
13-14	52,344
14-15	53,929
15-16	54,731

Fiscal Year	Timely Initial Benefit Payments	Timely Filing of First Reports
11-12	95%	95%
12-13	95%	95%
13-14	95%	95%
14-15	95%	93%
15-16	95%	93%

Fiscal Year	Number of Medical Bills Reviewed Through CPS	Timely Medical Bill Payments	Timely Medical Bill Filings
11-12	3,833,381	99%	99%
12-13	3,860,998	98%	96%
13-14	3,838,076	99%	98%
14-15	3,900,066	99%	99%
15-16	3,841,437	98%	98%

MEDICAL SERVICES SECTION

The Medical Services Section is responsible for establishing 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, as well as 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 over 5,500 Petitions for Resolution of Reimbursement Disputes (Petitions) during Fiscal Year 2015-2016. Reimbursement Disputes must be filed within 45 days from provider's receipt of the carrier's notice of disallowance or adjustment of payment.

PETITIONS SUBMITTED BY PROVIDER TYPE

Fiscal Year	11-12	12-13	13-14	14-15	15-16*
Practitioner	12,460	7,805	8,412	7,323	3,601
ASC	687	737	665	331	400
Hospital Inpatient	332	350	266	453	341
Hospital Outpatient	1,273	1,303	1,069	1,550	1,184
Total	14,752	10,195	10,412	9,657	5,526

* The decrease in practitioner petitions has been a result of the law changes to the reimbursement methodology for repackaged drugs, which became effective on July 1, 2013.

The Medical Services Section issues Dismissals or Determinations for all Petitions received. In Fiscal Year 2015-2016, the Section issued 9,570 Determinations (53%) and 8,546 Dismissals (47%).

The Medical Services Section is responsible for certifying Expert Medical Advisors (EMAs). As of June 30, 2016, there are 141 certified EMAs.

PETITIONS CLOSED BY

Fiscal Year	11-12	12-13	13-14	14-15	15-16
Dismissal	2,259	3,408	4,971	3,093	8,546
Determination	3,365	4,339	5,454	5,761	9,570
Total	5,624	7,747	10,425	8,854	18,116

PETITIONS DISMISSED BY PROVIDER TYPE

Fiscal Year	11-12	12-13	13-14	14-15	15-16
Practitioner	1,647	2,605	4,432	2,374	7,636
ASC	157	216	173	104	175
Hospital Inpatient	109	140	96	181	174
Hospital Outpatient	346	448	270	432	548
Total	2,259	3,409	4,971	3,091	8,533

PETITION DETERMINATIONS BY PROVIDER TYPE

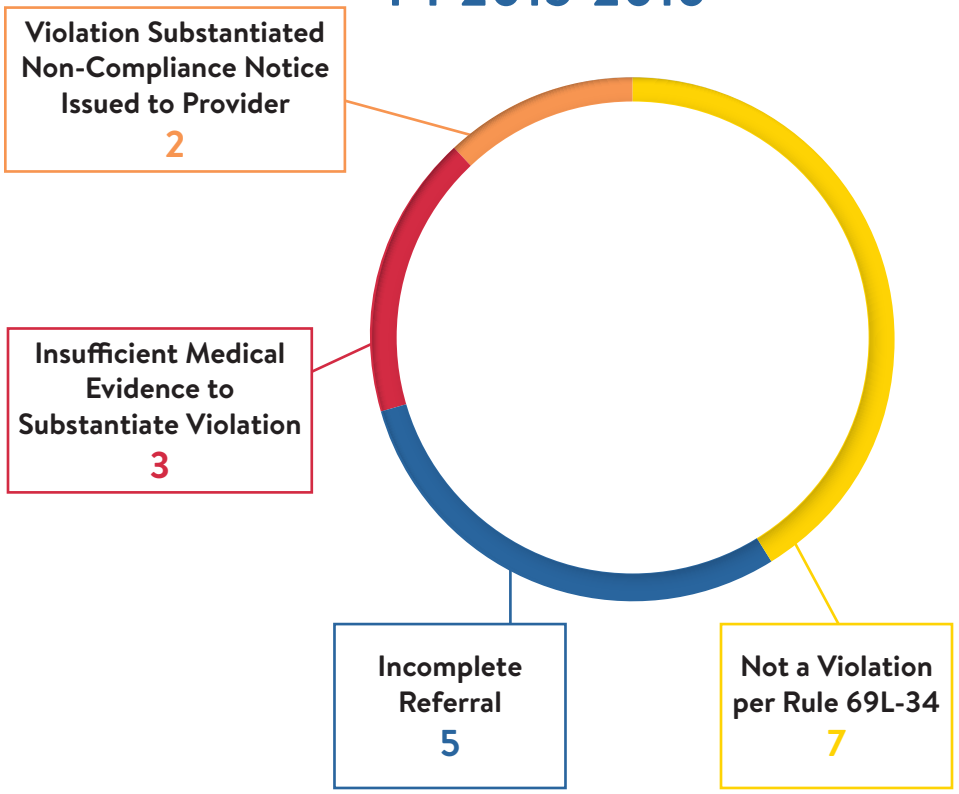
Fiscal Year	11-12	12-13	13-14	14-15	15-16
Practitioner	1,853	2,573	3,992	4,326	8,221
ASC	471	584	512	213	240
Hospital Inpatient	218	217	183	226	215
Hospital Outpatient	823	966	767	996	894
Total	3,365	4,340	5,454	5,761	9,570

DETERMINATIONS RESULTS

Fiscal Year	11-12	12-13	13-14	14-15	15-16
Under-Payment	3,095	3,871	4,699	5,279	8,189
Correct Payment	83	118	127	41	324
Over-Payment	75	96	97	44	72
No Additional Payment Due	109	244	515	387	957
Total	3,362	4,329	5,438	5,751	9,542

The Section also has the responsibility of investigating reports of provider violations. In Fiscal Year 2015-2016, the Medical Services Section processed 19 reports. Out of the 19 reports processed, 12 were Insurer referrals, and seven were referrals from injured workers, attorneys or other entities. The table below illustrates the end of year case status for reports of provider violations processed during Fiscal Year 2015-2016. Open cases are carried over into the next fiscal year for further investigation.

PROVIDER VIOLATION REFERRAL RESULTS FY 2015-2016



STATUSES OF REPORTS OF PROVIDER VIOLATIONS

Status	FY 14-15	FY 15-16
Open	4	2
Closed	27	17

BUREAU OF FINANCIAL ACCOUNTABILITY

The Bureau of Financial Accountability contains 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 their 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 are 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 made by insurance companies, assessable mutual insurance companies, self-insurance funds and individual self-insurers to the Special Disability Trust Fund (SDTF) and the Workers' Compensation Administration Trust Fund (WCATF). The Section also determines the annual assessment rate for both the SDTF and the WCATF. Click the link below to view rate histories of both trust funds.
Assessment rates

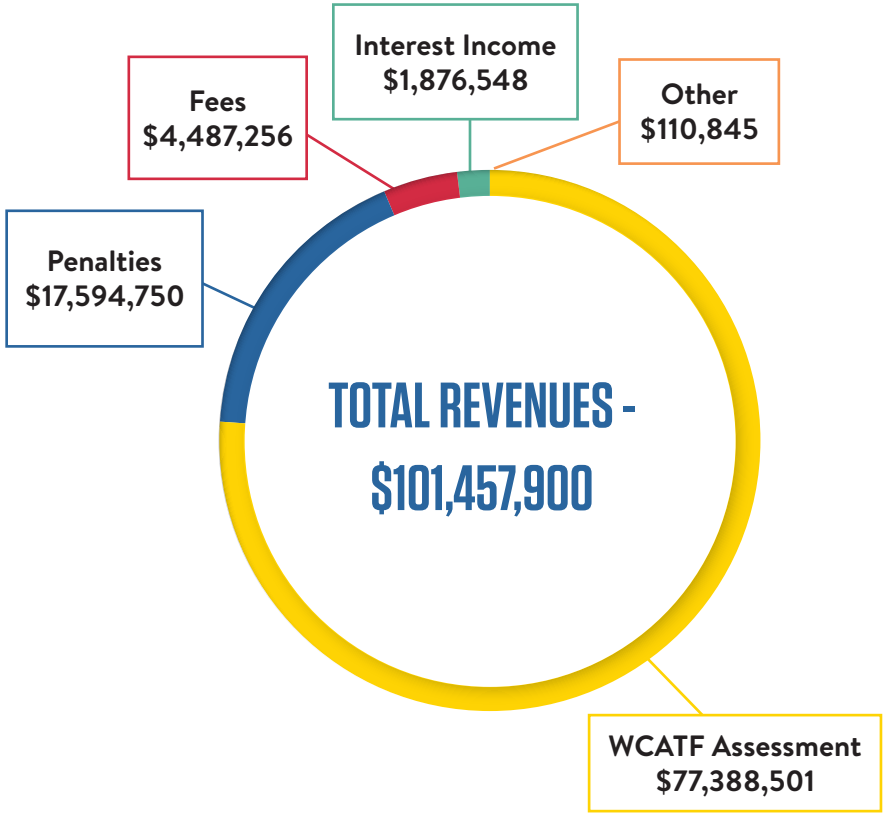
Both trust funds are supported by quarterly assessments. The Assessments Section collected a total of $122,263,906 in assessments for FY 2015-2016. The WCATF had a workers' compensation premium basis of $5.3 billion and collected $77,388,501 in assessments and the SDTF had a workers' compensation premium basis of $3.75 billion and collected $44,875,405 in assessments. Florida Statutes apply a different premium basis for each trust fund. The WCATF assessment is based on collected premium whereas the SDTF basis is written premium. Also, the WCATF assessment includes the deductible portion of insurers' policies.

In Fiscal Year 2015-2016, the Section collected, audited, and reconciled the quarterly assessments of 367 insurance companies and self-insurance funds. This Section also calculated the imputed premium of 402 individual, self-insured entities. The imputed premium is determined based on the self-insured's classifications, payrolls, volume discounts, approved credits, and experience modification factors. This imputed premium is then used to determine the assessments for the two trust funds.

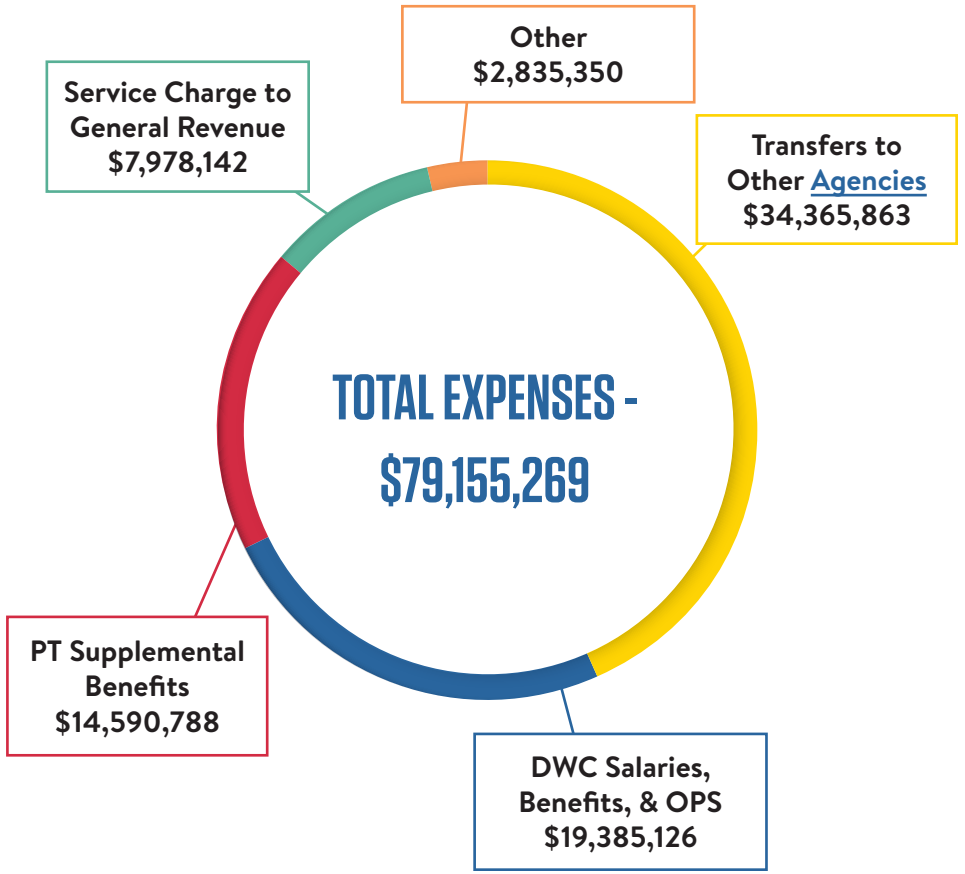
The Assessments Section implemented a web-based system that allows insurers and self-insurance funds to report premiums, generate assessment invoices and track assessment payments online. The system also provides real-time information regarding current and historical payments, internal controls and financial transparency, premium revisions and refund information to all stakeholders. The online System for Tracking Assessments, Reconciliations and Transactions (START) for individually self-insured employers is in the final stages of testing.

WORKERS' COMPENSATION ADMINISTRATION TRUST FUND (WCATF) FOR FY 2015-2016

REVENUE

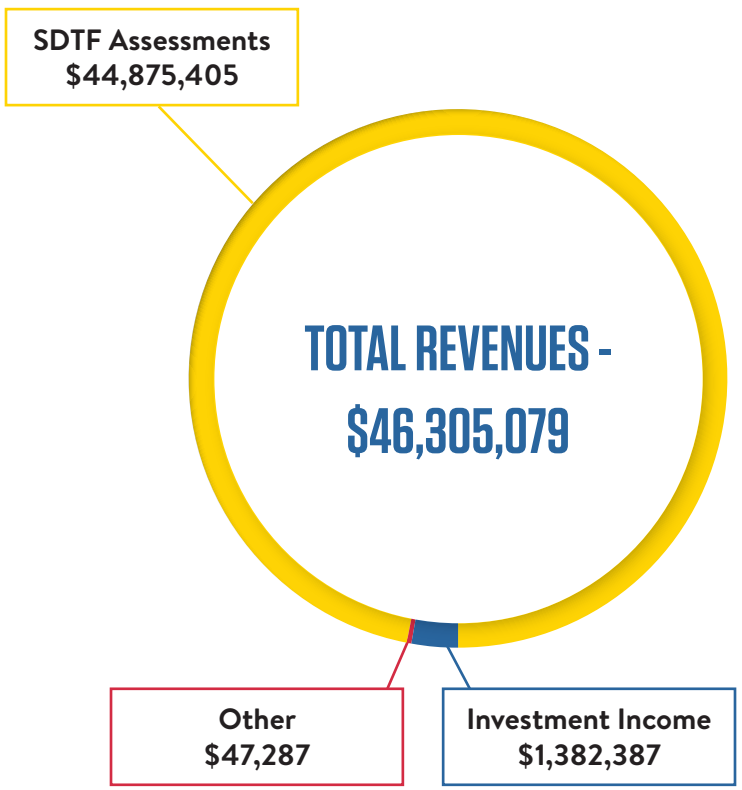


EXPENSES

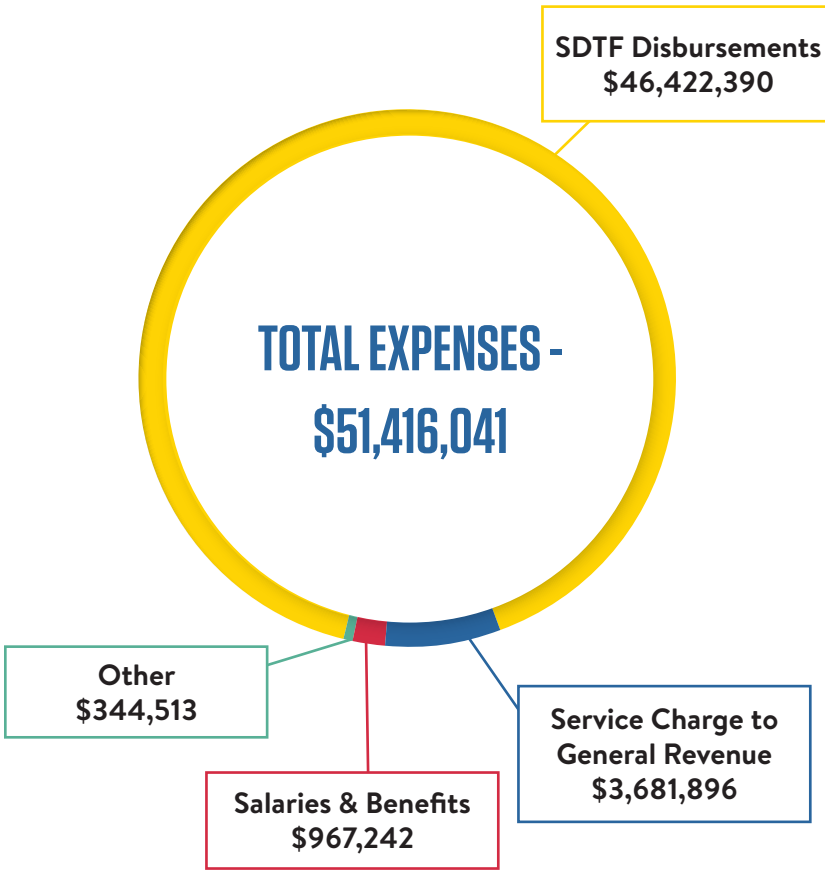


SPECIAL DISABILITY TRUST FUND (SDTF)
FY 2015-2016

REVENUE



EXPENSES



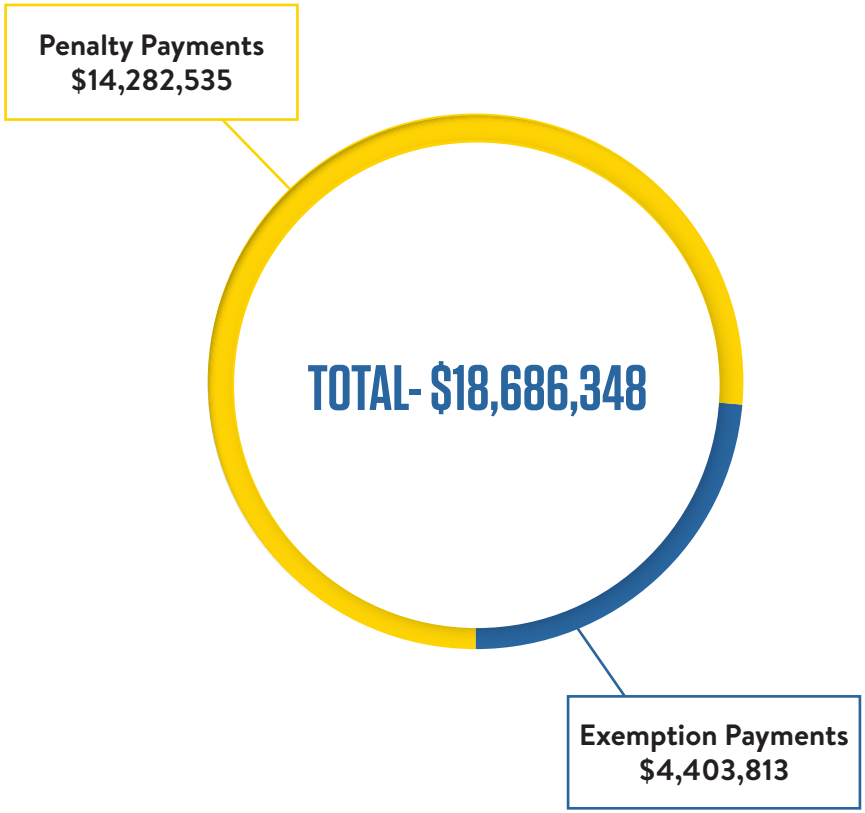
FINANCIAL ACCOUNTABILITY SECTION

The Financial Accountability Section (FAS) 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.

If an employer has violated the workers' compensation law and been assessed an employer compliance penalty, the employer has the option of paying the penalty over a five-year period. The employer must enter into a Penalty Payment Agreement (PPA) with FAS and agree to pay penalties monthly.

As of June 30, 2016, the FAS managed 3,730 PPA agreements. These PPA agreements have an outstanding balance owed totaling $49,788,285.

FINANCIAL ACCOUNTABILITY SECTION REVENUES FY 2015-2016



SELF-INSURANCE SECTION

The Self-Insurance Section is responsible for approving and regulating 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, collects, examines, and processes self-insurance payroll, loss data, outstanding liabilities, and financial statements.

The Self-Insurance Section conducts payroll audits of current self-insurers. The audits are conducted to determine the accuracy of payroll data reported annually on Self-Insurers Payroll Reports (DFS-F2-SI-5). The division uses the information to impute premiums and calculate self-insurers assessments.

29 payroll audits were conducted and it was determined that some self-insurers over-reported payroll by more than $15 million, while other self-insurers under-reported premium by more than $8 million. The Self-Insurance Section has implemented a multi-tiered education program to provide self-insurers with the information needed for accurate reporting of payroll.

During Fiscal Year 2015-2016, the Self-Insurance Section approved three entities to self-insure their workers' compensation liabilities and processed four entities' notices of self-insurance terminations.

The Self-Insurance Section reviews applications received from 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 submit annually, the QSE Annual Report, form (DFS-F2-S1-23) for re-certification by March 1st to the Self-Insurance Section.

During Fiscal Year 2015-2016, the Self-Insurance Section monitored 100 active Qualified Servicing Entities that serviced claims for self-insurers and insurers. Three new QSEs were approved to service claims for insurers.

SELF-INSURERS AND QUALIFIED SERVICING ENTITIES

Fiscal Year	Self-Insurers
11-12	410
12-13	404
13-14	399
14-15	395
15-16	394

Fiscal Year	Qualified Servicing Entities
11-12	97
12-13	97
13-14	95
14-15	97
15-16	100

SPECIAL DISABILITY TRUST FUND SECTION

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 work-related injury, subsequent to being hired, that resulted in a greater permanent impairment, the SDTF would reimburse the employer for excess costs. 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 Florida law, insurers and individual self-insured employers continue to be assessed to fund the run-off claims.

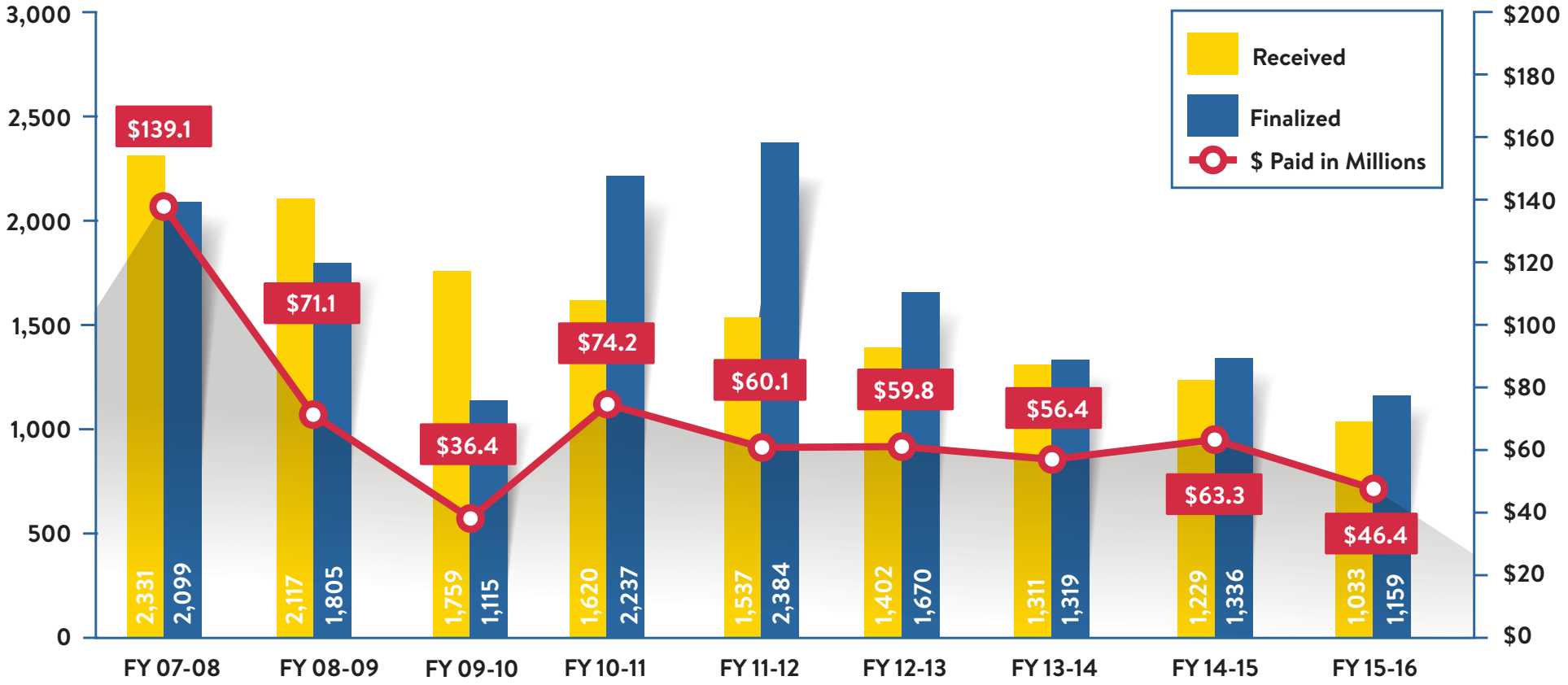
Presently, the SDTF has three primary business processes: (1) review all filed Proofs of Claim to determine if the claim meets eligibility requirements for reimbursement of benefits paid by the carrier and subsequently notify the carrier whether the claim has been accepted or denied; (2) determine eligibility 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.

During FY 2015-2016, the SDTF was able to issue $46,422,390 in reimbursements to carriers and self-insured employers while identifying and disallowing $3,817,259 in non-reimbursable benefits. Simultaneously, the SDTF reduced the average time to issue payment on an approved Reimbursement Request to 45 days. By comparison, the Fund's average payment time was 85 days during FY 2014-2015.

The SDTF Section is also responsible for the issuance of payments to permanently and totally disabled workers for whom the Division is responsible for paying permanent total supplemental benefits. During FY 2015-2016, the SDTF processed $14,590,788 in permanent total supplemental disability payments.

The 2016 Legislature abolished the Preferred Worker Program effective October 1, 2016. This program was created by the legislature to provide financial incentives to employers to hire employees who were unable to return to their to previous employment because of a permanent physical disability resulting from a compensable workplace injury. The expiration of eligible workers resulted in no future funding obligations; thus, eliminating the need for the program. Also of note, the 2016 Legislature eliminated the SDTF's $500 filing fee associated with submitting a Proof of Claim and the $250 filing fee for submitting a Notice of Claim. These changes took effect on October 1, 2016.

REIMBURSEMENT REQUESTS



ESTIMATED LIABILITIES SPECIAL DISABILITY TRUST FUND

As required by section 440.49, F.S., the Division is required to report annually on the status of the Special Disability Trust Fund's estimated fund liabilities. The estimated liabilities must be determined by an independent actuary and must determine both the undiscounted and discounted estimated liabilities. In the past five years, the SDTF's estimated undiscounted liabilities have been reduced by 46.9%.

Evaluation Date	Total Outstanding Unfunded Claim Liability	Discounted Unfunded Outstanding Claim Liability
June 30, 2012	$1,274	$815
June 30, 2013	$1,178	$773
June 30, 2014	$973	$654
June 30, 2015	$796.7	$535.1
June 30, 2016	$675.7	$454.9

(In Millions)

BUREAU OF EMPLOYEE ASSISTANCE AND OMBUDSMAN OFFICE

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 stakeholders, 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, and drug free workplace and safety programs. This team answered 92,631 calls in FY 2015-2016.

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.

CUSTOMER SERVICE CALL VOLUME FY 2015-2016

1st Qtr	24,481
2nd Qtr	20,297
3rd Qtr	24,515
4th Qtr	23,338
TOTAL	**92,631**

During Fiscal Year 2015-2016, the FROI Team contacted 27,790 injured workers by telephone and 2,446 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 36,539 injured workers in an effort to give assistance and advise of EAO's services.

Fiscal Year	Number Contacted	Percentage Contacted
10-11	32,140	71%
11-12	32,966	73%
12-13	31,303	81%
13-14	29,732	82%
14-15	29,116	81%
15-16	27,790	80%

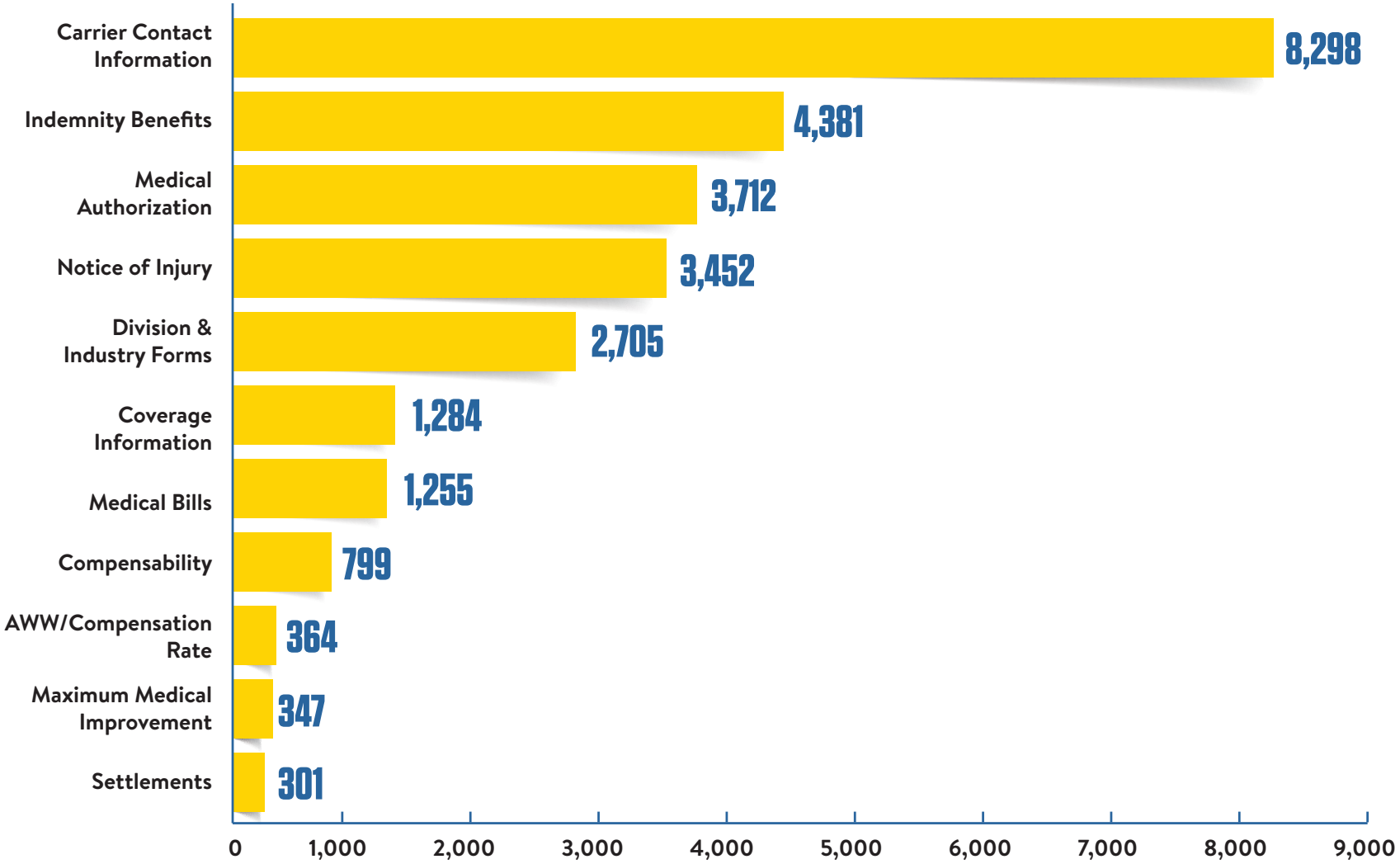
INJURED WORKER HELPLINE TEAM

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 its 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 2015-2016 the Injured Worker Helpline Team handled 45,291 calls, including 7,338 Spanish speaking callers.

INJURED WORKER HELPLINE TEAM – TYPE OF ASSISTANCE FOR EDUCATION CALLS FY 2015-2016



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.

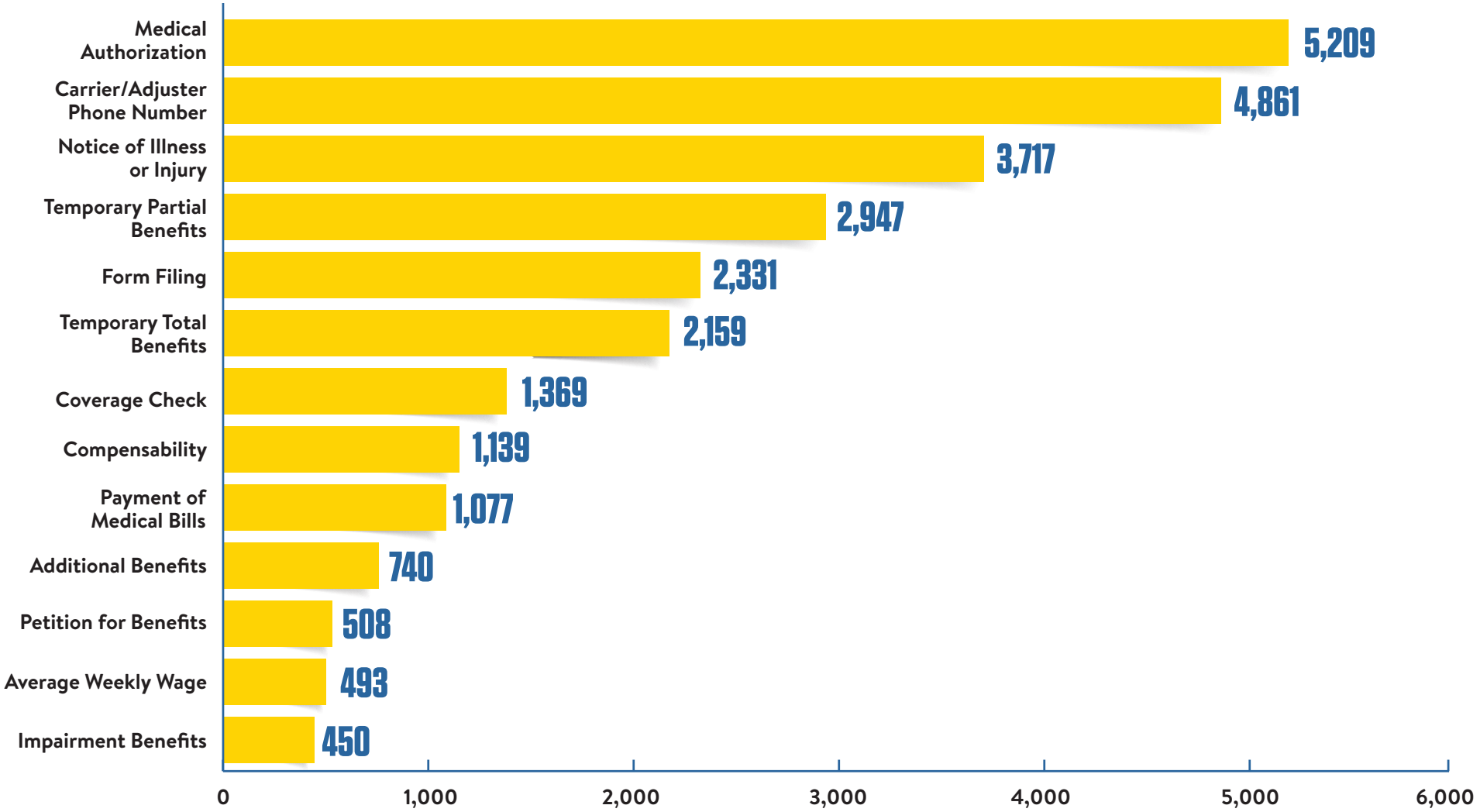
During Fiscal Year 2015-2016, the Ombudsman Team was involved in resolving 92% of the 528 disputes received. As a direct result of intervention by the Team, indemnity benefits totaling $107,313 were paid to injured workers and reimbursement of unpaid medical bills totaling $234,783 were paid to medical providers. Additionally, the Ombudsman Team prevented 4,346 potential disputes by educating injured workers with in-depth, case specific information.

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

TOP 10 ISSUES FY 2015-2016

Issue	Resolved	Unresolved	% Resolved
Average Weekly Wage	13	2	87
Medical Authorization	242	14	95
Notice of Injury	3	0	100
Indemnity - TPD	45	4	92
Indemnity - TTD	38	2	95
Compensability	1	4	20
Penalties & Interest	26	0	100
Medical Mileage	56	3	95
Medical Bills	39	2	95
Impairment Income Benefits	3	0	100

ISSUES ADDRESSED BY OMBUDSMAN AND HELPLINE TEAMS FY 2015-2016



REEMPLOYMENT SERVICES TEAM

The Reemployment Services Team (RES) 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 ensures that required documentation is received, interviews the injured employee and assesses their eligibility for services. The team provides services that include: vocational counseling, transferable skill analysis, resume writing/development, job search assistance, job seeking skills, vocational evaluations, and training and education (including GED). Injured employees submit screening requests for services through the Division's web portal. The team educates carriers about reemployment services requirements under Florida's Workers' Compensation Law.

During Fiscal Year 2015-2016, the Reemployment Services Team received 220 requests for screenings through the Division's Injured Worker Web Portal. Additionally, the team screened 380 injured workers for services and provided assistance to 90 injured workers who were eligible to return to suitable productive employment.

SUCCESS STORIES FROM FY 2015-2016

- An injured employee sustained an injury to her lumbar spine while working for a major hotel chain as a housekeeper earning an average weekly wage of $357.36. Upon reaching maximum medical improvement, she was restricted to no lifting greater than 30 pounds and no repetitive twisting or bending.

  Her employer had no work available for her within these restrictions. The injured employee applied for services with the Reemployment Services program. Following a vocational assessment, it was determined that the best way for her to return to suitable gainful employment was with contracted placement services. She worked with a certified rehabilitation counselor who determined that she possessed transferable skills and experience to offer an employer. With the reemployment skills she learned from one interaction with the counselor, she was able to return to work as a cashier at a local restaurant earning $13.05 an hour.

- Following a workplace accident involving multiple injuries, an injured employee submitted a request for reemployment services. The injured employee had been employed as an iron worker and was now restricted to lifting only 20 pounds. A vocational evaluation was conducted which recommended training and education in the Information Technology Support Specialist Certificate program at Indian River State College. He maintained a 4.0 GPA throughout the program and was successfully returned to work in a Computer Technical Support position shortly after graduating.

- An injured employee filed a request for services after a work-related injury that resulted in fractures of both wrists. He was assigned light duty restrictions, lifting no more than 20 pounds. Unfortunately, these restrictions prohibited him from returning to work on a demolition crew, his job at the time of injury.

  The injured employee's goal was to return to work as soon as possible because he had been out of the workforce for two years. After a vocational assessment, it was determined that the quickest way to assist him in retuning to suitable gainful employment was through contracted job placement services. The injured employee received the following services: resume writing, employability skills, transferable skills analysis, job leads, job development, and job search assistance. After working with a vocational counselor for a short time, the injured worker returned to work as a housekeeper/floor technician earning a substantial wage with the promise of full benefits after 90 days, and the opportunity for advancement as well as a chance to participate in an educational program to earn a college degree.

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.

BUREAU OF COMPLIANCE

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 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 2015-2016, BOC processed 99% of online exemption applications within five days of receipt, utilized data from various sources to identify and successfully find non-compliant employers, investigated 1,909 public referrals alleging non-compliance. Of the 1,909 referrals, 469 resulted in an enforcement action. The Bureau also conducted 47 seminars and 23 webinars on workers' compensation and workplace safety for over 2,112 employers statewide.

The Florida Legislature passed and the Governor signed into law CS/HB 613, which contains revisions to section 440.107, Florida Statutes. Effective October 1, 2016, the changes include reducing the imputed payroll multiplier related to penalty calculations from 2 to 1.5 times the statewide average weekly wage, establishing a deadline for employers to file business records to receive a penalty reduction, and providing a 25-percent penalty credit for employers who timely submit business records and who has not been previously issued a stop-work order or order of penalty assessment.

INVESTIGATIONS CONDUCTED

FY 11-12	34,780
FY 12-13	34,150
FY 13-14	35,294
FY 14-15	34,282
FY 15-16	33,681

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 has held steady during the last five fiscal years.

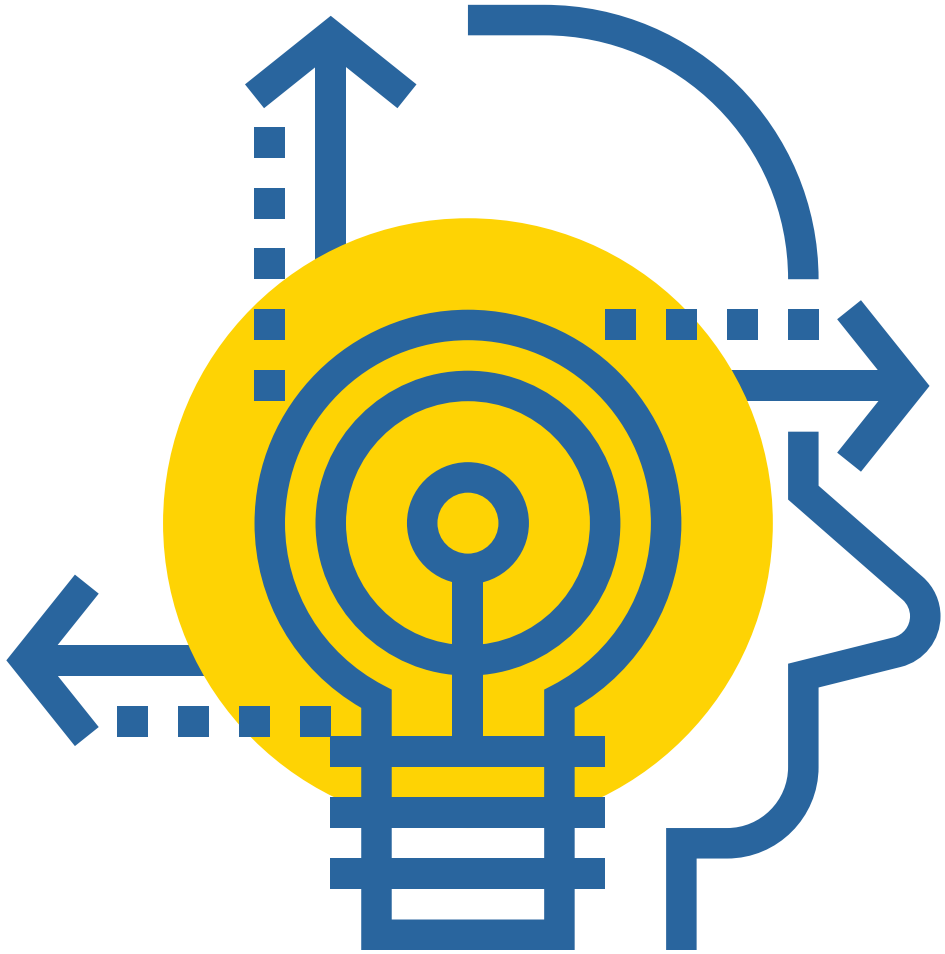
INITIATIVES

Several key initiatives are allowing the Division to focus its investigative efforts on identifying non-compliant employers to maximize its resources for the benefit of the citizens of this state.

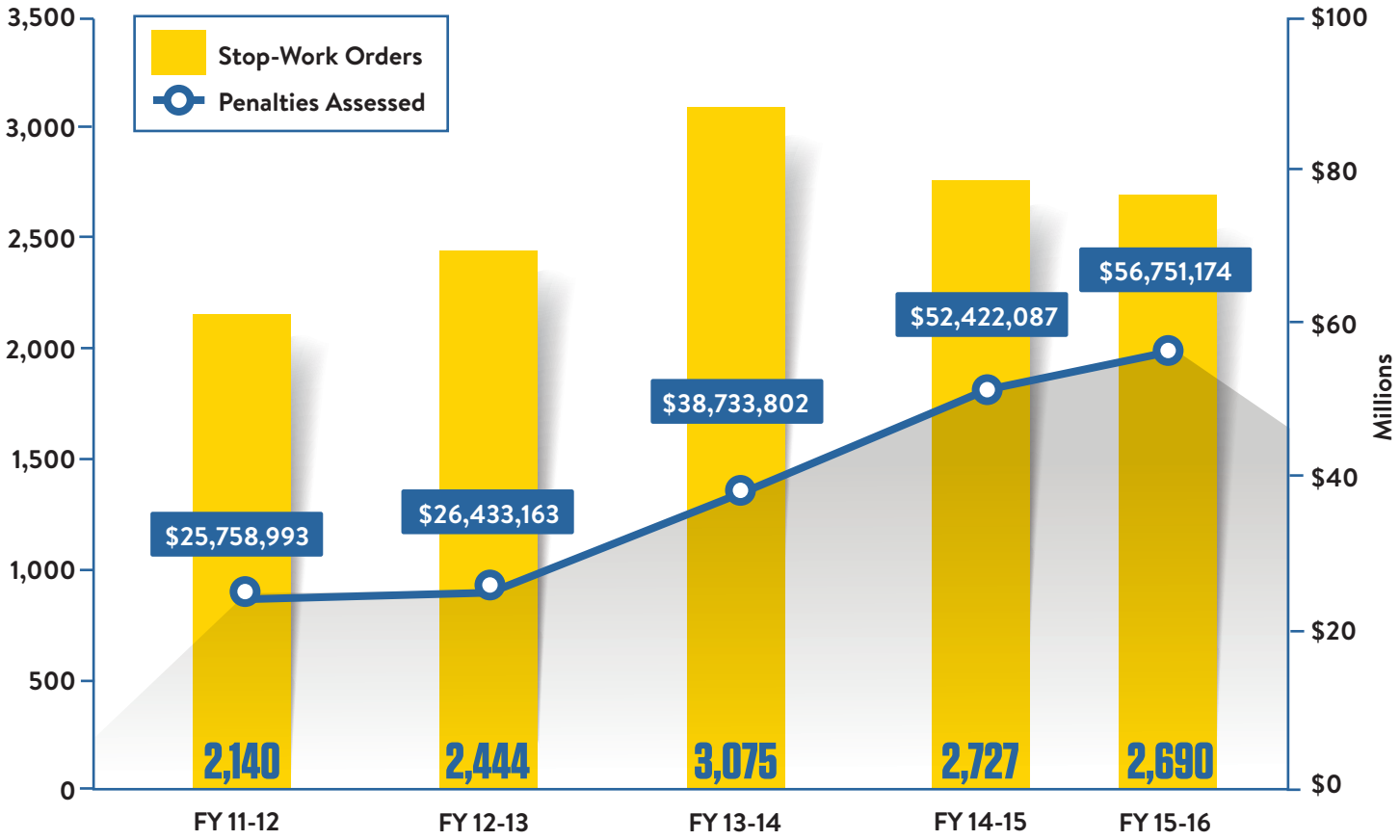
The Division utilizes several available data sources to identify non-compliant employers. This effort includes the use of information and data from other state agencies. For example, by utilizing payroll and employee information provided from the Department of Revenue to cross match with the Division's policy data, the Division is able to create lists of potentially 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. As a result of the Bureau's educational outreach efforts during FY 15-16, 814 employers voluntarily came into compliance; 12,771 employees were reported on new policies. Those employers that do not secure coverage following the notification are referred for investigation.

The Division conducted five state-wide construction sweeps, which resulted in 2,787 construction site visits, 4,003 employer investigations, and 245 enforcement actions.

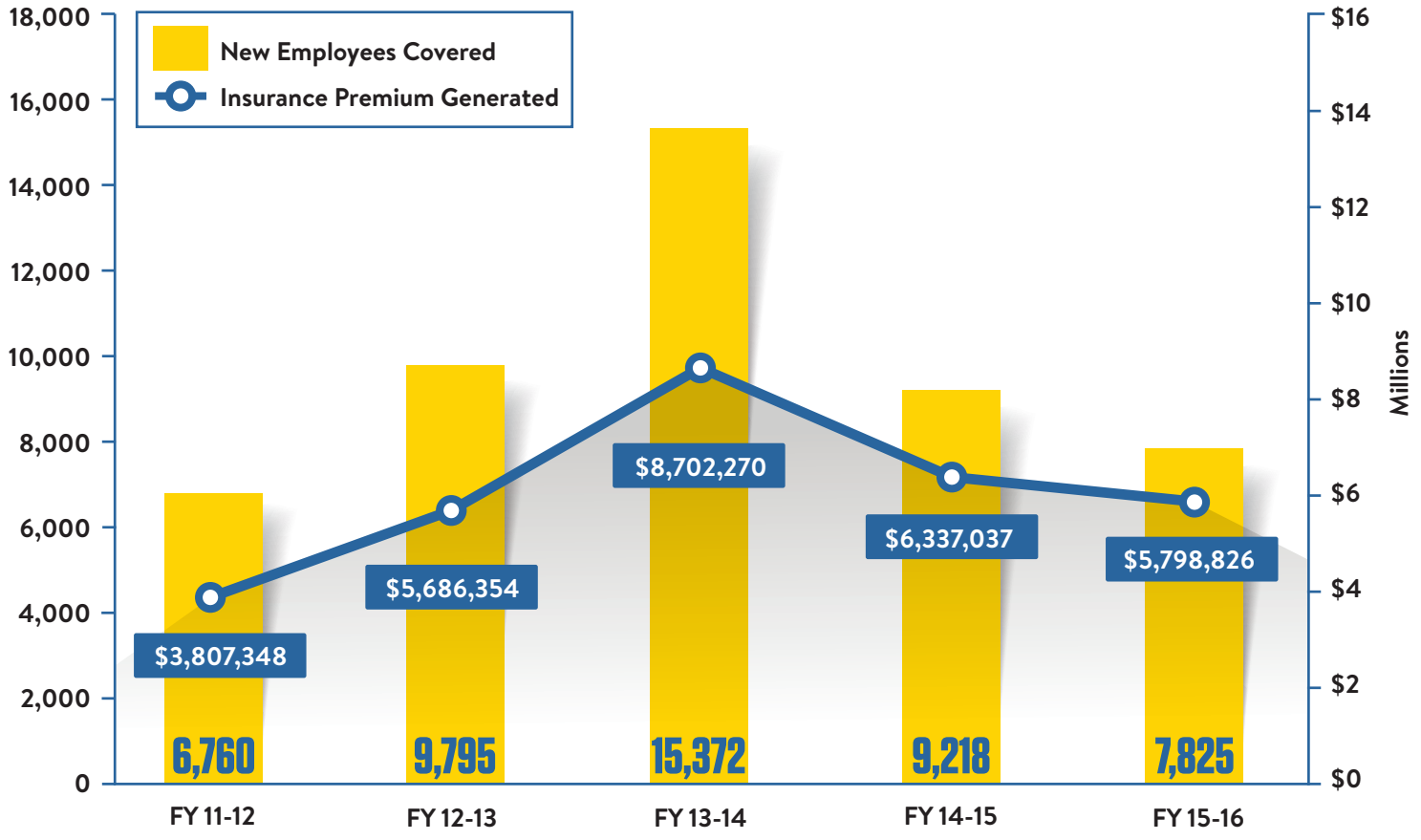


STOP-WORK ORDERS ISSUED & PENALTIES ASSESSED

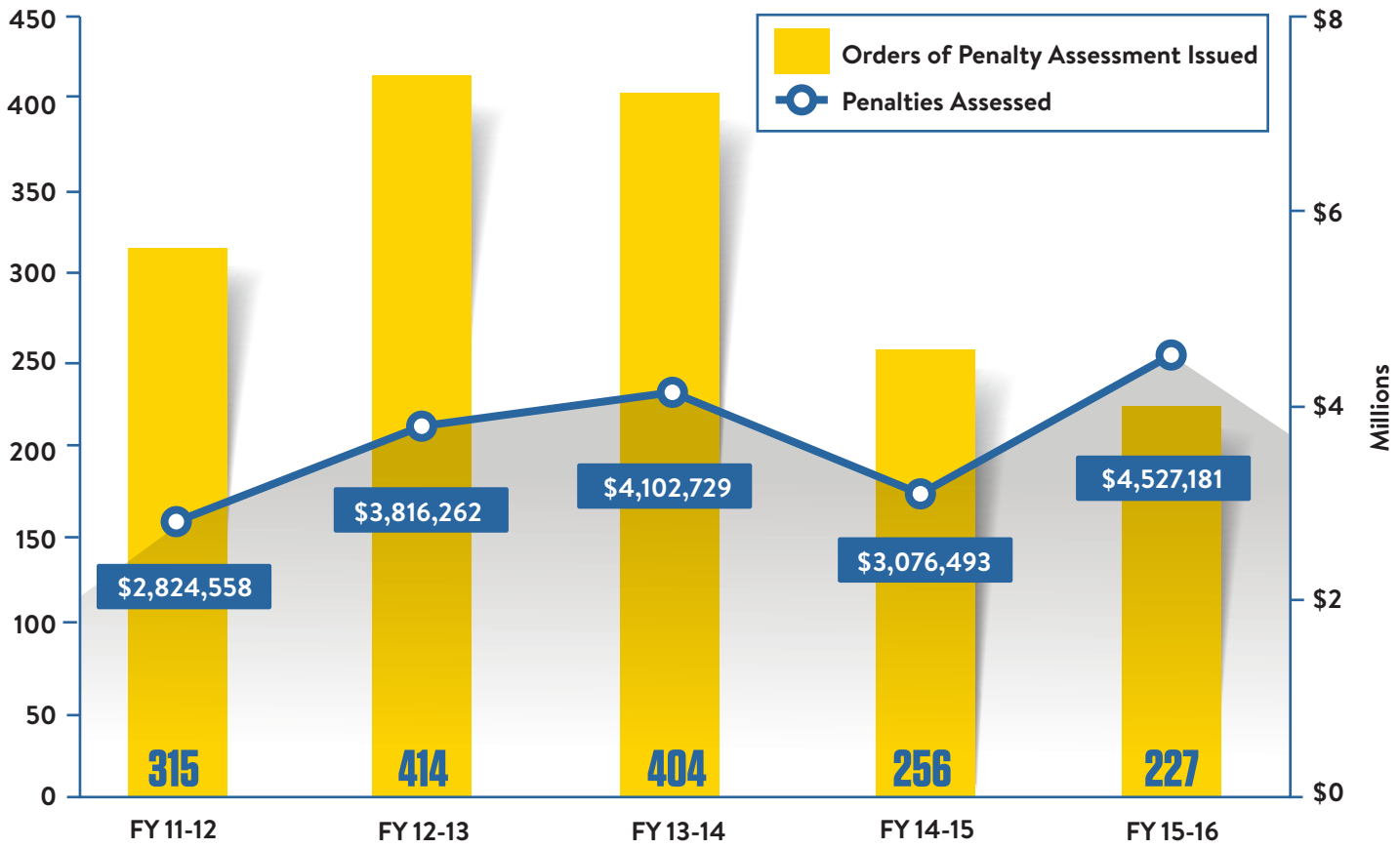


The number of Stop-Work Orders have generally increased during the last five years. The assessed penalties have increased due to employers lacking payroll records, or making undocumented cash payments to employees which results in the Division imputing employers' payrolls pursuant to section 440.107(7)(a), F.S.

NEW EMPLOYEES COVERED AND INSURANCE PREMIUM GENERATED BASED UPON STOP-WORK ORDERS ISSUED

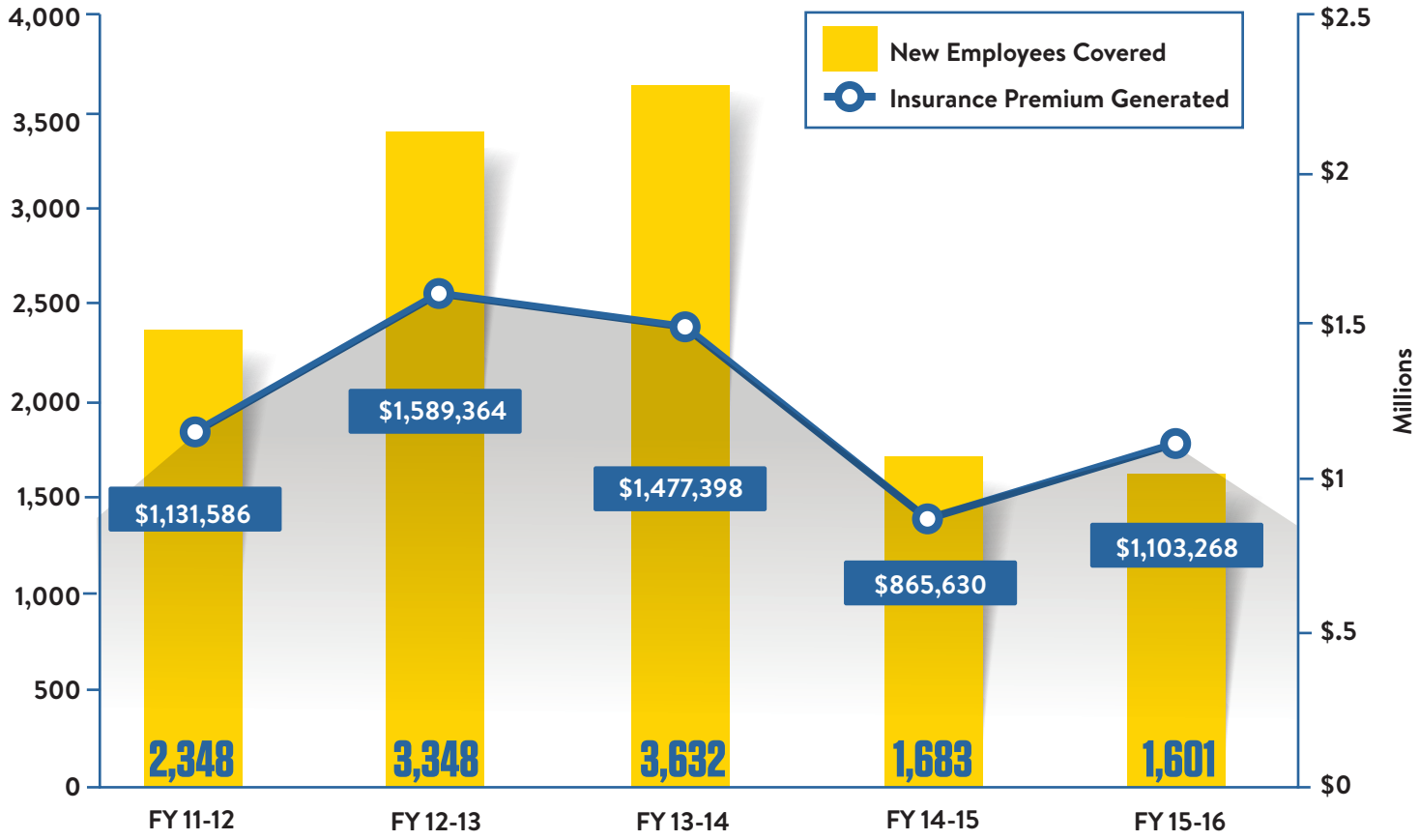


ORDERS OF PENALTY ASSESSMENT & PENALTIES ASSESSED



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 Orders.

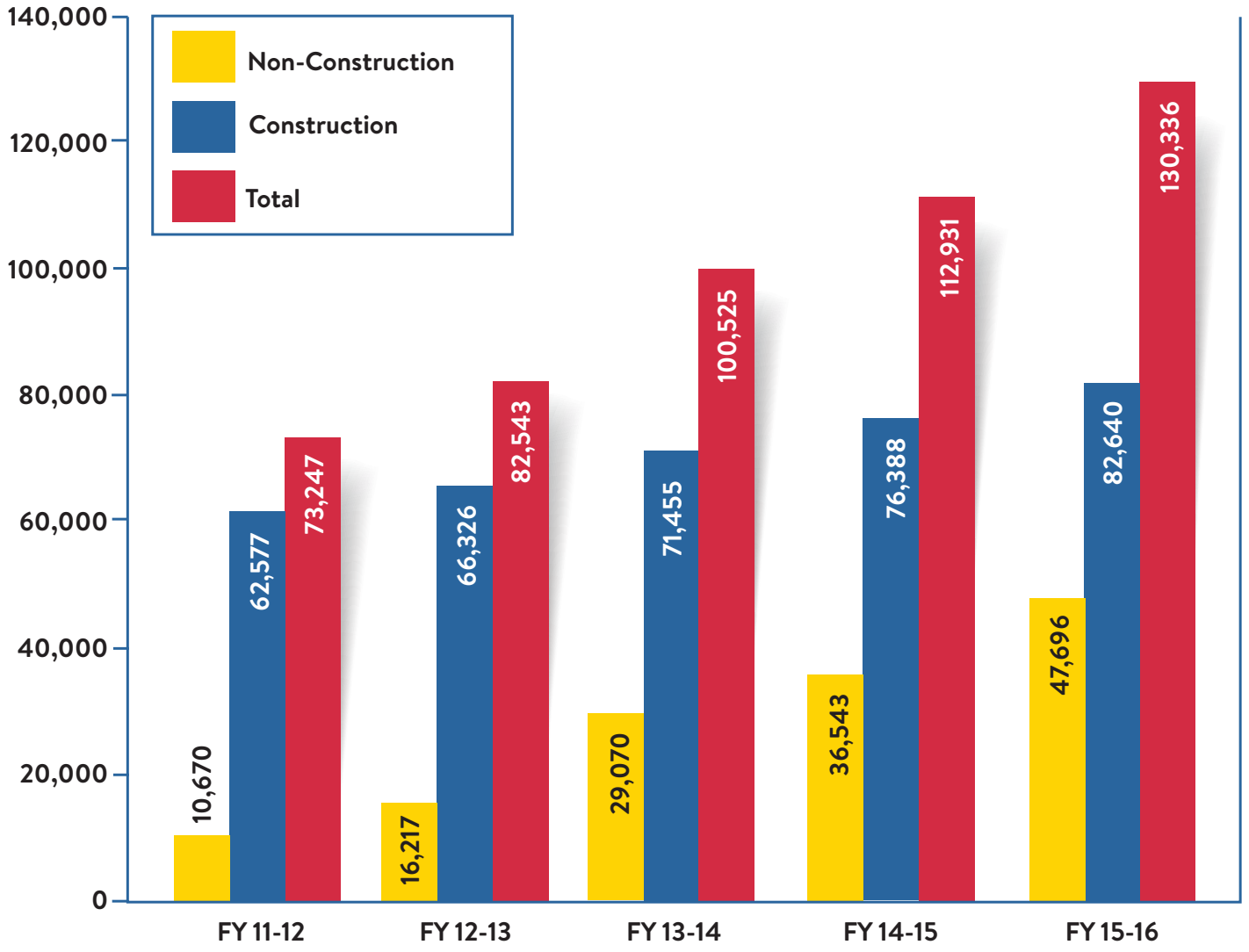
NEW EMPLOYEES COVERED AND INSURANCE PREMIUM GENERATED BASED UPON ORDERS OF PENALTY ASSESSMENT



EXEMPTION APPLICATIONS PROCESSED

The increase in construction industry exemptions is reflective of the general improvement in Florida's economy and in the construction industry in particular.

The rise in non-construction exemptions is due to the statutory change that defines non-construction limited liability company members as "corporate officers". Corporate officers are employees but are allowed to exempt themselves.



BUREAU OF DATA QUALITY & COLLECTION

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, F.S., and various corresponding Florida administrative rules.

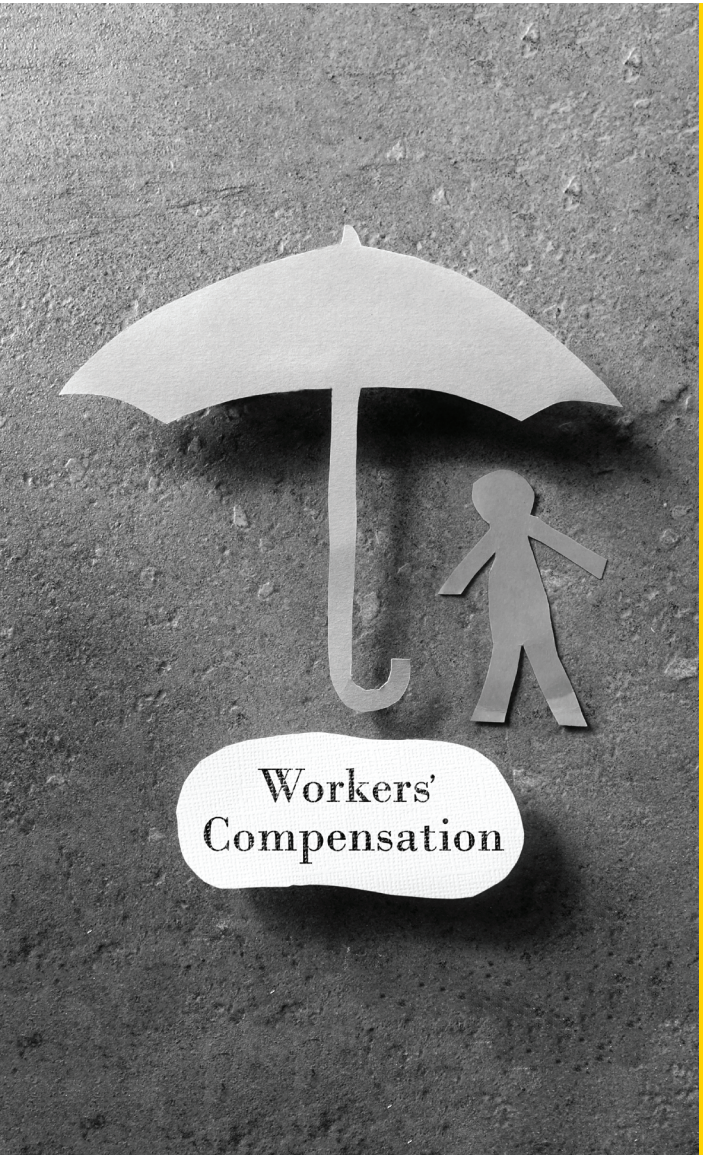
Each electronic transaction received by DQC undergoes extensive program edits to ensure data quality, reliability, and high degree of accuracy before being loaded to the appropriate Division databases. DQC is responsible for developing, improving, and maintaining business processes that comingle with 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. The "Construction Policy Tracking" database 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. In FY 2015-2016, 369 registrants signed up to use the Construction Policy Tracking database bringing the total registrants to 10,077. As of June 30, 2016, the number of policies being tracked is 44,062.

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

Fiscal Year	FY 11-12	FY 12-13	FY 13-14	FY 14-15	FY 15-16
New Policies	262,301	267,264	271,617	281,190	305,712
Binders	483	1,475	1,769	2,118	3,489
Reinstatements	79,958	78,089	83,449	84,765	86,558
Endorsements	208,553	246,040	389,596	415,389	363,471
Cancellations	157,405	150,321	156,300	160,193	158,659
Totals	708,700	743,189	902,731	943,655	917,889

MEDICAL EDI DATA COLLECTION

Pursuant to Rule 69L-7.710, F.A.C., all required medical billing (hospital, healthcare provider, ambulatory surgical center, dental, and pharmacy) form data must be submitted to the Division in accordance with the date-appropriate Florida Medical EDI Implementation Guide (MEIG). Medical bill data is used for developing medical fee schedules, evaluating carriers' performance for timely payments to providers, auditing SDTF reimbursements requests, and in support of analyzing allegations of health care provider violations.

To assist with the electronic filing of medical bills, the Medical Data Management System (MDMS) website was developed. Small insurers with a low volume of workers' compensation medical bills may utilize the MDMS website 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 11-12	3,834,451
FY 12-13	3,929,214
FY 13-14	3,969,831
FY 14-15	4,332,002
FY 15-16	4,111,714

CLAIMS EDI DATA COLLECTION

Claims EDI data is collected pursuant to Rule 69L-56, F.A.C., and is used to populate the Division's primary accident databases. As of Fiscal Year 2015-2016, claims data is submitted 99.99% via EDI. Claims EDI data is used to evaluate whether carriers are paying injured workers accurately and timely, to assist in resolving benefit disputes between injured workers and carriers, and to identify system costs.

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 for data submitters. Triage Assistance consists of mutually agreed-upon action plans between the Division and data submitters with timelines, teleconferences, on-site visits, and webinars. Personalized sessions are available upon request. During Fiscal Year 2015-2016, the team conducted over 100 Training/Triage Sessions resulting in a 10% increase to the acceptance rate of the industry. Sessions cover a range of topics such as:

- 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
11-12	500,613	2,223	502,836
12-13	474,666	422	475,088
13-14	469,556	74	469,630
14-15	474,942	140	475,082
15-16	482,815	106	482,921

RECORDS MANAGEMENT SECTION

Chapter 119, F.S., 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 2015-2016, DQC processed 4,389 subpoenas and 2,582 public records requests. Subpoenas were invoiced in less than two business days of receipt on average. Public records requests were invoiced, or documents provided if no charge, on average in less than two 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 mail to: **DWCPublicRecordsRequest@myfloridacfo.com**.

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 2015-2016, the Records Management Section processed 1,484 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**.

MEDICAL DATA

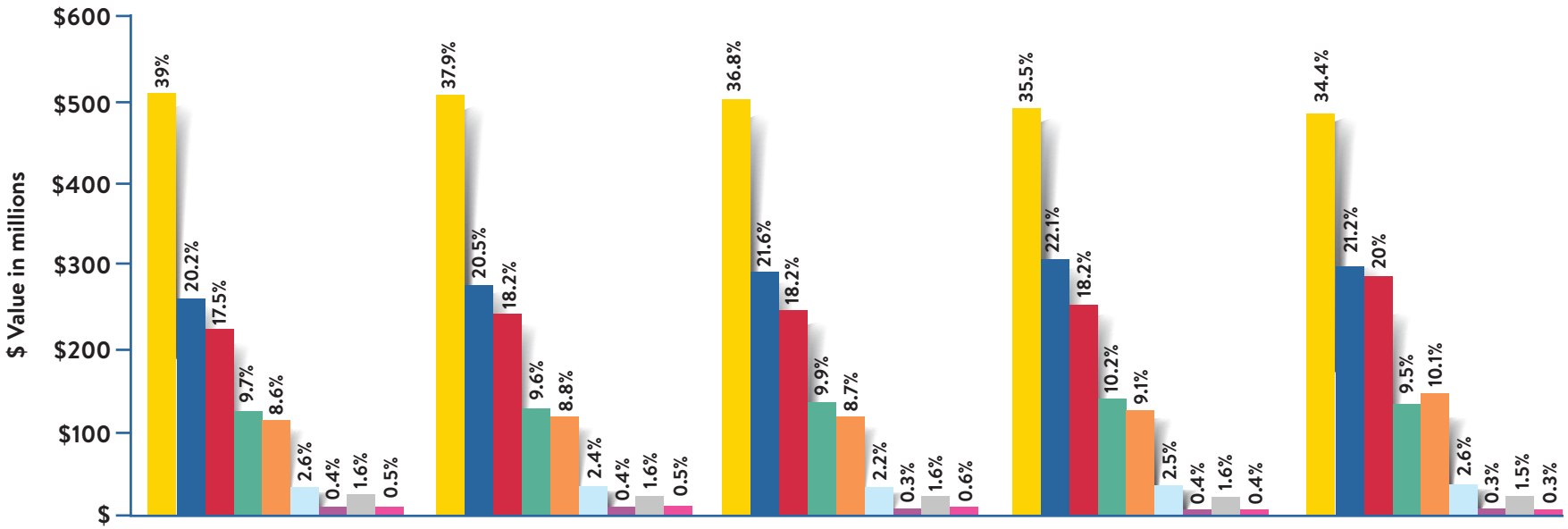
The Bureau of Data Quality and Collection receives over four million medical bill records each year via electronic submission, which is the largest volume of data electronically received by the Division. Reporting of medical data begins with a workplace injury that required medical care from a physician, 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 that 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.

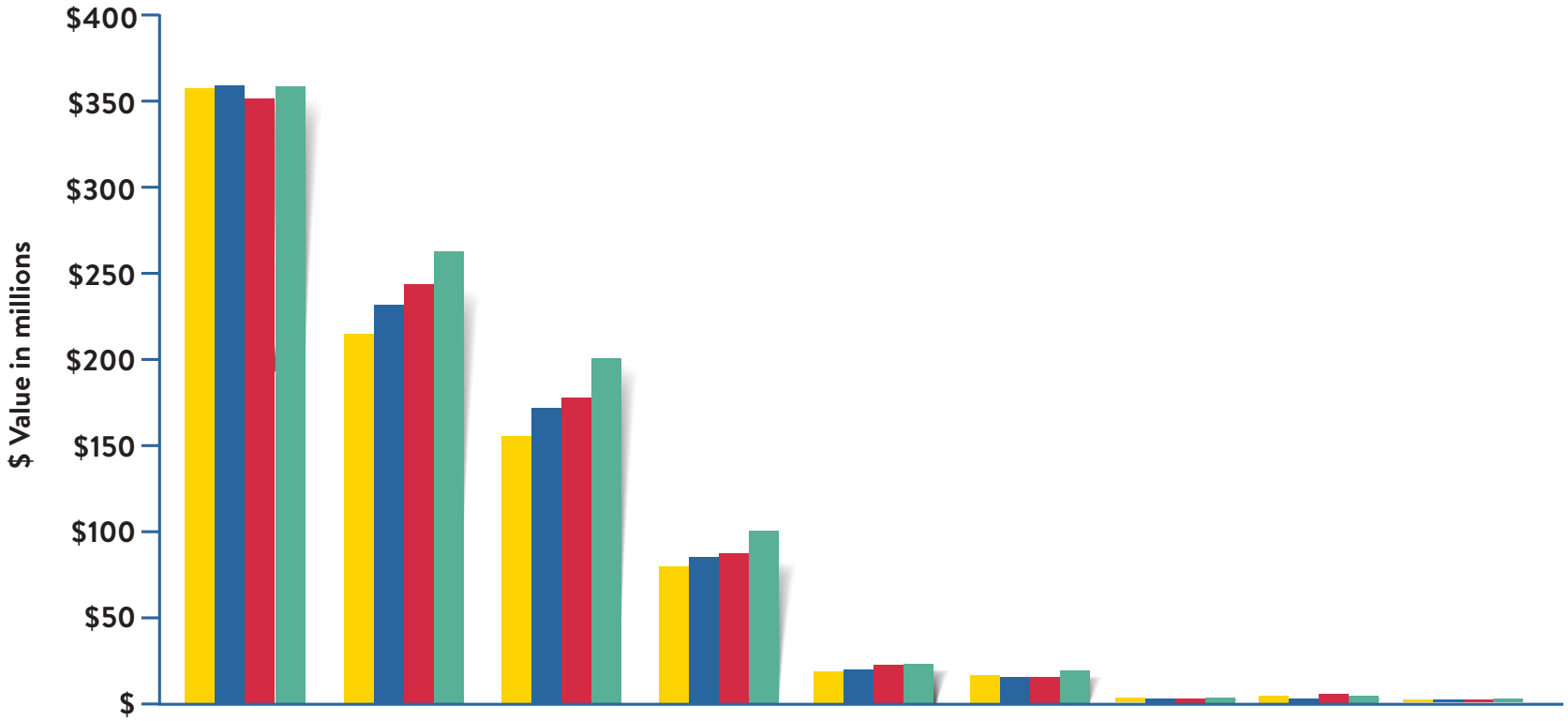
The following charts pertain to both lost-time and medical only claims. Data aggregation is by calendar year of the date of service, rather than injury year. The data for each year is restricted to medical bills received and accepted by the Division no later than six months after the end of that year.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



	2011	2012	2013	2014	2015
Health Care Provider	508	507	500	492	487
Hospital Outpatient	262	274	293	307	300
Hospital Inpatient	227	243	247	252	284
Pharmacy	127	129	135	141	134
Ambulatory Surgical Center	112	118	119	126	144
Medical Supplies	34	32	30	34	37
Dental	5	5	5	5	5
Home Health Services	21	22	22	23	22
Nursing Home	7	7	8	6	4

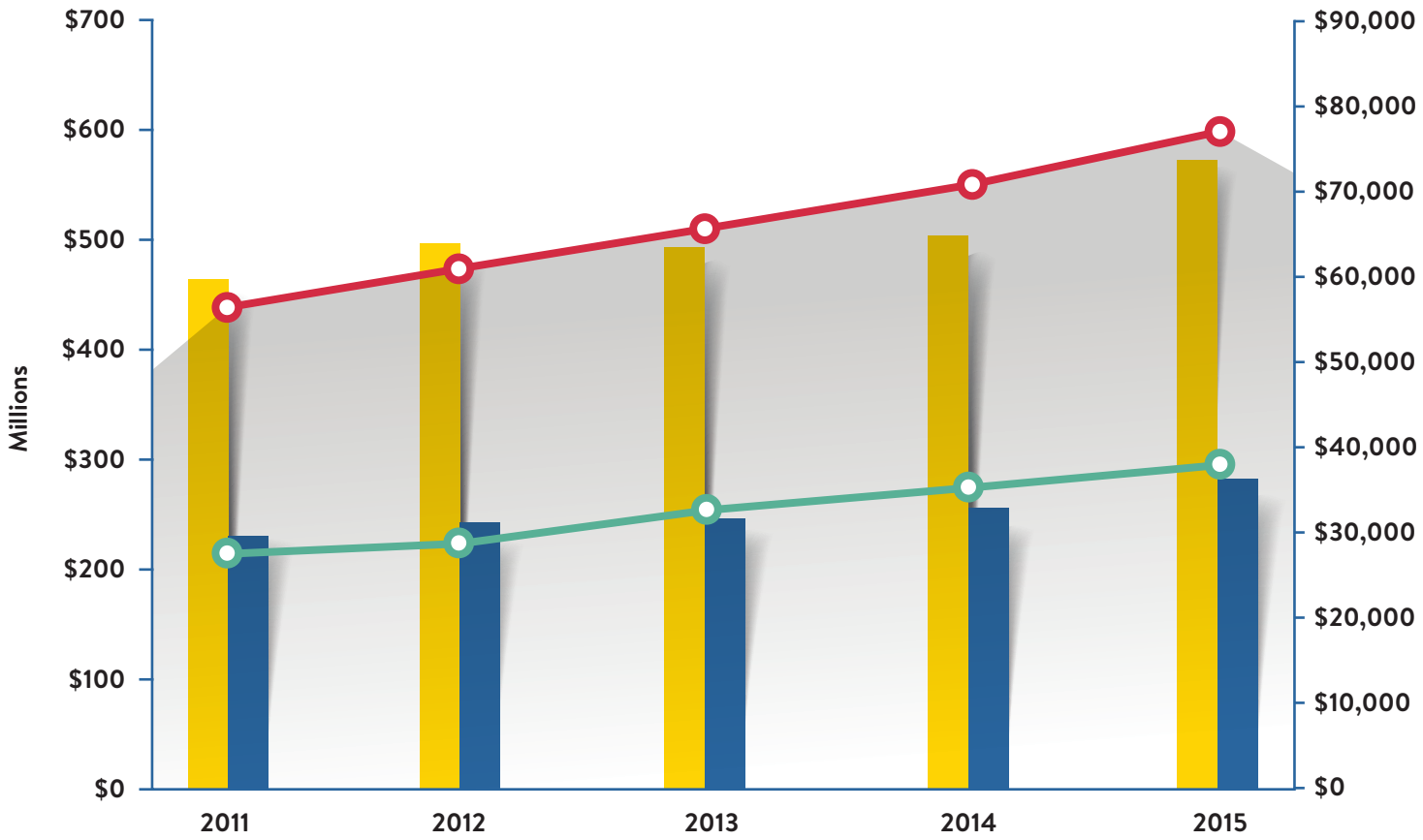
TOTAL MEDICAL PAID* FOR SERVICES PROVIDED WITHIN 12 MONTHS OF INJURY



	Health Care Provider	Hospital Outpatient	Hospital Inpatient	Ambulatory Surgical Center	Pharmacy	Medical Supplies	Dental	Home Health Services	Nursing Home
2011	355,961,628	215,201,946	155,471,391	80,730,670	18,791,335	17,144,660	3,726,836	5,993,492	2,749,592
2012	357,007,232	231,917,575	171,459,449	85,513,520	20,427,633	16,043,883	3,824,979	4,840,461	2,033,038
2013	350,317,088	244,548,000	177,844,686	87,640,638	22,150,860	16,280,807	3,607,652	6,147,245	2,149,873
2014	357,814,783	261,659,450	200,437,201	100,478,398	23,087,324	20,095,084	3,776,495	5,353,075	2,141,423

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

TOTAL CHARGES & TOTAL PAID FOR HOSPITAL INPATIENT SERVICES



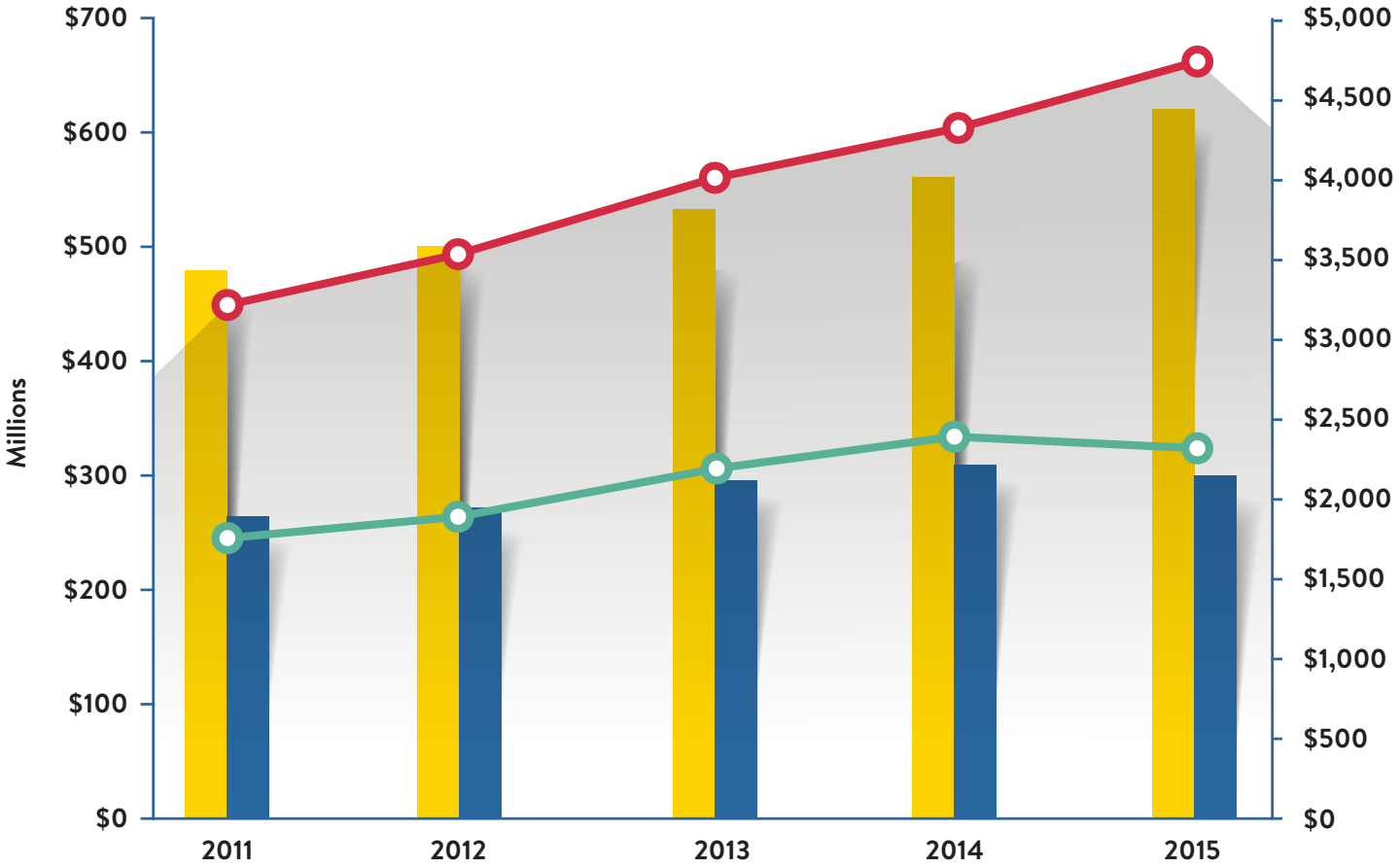
	2011	2012	2013	2014	2015
Charges	461,024,829	498,919,989	494,348,961	503,112,366	571,952,653
Paid	227,311,411	242,729,923	247,324,809	251,606,129	284,250,458
Avg Chg Per Bill	56,004	60,615	65,072	70,474	76,454
Avg Paid Per Bill	27,613	29,490	32,556	35,244	37,996
Number of Bills	8,232	8,231	7,597	7,139	7,481

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

TOTAL CHARGES & TOTAL PAID FOR HOSPITAL OUTPATIENT SERVICES

Hospital Outpatient billed charges include; outpatient surgeries, emergency room services, outpatient cardiology, pain injections, outpatient radiology and laboratory, physical, occupational, and speech therapies, and other non-surgical outpatient medical services such as observation, pulmonary testing, GI studies, etc. Outpatient radiology and laboratory, physical, occupational, and speech therapies are reimbursed at 110% of Medicare rates.

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

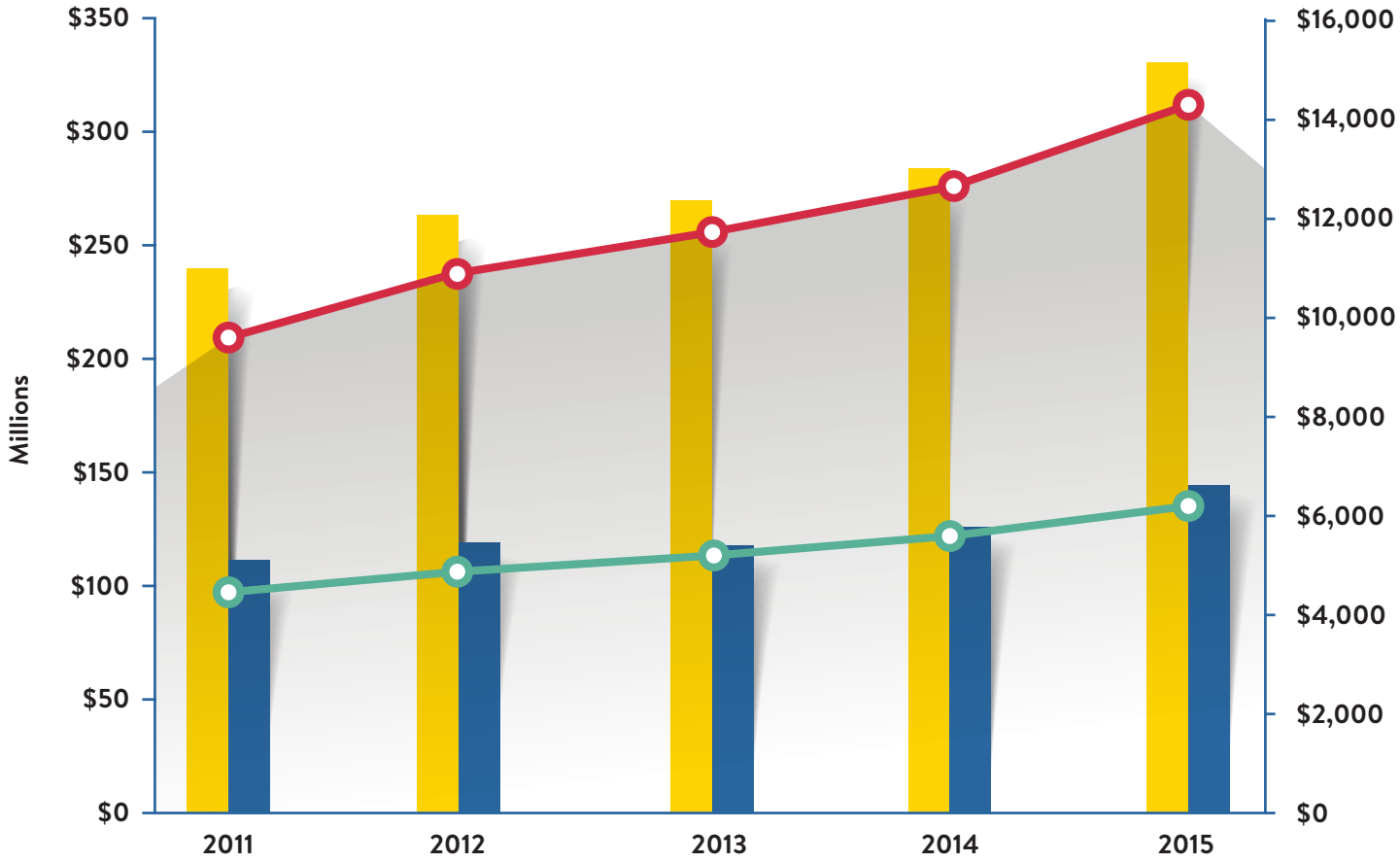


	2011	2012	2013	2014	2015
Charges	479,780,182	504,336,710	534,598,136	559,400,486	617,107,008
Paid	265,411,897	276,260,109	295,551,288	308,346,876	301,316,847
Avg Chg Per Bill	3,212	3,519	3,976	4,313	4,734
Avg Paid Per Bill	1,777	1,928	2,198	2,378	2,312
Number of Bills	149,385	143,305	134,468	129,692	130,346

TOTAL CHARGES & TOTAL PAID FOR AMBULATORY SURGICAL CENTER SERVICES

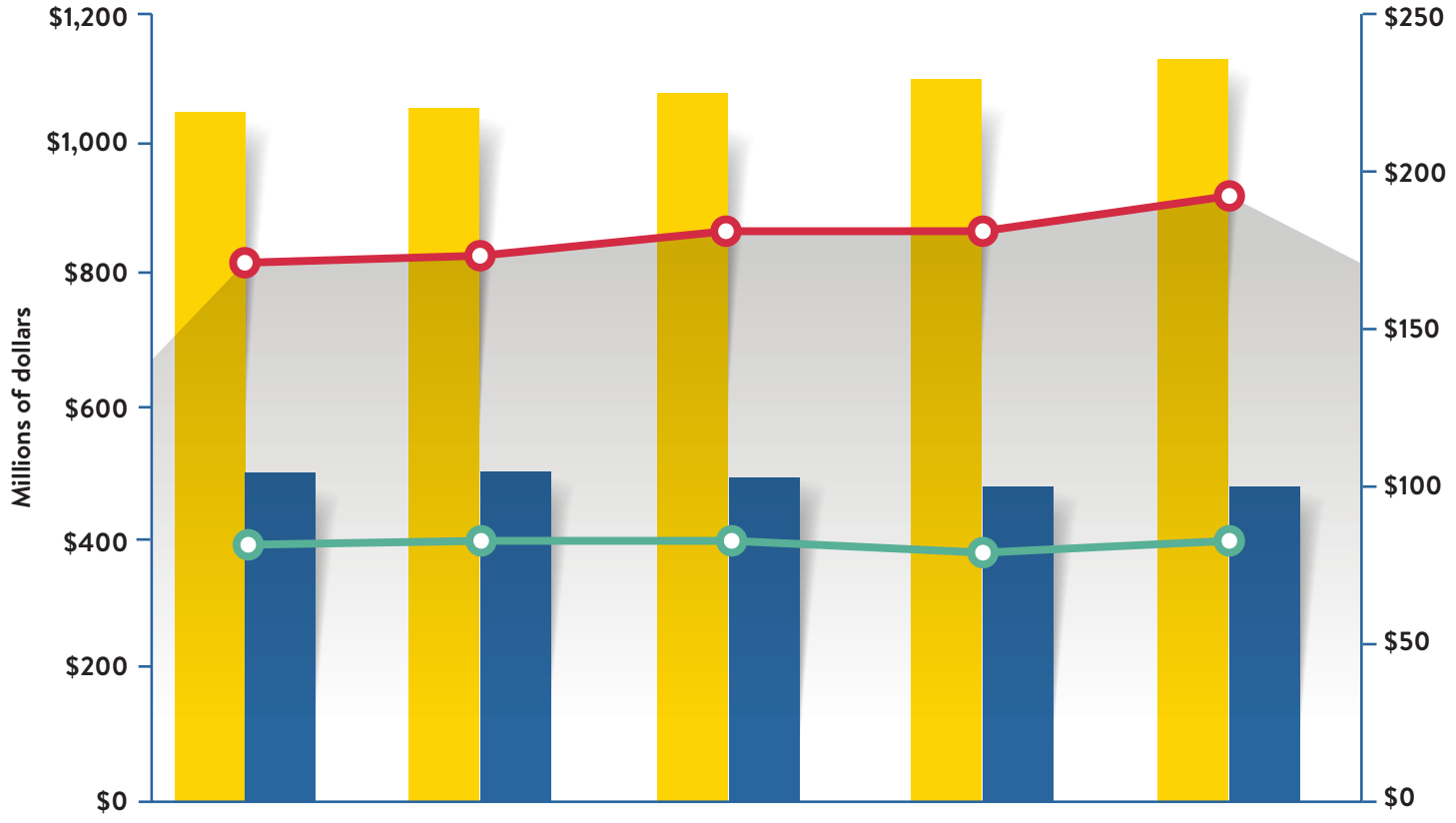
Ambulatory Surgical Center billed charges include; outpatient surgeries, radiology and imaging, post-operative pain management, and spinal injections for pain management.

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



	2011	2012	2013	2014	2015
Charges	240,206,720	263,105,769	270,040,152	284,849,984	331,940,172
Paid	111,583,112	117,762,279	118,452,447	125,905,896	143,758,099
Avg Charge Per Line Item	9,532	10,822	11,739	12,618	14,289
Avg Paid Per Line Item	4,428	4,844	5,149	5,577	6,188
Number of Bills	25,199	24,312	23,004	22,575	23,231

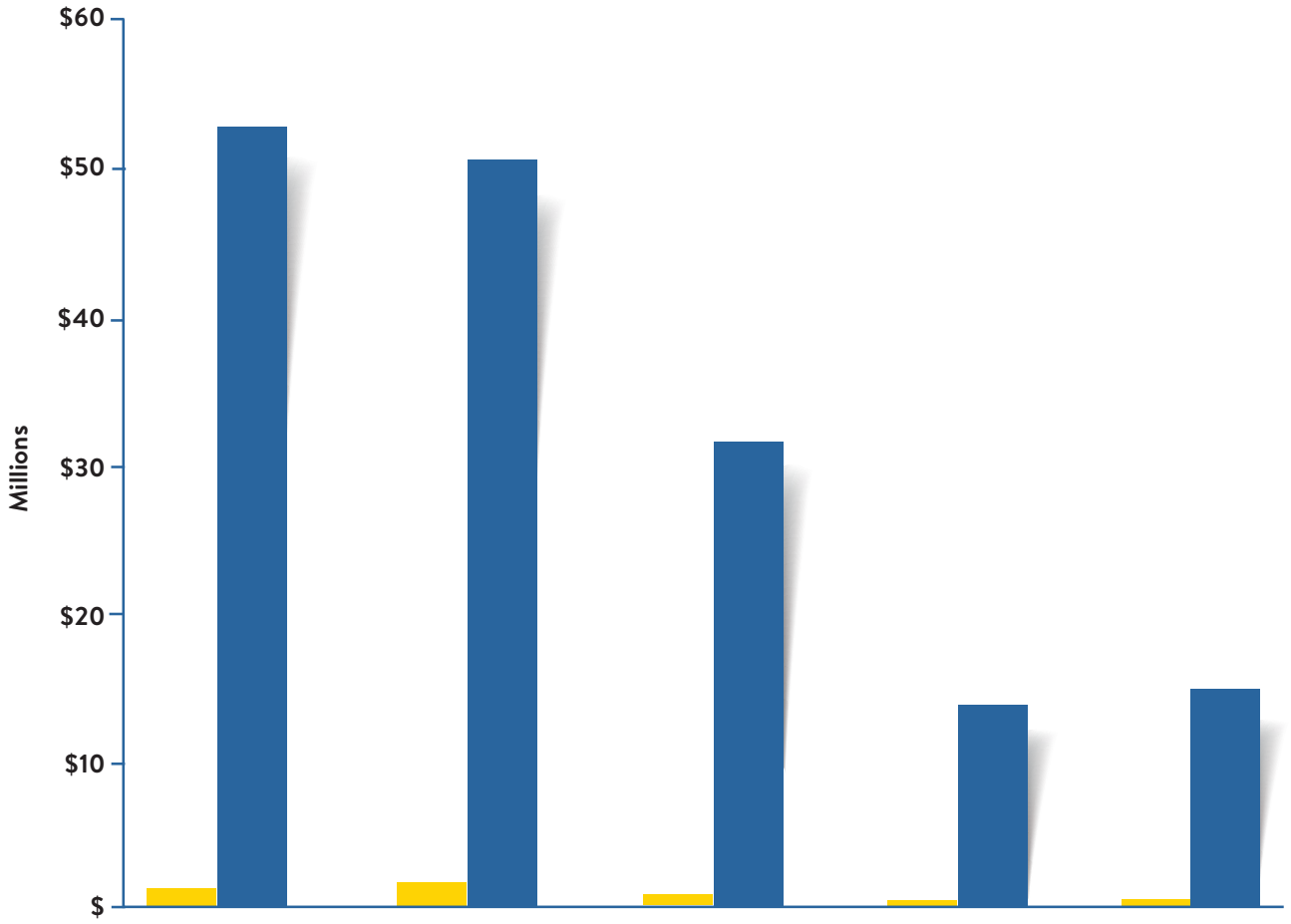
TOTAL CHARGES AND TOTAL PAID FOR HEALTH CARE PROVIDER SERVICES



	2011	2012	2013	2014	2015
Charges	1,055,599,677	1,065,772,212	1,088,855,680	1,105,093,569	1,138,586,525
Paid	507,945,436	506,836,092	499,899,199	491,545,393	486,991,596
Avg Chg Per Line Item	172	174	180	181	194
Avg Paid Per Line Item	83	83	83	80	83

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

PHARMACY VS. PHYSICIAN REPACKAGED DRUG PAYMENTS



	2011	2012	2013	2014	2015
Pharmacy Repackaged	1,071,147	1,421,244	685,361	338,818	370,523
Physician Repackaged	52,591,981	50,159,549	31,098,558	13,613,186	14,375,182

Note: Changes to the reimbursement methodology for repackaged drugs became effective on July 1, 2013.

TOP TEN PHYSICIAN REPACKAGED DRUGS

Drug Name	2011
Tramadol HCL	35,130
Meloxicam (15 Mg)	20,536
Naproxen	18,256
Carisoprodol	17,218
Meloxicam (7.5 Mg)	15,503
Cyclobenzaprine HCL	14,977
Ibuprofen (800 Mg)	14,338
Omeprazole	13,464
Tramadol HCL/Acetaminophen	11,220
Ibuprofen (600 Mg)	10,804

Drug Name	2012
Tramadol HCL	36,534
Meloxicam (15 Mg)	20,450
Naproxen	16,329
Omeprazole	15,269
Cyclobenzaprine HCL	14,519
Meloxicam (7.5 Mg)	13,860
Carisoprodol	13,464
Ibuprofen (800 Mg)	12,237
Ibuprofen (600 Mg)	10,493
Tramadol HCL/Acetaminophen	8,594

Drug Name	2013
Tramadol HCL	21,049
Meloxicam (15 Mg)	12,298
Meloxicam (7.5 Mg)	10,388
Naproxen	8,804
Omeprazole	8,460
Ibuprofen (800 Mg)	7,872
Cyclobenzaprine HCL	7,152
Carisoprodol	5,740
Ibuprofen (600 Mg)	5,696
Tramadol HCL/Acetaminophen	4,076

Drug Name	2014
Tramadol HCL	7,677
Meloxicam (15 Mg)	6,518
Meloxicam (7.5 Mg)	5,346
Naproxen	4,596
Ibuprofen (800 Mg)	3,581
Cyclobenzaprine HCL (10 Mg)	3,399
Tramadol HCL	3,003
Cyclobenzaprine HCL (7.5 Mg)	2,827
Omeprazole	2,649
Ibuprofen (600 Mg)	2,614

Drug Name	2015
Meloxicam (15 Mg)	7,372
Tramadol HCL (50 Mg)	5,042
Meloxicam (7.5 Mg)	4,732
Naproxen	4,214
Ibuprofen (800 Mg)	3,612
Cyclobenzaprine HCL (7.5 Mg)	3,555
Cyclobenzaprine HCL (10 Mg)	3,315
Tramadol HCL (150 Mg)	3,005
Ibuprofen (600 Mg)	2,596
Omeprazole	2,547

TOP TEN PHARMACY REPACKAGED DRUGS

Drug Name	2011
Ibuprofen (800 Mg)	1,688
Tramadol HCL	833
Ibuprofen (600 Mg)	678
Meloxicam (7.5 Mg)	415
Meloxicam (15 Mg)	381
Carisoprodol	355
Naproxen	345
Cyclobenzaprine HCL	301
Lidoderm	167
Etodolac	156

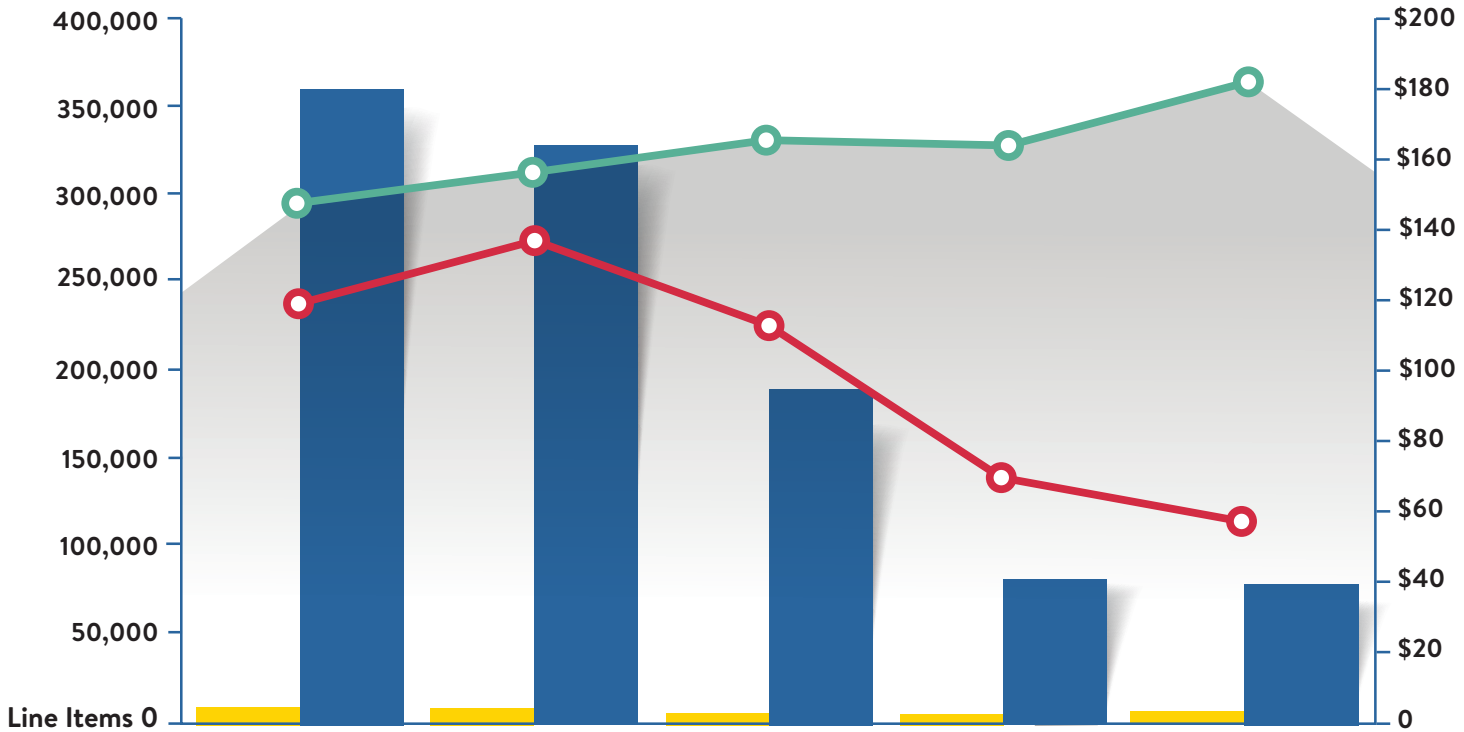
Drug Name	2012
Ibuprofen (800 Mg)	1,655
Ibuprofen (600 Mg)	912
Tramadol HCL	819
Meloxicam (7.5 Mg)	556
Meloxicam (15 Mg)	454
Naproxen	383
Carisoprodol	306
Omeprazole	296
Cyclobenzaprine HCL	291
Speedgel RX	215

Drug Name	2013
Ibuprofen (800 Mg)	1,396
Ibuprofen (600 Mg)	807
Tramadol HCL	307
Meloxicam (7.5 Mg)	301
Meloxicam (15 Mg)	194
Clopidogrel	174
Naproxen	131
Carisoprodol	111
Tizanidine HCL	109
Cyclobenzaprine HCL	102

Drug Name	2014
Ibuprofen (800 Mg)	1,284
Cyclobenzaprine HCL (10 Mg)	1,102
Ibuprofen (600 Mg)	568
Cyclobenzaprine HCL (5 Mg)	319
Amlodipine Besylate	84
Pantroprazole Sodium	78
Tramadol HCL	74
Meloxicam	68
Escitalopram	67
Naproxen	60

Drug Name	2015
Cyclobenzaprine HCL (10 Mg)	2,010
Ibuprofen (800 Mg)	1,613
Cyclobenzaprine HCL (5 Mg)	614
Ibuprofen (600 Mg)	590
Amlodipine Besylate	116
Fluoxetine HCL	98
Meloxicam	87
Escitalopram	82
Sertraline HCL	80
Losartan Potassium	58

PHARMACY VS. PHYSICIAN REPACKAGED DRUGS

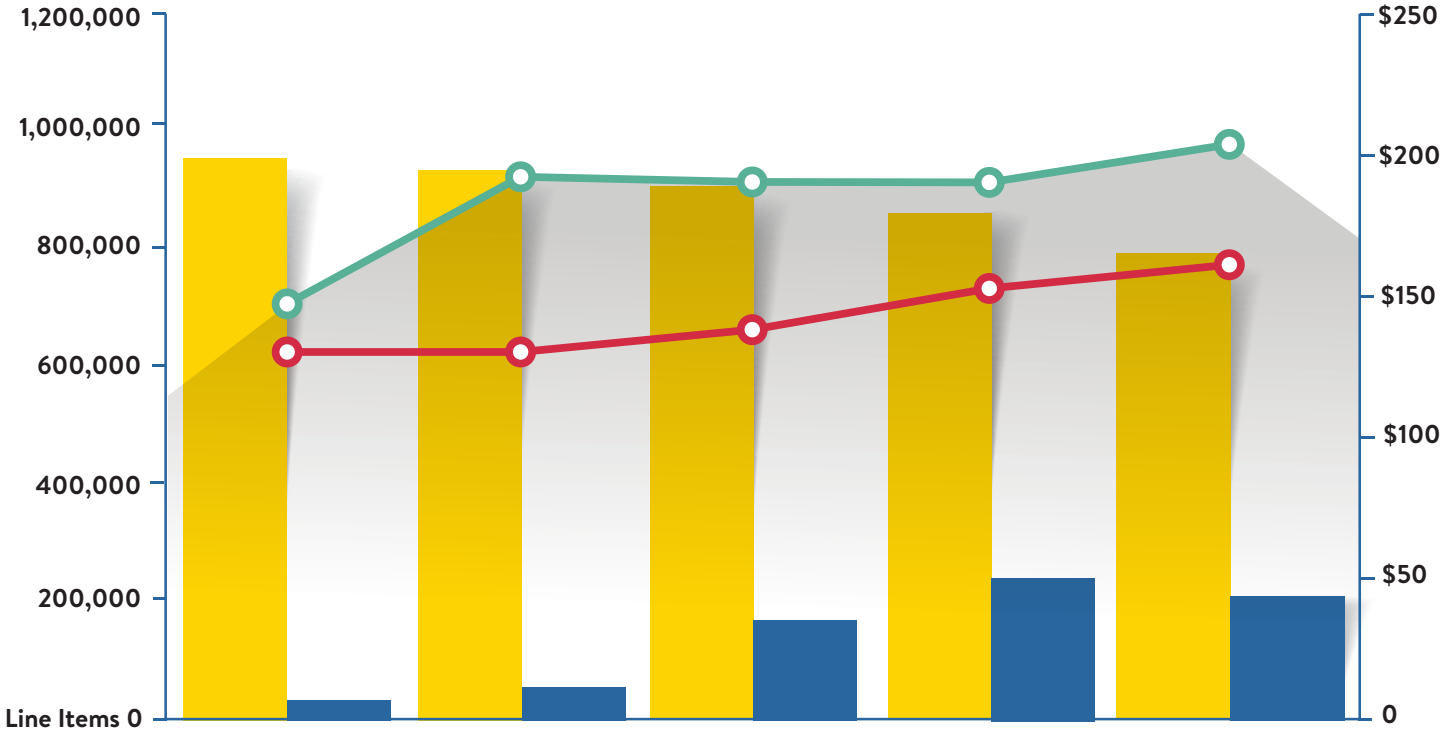


	2011	2012	2013	2014	2015
Pharmacy Repackaged Line Items	8,976	10,376	6,079	4,823	6,471
Physician Repackaged Line Items	357,573	320,560	188,374	83,351	78,910
Pharmacy Repackaged Avg $ Paid Per Line Item	119	137	113	70	57
Physician Repackaged Avg $ Paid Per Line Item	147	156	165	163	182

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.

Note: Changes to the reimbursement methodology for repackaged drugs became effective July 1, 2013.

PHARMACY VS. PHYSICIAN NON-REPACKAGED DRUGS



	2011	2012	2013	2014	2015
Pharmacy Non-repackaged Line Items	953,926	936,651	901,211	859,101	795,464
Physician Non-repackaged Line Items	42,305	61,161	169,193	246,831	220,263
Pharmacy Non-repackaged Avg $ Paid Per Line Items	130	131	139	154	161
Physician Non-repackaged Avg $ Paid Per Line Item	147	192	191	190	204

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 NON-REPACKAGED DRUG PAYMENTS

	2011	2012	2013	2014	2015
Pharmacy Non-repackaged	123,845,908	122,885,523	125,119,954	132,034,575	128,134,730
Physician Non-repackaged	6,197,831	11,718,010	32,388,346	46,811,805	44,999,772

TOP TEN PHYSICIAN NON-REPACKAGED DRUGS

Drug Name	2011
Medrox	3,139
Triple Antibiotic	2,094
Mediderm	1,566
Tramadol HCL	1,489
Naproxen	1,430
Dendracin Neurodendraxcin	1,390
Theramine	1,210
Cyclobenzaprine HCL	1,141
Ibuprofen	1,100
Cidaflex	1,067

Drug Name	2012
Medrox (0.0375% - 5% - 20%)	9,857
Theramine	2,725
Terocin	2,584
Tramadol HCL	2,177
Sentra PM	1,945
Naproxen	1,702
Dendracin Neurodendraxcin	1,573
Cyclobenzaprine HCL	1,494
Trepadone	1,352
Medrox (0.0375% - 5%)	1,341

Drug Name	2013
Tramadol HCL (50 Mg)	13,311
Meloxicam (15 Mg)	9,166
Meloxicam (7.5 Mg)	9,076
Naproxen	6,364
Omeprazole	6,194
Cyclobenzaprine HCL	4,842
Tramadol HCL/Acetaminophen	4,432
Cyclobenzaprine HCL	4,014
Tramadol HCL (150 Mg)	3,966
Ibuprofen	3,768

Drug Name	2014
Tramadol HCL (50 Mg)	17,693
Meloxicam (7.5 Mg)	16,928
Meloxicam (15 Mg)	15,798
Omeprazole	9,235
Tramadol HCL (150 Mg)	8,466
Naproxen	8,432
Cyclobenzaprine HCL (10 Mg)	8,216
Cyclobenzaprine HCL (7.5 Mg)	7,004
Ibuprofen (800 Mg)	6,817
Ibuprofen (600 Mg)	6,419

Drug Name	2015
Meloxicam (7.5 Mg)	15,212
Meloxicam (15 Mg)	15,114
Tramadol HCL (50 Mg)	10,635
Cyclobenzaprine HCL (7.5 Mg)	8,060
Omeprazole	7,972
Cyclobenzaprine HCL (10 Mg)	7,182
Naproxen	7,181
Tramadol HCL (150 Mg)	6,346
Ibuprofen	6,103
Lidorx	6,092

TOP TEN PHARMACY NON-REPACKAGED DRUGS

Drug Name	2011
Tramadol HCL	39,846
Hydrocodone Bitartrate-Acetaminophe (500 Mg - 5 Mg)	33,682
Cyclobenzaprine HCL	27,471
Celebrex	20,904
Naproxen	19,562
Ibuprofen	16,417
Lipoderm	16,270
Carisoprodol	15,146
Oxycodone HCL-Acetaminophen	14,656
Hydrocodone Bitartrate-Acetaminophe (500 Mg - 7.5 Mg)	14,379

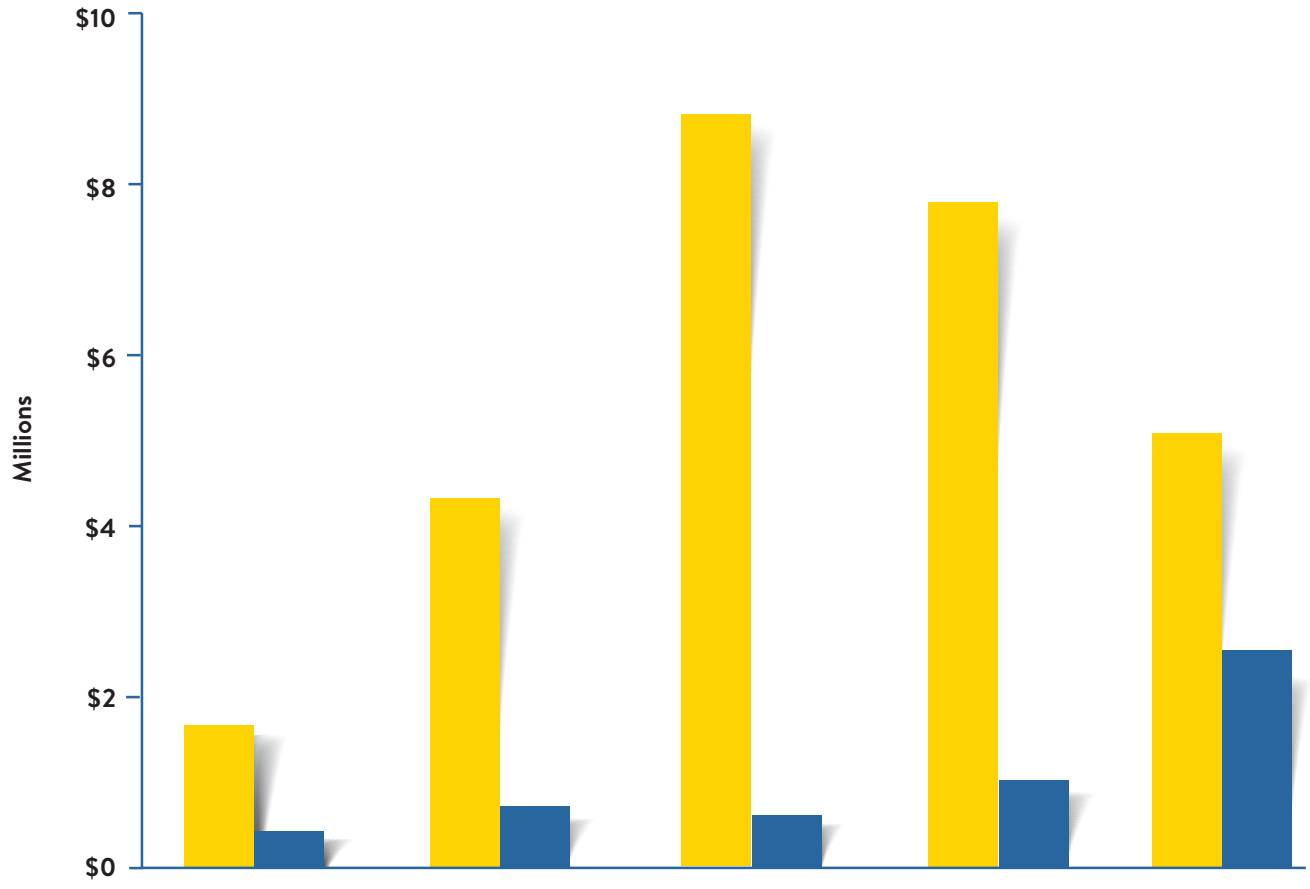
Drug Name	2012
Tramadol HCL	45,327
Cyclobenzaprine HCL	29,024
Hydrocodone Bitartrate-Acetaminophe (500 Mg - 5 Mg)	28,915
Celebrex	20,116
Naproxen	18,813
Ibuprofen	16,549
Oxycodone HCL-Acetaminophen	16,428
Lipoderm	15,640
Hydrocodone Bitartrate-Acetaminophe (325 Mg - 10 Mg)	15,562
Meloxicam	15,490

Drug Name	2013
Tramadol HCL	48,151
Cyclobenzaprine HCL	27,879
Hydrocodone Bitartrate-Acetaminophe (500 Mg - 5 Mg)	20,895
Naproxen	18,827
Celebrex	18,420
Ibuprofen	17,541
Hydrocodone Bitartrate-Acetaminophe (325 Mg - 5 Mg)	17,530
Meloxicam	16,475
Oxycodone HCL-Acetaminophen	15,402
Hydrocodone Bitartrate-Acetaminophe (325 Mg - 5 Mg)	15,380

Drug Name	2014
Tramadol HCL	45,098
Hydrocodone Bitartrate-Acetaminophe (325 Mg - 10 Mg)	30,157
Cyclobenzaprine HCL	26,860
Hydrocodone Bitartrate-Acetaminophe (325 Mg - 10 Mg)	26,230
Naproxen	18,728
Oxycodone HCL-Acetaminophen	17,095
Meloxicam	16,985
Hydrocodone Bitartrate-Acetaminophe (325 Mg - 7.5 Mg)	16,701
Celebrex	15,704
Ibuprofen	14,484

Drug Name	2015
Tramadol HCL	36,393
Cyclobenzaprine HCL	25,696
Hydrocodone Bitartrate-Acetaminophe (325 Mg - 5 Mg)	25,447
Hydrocodone Bitartrate-Acetaminophe (325 Mg - 10 Mg)	21,190
Oxycodone HCL-Acetaminophen (325 Mg - 5 Mg)	18,541
Naproxen	17,186
Meloxicam	16,543
Oxycodone HCL-Acetaminophen (325 Mg - 10 Mg)	15,217
Ibuprofen	14,369
Hydrocodone Bitartrate-Acetaminophe (325 Mg - 7.5 Mg)	13,052

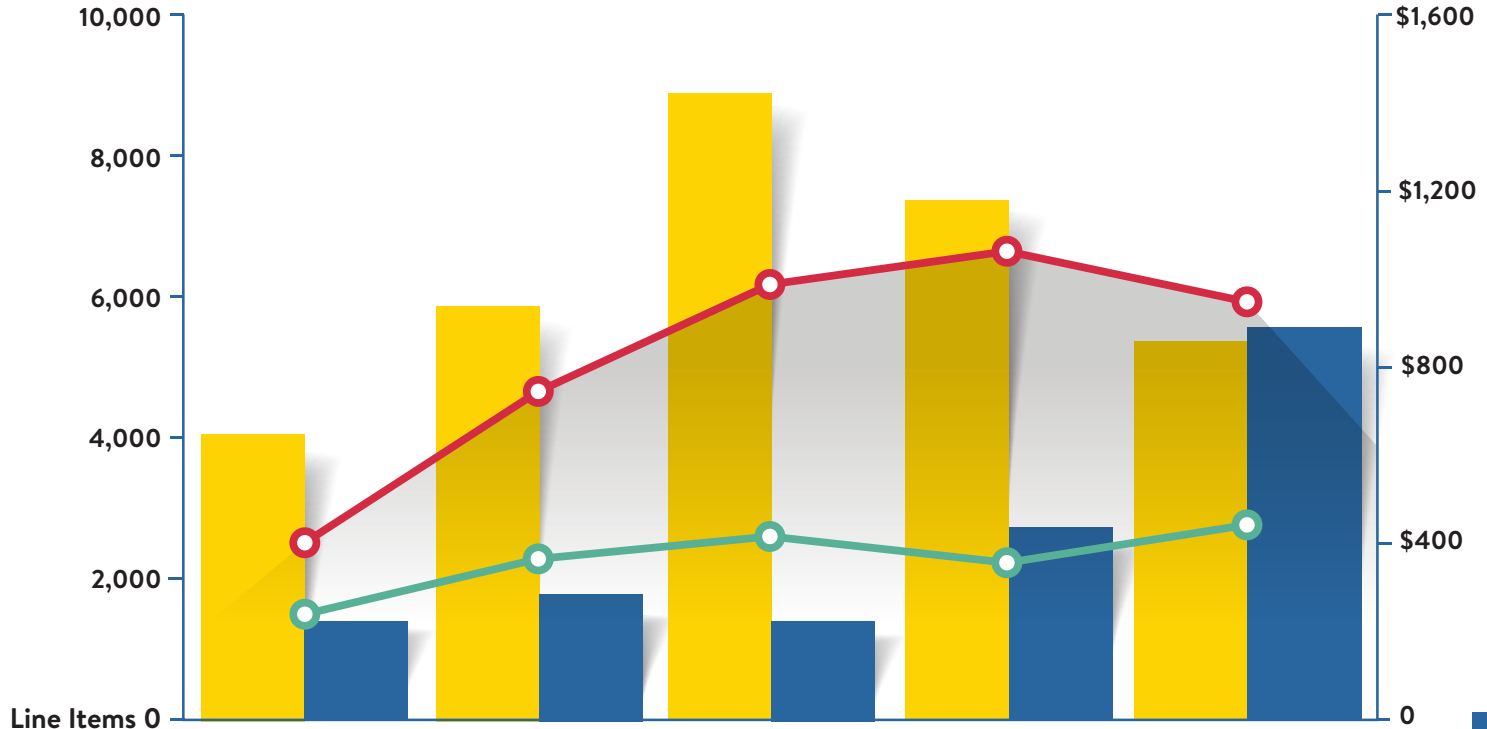
PHARMACY VS. PHYSICIAN COMPOUND DRUG PAYMENTS



	2011	2012	2013	2014	2015
Pharmacy Compound	1,623,977	4,353,422	8,845,612	7,841,763	5,104,280
Physician Compound	343,731	671,622	588,478	1,002,036	2,492,914

The Federal Drug Administration (FDA) defines compounding as "a practice in which a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient." Compound drugs are not FDA-approved, meaning that FDA does not verify the safety, or effectiveness of compounded drugs.

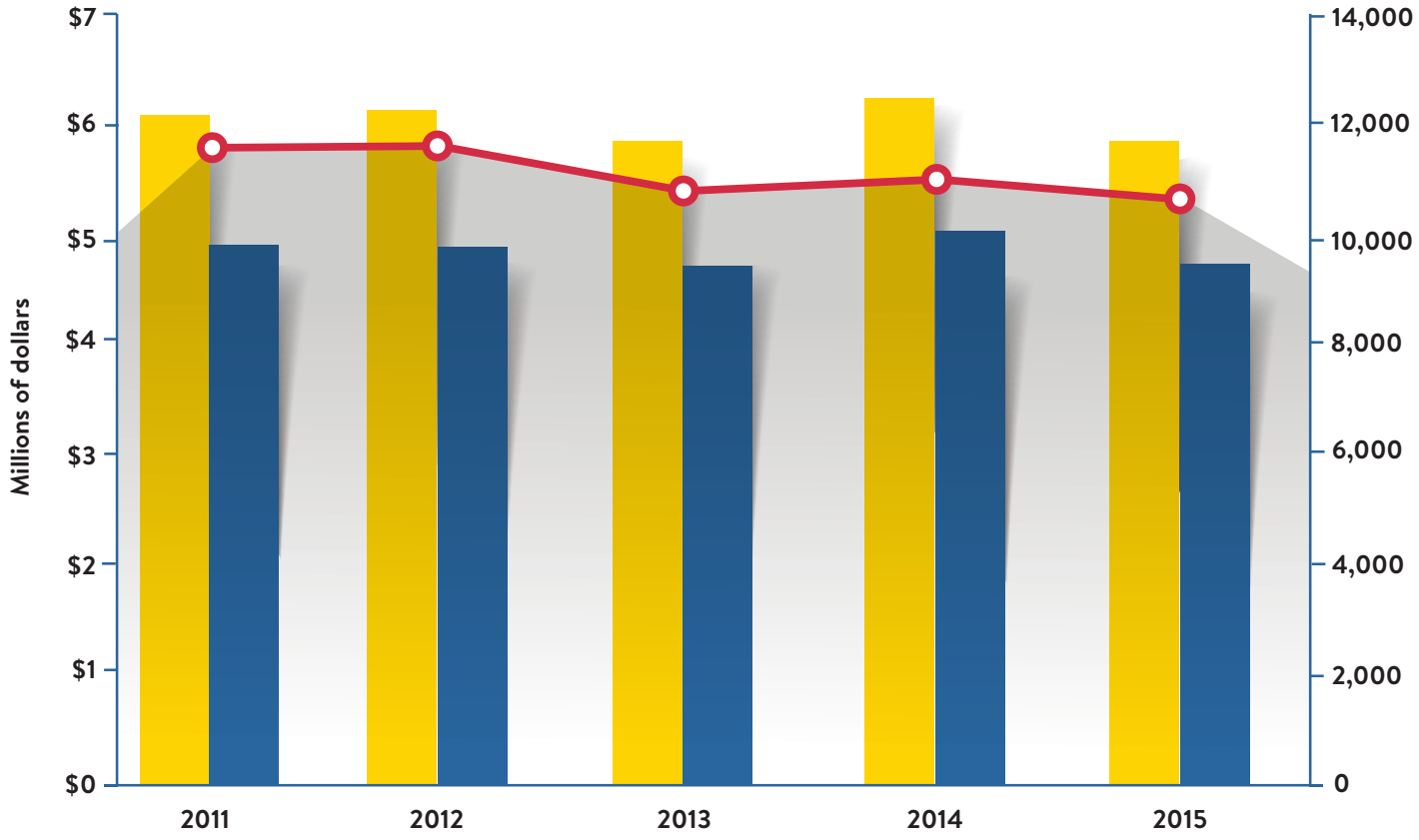
PHYSICIAN VS. PHARMACY COMPOUND DRUGS



	2011	2012	2013	2014	2015
Pharmacy Compound Line Items	4,100	5,874	8,950	7,358	5,380
Physician Compound Line Items	1,390	1,820	1,403	2,791	5,575
Pharmacy Compound Avg Billed $ Per Line Items	396	741	988	1,066	949
Physician Compound Avg Billed $ Per Line Items	247	369	419	359	447

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

TOTAL CHARGES AND TOTAL PAID FOR DENTAL SERVICES



	2011	2012	2013	2014	2015
Charges	6,041,692	6,114,348	5,834,292	6,244,355	5,827,694
Paid	4,887,736	4,908,445	4,699,735	5,002,178	4,750,836
Total Line Items	11,552	11,575	10,788	10,979	10,614

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

LOST-TIME CLAIMS DATA

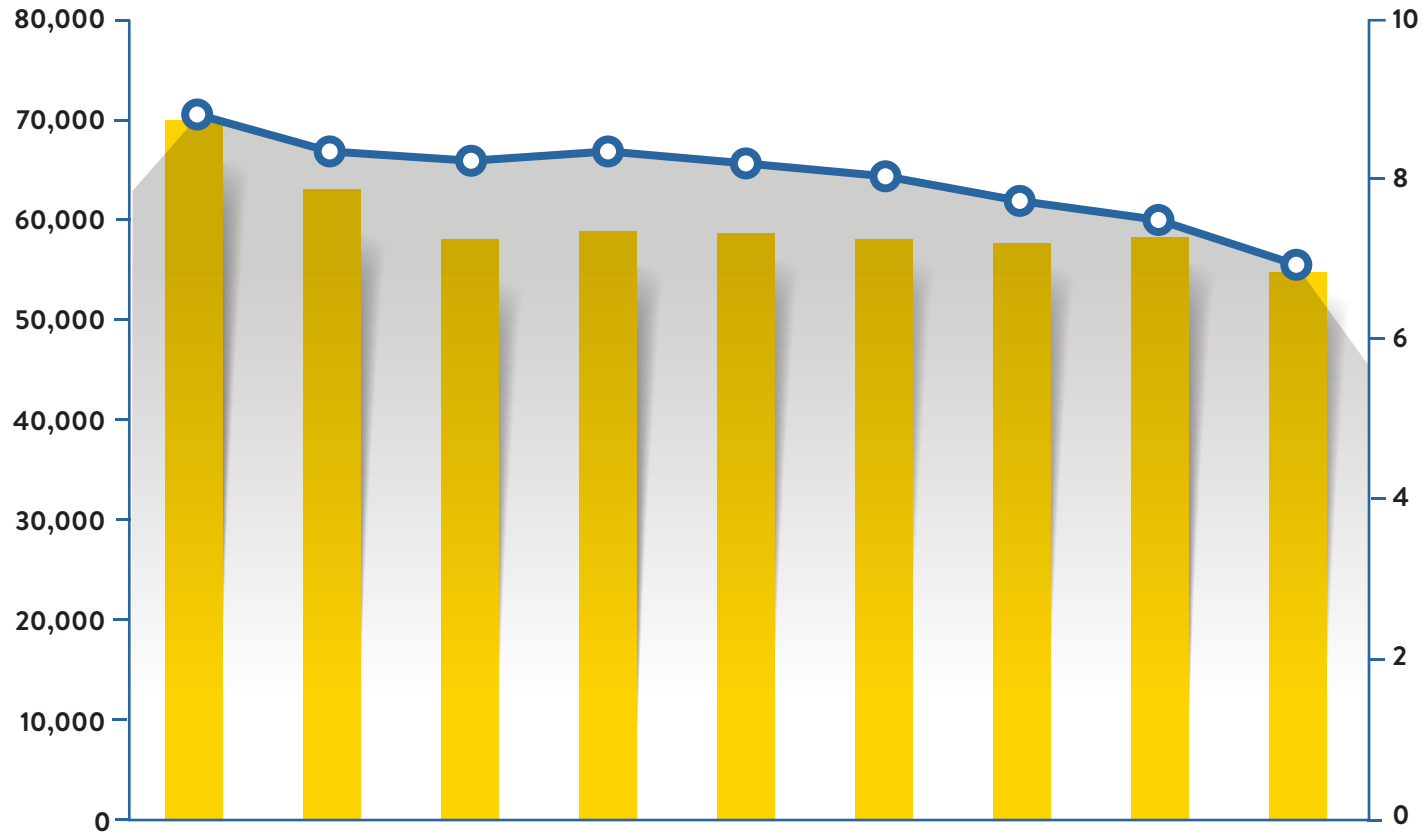
Workers who sustain a compensable injury are entitled to receive medically necessary treatment under Florida's workers' compensation statute. If the injury results in disability for more than seven days, the injured worker is entitled to payment for a portion of lost wages. Injuries resulting in permanent 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 2015 LOST-TIME CLAIMS

Industry Type	Number of Claims
Administrative, Support, Waste Management, Remediation	8,018
Retail Trade	6,080
Construction	5,540
Health Care & Social Assistance	5,352
Accommodation & Food Services	4,507
Public Administration	4,295
Transportation & Warehousing	3,858
Manufacturing	3,694
Educational Services	2,928
Wholesale Trade	2,104

LOST-TIME CLAIMS AND LOST-TIME CLAIM RATE*



	2007	2008	2009	2010	2011	2012	2013	2014	2015
Lost-Time Claims	69,357	62,834	57,864	58,659	58,504	57,930	57,726	58,031	54,564
Rate Per 1,000 Employees	8.8	8.3	8.2	8.3	8.2	8.0	7.7	7.5	6.9

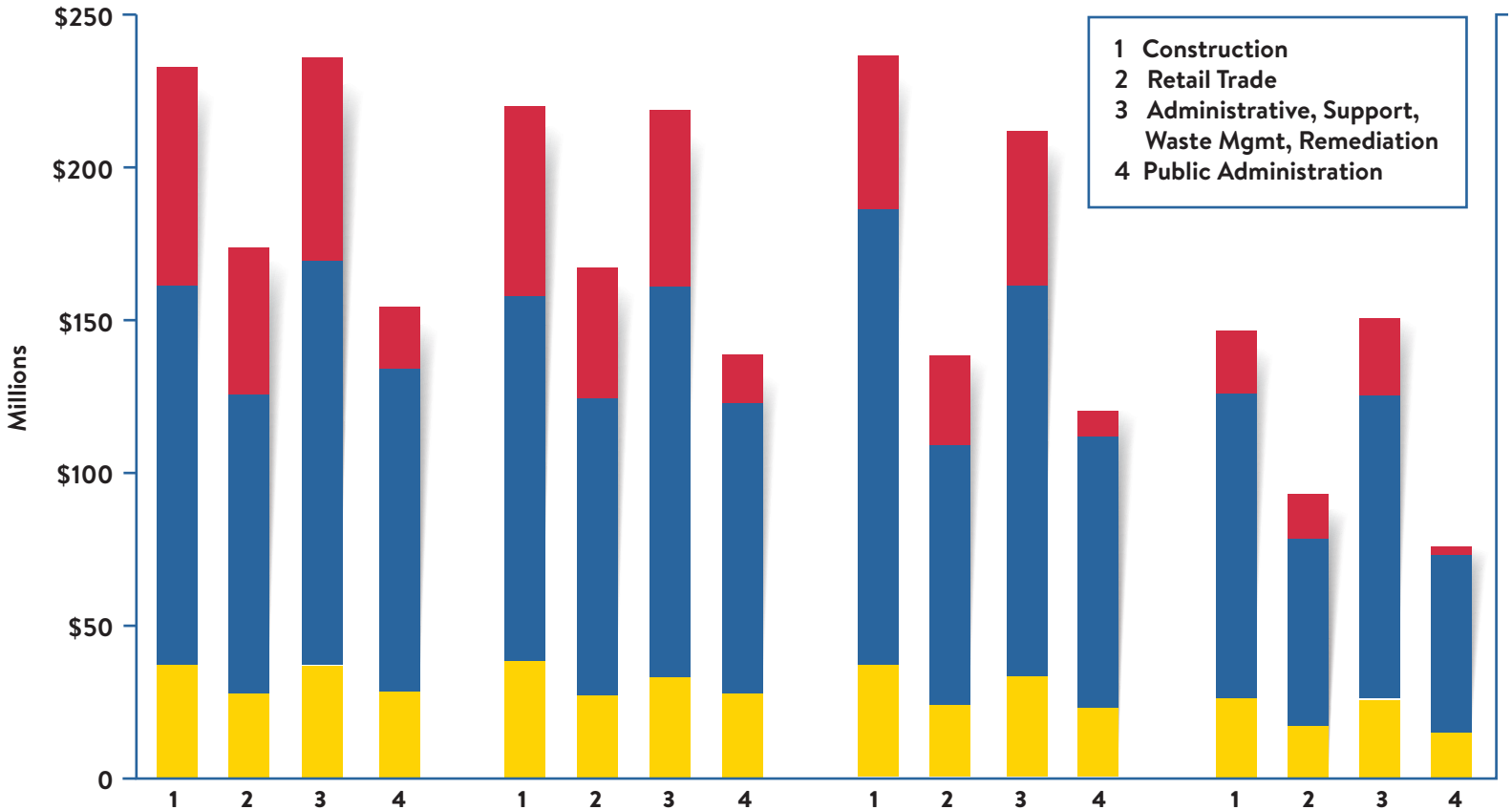
* Source: Florida Department of Economic Opportunity, Bureau of Labor Market Statistics.

Released: March 14, 2016.

Lost-Time claim frequencies as of June 30, 2016.

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 2012 being deemed mature.

BENEFIT PAYMENTS FOR THE FOUR LEADING INDUSTRIAL CLASSIFICATIONS*



	2012				2013*				2014*				2015*			
Injury Year	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Indemnity	37	28	38	29	38	26	33	26	37	23	34	23	26	16	25	14
Medical	123	99	133	106	121	100	129	97	150	84	84	88	98	61	101	58
Settlement	72	47	65	19	62	42	58	15	50	33	50	9	23	15	24	2

*Preliminary Data

MEDICAL PAYMENTS FOR LOST-TIME CLAIMS

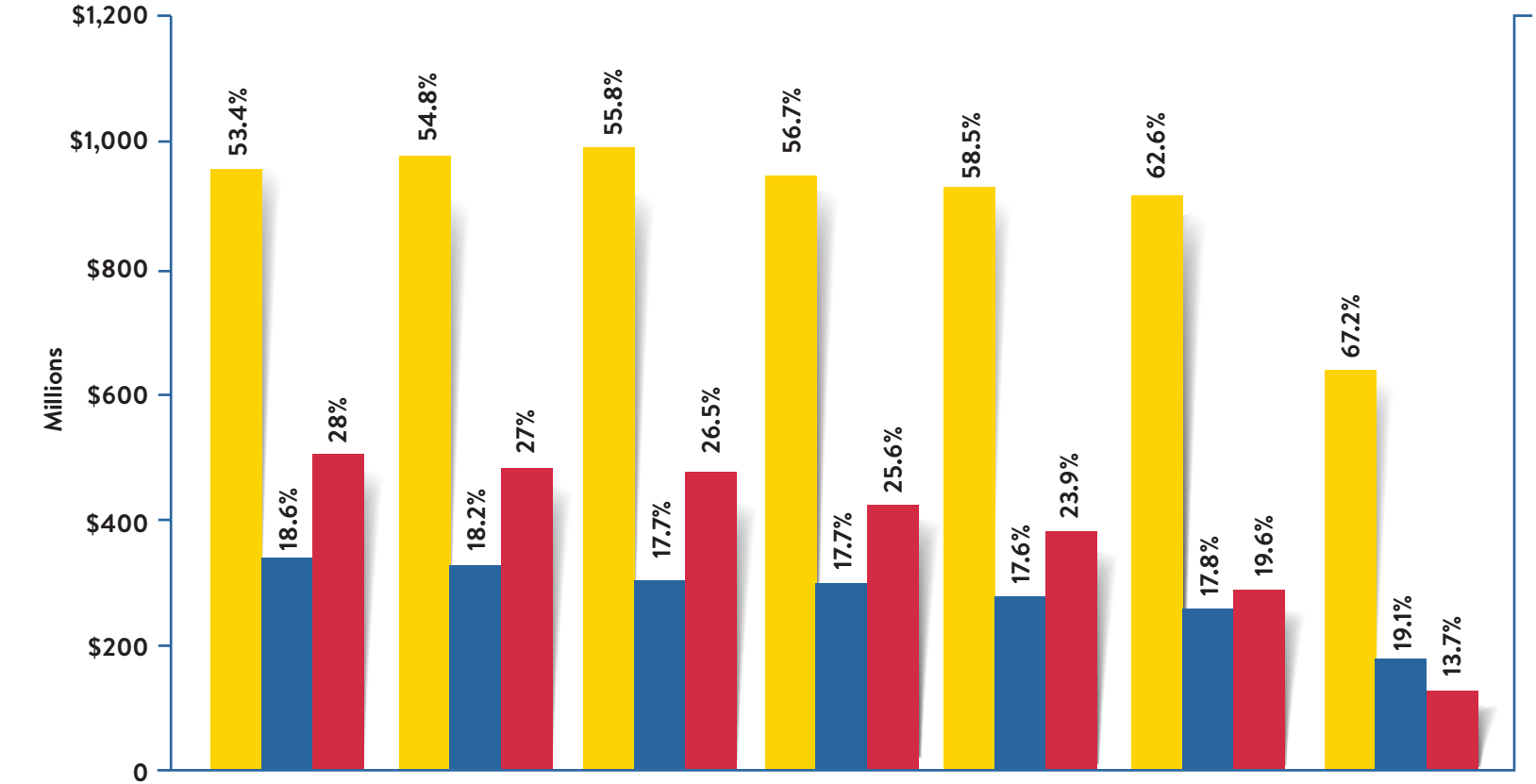
Medically necessary treatment for a work-related injury may involve: the services of physicians, physical therapists, chiropractors, dentists, or other health care providers; services of hospitals, ambulatory surgical centers, or skilled nursing facilities; and medicines, supplies, equipment, and related items such as prosthetic devices or implants. Until recovery is achieved, medical benefits continue.

Claim development differences explain the priority of medical services early in the life of a claim and the increase in settlements as claims progress.

Calendar Year	Health Care Providers, Dental, Ambulatory Surgical Center	Hospital	Pharmacy	All Other Medical
2009	38.32%	38.04%	6.78%	16.87%
2010	33.06%	44.17%	6.03%	16.74%
2011	30.87%	46.13%	5.57%	17.43%
2012	30.53%	48.92%	5.11%	15.44%
2013*	28.97%	51.13%	4.70%	15.20%
2014*	27.45%	53.18%	4.30%	15.07%
2015*	26.04%	56.18%	3.62%	14.16%

*Preliminary Data

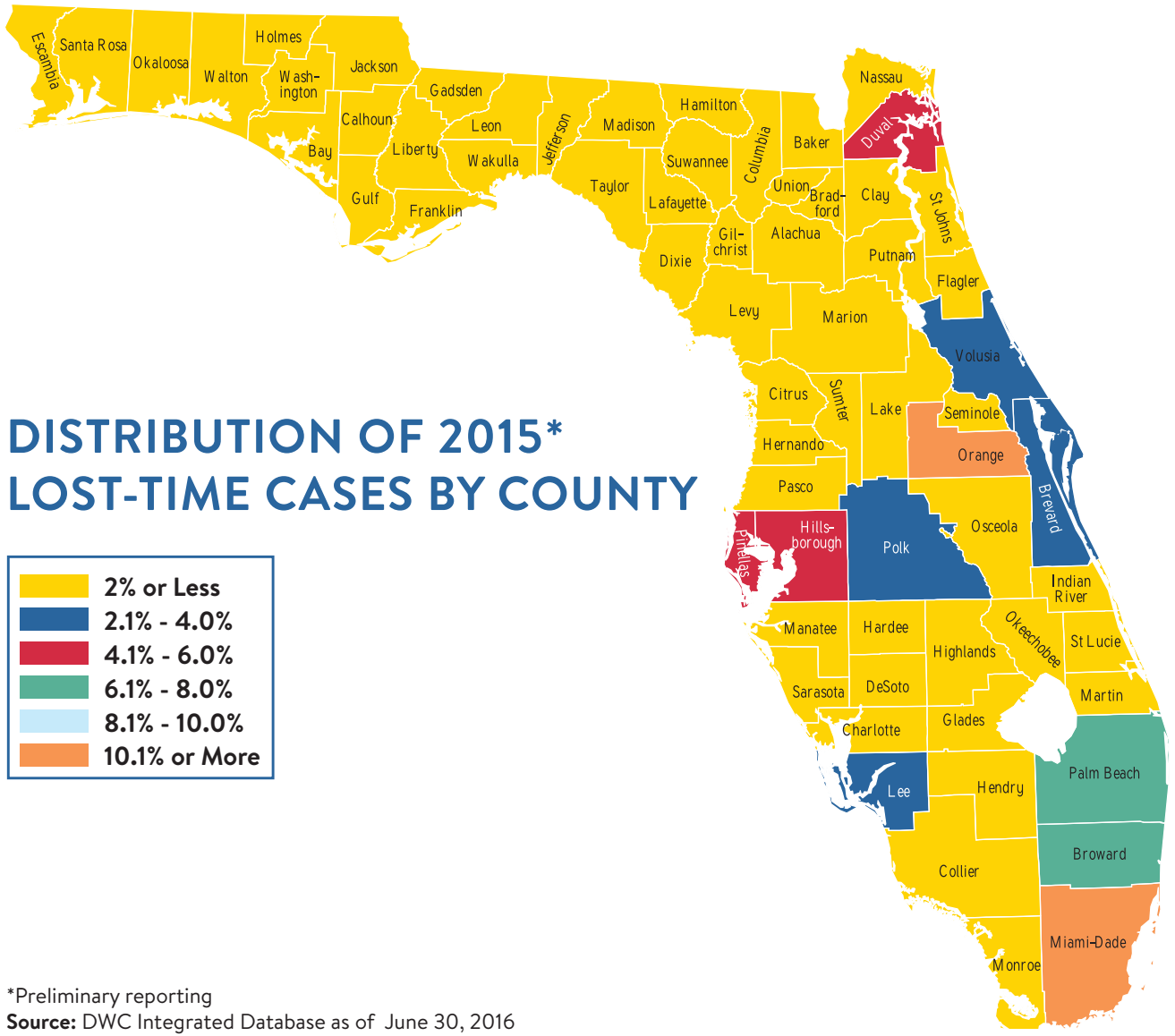
MEDICAL, INDEMNITY, AND SETTLEMENT COSTS FOR LOST-TIME CLAIMS



	2009	2010	2011	2012	2013*	2014*	2015*
Medical	960	977	994	952	931	917	639
Indemnity	335	324	316	297	281	261	182
Settlement	502	481	471	430	381	287	130

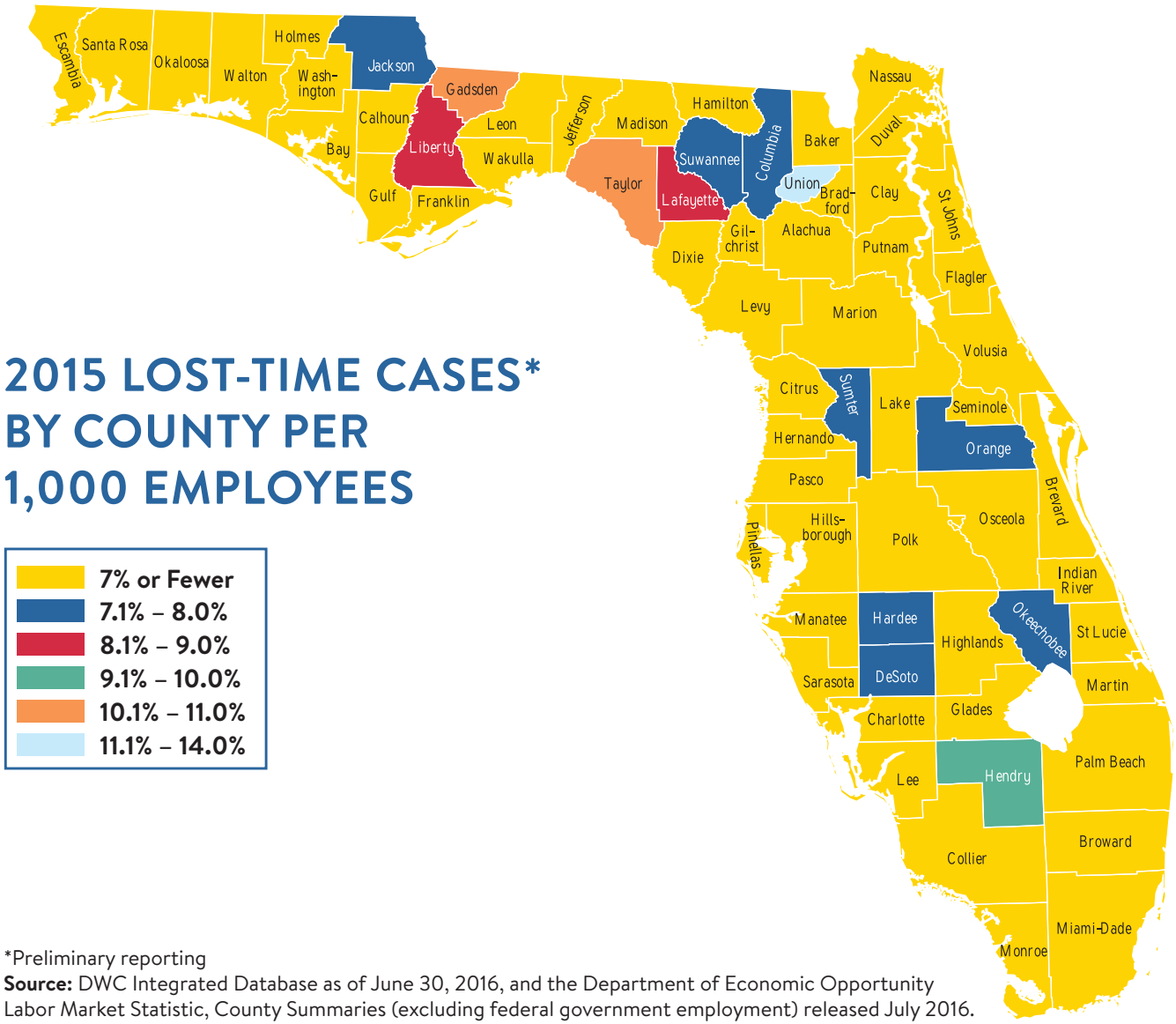
*Preliminary Data

DISTRIBUTION OF 2015* LOST-TIME CASES BY COUNTY



*Preliminary reporting
Source: DWC Integrated Database as of June 30, 2016

2015 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%

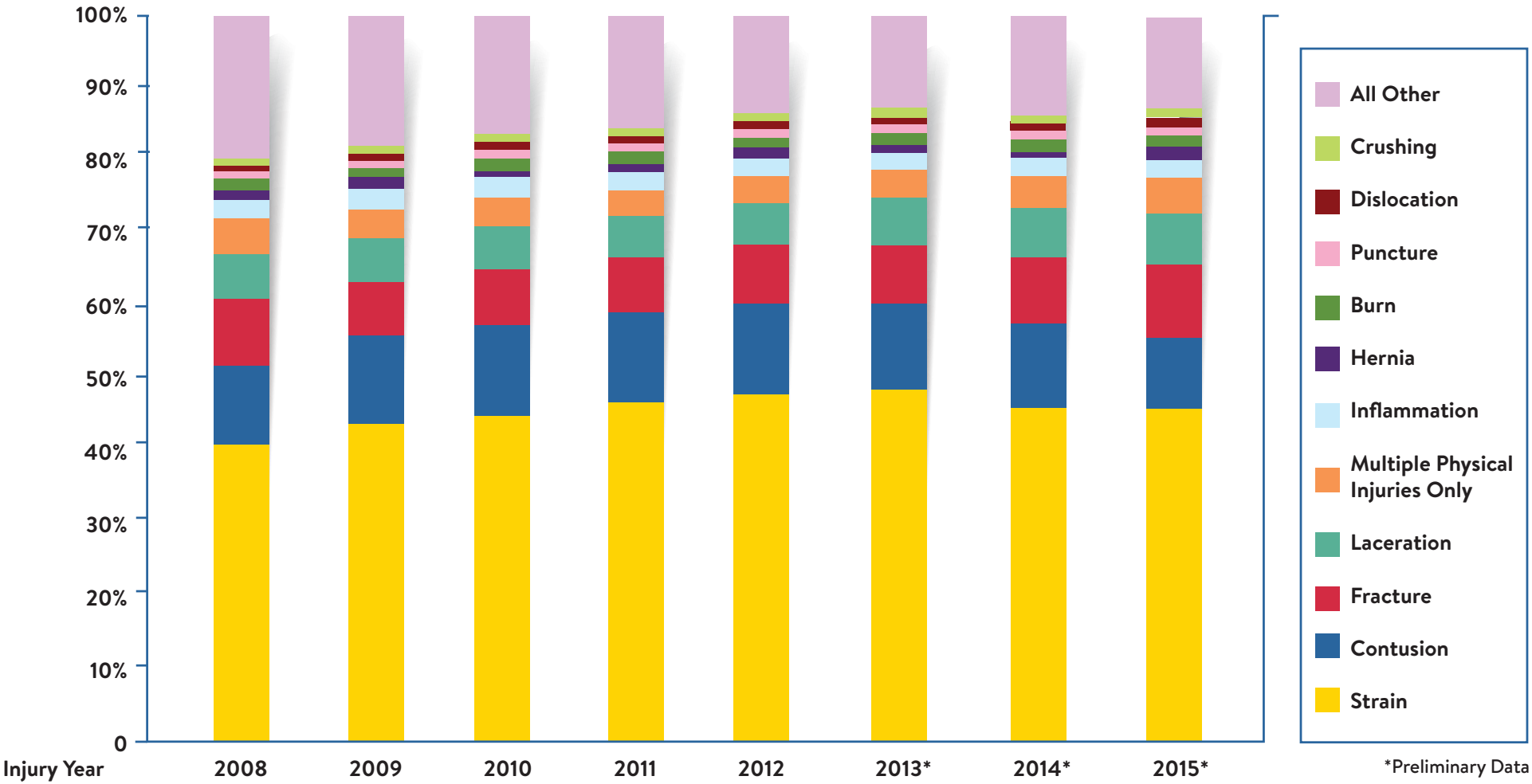
*Preliminary reporting

Source: DWC Integrated Database as of June 30, 2016, and the Department of Economic Opportunity Labor Market Statistic, County Summaries (excluding federal government employment) released July 2016.

INJURY BY NATURE, CAUSE, & BODY PART

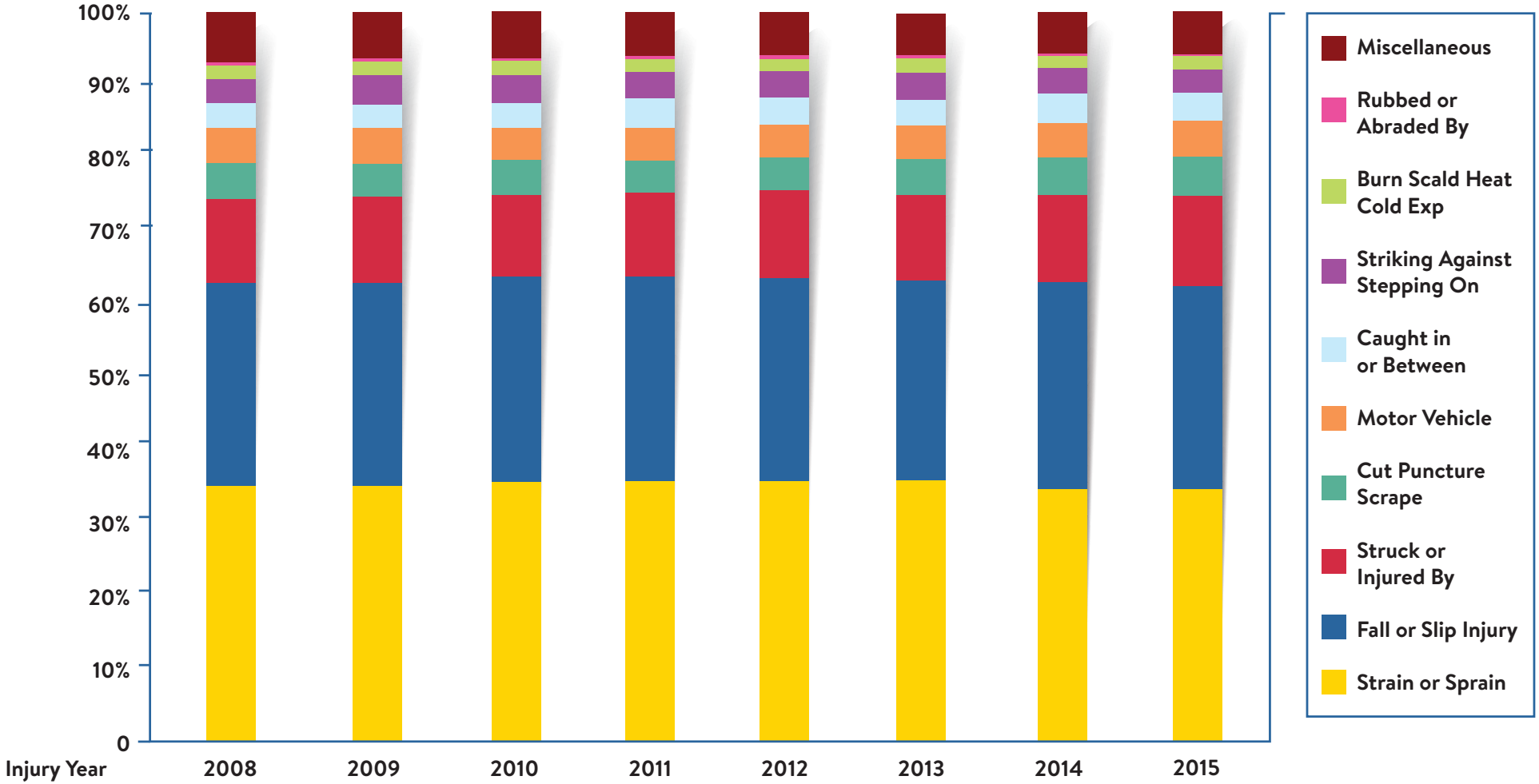
As part of the First Report of Injury or Illness, employers or claim administrators provide information on the nature, cause, and body part of each workplace injury. The following charts summarize that information to depict recent and historical patterns of lost-time injuries. Because the information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

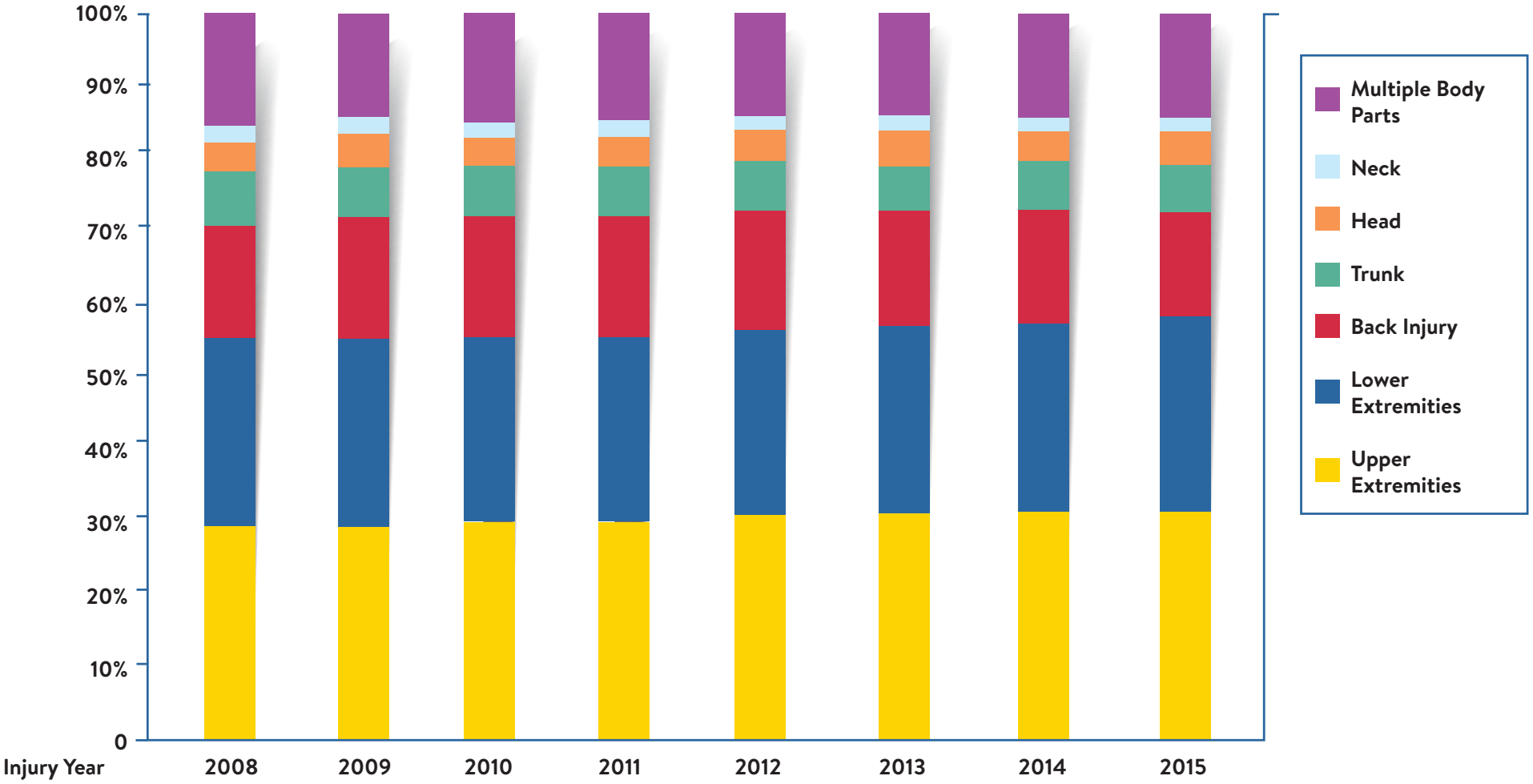


*Preliminary Data

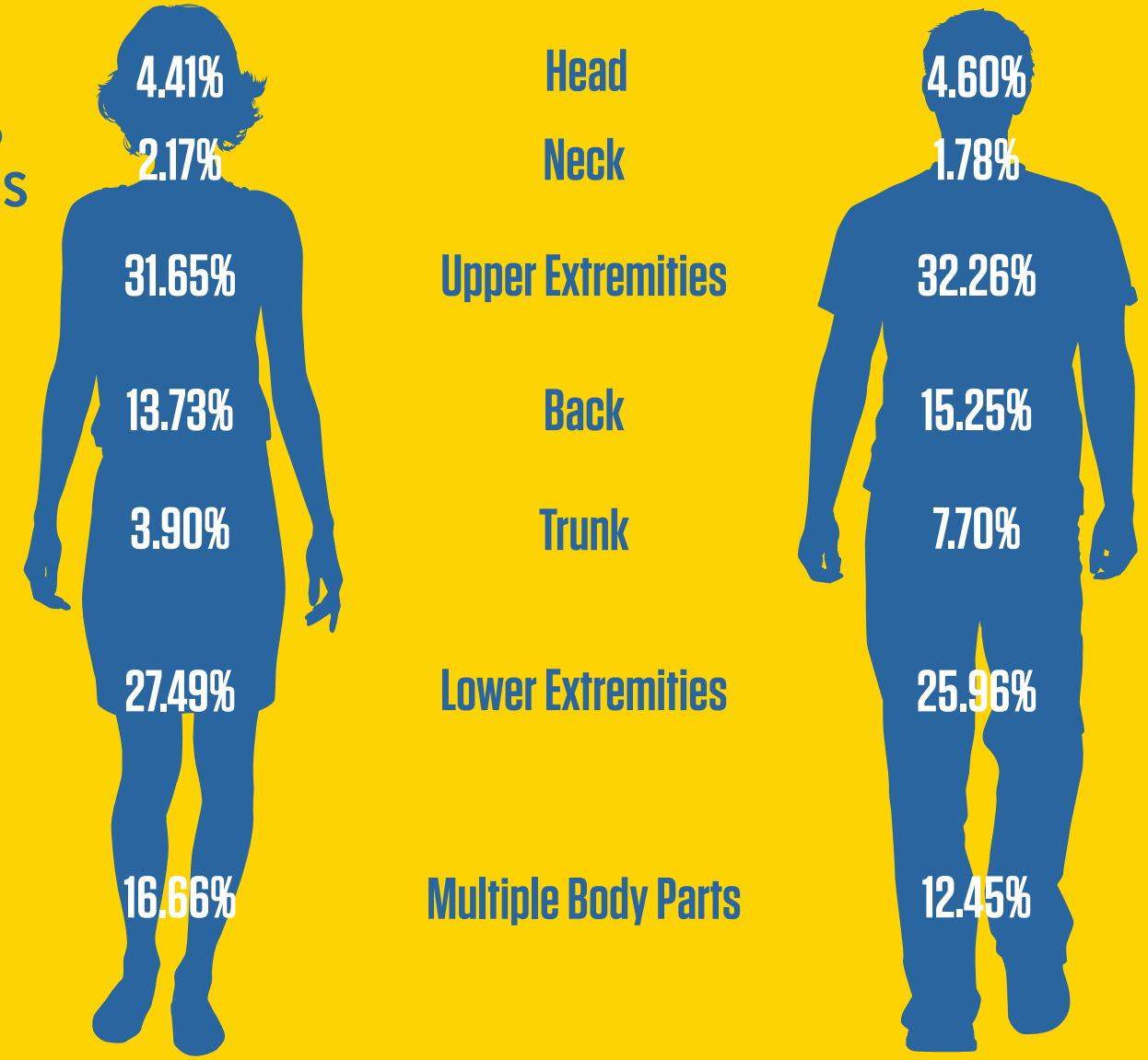
LOST-TIME CLAIMS BY CAUSE OF INJURY



LOST-TIME CLAIMS BY INJURED BODY PART



INJURY BODY PART BY GENDER FOR FY 2015-2016 LOST-TIME CLAIMS



DWC HOTLINES & WEBSITES

HOTLINES:

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/Division/WC/dist_offices.htm**.

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.

Workers' Compensation System Guide:
http://www.myfloridacfo.com/Division/WC/pdf/WC-System-Guide.pdf

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Lisel Laslie, Bureau Chief

Bureau of Compliance: (850) 413-1708
Pam Macon, Bureau Chief

DWC ORGANIZATIONAL CHART

CHIEF FINANCIAL OFFICER

JEFF ATWATER

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

DIVISION OF WORKERS' COMPENSATION

2016 RESULTS & ACCOMPLISHMENTS REPORT